NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 24th September 2020

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
24th September 2020
Virtual Meeting
WCFT
09:30 – 13.00

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 30th July 2020	J Rosser	Decision (d)
4	09.35	Patient Story	L Vlasman	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update - verbal	J Rosser/ H Citrine	Information (v)
6	10.10	COVID-19 Update	H Citrine/ Execs	Information (d)
7	10.30	Communication and Engagement Strategy	A Rose/ A Moore	Approval (d)
PERFORMANCE				
8	10.45	Integrated Performance Report	CEO/NED Chairs	Assurance (d)
QUALITY				
9	11.05	The NHS People Plan	M Gibney	Information (p)
10	11.20	Accountable Officer for Controlled Drugs Annual Report	D Thornton	Assurance (d)
11	11.30	Pharmacy &Medicines Management Annual Report	D Thornton	Assurance (d)
12	11.40	Guardian of Safe Working quarterly report	C Burness	Information (d)
13	12.00	Senior Information Responsible Officer Annual Report	M Burns	Assurance (d)
14	12.10	Workforce Related Equality Standard	M Gibney	Assurance (d)
15	12.25	Workforce Related Disability Standard	M Gibney	Assurance (d)
16	12.30	Revalidation Annual Report (Medical)	A Nicolson	Assurance (d)
GOVERANCE				
17	12.40	Quality Committee Chair's Report *To follow*	S Crofts	Assurance (d) *To follow*
18	12.45	Business Performance Committee Chair's Report	B Spicer	Assurance (v)
19	12.50	Research Development and Innovation Committee Chair's Report	S Crofts	Assurance (d)
CONCLUDING BUSINESS				
20	12.55	AOB Feedback from NED discussions with operational staff	J Rosser	Information

Date and Time of Next Meeting: 5th November 2020
Via MS Teams

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

30th July 2020

Present:

Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Ms S Samuels	Non-Executive Director
Ms B Spicer	Non-Executive Director
Professor N Thakkar	Non-Executive Director (part)
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 Salter	Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Ms J Hindle	Corporate Secretary

Observing

Ms J Vaughan	Partner Governor – Merseyside & Cheshire Clinical Network
Mr C Hill	Public Governor – Rest of England

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	✓	✓	✓	✓					
Ms S Rai	✓	✓	✓	✓					
Prof N Thakkar	✓	✓	✓	✓					
Ms H Citrine	✓	✓	✓	✓					
Mr M Burns	✓	✓	✓	✓					
Mr M Gibney	✓	✓	✓	✓					
Dr A Nicolson	✓	✓	✓	✓					
Ms J Ross	✓	✓	✓	✓					
Ms L Salter	✓	✓	✓	✓					

TB35-20/21 Welcome and apologies

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

There were no apologies to note. BS would join at around 10.30

TB36-20/21 Declarations of interest

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

TB37-20/21 Minutes of the meeting held on the 22nd June

Minor amendments had been sent to Ms Hindle.

TB38-20/21 Patient Story

Ms Salter shared her own personal patient story from her time as an in-patient in the Trust. Ms Salter used the admission to discharge patient journey and observation tool approach and shared her emotions, experience and learning. There were several areas to focus on going forward e.g. access out of hours that the senior nursing team were taking forward.

Discussion after the story focused on learning, admiration for Ms Salter sharing something with colleagues so personal and how powerful that had been.

TB39-20/21 Chair & Chief Executive Report

Ms Rosser and Ms Citrine updated members in relation to national and regional developments. Including NHSI next phase of planning, phase 3, NICE guidance and trust approach and the people plan.1

The Board

- **noted the report.**

TB40-20/21 Covid-19 Update

Ms Citrine referred to the report that had been circulated with the papers and shared updates on;
Stroke services
Seacole beds and rehabilitation
Spinal services
Financial changes

The Board

- **noted the report**

TB41-20/21 Five Year Strategy Update

Ms Citrine presented an update for delivery of the Trust's five year strategy and key achievements made during year two. It was noted that the commitments identified for year three had been re-focussed to some extent due to requirements around the response to Covid-19 and the ongoing challenges relating to this.

Overall, it had been a successful year, and the Trust had delivered on all commitments in year, together with some additional elements which helped demonstrate progress towards the overall strategic goals.

Mr Crofts commented that it was heartening to see all the Trust strategies come together and that aspirational areas like the research and innovation were clearly dovetailing with service development, and the revised operational plan.

ACTION: Non-Executives to provide any comments to Ms Citrine before the end of

the week. Due September 2020

Once the annual priorities had been approved by the board and any changes made, a summary document would be produced and circulated to all staff so that they can see the progress made and the new steps that were put in place this year.

The Board:

- **noted the progress made in 2019/20**
- **approved the priorities for year 3 of the strategy**

TB42-20/21 Integrated Performance Report

Ms Citrine provided an overview of performance noting the report had been discussed in detail at both Quality Committee and Business and 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 Salter updated on complaints and hospital acquired infections and how this benchmarked with other organisations. There had been a small number of cases of CPE and MSSA which were an area of focus; however the trust had retained excellent performance in relation to C-Difficile and MRSA

Ms Rai queried how incidents/complaints in relation to violence and aggression towards staff were captured and managed. Ms Salter outlined the robust approach of support and training for staff and care plans, additional monitoring/ trigger points for escalation for patients.

Performance

Ms Ross commented that the Trust continued to perform well with regards to continuing to see and treat cancer patients and had maintained that standard right through COVID. In terms of diagnostic testing Ms Ross advised members that the report detailed the Trust's position in relation to breaches however the Trust had a robust plan in place to recover diagnostics. All long waiter patients' cases were clinically assessed to ensure patient safety.

Workforce

Mr Gibney advised members that the workforce indicators which had previously been scrutinised at the Business Performance Committee and therefore drew attention to the key area around sickness absence. The position at 28th July was described with numbers of staff shielding, on special leave or unavailable due to COVID19; overall staff sickness was low.

Following a question from Professor Thakkar around shielding Mr Gibney updated the board on the Trusts approach of how we would support staff and work in partnership with staff side.

Finance

Mr Burns

- provided a high-level summary of the financial position at month 3 with a reported surplus before adjustment of 275K
- Explained the areas of underperformance in relation to Wales and Isle of Man finances.
- 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 and shared other thoughts on possible outcomes as a consequence

COVID costs, cash balance and capital position were all highlighted and management of these.

Ms Rai queried if the activity would be delivered in line with the budget. Mr Burns noted it was unlikely we would achieve the original planned levels of activity due to COVID infection control requirements; however the Trust was no longer working to the original activity plan which therefore would create variance against the financial plan.

Ms Samuels commented that the Business Performance Committee had considered the issue of performance against the original annual plan and performance standards and whether the Trust could deliver this given the change in planning since COVID-19. To assist with this Ms Ross had circulated a paper outside of the meeting that detailed the revised plan, expectations regarding recovery levels and the Trust's performance against that plan.

The Board
noted the report

TB43-20/21 Equality Diversity and Inclusion Annual Report

Mr Lynch- Equality Diversity and Inclusion Lead joined the meeting and advised members that there was a statutory requirement to produce an annual Equality, Diversity and Inclusion report which included the Workforce Race Equality Standard and the Workforce Disability Equality Standard and the Gender Pay Gap Report. Key areas were highlighted and areas of action required for example need to improve career progression of BAME staff

The report had been considered in detail by the Quality Committee and Mr Crofts , as chair of the Quality Committee said the Quality Committee had some concerns that the Trust was not making the expected progress in terms of supporting career development for BAME staff so to progress this a working group had been convened.

Ms Rosser thanked Mr Lynch for the report

The Board:

- **noted the report**

TB44-20/21 Equality Diversity and Inclusion -Tackling Racism

Ms Citrine outlined a series of steps that would bring increased pace and focus to the

Trust's Equality, Diversity, and Inclusion Vision.,
National and regional leaders in the NHS recognised that the health service is in a strong position to address inequalities and therefore use its position in society to be part of the solution. As part of this work Bill McCarthy, Regional Director for NHS Improvement had established a Strategic NW BAME Advisory Committee and Professor Thakkar and Ms Rai had joined to support this work.

Ms Citrine highlighted actions taken to date and then proposed the establishment of a senior committee dedicated to this agenda to ensure clear commitment to addressing discriminatory behaviours and eradicating institutional racism - its focus would also align with national, regional, and local strategies.

Ms Samuels queried what, if any work was being undertaken with all staff (not just BAME) in order that they understand the issues. Ms Citrine responded that it was really important that all staff were engaged in this agenda in order to ensure that the Trust could move at the required pace. The senior committee (that's Bills committee above not ours)not just black and Asian staff and will determine what additional work is required around training, support and coaching for staff and patients.

Ms Rai queried what the main themes were following the early discussions with BAME groups. Ms Citrine shared areas such as risk assessments, career progression, sharing stories and experiences and white privilege – these had helped shape the area of focus for the committee. Ms Citrine proposed she would personally lead the advisory committee and that it should report to Trust Board quarterly.

Professor Thakkar commended Ms Citrine on the approach taken to date and added that in relation to the recruitment of staff the data showed a need to focus on shortlisting for interviews – which was agreed.

Ms Rai added that it was important when looking at racial issues to acknowledge that it is possible to see inequalities/racism within black and Asian groups, e.g. due to caste systems amongst other factors and that this should also be factored into the Trust's approach

Mr Gibney stated that a key element of the work would be supporting staff to feel comfortable to talk about and challenge each other and that this would require a more dynamic approach rather than something that is focussed on compliance with standards.

The Board:

- **endorsed the approach**

TB45-20/21 Quality Account 2019/20

Ms Spicer joined the meeting.at 11.42

Ms Salter advised members that the Quality Account 2019/20 which reflected the position in relation to the delivery of the quality priorities had been reviewed in detail at the Quality Committee.

Due to the changes in the external environment through the response to Covid-19 the usual external assurance processes had been extended and the Quality Account would

now be issued to stakeholders for comment in October with a view to it coming back to the Board in December.

Mr Crofts confirmed that there had been no issues identified at the Quality Committee to bring to the Board's attention.

The Board:

- **noted the Quality Account for 2019/20**

TB46-20/21 Freedom to speak up Report

Ms Kane joined the meeting to present the Freedom to Speak Up Guardian (FTSUG) and provide an update on the progress of the role and plans for strengthening current speak up arrangements.

Areas of focus included FTSPU champions, review of staff survey, areas of focus in particular questions associated with the WRES data and minority groups.

The report also detailed concerns raised by divisions/corporate function and Ms Kane described the process for investigating such concerns. This data was reported to the National Guardian Office.

Mr Crofts commented that he had continued to maintain contact with Ms Kane throughout lockdown and was aware of the work that had taken place to ensure that staff could raise concerns regarding PPE etc.

Ms Kane referred to the Freedom to Speak Up (FTSU) Index Reports published in October 2019 and July 2020. The North West region had seen an improved score from 2018 to 2019 and when benchmarked with other trusts the Walton Centre appeared in the top 3 within the region.

The Board:

- **noted the report and the Freedom to Speak Up arrangements in place within the Trust.**

TB47-20/21 National Inpatients Survey Results

Ms Salter presented the results of the CQC National Impatient Survey which had been reviewed in detail by the Quality Committee. Every Trust is required to participate in this annual survey to benchmark patients' experience with other NHS providers. The survey is a key indicator of overall care both for Trusts and for regulators including the CQC and commissioners

The Walton Centre was rated 6th in England for overall patient experience and Ms Salter noted that this was an excellent result and demonstrated the commitment of staff.

Areas for improvement were identified and an action plan relating to these would be monitored by the Quality Committee.

Mr Crofts commented that it was an outstanding report and that thanks should be passed

on to front line staff. Ms Salter confirmed that the report had been shared via the Safety Huddle, and via Team Brief. Ms Rosser stated that on behalf of the Board she would thank staff via her regular blog.

The Board:

- **noted the results of Inpatient Survey**

TB48-20/21 Governance Report

Ms Hindle presented the governance report.

In line with the Standing Orders and Scheme of Reservation and Delegation the Board is required to ratify the use of the Trust Seal at least annually. Ms Hindle advised members that the last recorded use of the Seal was in 2015.

In relation to the review of each Committee's Terms of Reference the remaining Committees had been reviewed and the revisions had been presented to each Committee for consideration. Specific changes to note:

Charity Committee chair report

There was now an explicit reference to the review of risks as the guidance from the Charity Commission suggested that a number of risk assessments should be undertaken for the management of fraud, reputation and business continuity.

Research, Innovation and Medical Education chair report

As the Research and Innovation Strategies both described the importance of Medical Education so it was proposed that Medical Education would report through the RD&I Committee and that the name would reflect this, becoming the Research, Innovation and Medical Education Committee.

Changes will now be needed to the membership and this was reflected in the draft TORs and the duties of the Committee. It was also reported that the Director of Finance would no longer continue as a member and consideration should be given whether the Director of Nursing was appointed as a second voting member.

Dr Nicolson stated that there were a number of amendments required to the job titles and he would share these with Ms Hindle.

ACTION: Dr Nicolson to provide the correct job titles for the membership of RIME.
DUE Sept 2020

ACTION: Ms Salter to confirm her appointment to RIME
DUE Sept 2020

Remuneration Committee

The Remuneration Committee have not met and considered the revised terms of reference and therefore they would come back to a future meeting.

The Board

- **noted the use of the Trust Seal**
- **approved the terms of reference and membership for the Charity Committee and RIME Committee**

TB49-20/21 Quality Committee chair report

Mr Crofts provided an update from the meeting of the Quality Committee held on 23rd July focusing in particular on a presentation from the rehabilitation network, mortality and morbidity, the annual reports for medicines and controlled drugs and infection control. In particular the two patients with CPE were noted and the data had been shared with commissioners.

The Committee also approved the pressure ulcer policy.

The Board:

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

TB50-20/21 Business Performance Committee chair report

Ms Samuels provided a verbal update following the meeting held on 28th July

The Committee

- received an update for the Transformation Programme .The response to Covid-19 had an impact on the programme but , some areas were progressing due to the need to introduce more innovative ways of delivering services such as maintaining patient contact remotely.
- noted that whilst there was no longer a need to deliver a cost improvement plan it was sensible to capture some of the former CIP efficiencies.

- approved the Agile Working Policy which supported managers in defining the roles that could work in a more agile manner. There was a discussion regarding whether defining a set of KPIs for the policy would be feasible.

- approved the Overseas Patient Policy which had been revised following comments provided by the Audit Committee.

- approved the Access and Performance Business Case with an overall investment of £226,972,
- approved the Website Business Case.

- received an update in relation to the Trust's People Strategy and noted that the revised national People Plan would further shape the Trust's strategy and implementation plan. This would be reported to the Board in September.

The Board:

noted the update from the Committee

TB51-20/21 Research, Development & Innovation Committee chair report

Mr Crofts presented the report from the meeting of the Committee held on 1st July 2020:

Clinical Trials –due to the impact of COVID there was a national challenge around getting people into trials due to decreased activity. Ultimately it might have a major impact on the Trust's Clinical Research Unit and income.

Intellectual Property and Data Transfer - The Committee discussed intellectual property and engagement with commercial trials. The Committee requested an update detailing how the Trust's processes for managing intellectual property could be more effective to ensure that commercial opportunities were not lost.

Trajectories of Outcome in Neurological Conditions (TONiC) – The Committee received an update from Professor Young regarding the work to create a bio-bank of MS samples from the study. The majority of the contractual work was being undertaken by the University of Liverpool due to limited internal resources. However, it was confirmed that the clinical data would remain at The Walton Centre. Mr Gibney added that the work was progressing and an update had since been provided to the Executive Team which included a discussion on the financials.

The Board:

- **Noted the update from the Committee**

TB52-20/21 Walton Centre Charity Committee

Ms Rai provided an update from the meeting of the Charity Committee that had taken place on the 9th July 2020

The Committee had made 2 recommendations to the Board

- To approve the application for Endoscopic Spinal equipment.
- To approve the revised terms of reference for the Committee

Board had seen the endoscopic proposal earlier; the proposal had been agreed in principle at Charity Committee but required final Board approval due to the level of investment,. The committee also recommended the approval of the revised terms of reference.

Financials -to 31 May 2020 the Charity had received £100,896 income and incurred £34,747 of fundraising and administration costs. Due to Covid-19 many of the annual fundraising events had been cancelled and therefore the Committee would be keeping the Trusts commitments under review as there were a lot of projects which have been approved.

The Committee also received a Fundraising Activity Report, the target income for 2019/20 was approx. £800,000, and the Trust was only just short of that target. The target for 2020/21 was £1m.

The Board:

- **noted the update from the Committee and approved recommendations**

TB53-20/21 Audit Committee

Ms Rai provided a verbal update from the meeting held on 21st July 2020 and highlighted the following:

External Audit – the update focussed on finalising the year end work around the audit of the annual report and accounts and the auditor had presented their final letter summarising this work.

Internal Audit – had provided an update regarding their work and the challenges of completing the majority of their work remotely. The Committee noted that the audit of the Rehab access and bed utilisation KPI's had been awarded significant assurance.

Counter Fraud Authority Review – The Committee received a report following a visit to the Trust by the Counter Fraud Authority in February 2020. The review found the Trust to be compliant with the five strategic foundations and contained only 2 recommendations, one of which related to the effectiveness of the Counter Fraud Programme.

Challenge Questions – The Committee received the Trust's response on the key strategic challenge questions and topics included, Brexit, Collaborative working, Leadership, Backlog Maintenance and Capital funding.

Ms Rai and Mr Burns had also discussed the external audit contract and the next steps around awarding a new contract.

The Board

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

TB54-20/21 AOB

Due to the restrictions in place Non-Executives had been unable to conduct Board Walkabouts. Ms Salter had organised virtual meetings between the Non-Executives and operational staff to ensure that any issues could be escalated and so that information within reports could be triangulated in a meaningful way.

Key themes and learnings from the initial discussions were:

- It provided a useful understanding of command and control approach
- Covid-19 and the challenges faced by operational staff were understood in greater detail
- Strong leadership and passion for the Trust was evident
- Clinical staff provided support to non-clinical colleagues throughout
- Staff had understandably been fatigued but morale was now improving
- Focus on transitioning back to normal service delivery

All agreed that the conversations were extremely useful and no patient safety matters had

been raised as a result of the discussions with Non-Executives.

Ms Rosser invited questions and observations from the governors.

Ms Vaughan commented that the meeting had run well and the use of technology was becoming more familiar to those in the NHS. In relation to the patient story Ms Vaughan commented that it was apparent that Ms Salter was used to addressing large groups of people and yet it must have been challenging to report something personal The Trust should be mindful of that when involving patients in sharing their stories.

Mr Hill stated as a patient of the Trust he had recognised Ms Salter's experience and found it valuable to hear how the learning was being taken forward.

There being no further business the meeting closed at 12.43pm

TRUST BOARD
Matters arising Action Log
September 2020

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
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	
22.06.2020	TBC	**BPC Chairs Report** The Board will consider its risk appetite in a future Board Development Session	J Rosser	J Rosser to ensure that the Board Development programme includes a session to consider the risk appetite	tbc	
30.07.2020	TBC	**Inpatient Survey Results** To ensure that the positive results and thanks have been communicated by the Chair on behalf of the Board	J Rosser	This was fed back via the AGM and a communication to Trust staff		
30.07.2020	**TB41-20/21**	**Five Year Strategy Update** Non-Executives to provide any comments to Ms Citrine before the end of the week.	NEDs	Ms Citrine confirmed feedback received	Sept 2020	

30.07.2020	**TB48-20/21**	**Governance Report** **Research, Innovation and Medical Education chair report** Dr Nicolson to provide the correct job titles for the membership of RIME Ms Salter to confirm her appointment to RIME	 A Nicolson L Salter		Sept 2020	

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	

REPORT TO TRUST BOARD
Date 24 September 2020

Title	**COVID-19 Update Report**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Jan Ross, Director of Operations and Strategy, Mike Gibney, Director of Workforce and Innovation, Lindsey Vlasman, Acting 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	BAF Risk ID001 COVID-19
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 national, regional and local developments in relation to COVID-19.

2.0 NATIONAL CONTEXT

2.1 On the 19th June 2020 the UKs overall COVID alert level was lowered from four to three, signifying that the virus remains in general circulation with the expectation of localised outbreaks. Overall impatient numbers fell considerably and the phase 3 planning letter (31st July 2020) was focused on recovery of services with the aim to accelerate services to near full capacity before winter.

The Trust's initial phase 3 submission was based on observed activity levels and 19/20 activity. The final submission will be made to the in hospital cell on Monday the 21st September 2020.

The current risk and concern is the steady increase in positive cases regionally with Liverpool on the current watch list, and likely to move into a local lockdown.

2.2 COVID Recovery Service

Tens of thousands of people who are suffering long-term effects of coronavirus will benefit from a revolutionary on-demand recovery service. Nurses and physiotherapists will be on hand to reply to patients' needs either online or over the phone as part of the service.

The new 'Your COVID Recovery' service forms part of NHS plans to expand access to COVID-19 rehabilitation treatments for those who have survived the virus but still have problems with breathing, mental health problems or other complications. https://www.england.nhs.uk/2020/07/nhs-to-launch-ground-breaking-online-covid-19-rehab-service/

3.0 REGIONAL POSITION

Sickness Absence in the North West – Good Practice and Peer Support

Anthony Hassall, Regional Chief People Office for NHSE&I North West, sent a letter on the 26 August 2020 to the Chief Executive as The Walton Centre is one of the five trusts with the lowest sickness absence rate in the North West. NHSE&I are looking for this organisation to share its good practice and to support those organisations that are in the most difficulty.

We have agreed to support the system and have shared our initial thoughts upon the key actions that have underpinned the low rates of sickness absence. A few of the key points are as follows:

- A strong tradition and focus upon promoting an open and positive culture. Clearly this isn't something that can be developed overnight but has to be the focus and long term vision for the whole Trust, management and the

Board.

- Genuine and proactive culture of partnership working between management and staff side.
- Daily reporting (via command and control structure) over all 7 days on sickness absence data by divisions, wards and teams. Individual HR support for staff whose absence was COVID related.
- Long standing commitment to health and wellbeing offering a broad and flexible range of support. Critically, the Walton charity suspended business as usual to focus upon supporting the Trusts response to the pandemic. Often the charitable offer was in the form of direct health and wellbeing support for staff that we can evidence has been well received.
- Finally, an immediate adoption of agile working enabled the Trust to ensure that those who could work from home did so, and this also created space/improved working conditions for those on site.

4.0 LOCAL POSITION

4.1 Finance

The Trust continues to account on a 'top up' basis until month 6 (September) to report a breakeven position. We recently received our block financial allocation from NHSE/I for the second half of the year and finance have been working through what this means for the trust compared to what it had assumed in its forecast for the rest of the year. The methodology for the allocation is in line with months 1 – 6 i.e. based on the income / expenditure run rates between months 8 and 10 in 2019/20. Initial calculations indicate that the trust is likely to be short in its planned allocation from NHSE/I, due in the main to out of system income / other income assumptions being higher than the trust is actually experiencing, however work continues to understand this impact.

In theory, the overall block allocation for Cheshire & Merseyside should allow the HCP to breakeven, with individual trusts allocated a block income contract and a top up and the HCP holding a separate Covid fund to be allocated to cover individual costs (up to the value of what is held). The system in the second half of the year allows for providers to make surpluses and deficits with incentives and penalties based on the delivery of activity in line with the phase 3 planning letter. Early indications would suggest that delivery of system financial balance will be a challenge.

The Trust has been allocated a further amount of capital (£0.5m) on top of its £4m capital resource limit in relation to the critical infrastructure fund that was made available recently. This is to reduce backlog maintenance within the Trust. This takes some pressure off the capital programme, although the programme continues to be over-subscribed and regular prioritisation takes place via the Capital Management Group.

4.2 Patient Experience

We have received a number of concerns raised from families in relation to the non-visiting policy. The theme is that families are understandably frustrated/anxious because they are unable to visit loved-ones. Families are provided with support and staff continues to support and encourage virtual visiting. The majority accept the reasons for this and today received a compliment from a patient with this regard. *'I feel the care and compassion from staff has helped him recover quicker as they supported him with his iPad which helped him speak to his wife as there is not visiting'*.

Feedback in relation to virtual appointments has been positive overall, with no formal concerns raised regarding this method of appointment, however it is recognised that further work is required to ensure that the patients who require face to face consultations are triaged to this method of appointment. Some patients have been supported by PET during consultations virtually and we have continued to safely socially distance meet with families to discuss complaints where appropriate.

Whilst our volunteers are not back on site we remain in regular contact and engagement with them for example, socially distance walks planned, and held a virtual coffee morning which was well received. A newsletter will also be shared with next week.

We continue to receive compliments regarding care and treatment and support provided during the pandemic.

The Trust in line with the hospital cell has started to reintroduced visiting, however due to the local and regional rates of COVID infection has reverted back to its flexible approach to visiting in exceptional circumstances, to protect our patients and staff., this is being done in a very controlled manner with strict guidance.

All elective patients are tested for covid19 pre operatively and if negative follow a green pathway. Emergency patients are tested on admission and follow an amber pathway and any positive patients follow a red pathway. This follows strict infection control principles and supports the required increase in activity and efficient use of our capacity.

4.2 Infection Prevention Control

The increase in both the local and regional rates of COVID are concerning and guidance continues to be reviewed and followed with Trust policies and SOP's updated as required. Currently the Trust is in winter planning phase, there is a robust influenza pandemic plan which is under review

4.3 PPE

PPE continues to be a challenge as we continue to get push deliveries however no immediate concerns. Fit testing has moved into our flu pandemic planning.
Anyone who enters the Walton Centre buildings must now have their temperature checked and wear a surgical mask in line with national guidance.

4.4 The Walton Centre Charity

The impact on fundraising income due to the covid-19 situation is felt across the sector, with most community initiatives and mass participation events cancelled. The Walton Centre Charity has also been affected with annual events such as the Hope Hike and Golf Day having been cancelled, however because of our grants from NHS Charities Together, the income comparison to date with last year, is at a similar level (not including the income from two significant legacies received during this period last year).

Focus for the team over the next few months is to promote our partnership with Bequethed, an online will making service, to raise awareness of legacy giving; to increase our regular giving through the launch of the Everton in the Community lottery scheme; and plan and implement this year's Christmas Campaign – Christmas cards are already being sold, both from the Charity website and from the Fundraising Office!

Work is also underway to explore options to improve staff areas utilising the £35,000 allocated from NHS Charities Together for this purpose.

4.5 Health & Wellbeing

The Trust is underway with listening sessions for staff to share their experiences during the pandemic. These sessions are being held for both clinical and non-clinical staff to allow them to feedback how they felt during the height of COVID, highlighting areas of good practice along with what could be done better should a second surge occur.

For the first sessions the Trust has targeted the Senior Nurses, Theatres, Horsley and Chavasse. All staff groups and departments across the Trust will be invited to attend one of the sessions, with the aim to have these completed by the end of October. Once the feedback has been collated the findings and suggested actions will be presented to the Board along with an update to staff in the form of 'You said, we did' format.

The internal psychology support line will cease from the 30th September however the Trust continues to offer a number of local, regional and national support initiatives. All staff have been encouraged to complete the updated COVID risk assessment that has been recently circulated.

4.6 Transformation

The Trust continues to conduct virtual appointments for patients and have received positive feedback on the new way of working from both patients and clinicians. Month on month the Trust has seen the number of patients seen virtually increase with 2653 appointments conducted in August.

Agile working pods are now in place at Sid Watkins Building with more and more staff utilising this space on a daily basis. The Trust continues to work through the Agile deployment project plan with support and guidance from Staff Side. The next phase of the programme will begin work on the 2nd floor Main building, with meetings scheduled for the end of August.

Theatres have restarted their transformation programme of work and have identified four initial areas to focus on to enable the Trust to start to return to pre COVID activity levels. The aims for this are to ensure that theatre lists start on time and that we improve patient flow and experience within the department.

Patient flow has introduced daily bed meetings with the mutli-disciplinary team to ensure rapid escalation of issues. This is to enable rapid response with the view to reduce length of stay along with identifying any blockers that need to be addressed. This in turn will allow the Trust to maintain appropriate occupancy levels supporting phase 3 planning.

REPORT TO TRUST BOARD

Date: 24 September 2020

The Walton Centre NHS Foundation Trust

Title	**Communications and Engagement Strategy**
Sponsoring Director	Name: Michael Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Alex Moore Title: Communications and Engagement Officer Name: Sam Fleet Title: External Communications Officer Name: Steven Carney Title: Communications & Graphic Design Officer Name: Dr Andrew Rose Title: Head of Commercial Engagement and Marketing
Previously considered by:	• Committee Executive, and on 22 September BPC and SPC • Group NA • Other Governor Membership Group

Executive Summary

The Communications and Engagement Strategy sets out how communications and engagement activities will reinforce the goals and ambitions of the Trust's five year strategy, and provide cohesive and engaging communications for a range of internal and external stakeholders. The strategy outlines how communications will enhance the profile of the organisation and protect its reputation.

Internally, there will be a focus on evaluating the effectiveness of existing communication channels and working to enhance and strengthen the Trust's ability to communicate and engage effectively with staff. Externally, there will be a stronger and more robust focus on evaluation and on stakeholder and partner engagement. Work will continue to build a strong online presence to enhance and support the Trust's growing reputation with a wide and varied audience, notably with the development and launch of a new Trust website. There will be a greater focus on marketing, media and public relations to continue to optimally position the Trust on a regional and national footing.

The strategy has been designed to meet the needs of a changeable environment and will be treated as a living document. Therefore, it will be regularly reviewed to ensure it continues to meet the needs of the organisation and its audiences.

Related Trust Ambitions	• Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Risks associated with failure to communicate with and engage staff, patients, carers, public and wider stakeholders appropriately
Related Assurance Framework entries	• BAF 006 (Staffing)
Equality Impact Assessment completed	• Yes
Any associated legal implications / regulatory requirements?	• The Communication function facilitates of Trust statutory reporting and accessibility requirements
Action required by the Board	• To consider and approve

NHS
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

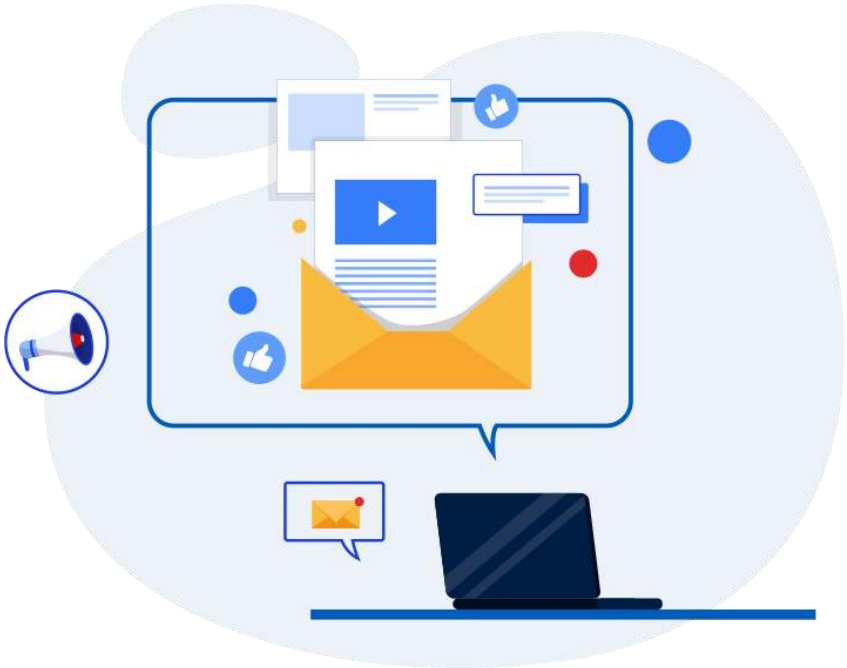
Communications and Engagement Strategy

Executive summary

The Communications and Engagement Strategy sets out how communications and engagement activities will reinforce the goals and ambitions of the Trust's five year strategy, and provide cohesive and engaging communications for a range of internal and external stakeholders. The strategy outlines how communications will enhance the profile of the organisation and protect its reputation.

Internally, there will be a focus on evaluating the effectiveness of existing communication channels and working to enhance and strengthen the Trust's ability to communicate and engage effectively with staff. Externally, there will be a stronger and more robust focus on evaluation and on stakeholder and partner engagement. Work will continue to build a strong online presence to enhance and support the Trust's growing reputation with a wide and varied audience, notably with the development and launch of a new Trust website. There will be a greater focus on marketing, media and public relations to continue to optimally position the Trust on a regional and national footing.

The strategy has been designed to meet the needs of a changeable environment and will be treated as a living document. Therefore, it will be regularly reviewed to ensure it continues to meet the needs of the organisation and its audiences.



Context

To achieve its strategic aims, the Trust must build on its reputation as a provider of excellent specialist care and treatment, an employer of choice and an innovative and collaborative partner. As demand for healthcare services increases and patient expectations continue to rise, high quality communication and engagement is more important than ever before.

The NHS Constitution states that staff and patients have a right to be kept informed and to be engaged with by the NHS. This principle goes beyond regulatory requirements, and it is widely acknowledged that effective communications and engagement with workforce and stakeholders lie at the core of a successful organisation.

The COVID-19 pandemic will have a lasting effect on the NHS and the Trust in terms of operational changes, demand for services, collaborative working across health economies and a greater utilisation of technology. The pandemic has demonstrated a public appetite for more technology-based services e.g. video consultations, and this presents an opportunity for clinical services. Responding to this will require robust communications and stakeholder management to embed new approaches and to ensure the organisation can deliver on the opportunity for transformation. The development and launch of a new Trust website will play a large role in ensuring external stakeholders' needs are met through a much improved online offering.

Communications team will enable the Trust to achieve the ambitions of its five year strategy:

- Deliver best practice care and treatments in our specialist field: in particular the Communications team will showcase the Trust's delivery of excellent services in the neurosciences.
- Provide more services closer to patients' homes, driven by the needs of our communities, extending partnership working: the Communications team will support Trust ambitions to deliver more technology-based services for patients.
- Be financially strong, meeting our targets and investing in our services, facilities, and innovations for patients and staff: investment in a new Trust website and an increased focus on evaluating Communication activities will enhance performance.
- Lead research, education, and innovation, pioneering new treatments nationally and internationally: stakeholders will be informed about cutting edge research, innovation and educational approaches supported by the Trust.
- Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family-centred care: new technologies and treatments adopted by the Trust will be showcased.
- Be recognised as excellent in our patient and family-centred care, clinical outcomes, innovation, and staff wellbeing: an increased focus on engagement and marketing will enhance delivery of key initiatives and the Trust's reputation.

The Communications and Engagement Strategy will need to flex and adapt to the needs of patients, their families, staff and other stakeholders to support the delivery of the Trust's Five Year Strategy (2018 – 2023). It will also need to reflect new ways of working and meet the expectations of people as the longer term effects of COVID-19 on the health service and the Trust are understood.

Aims of the Communications and Engagement Strategy

The Communications and Engagement Strategy will establish and embed an approach that enables The Walton Centre to achieve its corporate objectives, ambitions, and vision. Through effective high-quality communications, audiences will be informed about the Trust's objectives, vision and values, and how the organisation supports patient care, staff wellbeing and the efficient use of resources. Activities will focus on:

Staff • Ensure staff have the information they need to deliver the best care for our patients. • Create a culture of staff engagement and involvement to ensure staff are fully involved in the Trust's commitment to deliver high quality safe care. • Support staff to deliver their own communications, events or initiatives.	**Patients** • Ensuring patients are informed about the availability, quality, and safety of the services provided. • Strengthen confidence in the standard of care provided at The Walton Centre.	**External stakeholders** • Improve stakeholder engagement, identifying and coordinating relationships with a wide range of stakeholders including new and existing relationships. • Increasing the confidence that commissioners have in the Trust and its ability to deliver high quality services and outcomes.
Trust brand • Develop the brand and reputation of the Trust through effective engagement, high quality accessible information, proactive media management and the development of marketing expertise. • Effective management of the Trust's identity and style to safeguard its image and reputation.	**Fundraising** • Promote the Trust's charity to maximise fundraising opportunities. • Support the charity's donor recognition work, highlighting and celebrating the work of supporters and what their contributions have helped realise.	**Research and Innovation opportunities** • Support the Trust's research and innovation agenda. • Support the Trust in its aims to become an Anchor Institute. • Support the Trust's work to build and develop successful commercial connections, relationships, and opportunities. • Promote achievements externally.

Delivery

The priority of this strategy is to ensure effective two-way communication and engagement exists between the Trust's key audiences, notably staff, patients, and other external stakeholders. This strategy will be underpinned by robust communication plans for specific projects and campaigns as required. The plans will contain the detailed elements of communications channels and audiences/stakeholders to be engaged to deliver projects (please see sections below on communications channels and stakeholders).

All communication and engagement activity will be:

- Clear, timely and accurate
- Planned, consistent and professional
- Consistent with the Trust's brand, mission, vision and values
- Targeted and relevant to the audience's needs
- Based on research, insight and emerging issues
- Available on a range of channels, using different communications techniques to reach different audiences.

The Communications team utilises a range of different channels to best meet the needs of the Trust's audiences. Going forward, a renewed focus on engagement to ensure two-way communication takes place will be important to give patients, staff, the public, and stakeholders a voice wherever possible and an opportunity to give feedback and help to shape communications in the future.

Internal communications

Effective communication with staff is central to the success of the organisation as well as the achievement of its strategic ambitions. This ranges from regular information updates and alerts to long-term campaigns and engagement. Internal communications fosters a sense of connection between the workforce and leadership, and supports the health and development of the organisation's culture.

Key internal communications objectives include:

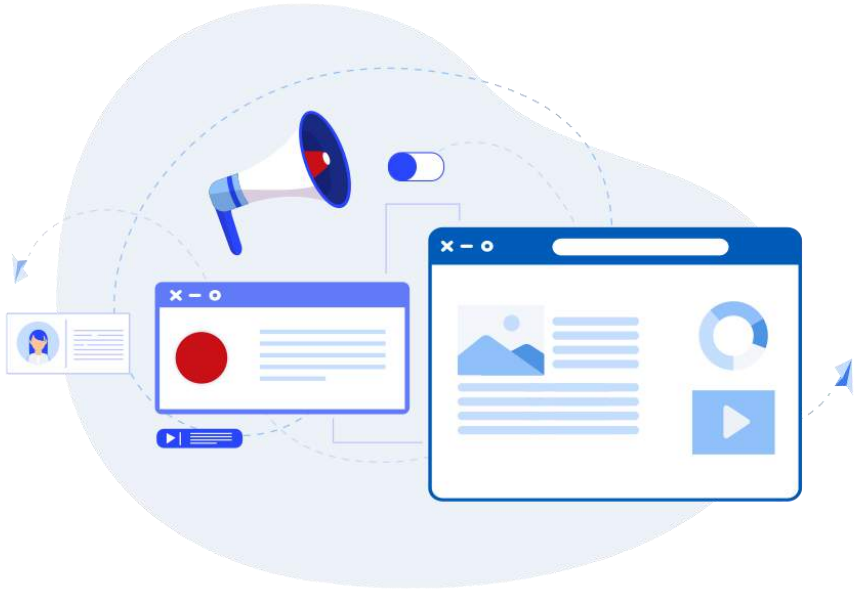
- Ensure staff are informed about all applicable information and developments to help facilitate their best work.
- Enhance meaningful and productive dialogue between the Trust's leadership and its workforce.
- Enhance the effectiveness of communications through an increased focus on evaluation.
- Ensure staff are recognised for their accomplishments, and that best practice is shared and celebrated.
- Deliver Trust campaigns, initiatives and events, and help promote the organisation's successful Health and Wellbeing programme.
- Embed and refine the Trust's 'voice' to ensure all internal communications fit the internal brand.
- Plan for the development of a new intranet.

External communications

Proactively managing the Trust's reputation is vital to maintaining the confidence in its services, quality of care and status as an employer of choice. Reputation is essential for the effective recruitment and retention of the best staff, contributes directly to the way patients and their families feel about receiving treatment and influences the Trust's ability to attract the best collaborators. It also increases the confidence that commissioners have in the Trust's ability to deliver high quality services and outcomes. Reputation is also an essential component in the success of The Walton Centre Charity where experiences, reputation and perception of the organisation are major motivators for involvement and donations.

Key external communications objectives to protect and enhance the Trust's reputation include:

- Reflect the Trust's Strategy, objectives and values in all communications activity.
- Actively promote and publicise the Trust's Strategy, building a narrative to ensure objectives are understood.
- Champion staff and patient achievements that demonstrate outstanding care and innovative ways of working.
- Deliver the new Trust website.
- Proactively manage activities and emerging issues through effective horizon scanning.
- Enable the Trust to engage and build strong relationships with stakeholders, increasing the opportunities for collaboration and charity support.
- Develop marketing expertise, utilise new approaches to communications and make more use of analytics to effectively evaluate and improve future communications and marketing activity.



Social Media

Social media is an increasingly valuable communications channel, providing direct and instantaneous engagement with patients, other external stakeholders, and staff. Currently, the hospital primarily uses Facebook, Twitter, Instagram, and Linkedin, and collectively on these four social media accounts the hospital has over 20,000 followers. These followers include patients, visitors, staff, medical professionals and wider supporters. The Trust provides engaging content that showcases the outstanding services and innovative treatments on offer. The Trust endeavours to provide open and inviting communications channels where patients and potential patients can feel empowered to ask questions and seek advice on how to benefit from our world class services.

Through effectively utilising social media the team will:

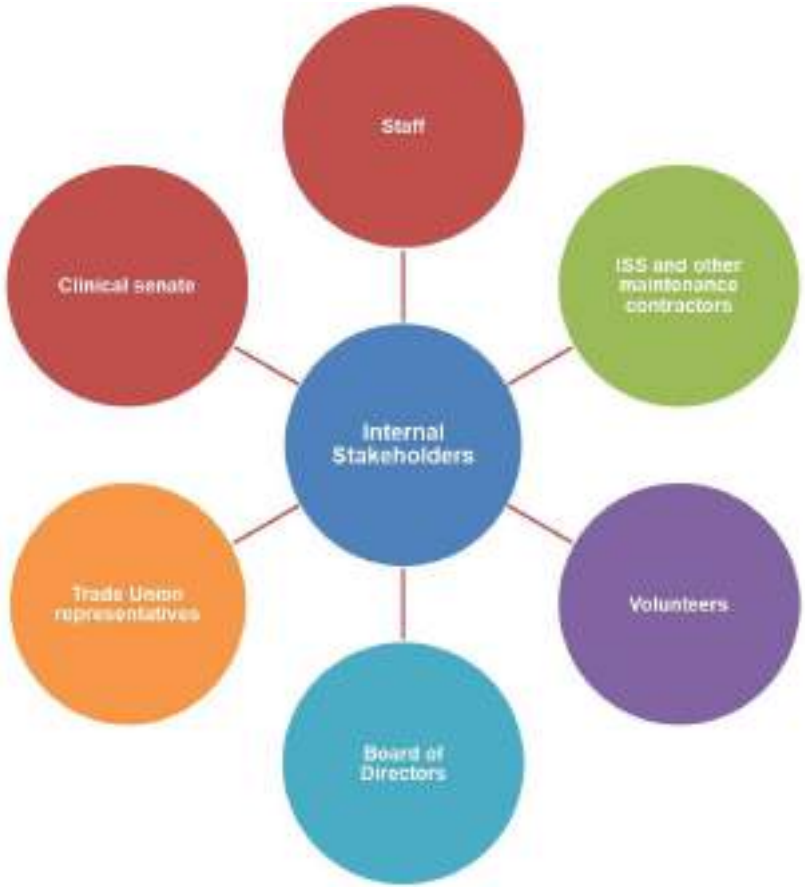
- Keep patients, visitors and staff informed of the latest patient outcomes and the best patient, family and carer experiences. This includes promoting the high standards we already have, as well as showcasing pioneering techniques, use of innovation and advanced technology.
- Share stories of patients and staff which evidence best practice care and treatments, and highlight Trust work in bringing care closer to home for patients.
- Promote new services and facilities which benefit patients and staff.
- Promote successes and innovations which enhance The Walton Centre nationally and internationally.
- Highlight the hospital's learning culture, which empowers staff to continuously improve.
- Inform patients and visitors of any applicable service or operational changes, including crisis communications during major incidents.
- Continue to build an online community around the hospital.
- Increase awareness of The Walton Centre brand and service as a whole.

Social media is an ever changing, ever growing platform. Over the next few years, the Communications team will monitor new trends/approaches and assess their usefulness in serving existing and new audiences. Content will continue to be created along the themes described above, but will also extend more into new areas such as innovation and the use of technology to better serve patients. Due to the success rates of video content in recent history, an increase in creating more video content will be implemented, resources permitting. This greater emphasis on video will be evaluated regularly to ensure that prioritising this kind of content is still valid.

Details of actions to operationalise communications and engagement objectives are included at the end of the Strategy.

Stakeholders

The Communications team has mapped the Trust's internal and external stakeholders, which are summarised in the diagrams overleaf. Going forward, activities will be undertaken to engage stakeholders more comprehensively.




External Stakeholders
Commissioners
NHS England and Improvement & relevant health boards
Local and Combined Authorities
Cheshire and Merseyside Health and Care Partnership
Patients & relatives
Carers
National and neighbouring NHS Trusts
Maintenance contractors
Voluntary, community, faith and social enterprise organisations
Satellite/spoke units
Universities
CPs
Voluntary sector
Local schools
Further education colleges
Regulators
DH&SC
Fundraisers
Healthwatch
Press/media (local and national outlets)
MPs & National Government
Trade Unions
Governors
Members

Channels

The range of existing communication channels used by the Trust are listed overleaf. They support awareness-raising and engagement across a range of broad audiences/stakeholders, support one way communication (awareness) and two way communication (engagement). Channels also facilitate the development of relationships and enable information sharing, engagement and promotion of the Trust's strategy and objectives.

Activity	Channel	Awareness (A)/ Engagement (E)		Frequency
Staff				
Walton Weekly	Email	**A**	**E**	Weekly
All user emails	Email	**A**		To meet needs of business
Posters	Print	**A**		To meet needs of business
Service improvement displays on site	Print	**A**		Quarterly
Team Brief	Face to face/virtual & digital	**A**	**E**	Monthly
CEO blog	Email	**A**		Monthly
Chair blog	Email	**A**		Monthly
Executive director blogs	Email	**A**		To meet needs of business
Neuromatters magazine	Print & digital	**A**		Quarterly
Intranet	Digital	**A**		Ongoing
Staff Facebook group	Digital	**A**	**E**	Ongoing
Hayley's Huddles	Face to face & virtual	**A**	**E**	Quarterly
Schwartz Rounds	Face to face & virtual		**E**	TBC
Berwick sessions	Face to face & virtual		**E**	TBC
Executive team walkabouts	Face to face		**E**	Weekly
Ask Hayley	Email		**E**	Ongoing
Listening Weeks	Face to face		**E**	Quarterly
Campaigns	All channels	**A**	**E**	To meet needs of business
Vivup platform	Digital	**A**	**E**	Ongoing
Patients and the public				
Social media	Digital	**A**	**E**	Ongoing
Website	Digital	**A**		Ongoing
Neuromatters magazine	Print & digital	**A**		Quarterly
Posters on site	Print	**A**		To meet needs of business
Service improvement displays on site	Print	**A**		Quarterly

Leaflets	Print & digital	**A**		Ongoing
Digital screens (waiting rooms)	Digital	**A**		Ongoing (approval required)
Events (e.g. recruitment days)	Face to face & virtual	**A**	**E**	To meet needs of business
Media	Print & digital	**A**		Ongoing
Campaigns	All channels	**A**	**E**	To meet needs of business
Members				
Neuromatters	Print & digital	**A**		Quarterly
Annual Member Meeting	Face to face & virtual	**A**	**E**	Annual
Ask an Executive email	Email & digital		**E**	Ongoing
Governor surgeries	Digital	**A**	**E**	Quarterly
Governors				
Email update	Email	**A**		Fortnightly
Email updates: emerging issues	Email	**A**		To meet needs of business
Council of Governor meetings	Face to face & virtual	**A**	**E**	Quarterly
Partners				
Stakeholder briefing	Email	**A**		Quarterly
Face to face meetings	Face to face & virtual	**A**	**E**	To meet needs of business
Whole system meetings	Face to face & virtual	**A**	**E**	
Stakeholders				
Stakeholder briefing	Email	**A**		Quarterly
Face to face meetings	Face to face & virtual	**A**	**E**	To meet needs of business

Evaluation

The Communications team recognises that the successful delivery of the strategy will require continuous evaluation and the measurement of key performance indicators. Enhanced emphasis will be placed on evaluation of communications activities going forward. The key performance indicators to be utilised will address the following four themes:

- How we are perceived by our staff, stakeholders and the wider community
- How we engage and involve our staff, stakeholders and our community in setting, delivering, and reviewing our strategy
- How we capture insights into our stakeholders' experiences
- How we plan, deliver and evaluate our communications and engagement activity

The following metrics and indicators will be refined and monitored to assess strategic progress and enhance services:

- Annual internal and external communications survey
- Quarterly Staff Listening Week feedback
- National Staff Survey results
- Social Media performance data including follower count and engagement
- Media monitoring including proactive and reactive communications, ongoing press relationships
- Website analytics
- Vivup platform analytics
- Ad hoc surveys and polls, anecdotal feedback where applicable

This list is not exhaustive and the transition to newer systems during the life of the strategy (for example the delivery of a new intranet system) will create new opportunities for data collection.

Operationalising the Strategy

This Strategy will be operationalised through the delivery of the following outputs by the Communications team, subject to developing issues and priorities.

Activity			Timeframe		
			2020-2021	2021-2022	2022-2025
Staff					
Walton Weekly		Investigate solutions to provide analytics/audit and evaluation			
		Implement changes as applicable following evaluation and engagement			
All user emails		Explore options for analytics/audit and evaluation			
Team Brief		Complete an audit to evaluate the new style, ensuring effective cascade			
		Continue to host as a virtual event, recording and making available digitally and explore options for expanding attendance by hosting virtually as well as potentially face to face again in the future.			
CEO blog		Investigate solutions to provide analytics/audit and evaluation			
Chair blog		Investigate solutions to provide analytics/audit and evaluation			

Executive director blogs		Investigate solutions to provide analytics/audit and evaluation			
		Assess the potential benefits of producing vlogs			
Neuromatters magazine		Survey readership and assess differences in print copy versus electronic copy for members/staff/general public			
		Evaluate whether meeting the needs of the audience			
Intranet		Explore possibility of replacing the existing intranet with a new Content Management System			
		Depending on viability of a new solution, assess what quick-wins can be achieved on the existing intranet to improve user experience			
		Develop a business case			
Staff Facebook group		Review activity after first 12 months, survey users to evaluate and plan a future direction for the group			
Hayley's Huddles		Embed new mechanism for delivering the huddles			
Schwartz Rounds		Identify whether these engagement sessions will take place and provide support where necessary			
Berwick sessions		Identify whether these engagement sessions will take place and provide support where necessary			

Executive team walkabouts		Identify ways to better communicate when these happen and outcomes			
Ask Hayley		Set up new initiative, launch and continue to promote			
		Audit and evaluate			
Listening Weeks		Assess viability of hosting F2F events during the pandemic and what alternatives can be provided in the meantime e.g virtual			
		Improve feedback mechanisms and evaluation of events			
		Improve evaluation mechanisms			
Campaigns		Develop, plan and launch as required by the business			
		Plan campaigns to support other local and national initiatives			
Vivup platform		Enhance the content based on user feedback and analytics			
Brand		Continue to develop and embed Trust ‘voice’ in all internal communications			
Patients and the public					
Social media		Increase followers and engagement			
		Increase use of video produced in-house ensuring relevant hardware is purchased to support this			
		Increase use of calls to action to increase engagement and support Trust objectives			
		Extend the range of organisations followed			

		Increase visibility and activity on LinkedIn, moving followers across to new Trust page			
		Develop a performance dashboard which also encompasses media relations, internal and external communications			
		Seek funding for digital management tools			
Website		Build new website			
		Launch new website			
		Audit and evaluate website			
Neuromatters		Survey readership and assess differences in print copy versus electronic copy for members/staff/general public			
		Evaluate whether meeting the needs of the audience			
Posters on site		Replace current noticeboards with new clip frames			
		Assess content requirements for the new noticeboards and design assets as necessary			
		Devise an effective schedule to manage the content regularly			
Service Improvement displays on site		Devise a plan, or add it to an annual work plan to ensure the displays are updated regularly			
		Work closely with staff to produce relevant information in an attractive format			
		Consider if position and number of displays meets audience needs			
Leaflets		Launch new branding and format for patient information leaflets			
Digital screens (waiting rooms/corridors)		Revisit the latest proposal, liaising with IT and executive directors as required			
		If approved, develop a communications approach to the management of content spanning corporate communications, PEFT, clinical information.			

Events (e.g. recruitment days)		Provide support as required to manage and deliver corporate events or to support staff to deliver their own events			
Media		Prioritise broadcast opportunities, building relationship with BBC Radio Merseyside and other local media outlets			
Campaigns		Develop, plan and launch as required by the business, working with key staff on specific campaigns			
		Support other local and national initiatives with promotion and support			
Brand		Develop Trust Branding - aligned with the national NHS Brand Guidelines			
		Create brand guidelines document for use internally and with external suppliers			
Members					
Neuromatters		Survey readership and assess differences in print copy versus electronic copy for members/staff/general public			
		Evaluate whether meeting the needs of the audience			
Annual Member Meeting		Work with the Membership team to devise and deliver a virtual meeting for 2020			
		Support the Membership team to utilise technology to deliver virtual member events in the future to enhance accessibility.			
Ask an executive email		Launch in conjunction with the Membership team			

Governor surgeries		Launch in conjunction with the Membership team			
Governors					
Email update		Support the Membership team as necessary			
Email updates: emerging issues		Support the Membership team as necessary			
Council of Governor meetings		Support the Membership team as necessary			
Partners					
Stakeholder briefing		Investigate options for improving presentation, accessibility, functionality			
		Identify a solution to provide analytics and evaluation			
Stakeholder mapping		Plan further approaches to map and engage stakeholders			
Anchor Institution		Develop communications approach to support the Trust's ambition to be an Anchor Institution			

Resources					
Team development		Develop team profile within the Trust (potentially including through the delivery of training for Trust staff)			
		Develop annual work plan to ensure effective proactive management of activities			
		Explore opportunities to develop new communication tools and channels			
		Develop marketing expertise			
		Identify hardware and software required to better support and deliver communications in an agile workplace			

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part 1

1. Person(s) Responsible for Assessment: **Dr Andrew Rose**

2. Contact Number: **07813 998372**

3. Department(s): **Communications**

4. Date of Assessment: **11/09/20**

5. Name of the policy/procedure being assessed: **Communications and Engagement Strategy**

6. Is the report new or existing?

New Existing

7. Who will be affected by the strategy? **All groups**

Staff **Patients** **Visitors** **Public**

8. How will these groups/key stakeholders be consulted with? **Engagement of each audience will be central to the strategy's implementation. To-date, a range of Trust staff and Governors were consulted**

9. What is the main purpose of the report? **To outline the ambitions and goals of communications activity going forward, in line with the Trust's overall strategy.**

10. What are the benefits of the report and how will these be measured? **Benefits include alignment with overall Trust goals and enhanced communications activity. Measured via regular surveys and other analytics**

11. Is the strategy associated with any other policies, procedures, guidelines, projects or services? **The Trust vision and Strategy 2018-2023**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **See below**

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age			✓	The Strategy has been developed to not impact any protected characteristic. Mitigation identified for this protected characteristic.	Information will be communicated in a range of ways so that different age groups can access messages, as appropriate.
Sex			✓	The Strategy has been developed to not impact any protected characteristic.	
Race			✓	The Strategy has been developed to not impact any protected characteristic.	
Religion or Belief			✓	The Strategy has been developed to not impact any protected characteristic..	
Disability			✓	The Strategy has been developed to not impact any protected characteristic. Mitigation identified for this protected characteristic.	Information will be communicated in a range of ways so that those with disabilities that impact understanding can access messages, as appropriate.
Sexual Orientation			✓	The Strategy has been developed to not impact any protected characteristic.	
Pregnancy / maternity			✓	The Strategy has been developed to not impact any protected characteristic.	
Gender Reassignment			✓	The Strategy has been developed to not impact any protected characteristic.	

Marriage & Civil Partnership			✓	The Strategy has been developed to not impact any protected characteristic.	
Other					

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) **The Communications Team have considered the impact of communications approaches on protected characteristics. Further engagement and assessments to be made as the Strategy is implemented to ensure that approaches are appropriate.**

13. Does the strategy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? **No**

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken ✓

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Andrew Rose Date: 11/09/20

Signed: Andrew Rose

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD

Date: 24 September 2020

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

Executive Summary

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

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

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.

Key Performance Indicators – Caring

Opportunity for Improvement Measures

Complaints – Due to covid19 all complainants were written to and advised there may be a delay in response. The divisions and patient experience team are now working closely together to respond to the backlog of complaints.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

Underperforming Measures

6 Week Diagnostic Waits – has improved over last two months but due to infection prevention and controls measure resulting in activity being limited to 90% of normal levels in Radiology performance remains a risk.

Key Performance Indicators – Well Led **High Performing Measures** Agency Spend Staff Friends & Family Test **Opportunity for Improvement Measures** Vacancy Levels Nursing Turnover Sickness/Absence	**Key Performance Indicators – Effective** **Underperforming Measures** Referral to Treatment – Wales as described in the paper the trust has only seen and treated urgent patients **Key Performance Indicators – Safe** **Opportunity for Improvement Measures** Infection Control – local performance is on plan with the exception of MSSA and the Trust is generally in line with national benchmark average, also with the exception of MSSA in which incidences have increased in Q1 20/21.
Related Trust Ambitions	Delete as appropriate: • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____
Action required by the Board	Delete as Appropriate • To consider and note

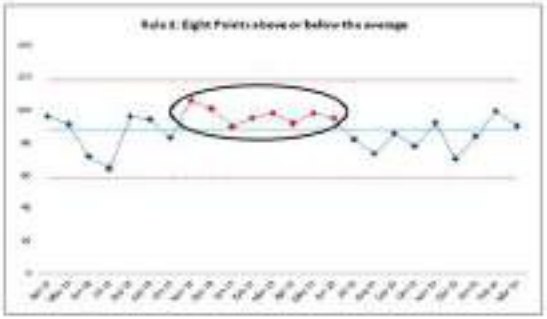
Board KPI Report
September 2020

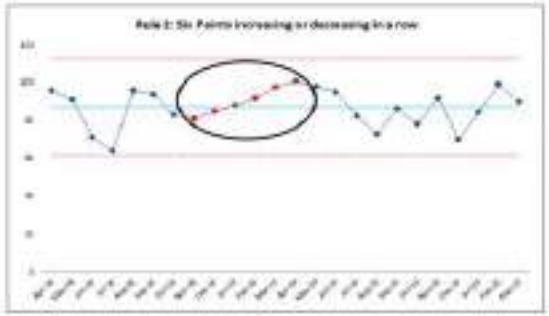
Data for August 2020 unless indicated

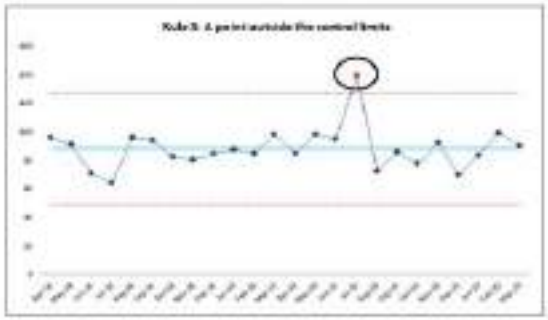
SPC Charts Rules

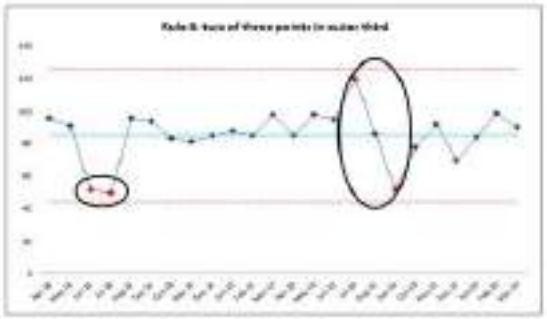
The Walton Centre NHS Foundation Trust

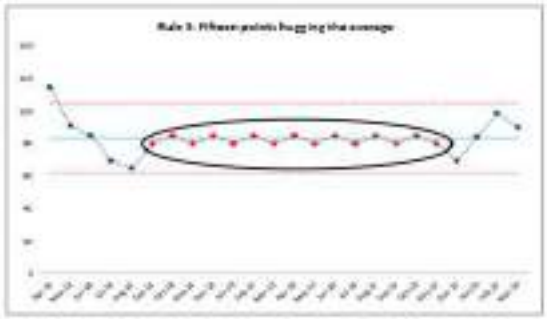
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in seperating normal variation (exepcted performance) from special cause variation (unexpected performance).











All SPC charts will follow the below Key unless indicated

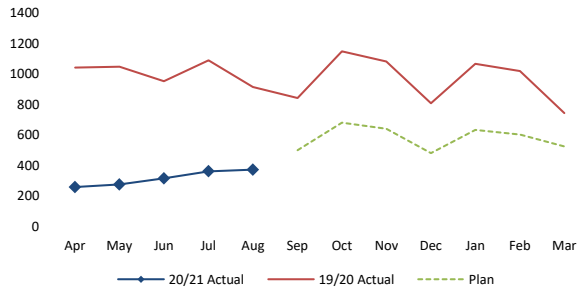
Actual — UCL — Average — LCL — National Average — Target

Operational

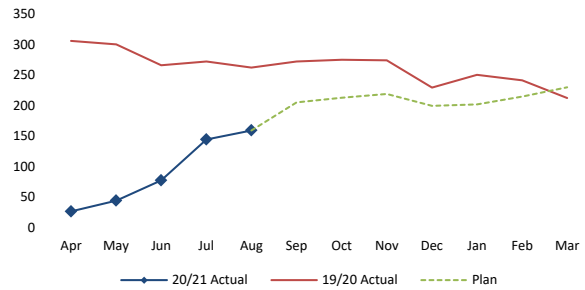
Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

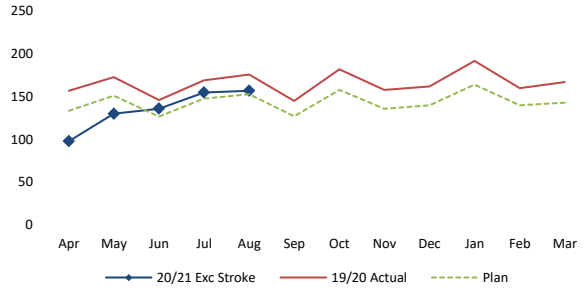
Daycase Activity v Plan



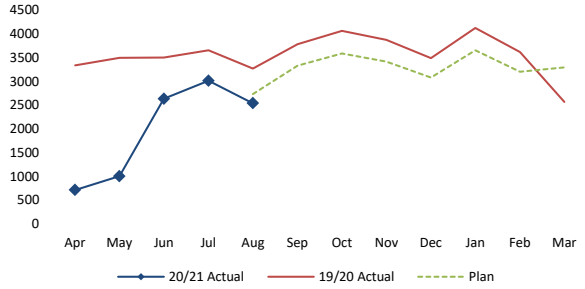
Elective Activity v Plan



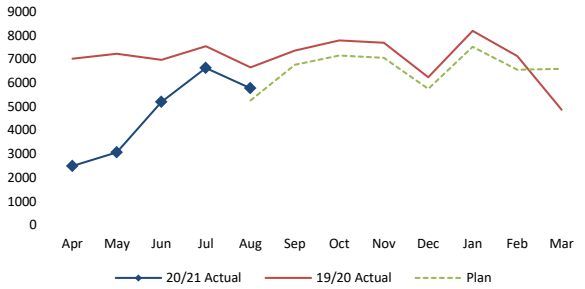
Non Elective Activity v Plan



New Outpatients Activity v Plan



Follow Up Outpatients Activity v Plan



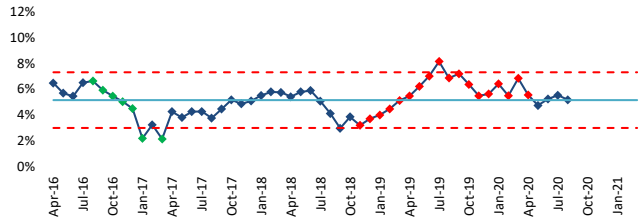
Please note that the activity plans are those that the Trust has submitted as part of the Phase 3 planning submission, at the time of reporting these are still draft and have not been signed off by NHSE/I.

Quality of Care

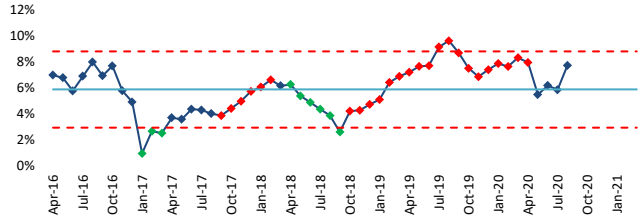
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

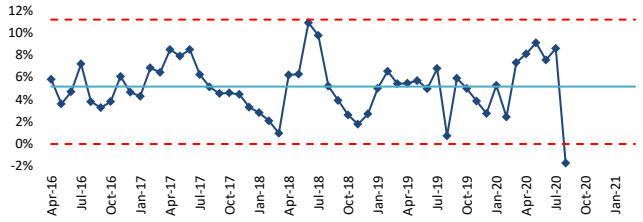
Overall Vacancy Level %



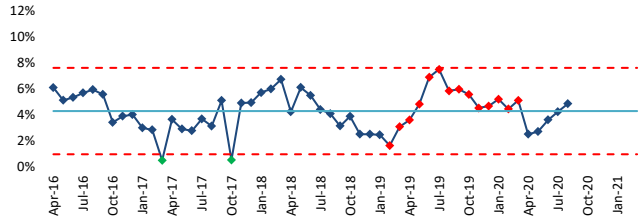
Nursing Vacancy Level %



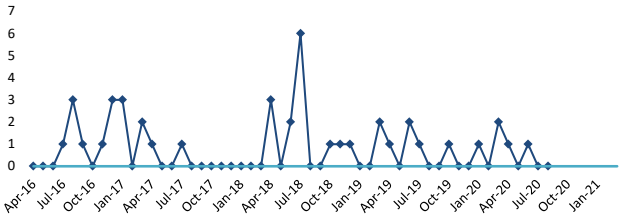
Medical Vacancy Level %



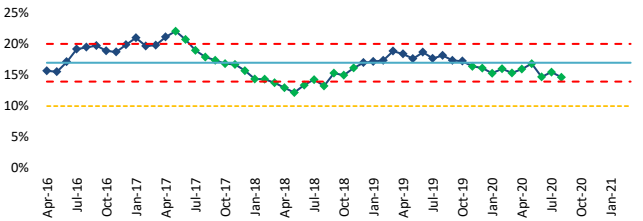
Other Staff Vacancy Level %



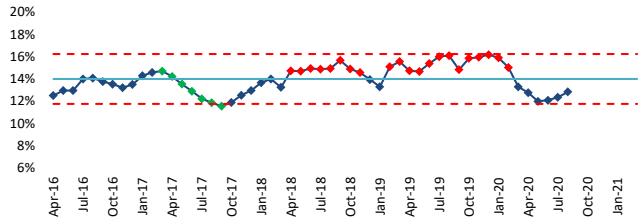
Medical Leavers



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.

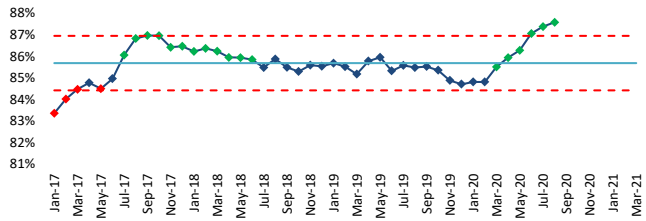
Sickness/Absence

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

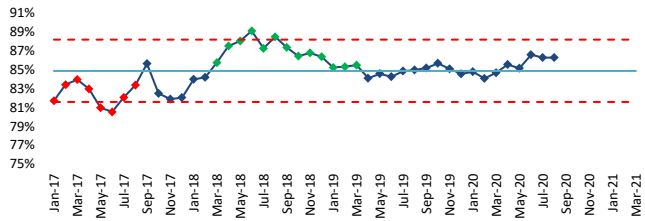
Staff Stability

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.

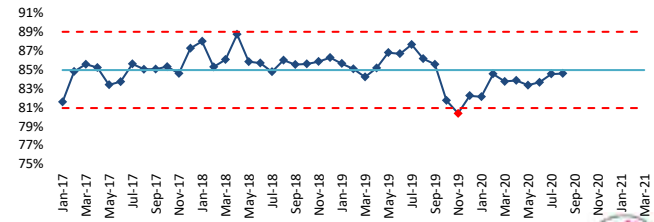
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

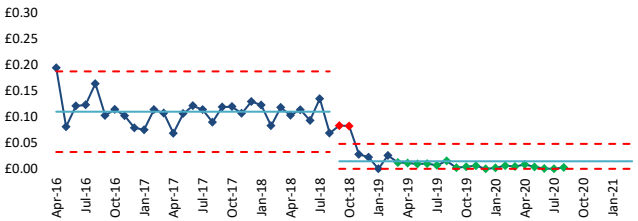


Quality of Care

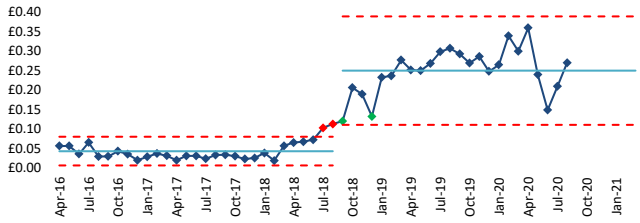
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

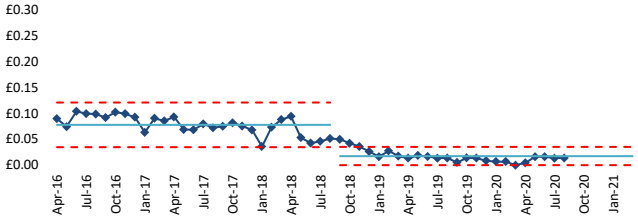
Nursing & HCA Agency Spend (£m)



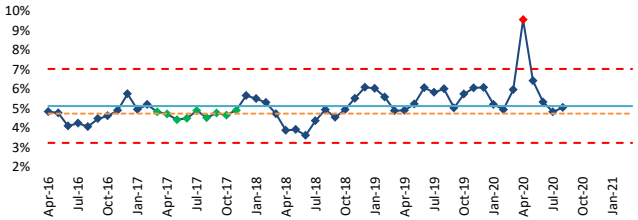
Nursing & HCA Bank Spend (£m)



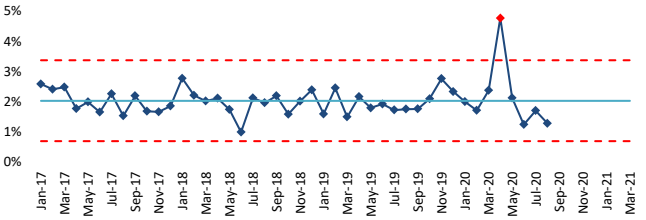
Nursing & HCA Overtime Spend (£m)



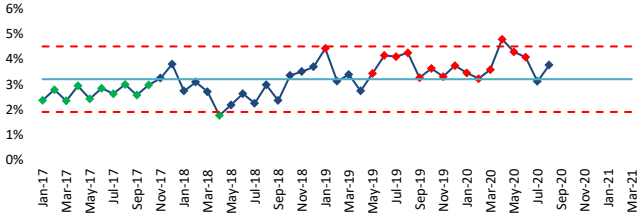
Sickness/Absence (Monthly)



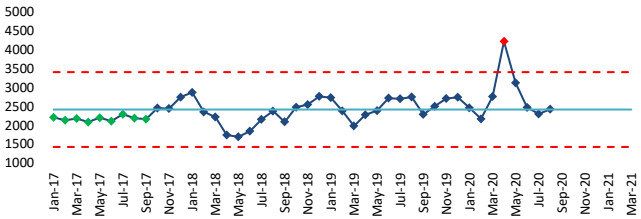
Short Term Sickness/Absence (Monthly)



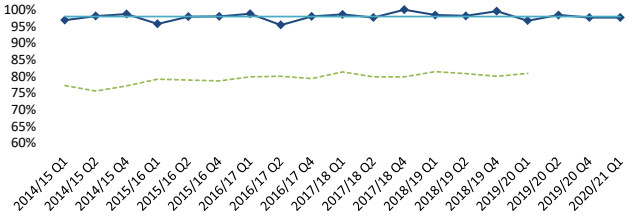
Long Term Sickness/Absence (Monthly)



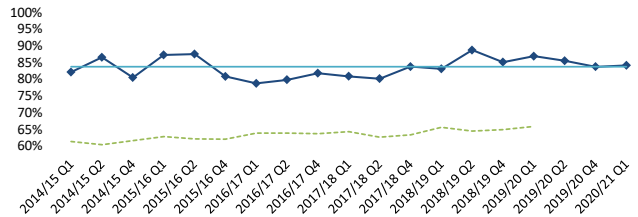
Lost Days due to Sickness/Absense (Monthly)



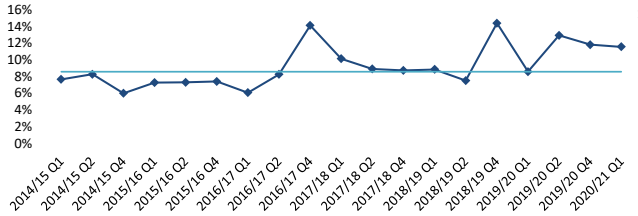
Staff FFT - % Recommend as Place of Care



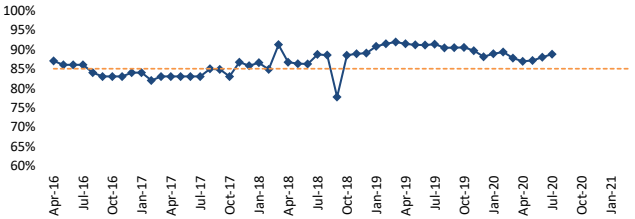
Staff FFT - % Recommend as Place of Work



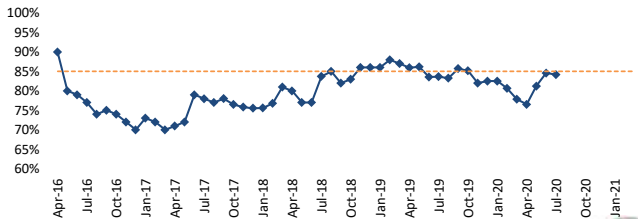
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)

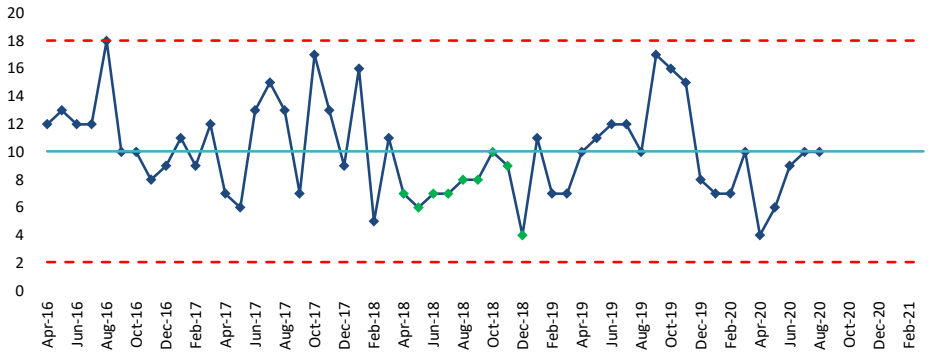


Quality of Care

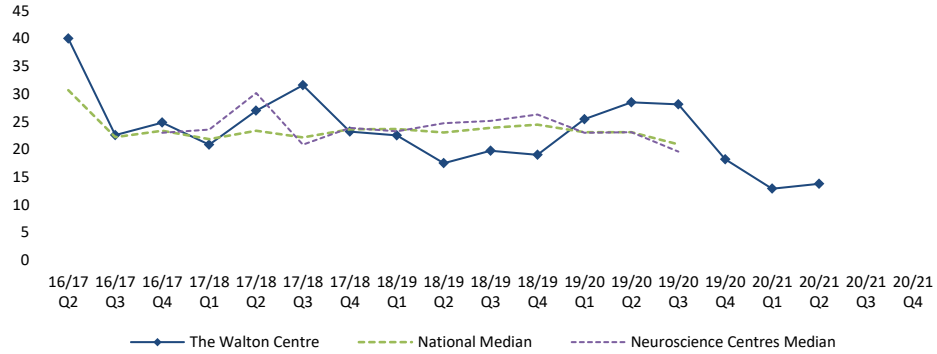
Caring - Complaints

The Walton Centre NHS Foundation Trust

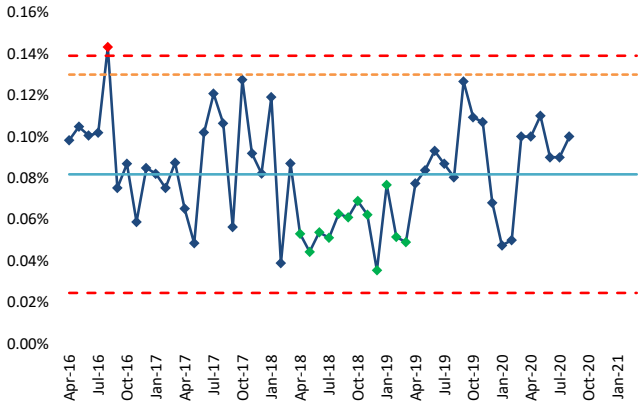
Total Complaints Received in month



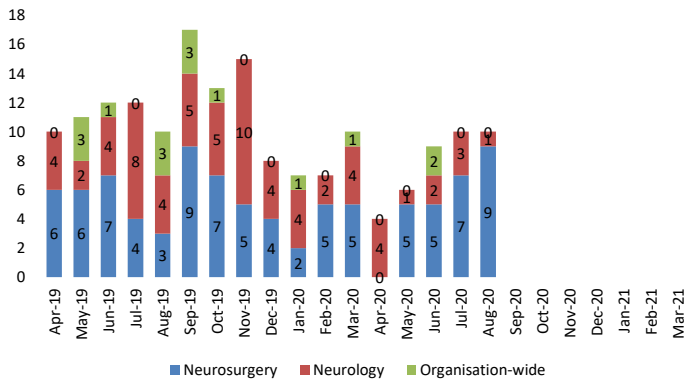
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In August 2020 the Trust received 10 complaints. 1 Neurology and 9 Surgery.

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

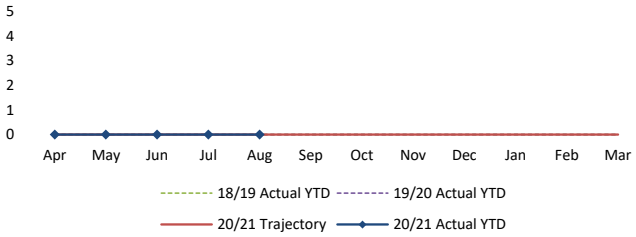
Excellence in Neuroscience

Quality of Care

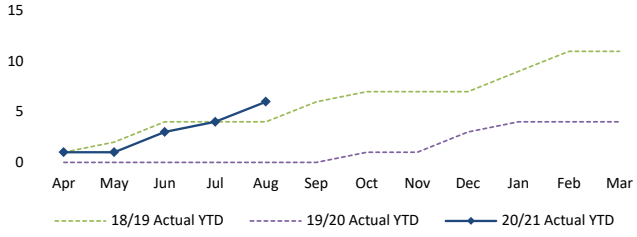
Safe - Infection Control

The Walton Centre NHS Foundation Trust

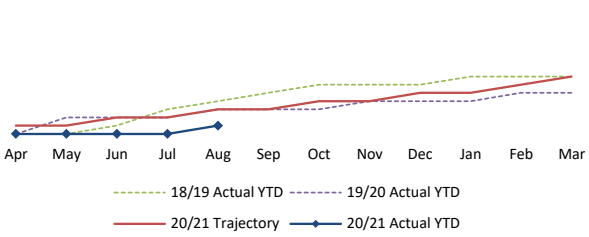
MRSA Bacteraemia



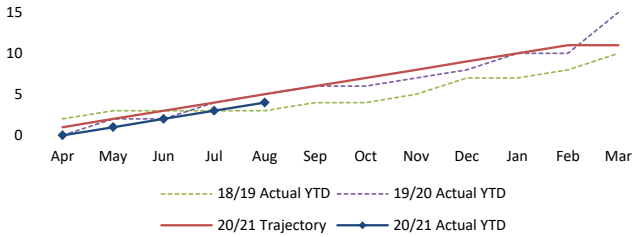
CPE



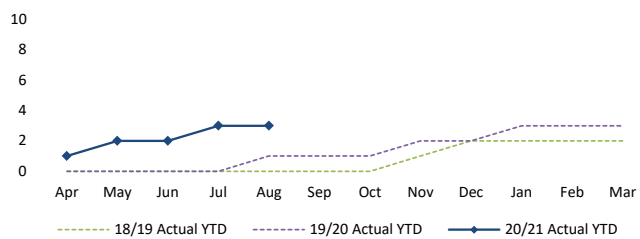
C.Diff



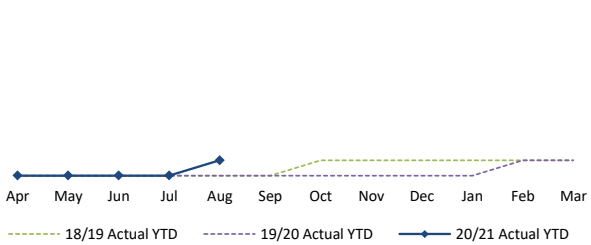
E.Coli



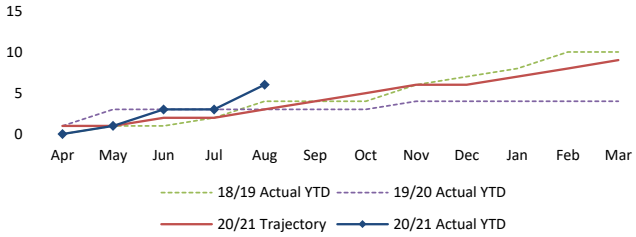
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		1	1				1	**3**
Caton		1					1	**2**
Chavasse				1				**1**
CRU					1			**1**
Dott		3		1			1	**5**
Horsley		1		1	1	1	3	**7**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**6**	**1**	**4**	**3**	**1**	**6**	**21**

August Breakdown

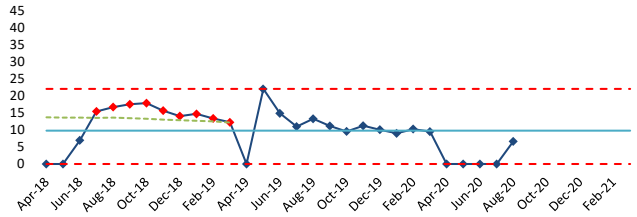
1x C.Diff - Cairns
1x E.Coli - Lipton
2x CPE - 2x Dott
3x MSSA - 3x Horsley
1x PB - Horsley

Quality of Care

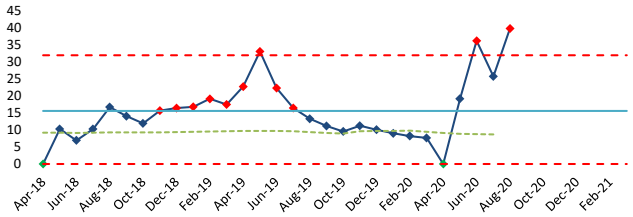
Safe - Infection Control

The Walton Centre NHS Foundation Trust

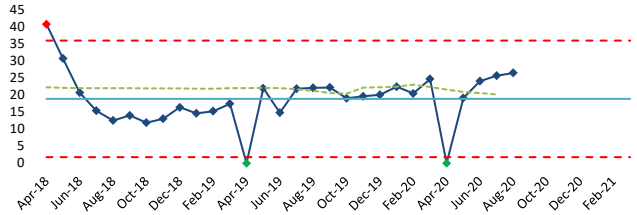
C.Diff Rate per 100,000 Bed Days YTD



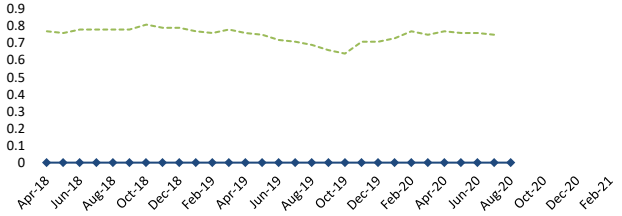
MSSA Rate per 100,000 Bed Days YTD



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 August 20 with the exception of MSSA in which there has been six recorded instances against a YTD trajectory of three.

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.

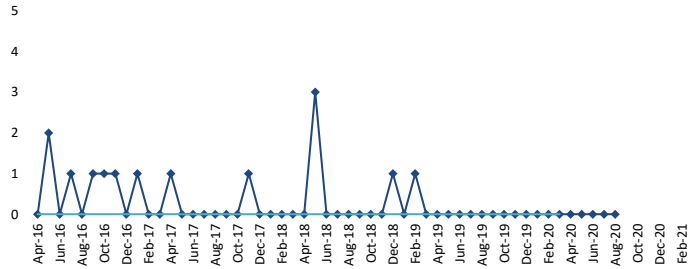
As of March 19 the C.Diff hospital acquired rate is no longer published.

Quality of Care

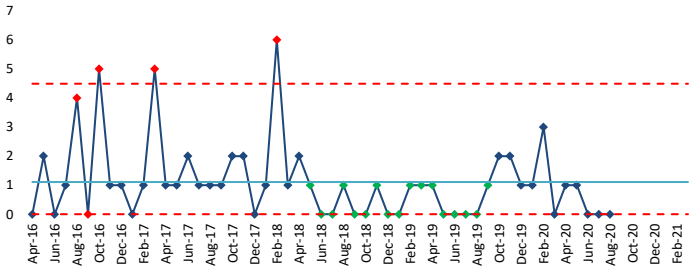
Safe - Harm Free Care

The Walton Centre NHS Foundation Trust

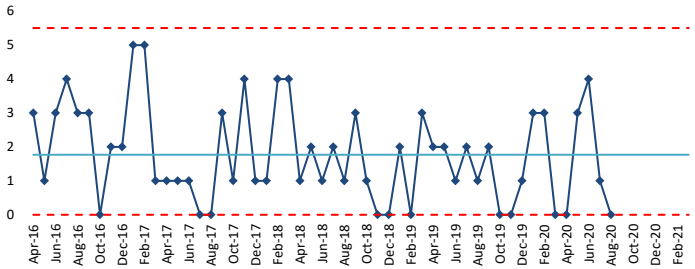
Total Moderate or Above Harm Patient Falls



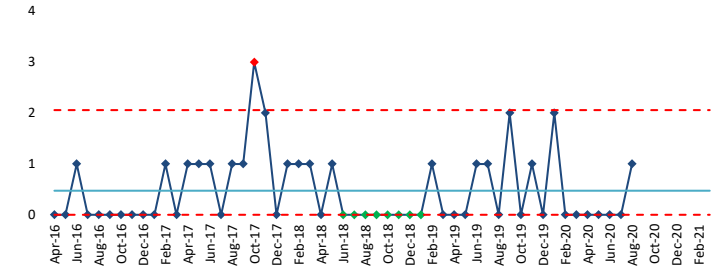
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

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

There were no Hospital Acquired Category two Pressure Ulcer in August 20.

There were no CAUTI incidences in August 20

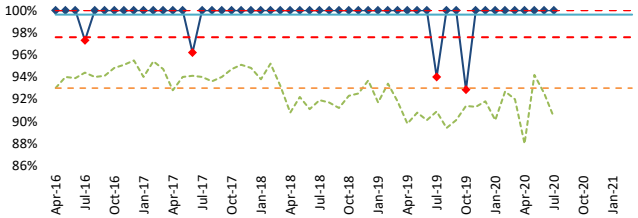
There was one VTE incidence in August 20

All Harm indicators are within normal variation.

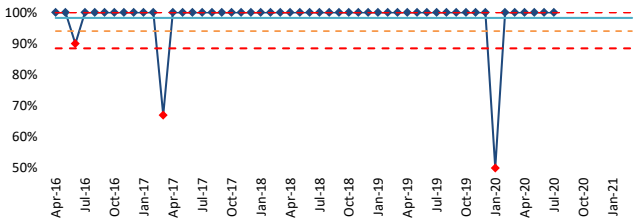
Operational
Responsive - Cancer

The Walton Centre NHS Foundation Trust

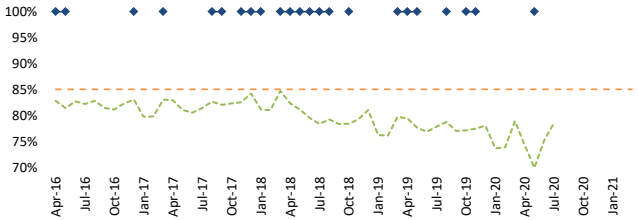
14 Day Performance



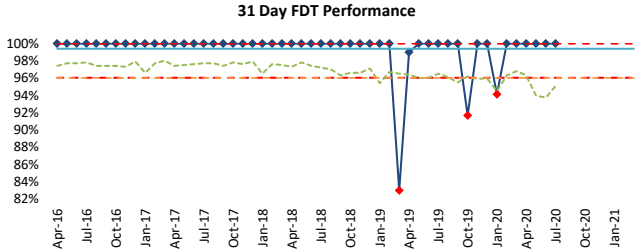
31 Day Subsequent Performance



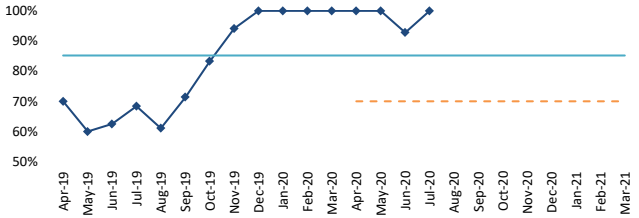
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

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

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

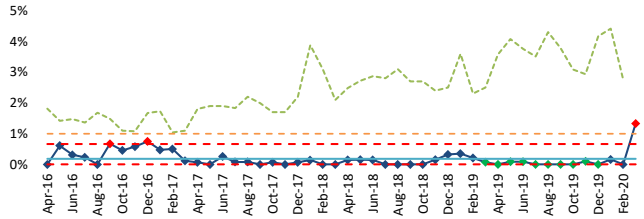
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has consistently met this target since its introduction.

Operational

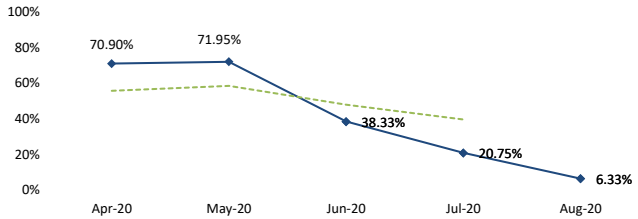
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

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



6 Week Diagnostic Performance (20/21)

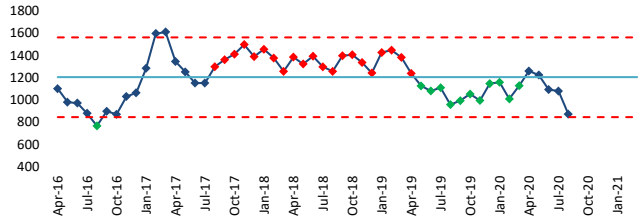


Narrative

Diagnostic performance in August 20 was 6.33%. This is a significant improvement from 20.75% in July 20.

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

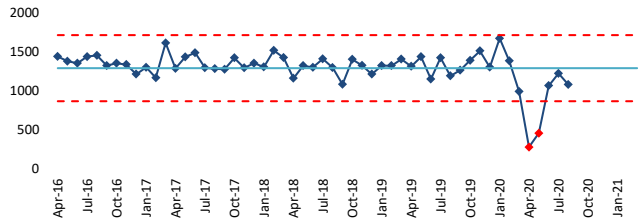
Total Diagnostic Waits at Month End



There were 46 six week diagnostic breaches in month.

MR - 35
CT - 10
EMG - 0
Sleep - 1

Total Diagnostic Activity in Month



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	8,762	81	43,405	42,038	(1,367)
Exclusions	1,786	1,786	0	8,928	8,928	0
Private Patient	20	0	(20)	100	0	(100)
Other Operating	613	196	(417)	3,067	2,194	(873)
Total Operating Income	**11,100**	**10,744**	**(356)**	**55,500**	**53,160**	**(2,340)**
Pay	(6,116)	(5,953)	163	(30,580)	(29,686)	894
Non-Pay	(2,660)	(2,477)	183	(13,300)	(11,798)	1,502
Exclusions	(1,798)	(1,529)	269	(8,990)	(6,428)	2,562
COVID / Reserves	31	(221)	(252)	155	(2,409)	(2,564)
Total Operating Expenditure	**(10,543)**	**(10,180)**	**363**	**(52,715)**	**(50,321)**	**2,394**
EBITDA	**557**	**564**	**7**	**2,785**	**2,839**	**54**
Depreciation	(387)	(402)	(15)	(1,935)	(2,015)	(80)
Profit / Loss On Disp Of Asset	0	0	0	0	2	2
Interest Receivable	14	0	(14)	70	5	(65)
Financing Costs	(53)	(52)	1	(265)	(259)	6
Dividends on PDC	(131)	(129)	2	(655)	(655)	0
I & E Surplus / (Deficit)	**0**	**(19)**	**(19)**	**0**	**(83)**	**(83)**
Capital donations I&E impact	**0**	**19**	**19**	**0**	**83**	**83**
I & E Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**

At month 5, the Trust reported a £307k 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, and a reduction in funding from Health Education England in relation to undergraduate funding.

The in month position includes £0.1m spend incurred as a result of COVID-19, which has been partially offset by a reduction in clinical supplies and excluded drugs and devices spend compared to M8-10 in 19/20 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	Aug-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	40	(9)
Tangible Assets	82,591	81,298	(1,293)
TOTAL NON CURRENT ASSETS	**82,640**	**81,338**	**(1,302)**
Inventories	1,232	1,212	(20)
Receivables	9,287	6,848	(2,439)
Cash at bank and in hand	26,673	38,839	12,166
TOTAL CURRENT ASSETS	**37,192**	**46,899**	**9,707**
Payables	(18,088)	(27,159)	(9,071)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(28,833)**	**(9,071)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,066**	**636**
Provisions	(639)	(628)	11
Finance Lease	(115)	(99)	16
Loans	(25,031)	(24,334)	697
TOTAL ASSETS EMPLOYED	**74,285**	**74,343**	**58**
Public Dividend Capital	27,554	27,696	142
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,103	(84)
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,343**	**58**

STATEMENT OF CASH FLOW - 2019/20	August-20 Actual	Movement Jul-Aug
	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(83)**	**(19)**
Non-Cash Flows In Operating Surplus/(Deficit)	2,925	584
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**2,842**	**565**
Increase/(Decrease) In Working Capital	13,185	321
Increase/(Decrease) In Non-Current Provisions	(11)	(11)
Net Cash Inflow/(Outflow) From Investing Activities	(2,971)	(143)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**13,045**	**732**
Net Cash Inflow/(Outflow) From Financing Activities	(879)	(3)
NET INCREASE/(DECREASE) IN CASH	**12,166**	**729**
OPENING CASH	**26,673**	**38,110**
CLOSING CASH	**38,839**	**38,838**

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

COVID-19 expenditure:

YTD £1.6m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

Any reasonable COVID costs will be reimbursed by NHSI/E if over and above block income levels.

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	Jul-20 Actual £'000	Aug-20 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	758
Annual leave provision	287	(287)	52	0	0	52
PPE	62	148	259	63	10	542
Decontamination	9	8	(2)	6	(3)	18
Agile working	21	(19)	1	92	0	95
ITU	5	2	(3)	0	2	6
Other	37	24	18	23	18	120
TOTAL	**520**	**130**	**516**	**302**	**123**	**1,591**

Other spend includes providing free car parking for staff and increasing the number of staff uniforms for staff.

Capital

In month plan - £409k

In month actual - £132k

In month variance - £277k below plan.

Year to date actual - £714k

The full year plan includes additional non-recurrent funding of £0.5m allocated by NHSI for critical infrastructure costs. This has resulted in the 20/21 capital plan increasing to £4.5m.

Despite this increase there is still a forecast over commitment against annual plan of approx. £0.5m. The detailed capital forecast is being monitored and reviewed regularly by Director of Finance and Director of Ops and Strategy.

CAPITAL

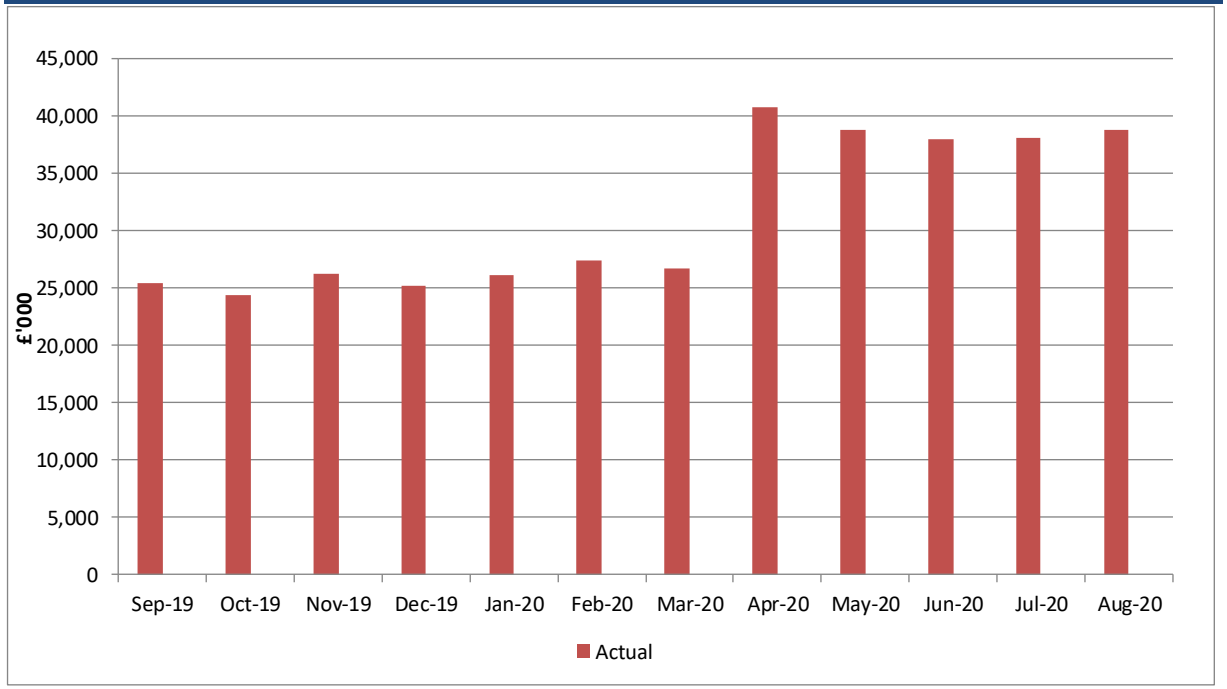
	Annual	In month			Year to Date		
	Plan £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division							
Heating & Pipework	1,482	195	82	113	440	176	264
Estates	368	30	23	7	153	96	57
IM&T	1,283	107	25	82	535	153	382
Neurology	2,122	43	0	43	216	21	195
Neurosurgery	1,702	142	0	142	709	29	680
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,603)	(108)	0	(108)	(626)	0	(626)
TOTAL (excl. COVID-19)	**4,504**	**409**	**130**	**279**	**1,427**	**475**	**952**
COVID-19	0	0	2	(2)	0	239	(239)
TOTAL	**4,504**	**409**	**132**	**277**	**1,427**	**714**	**713**

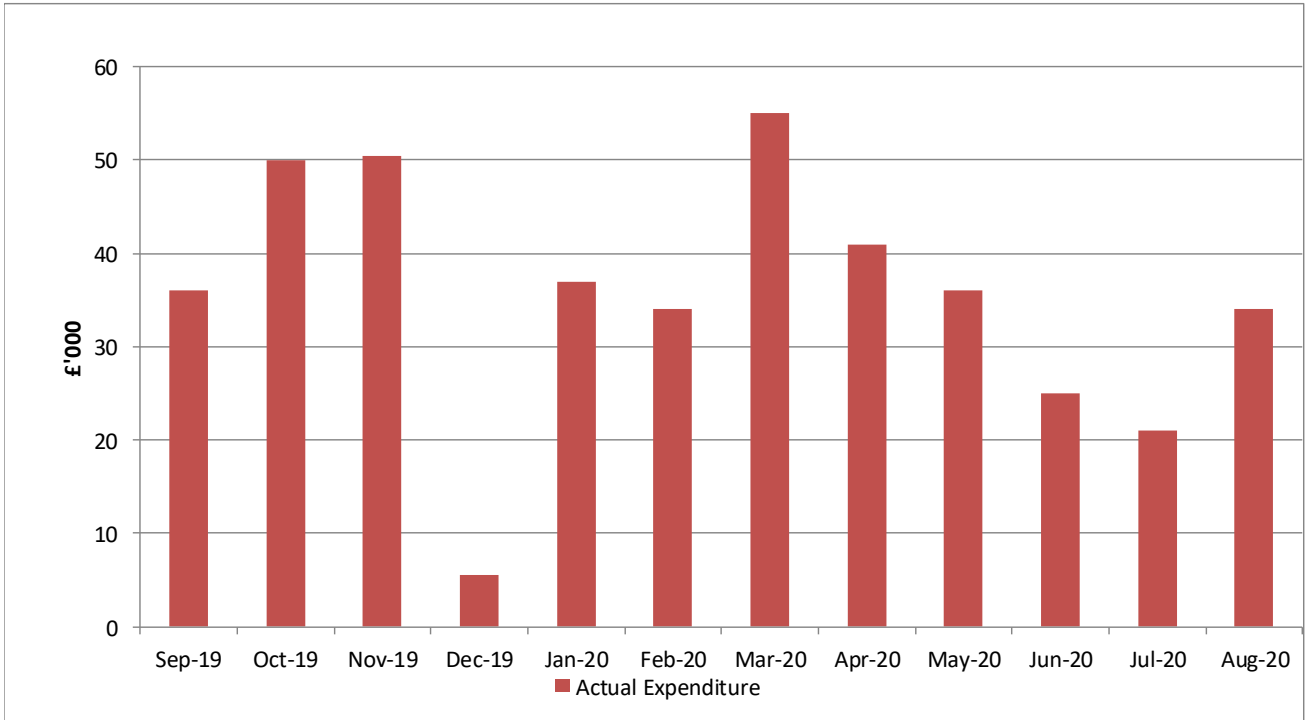
Capital spend in month is £132k; there was a minor adjustment to the YTD COVID-19 in M5.

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

There is £82k capital spend on phase 3 heating/pipework scheme, in addition to this Estates have also spent £23k on CCT/Access Control upgrades, replacement of air conditioning units and design costs in relation to ultraclean conversion of theatre 4. There has been £25k of IMT spend on staffing for projects. There was no additional capital expenditure across the divisions in month.

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

As of the end of August: Actual Cash Balance: £38.8m Number of days operating expenses = 116 days	**Cashflow against plan (Rolling 12 months)**  	The Trust cash balance at the end of August was £38.8m. This is an increase of £0.7m from the end of July. 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: £34k YTD Actual: £157k	**Monthly Agency Expenditure (Rolling 12 months)**  	Agency spend incurred in August was £34k, an increase of £13k compared to July. There was no additional agency expenditure in month relating to the COVID-19 response. At the end of August, £41k agency expenditure relates to COVID (and is included within the COVID 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 October and December 2019). The suspension of PbR is anticipated (though not confirmed) to remain in place at least for the remainder of 2020/21. 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);
- The expectation that trusts will deliver breakeven during the pandemic but it is currently not clear what 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 are required to submit draft phase 3 plans by 1st September with final submissions due 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 as funding allocations are awaited;
- 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 2/3 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 but have issued a revised offer which is based on the 2019/20 M9 position + 2.8% inflation which is still lower than the Trusts expectations (resulting in an underpayment on expected levels of income), which has been reflected in the financial position. The Trust has issued a counter offer to this but Wales have stated that they will not

	increase the current offer. IOM are only paying for actual activity that has been delivered, again resulting in an under payment compared to expected levels of income. Both issues have been raised with NHSI/E and in months 1-5, 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. 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; however it is not clear what the financial architecture will be beyond this time. Due to the level of uncertainty it is not possible to undertake financial planning or fully understand the future financial position of the Trust. STP's are required to submit phase 3 recovery plans for activity (and associated financial implications) by 1st September with final plans being due by 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. Further updates will be provided once available.
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 during July 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 COVID19	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 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.

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

People Plan/Strategy Update

Mike Gibney

Director of Workforce and Innovation

Jane Mullin

Deputy Director of Workforce and Innovation

Our Aim

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Our People Strategy places our staff at the heart of our plans and sets out the key strategic themes and objectives through which we wish to harness our commitment and engage with staff across the Trust.

National Context

NHS Interim People Plan published 3rd June 2019:

1. Make the NHS the best place to work
2. Improve our leadership culture
3. Prioritise urgent action on nursing shortages
4. Develop a workforce to deliver 21st century care
5. Develop a new operating model for workforce

We are the NHS: People Plan 2020/21 – action for us all

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Response to COVID-19 pandemic - Review and refresh the plan:

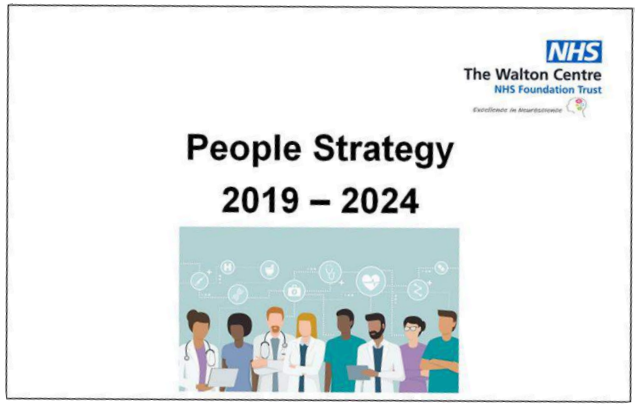
- Responding to new challenges and opportunities
- Looking after our people
- Belonging to the NHS
- New ways of working and delivering care
- Growing for the future
- Supporting out people for the long term

Prerana Issar, Chief People Officer for NHS Improvement

People Plan

The plan will influence our local strategy:

- The People Strategy is central to putting our people at the heart of the recovery and builds on much of the work we have supported over the past few months
- The Cheshire and Mersey response developed by the Cheshire and Merseyside Health and Care Partnership



Cheshire & Merseyside
Health & Care Partnership

"Be the reason someone receives better care today"

Deliver

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

To provide the right systems, processes and environment to enable our workforce to be as efficient and effective as they can be in delivering high quality care to patients:

- A suite of HR policies covering a range of employment areas including supporting staff who are absent due to illness and supporting their return to work
- Ensure staff have sufficient rests and breaks from work and encourage them to take annual leave in a managed way
- Pension flexibilities

Provide

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

To provide a compassionate and inclusive work environment working at the Centre, or in the community, where our staff our motivated, engaged, valued and share the same vision:

- Ensure staffing reflects the diversity of the community, regional and national labour markets
- Workforce leadership is representative of the overall BAME workforce
- Risk assessments
- Tackle the disciplinary gap

Invest

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

To invest in education and training to ensure we deliver the highest calibre of health care staff for future NHS patients:

- Offer more apprenticeships ranging from entry level jobs through to senior clinical, scientific and managerial roles
- Ensure staff have CPD, supportive supervision and protected time for training
- Support expansion of clinical placement capacity during 2020/21; provide an increased focus on support for students and trainees

Lead

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

To lead education and training, embedding research and innovative approaches to deliver changes across the health economy:

- Flexible working to be discussed at induction and in annual appraisal
- Roll out the new carers passport to support people with caring responsibilities
- Board members to give flexible working their focus and support

Adopt

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

To adopt new ways of working to create a place that recruits, retains and supports an efficient, resilient and productive workforce delivering excellence in healthcare:

- Flexible working - for all from day 1
- Modelled from the top
- Design new roles which make the greatest use of each person's skills and experiences and fits in with their needs and preferences

Recognise

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

To recognise the importance of excellence in staff wellbeing and to embed a high performing culture based upon our Walton Way values and standards of behaviour:

- Ensure line managers have wellbeing conversations with staff and encourage wellbeing to reduce stress and burnout. Conversations to include equality, diversity and inclusion
- Ensure staff have a safe rest space to manage and process the physical and psychological demands of work
- Prevent and tackle bullying, harassment and abuse against staff and create a culture of civility and respect
- Prevent and control violence in the workplace - in line with existing legislation
- Board - Wellbeing Guardian

Key Dates…

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

- Speaking up - quarterly staff survey to track morale - commences **first quarter of 2020/21**
- All staff to have personalised H&W plan - reviewed annually- **September 2020**
- Health and Wellbeing induction - **October 2020**
- Review of recruitment – staffing reflects diversity - **October 2020**
- Resources to help leaders have conversations regarding race - **October 2020**
- NHS violence reduction standard - approach to protecting staff- **December 2020**

Key Dates…

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

- Universities offering blended nursing degree programme and more flexible approach to learning - **January 2021**
- Toolkit for civility – **March 2021**
- Board level competency framework for ED&I - **March 2021**
- Review of HR/OD - **end of 2020/21**
- Review of governance arrangements to allow staff networks to contribute to and inform decisions - cross system by **December 2021**

Any questions?

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

REPORT TO TRUST BOARD

Date: 24 September 2020

The Walton Centre NHS Foundation Trust

Title	Accountable Officer for Controlled Drugs Annual Report 2019/20
Sponsoring Director	Name: Andrew Nicolson Title: Medical Director
Author (s)	Name: Dave Thornton Title: Associate Clinical Director, Pharmacy
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____

Executive Summary

- Following the Shipman Report all Trusts were mandated to appoint an Accountable Officer for controlled drugs (CDAO) who monitors all CD incidents within the Trust. At The Walton Centre NHS Foundation Trust, the CDAO is the Clinical Director of Pharmacy, Alison Ewing.

- Quarterly controlled drug assurance audits continue to be undertaken by the pharmacy department to identify compliance with Trust standards. No areas for concern have been highlighted.

- The level of concern around the handling of PODs highlighted in the last report has reduced but this still remains as an area for improvement.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	Nil
Related Assurance Framework entries	Nil
Equality Impact Assessment completed	• No – (please specify) Not applicable
Any associated legal implications / regulatory requirements?	• No – (please specify) No breach of legislation identified
Action required by the Board	Delete as Appropriate • To consider and note

Accountable Officer for Controlled Drugs – Annual Report
August 2019 to June 2020

1. Executive Summary

This report provides the Trust Board with an overview of Controlled Drug (CD) activity during 2019/20. The following are the key issues of note from the report:

- Following the Shipman Report all Trusts were mandated to appoint an Accountable Officer for controlled drugs (CDAO) who monitors all CD incidents within the Trust. At The Walton Centre NHS Foundation Trust, the CDAO is the Clinical Director of Pharmacy, Alison Ewing.

- Quarterly controlled drug assurance audits continue to be undertaken by the pharmacy department to identify compliance with Trust standards. No areas for concern have been highlighted.

- The level of concern around the handling of PODs highlighted in the last report has reduced but this still remains as an area for improvement.

The Trust Board members are asked to note the report.

2. Background

In response to the Shipman Inquiry, the Government introduced a range of measures to strengthen the systems for managing CDs and to minimise the risks to patient safety as a result of inappropriate use. The new arrangements are underpinned by the Health Act 2006 and The Controlled Drugs Regulations 2006. One of the requirements is to have a Controlled Drugs Accountable Officer who has responsibility for the safe use and management of controlled drugs. The CDAO works in accordance with legislation regarding the role and in line with the Handbook for Controlled Drugs Accountable Officers in England and keeps up to date from the national quarterly newsletter for Controlled Drugs Accountable Officers. It is the CDAO's responsibility to produce an annual report for the Trust Board.

3. Introduction

A Controlled Drug Accountable Officer is responsible for the safe and effective management of medicines classified as Controlled Drugs and must ensure the safe management of controlled drugs at a local level. The Clinical Director of Pharmacy is the CD Accountable Officer for The Walton Centre NHS Foundation Trust.

There are four key aspects mandated for the CD Accountable Officer:

- *CD policy and supporting standard operating procedures*

The Accountable Officer must ensure adequate and up-to-date standard operating procedures are in place within their organisation. The Medicines Policy and supporting CD Standard Operating Procedures are available to all staff through the hospital intranet. The Medicines Policy was reviewed and republished in January 2018; it is due its next full review in January 2021. The Trust CD Standard Operating

Procedures (SOPs) are updated as required to ensure that they reflect requested clarifications, following learning from incidents, internal audit recommendations or published changes in legislation.

- *Routine Monitoring and Audit*

The Accountable Officer must ensure that the use of Controlled Drugs is monitored through routine processes. This report provides details of the monitoring and assurance obtained about the management of CDs at The Walton Centre.

Within The Walton Centre, there are 12 wards and departments holding controlled drugs. Quarterly audits are undertaken by the pharmacists to ensure all controlled drugs are stored correctly, that the stationery for ordering and recording controlled drugs is held securely and that there are no discrepancies in the stock balances. The ward managers have been tasked to ensure regular balance monitoring is taking place.

- *Inspection, self-assessment and declaration to the relevant authority*

This report demonstrates compliance with all elements of the CD Accountable Officer and organisational responsibilities and summarises the evidence to support assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12; Safe care and treatment, section (g) the proper and safe management of medicines. Following the re-audit of the management of controlled drugs at The Walton Centre by MIAA in January 2019, where the handling of patients own CDs was raised as an area of concern, good progress has been made to rectify the issues. There still remains further room for improvement however.

- *Collaboration and Local Intelligence Networks*

Accountable Officers must establish and operate arrangements for sharing information. The Trust CD Accountable Officer continues to participate in a Local Intelligence Network (LIN), now co-ordinated by the NHS England Controlled Drug Accountable Officer and support team.

WCFT is represented at the NHS England North (Cheshire and Merseyside) LIN group.

4. Key issues

4.1 Monitoring of CD Incidents

There were 87 incidents that involved CDs reported at The Walton Centre between August 2019 and June 2020 compared with 99 in the same period last year. The majority of these issues continue to be low risk and related to balance discrepancies and do not raise any issues of concern.

All of the 2019/20 incidents occurred in Trust wards and departments. All incidents are investigated when they are reported. CD incidents are monitored regularly by the

Principal Pharmacist and incidents are escalated to the Controlled Drug Accountable Officer as necessary.

4.2 Incidents by category

Administration	3
Dispensing	1
Governance	3
Patients/public of concern	2
Prescribing	6
Record keeping	16
Accounted for losses	6
Unaccounted for losses*	50

*Includes all balance discrepancies no matter how small. Comprises predominantly low volume liquid discrepancies.

There were no issues of concern raised and all unaccounted for losses were within acceptable tolerance limits (set as <5% of actual recorded volume by NHSE CDAO). Two incidents were deemed high risk (using the NHSE risk matrix). One was related to a prescribing error that was picked up before any doses were administered (but had the potential to cause harm) and the other was in relation to a patient of concern who was found to be using drugs on the ward illicitly.

4.3 Quarterly Ward/Department CD Stock Checks by Pharmacy Staff

It is a requirement of the Department of Health Safer Management of CD's Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. At The Walton Centre these checks are carried out quarterly in accordance with best practice. In every audit all cupboards were locked and controlled drugs were stored correctly. Controlled drug stationery was stored securely in the majority of areas. Ward Nurse Managers are informed when stationary is not securely stored and remedial action to rectify this is undertaken. A small number of CD balances were incorrect with balances of liquids and patient's own drugs accounting for all of the discrepancies. All balance discrepancies are investigated by the ward pharmacist and ward manager. Inappropriate amendment of records has also been highlighted as a continuing area for improvement.

All ward managers undertook regular controlled drug checks; daily stock checks were carried out on the majority of wards.

The results of the audits are shared with the Trust's Director of Nursing, the Medical Director and the ward managers.

Naloxone and Flumazenil should be available on all areas where CDs are administered as they can be used to reverse the effects of the drug in the event of an overdose. Stocks were supplied to all areas that did not have them. It is good practice for each area to have a stock list of controlled drugs in the CD cupboard.

4.4 Pharmacy Department Stock Checks

Individual CD stock levels are checked each time a CD is dispensed or a delivery is received into the pharmacy. There were no unexplained CD stock discrepancies in the pharmacy department.

4.5 Controlled Drug Destruction

Controlled drugs are destroyed in the pharmacy at Aintree University Hospital in accordance with CD regulations. All controlled drugs were disposed of in a way that ensured they were denatured and could not be reused. Records were kept of all controlled drugs that were destroyed.

4.6 Local Information Network Activity (LIN)

Following the Shipman report, local information networks were established. The Trust has been assigned to the NHS England North (Cheshire and Merseyside) LIN and the CDAO has been represented at all meetings to date.

The Trust's Controlled Drug Accountable Officer has a duty to submit quarterly occurrence reports to the LIN with information about any issues identified regarding prescribing or abuse of CDs. Occurrence reports for the first two quarters were submitted this year; the subsequent reports were not requested due to the COVID 19 pandemic. Alternatively, advice from the LIN was to report incidents or concerns that you consider are **"extremely serious"** or have had a **"catastrophic"** outcome. To the end of this reporting period, no such incidents were reported to the LIN.

5. Conclusion

The management of controlled drugs continues to be monitored by the Trust's Controlled Drug Accountable Officer and reported via the Trust incident reporting system. The programme of audit demonstrates that robust systems are in place to ensure the safe handling of controlled drugs. The handling of patient's own CDs requires further improvement, although it should be noted that significant progress has been made over the last year.

Alison Ewing
Controlled Drugs Accountable Officer
July 2020

Prepared by: Dave Thornton, Assistant Clinical Director, Pharmacy

REPORT TO TRUST BOARD

Date: 24 September 2020

Title	**Pharmacy and Medicines Management Annual Report 2019-20**
Sponsoring Director	Name: Andrew Nicolson Title: Medical Director
Author (s)	Name: Dave Thornton Eleri Philips Title: Associate Clinical Director, Pharmacy Acting Lead Neurosciences Pharmacist
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____

Executive Summary

- Pharmacy services continue to be delivered in line with the Service Level Agreement and associated key performance indicators
- Further service evaluation showed that the pharmacist independent prescribers continue to make a significant number of interventions to improve medicines optimisation for neurosurgical inpatients. Qualitative data collection showed that healthcare professionals at the Trust highly rate the service provided
- Successful transition of pharmacy outpatient services to Lloyds
- Recruitment of a new WTE 8a pharmacist to post. This recruitment has enabled the 0.4 WTE previously agreed for antimicrobial stewardship to be realised. Improvements to date include establishment of a dedicated outpatient antimicrobial therapy (OPAT) service and measures to improve the safety of antimicrobial use in myasthenia gravis. The remaining 0.6 WTE of this post has created additional capacity within the homecare team and will enable further improvements in homecare governance.
- Innovative team working during the beginning of the COVID-19 pandemic to ensure pharmacy services continued to be delivered, including remote contributions from staff self-isolating. Measures implemented to facilitate the transition of the acute stroke service to Walton and preparedness for increased demands on ITU services.
- Funding agreed for an additional senior pharmacist for critical care, which will allow compliance with national standards for critical care pharmacist staffing.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Risks highlighted in the report include: • The upgrade of the Electronic Prescribing system at Aintree, and the impact of this on Walton. • Liaison with Liverpool Hospital Foundation Trust aseptic department regarding the aseptic production of pre-filled syringes for intrathecal pump refill • Ongoing responsiveness to the COVID-19 pandemic

Related Assurance Framework entries	Nil
Equality Impact Assessment completed	• No – (please specify) Not relevant
Any associated legal implications / regulatory requirements?	• No – (please specify) _____
Action required by the Board	Delete as Appropriate • To consider and note

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

Pharmacy and Medicines Management

Annual Report 2019-20

Our Mission:

To provide a comprehensive, high quality and cost-effective pharmacy service, ensuring that all patients receive
the correct drug,
at the correct dose,
at the correct time.

Report prepared by:

Dave Thornton, Assistant Clinical Director of Pharmacy, WCFT Lead
Eleri Phillips, Acting Lead Neurosciences Pharmacist
Ruth Bennett, Advanced Clinical Pharmacist
Sian Davison, Advanced Clinical & Antimicrobial Lead Pharmacist
Greg Musial, Advanced Clinical & Critical Care Lead Pharmacist
Elizabeth Akinsanya, Advanced Clinical & Homecare Lead Pharmacist
Kelly Connah, Senior Pharmacist
Jenny Sparrow, Lead Neurosciences Pharmacist

Executive Summary

Purpose
To update the Trust Board on the pharmacy department's activity and developments of the Trust's medicines management processes between April 2019 and March 2020.

Context
Medicines management in hospitals encompasses processes from medicines selection, procurement and delivery to prescription, administration and review. Medicines optimisation is a person centred approach to safe and effective medicine use that seeks to maximise the clinical and cost-effectiveness of patients' medicines.

Pharmacy services at The Walton Centre are provided by Liverpool University Hospitals NHS Foundation Trust, from the Aintree Pharmacy department under a service level agreement. This report covers all pharmacy services to Walton and also many wider issues relating to medicines management and clinical governance within Walton in which pharmacy staff have a role.

Highlights in 2019-20
- Further service evaluation showed that the pharmacist independent prescribers continue to make a significant number of interventions to improve medicines optimisation for neurosurgical inpatients. Qualitative data collection showed that healthcare professionals at the Trust highly rate the service provided.
- A collation of audits demonstrating the benefits of a pharmacist prescribing service in a neurosurgical unit were presented in poster format at the UK Clinical Pharmacy Association (UKCPA) Pharmacy Together conference.
- Launch of a Pharmacy service to submit adverse drug reactions identified by Trust staff to the MHRA 'Yellow Card' reporting system. This contribution builds on our collective knowledge of the safety of drugs in practice
- Successful transition of pharmacy outpatient services to Lloyds
- Recruitment of a new WTE 8a pharmacist to post. This recruitment has enabled the 0.4 WTE previously agreed for antimicrobial stewardship to be realised. Improvements to date include establishment of a dedicated outpatient antimicrobial therapy (OPAT) service and measures to improve the safety of antimicrobial use in myasthenia gravis. The remaining 0.6 WTE of this post has created additional capacity within the homecare team and will enable further improvements in homecare governance.
- Contribution to The Walton Centre receiving an outstanding CQC rating
- Innovative team working during the beginning of the COVID-19 pandemic to ensure pharmacy services continued to be delivered, including remote contributions from staff self-isolating. Measures implemented to facilitate the transition of the acute stroke service to Walton and preparedness for increased demands on ITU services.
- Funding agreed for an additional senior pharmacist for critical care, which will allow compliance with national standards for critical care pharmacist staffing.

Areas for further development
- Ongoing discussions and planning regarding the upgrade of the Electronic Prescribing system at Aintree, and the impact of this on Walton.
- Implementation of medication storage temperature reporting via the electronic web portal
- Transition of patients established on erenumab for the treatment of chronic migraine from outpatient prescription collection to homecare delivery service following approval of the necessary SLA

- Liaison with Liverpool Hospital Foundation Trust aseptic department regarding the aseptic production of pre-filled syringes for intrathecal pump refill
- Further development of governance and support for non-medical prescribers
- Review of the Medication Safety Officer's responsibilities and consideration of a business case submission to enable development of the role
- Ongoing responsiveness to the COVID-19 pandemic

Dave Thornton - Assistant Clinical Director of Pharmacy, WCFT Lead
Alison Ewing - Clinical Director of Pharmacy

1. Core Pharmacy Services

Within most of the core services listed below, work for Aintree and Walton is integrated, meaning that every member of Aintree Pharmacy staff, without exception, contributes to part of the service to the Walton Centre during their day to day work. The figures presented only include work relevant to Walton, unless otherwise specified. The developments described benefit both Trusts.

1.1 General information

Aintree Pharmacy employs 142 staff, comprising pharmacists, pharmacy technicians, assistant technical officers (ATOs) and administrative staff. In March 2020 compliance with mandatory training was 97%, sickness absence 3.72% and completion of annual appraisals 60% (these figures relate to the whole department).

Aintree pharmacy is a Registered Pharmacy with the General Pharmaceutical Council (GPhC), and has a wholesale dealer's license which enables supply of medicines to the Walton Centre. It has a license to supply controlled drugs to the Walton Centre and is inspected by The Home Office for renewal of this license to supply. The current license is valid until May 2021.

1.2 Dispensary services - medication supply

During 2019-20, a total of 60,484 items were dispensed for individual Walton inpatients, discharge prescriptions and outpatients, and 20,112 stock items were issued. 3528 items were returned to stock and credited to The Walton Centre.

The average turnaround time for Walton discharge prescriptions was 70 minutes; consistently under the target time of 2 hours. The average number of Walton discharge prescriptions clinically checked by the ward pharmacist was 76%, exceeding the 70% target.

The automated dispensing robot. When medicine labels are requested, or ward stock orders scanned by barcode, one of the robot 'arms' moves along to the required row & column and selects the correct medicine, and outputs it to a conveyer belt system which delivers it to the appropriate output chute. Most medicines are processed into the robot automatically via a 'hopper' that conveys them into the robot for bar code scanning and storage.

The EPMA portal is a web based system designed by Aintree Pharmacy, which reads information from the electronic prescribing and medicines administration (EPMA) system. Benefits include:

- Nurses can order individual inpatient medicines electronically using the portal at any time of the day, including out of hours. The 'out of hours' orders are dispensed when

Pharmacy is next open. Nurses can generate a medication order by simply selecting the item(s) required for the patient and submitting the request. There is an option to mark the item as urgent. Pharmacists view all requests and authorise them before they are dispensed.

- The portal displays recent medication supplies made by Pharmacy for each patient and indicates the ward the medicines were sent to. This reduces duplicate ordering, medication wastage and unnecessary expenditure.
- The portal is directly linked to automatic labelling systems in pharmacy. Once a medication supply order has been authorised by a pharmacist, the labels are automatically generated in pharmacy within minutes and thus dispensed in a timely manner. The automatic labelling systems use information pulled from the electronic prescription, avoiding the need for manual input of medicine details. Most medicines are stored in the 'robot', which identifies medicines by bar codes, and automatically delivers the medicinal product selected during the labelling process. When used together, the automatic labelling system and robot abolish the potential for dispensing errors due to incorrect manual entry of medicine details, manual selection of medicine or incorrect entry of patient details or dosage instructions. Those risks remain for the small minority of medicines not stored in the robot or where medicine and labelling details cannot be automatically pulled from the prescription. All dispensed items routinely undergo a final check, mitigating these risks so very few dispensing errors leave Pharmacy.
- Ordering of controlled drugs (CDs) is also performed electronically. This removes the need for porters to bring CD order books to Pharmacy from Walton. As well as being linked to the automatic labelling systems the EPMA system is linked to the Omnicell electronic CD cabinet. This improves the safety and security of CDs and automates the completion of the mandatory CD records.

These systems all improve patient safety by reducing the risk of error, and increase efficiency by streamlining the medication acquisition process for nursing, porter and pharmacy staff.

In addition to the ordering of medicines and controlled drugs already described the web portal also has a nurse dashboard for each ward which includes a discharge prescription tracker, indicating when these have been received and completed in Pharmacy, and highlighting patients on certain medicines such as intravenous (IV) medicines or CDs. Finally nurses can view where to find each medicine out of hours, and there are links to medicine information resources online. As an in house system the web portal is subject to continuous development to improve safety and efficiency in labelling and dispensing of medicines.

As of November 2019 an outsourced Lloyd's pharmacy opened at Aintree Hospital to dispense outpatient prescriptions for both Aintree and Walton. This dedicated outpatient service was implemented to help reduce outpatient waiting times and enable the hospital pharmacy team to focus solely on inpatient care and the processing of inpatient and discharge medication. The new pharmacy is also able to sell over the counter medicines to both patients and staff.

Pharmacy staff worked closely with Lloyds to ensure a smooth transition of services. Senior neurosciences pharmacists liaised with Lloyds to prepare them for specific issues involved with Walton prescriptions. For example, unlicensed medicines, frequent use of licensed medicines outside the licensed indications, posting medicines to patients and many issues unique to specific specialist medicines. Pharmacy also liaised with Walton's Outpatient Manager and Communications team to ensure timely and appropriate information about the change was provided to staff, patients/carers and visitors.

1.3 Pharmacy stores - procurement, stock distribution and medicine recalls

Pharmacy stores provided a stock top up service to all wards and departments, including refills and checks of used or expired resuscitation medicine boxes and intubation kits. Ward stock lists were reviewed regularly by ward pharmacists in conjunction with ward managers. In October 2019 ATOs were provided with tablet devices to conduct stock top-ups electronically, including recording of expiry date checking. This has made top-ups more efficient and improved patient safety by providing assurance that medication expiry dates have been checked.

National shortages of specific medicines have been an increasing problem in recent years. Pharmacy stores play a key role in managing stocks and sourcing alternative products where possible. They disseminate information to pharmacists who in turn can inform and/or liaise with other clinical staff to ensure everything possible is done to maintain optimal patient care and safety. Approximately 70 drug alerts and supply disruption notices were received during the year, and appropriate action taken. Significant shortages included: Plasma-lyte fluid, enteral and parenteral ranitidine formulations, phenytoin liquid, NeuroBloc botulinum toxin, Moffets solution, opicapone, levomepromazine and hyoscine hydrochloride injection. Baxter's mannitol 20% solution was discontinued. The alternative product which is prone to precipitation was made available as an interim measure and storage arrangements in Theatres' warming cabinets were made in order to reduce the risk of crystallisation.

The procurement team's work also included:

- monitoring changes in contracts negotiated by the regional purchasing hub, and alerting pharmacists to significant price changes or safety issues e.g. packaging similar to other medicines
- scrutiny of a monthly audit report of all off contract purchases to ensure that the lowest possible prices had been paid, and that any contract changes had not been missed.
- sourcing unlicensed medicines
- revision of the supply, location and number of resuscitation boxes.

1.4 Aseptic Unit

Aseptic preparation refers to "operating in conditions and in facilities designed to prevent microbial and chemical contamination." It is a complex activity which requires skilled staff and appropriate facilities with close monitoring and control.

As a licensed unit all activity complies with the principles and guidelines of good manufacturing practice (GMP). Sterile, high quality products such as chemotherapy and parenteral nutrition were produced in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements.

The Aseptic unit facility consists of four clean rooms, one of which is designated to the production of cytotoxic agents such as chemotherapy. This isolator is ducted externally to restrict any recirculation of contaminated air back into the clean room. The use of this

isolator prevents risk of ward staff exposure to those harmful agents. The environmental conditions in the clean rooms are continuously monitored, including pressure and temperature checks. A particle counter is present to detect contamination. Manipulations and checking of volumes are completed using CCTV.

Preparation of injectable medicines by the Aseptic unit provides a greater assurance of asepsis than is possible at ward level. Preparation within such a controlled environment minimises the risk of calculation errors and incorrect preparation of medicines. The ability to provide ready-to-use medicines as batches also saves time for nursing staff. In addition, aseptic production can achieve resources and cost efficiencies by allowing multiple doses to be prepared from one vial.

Overall, the quality and safety of the injectable medicines produced is assured and consistent, to facilitate accurate and timely administration to patients.

In 2019/2020 the licensed Pharmacy Aseptic unit prepared for Walton approximately:

- 1300 batches of ready to use injectable medicines for Walton for stock on wards e.g. intrathecal vancomycin and prefilled syringes of ketamine
- 390 ready to use medicines prepared specifically for individual patients including cytotoxic (chemotherapy) medicines such as cyclophosphamide and monoclonal antibodies including alemtuzumab and rituximab
- 40 bags of total parenteral nutrition (TPN) made to specific daily formulation for individual patients
- 60 ready to use medicines for clinical trials

An improved system for medication collection from Aseptics was introduced in December 2019 with Aseptics staff phoning the estates helpdesk to log an urgent e-portering job. This helps to minimise patient delay in administration of aseptically prepared medications.

1.5 Medicines Information service

The Medicines Information team answered 114 queries regarding medicines during the year, using a wide variety of specialist reference sources and/or comprehensive literature searches. 87% of these were complex (level 2 and 3) enquiries taking, on average, more than 2 hours to complete. For example a document detailing the washout period of various

antiepileptic therapies was produced to assist the medical team when admitting telemetry patients.

In addition, medication related patient enquiries were received via the patient hotline, a service advertised to all patients discharged from Walton via an insert in their discharge prescriptions. The Medicines Information team also took over 50 informal miscellaneous queries regarding Walton patients from a wide variety of internal and external staff. For example, information for community healthcare workers regarding discharge prescriptions.

The team updated monographs for the national electronic guide to injectable medicines (Medusa), thereby enabling free of charge access for all Walton staff. This resource is used frequently by pharmacy and nursing staff.

Significant updates were disseminated via Safeline bulletins e.g. the change in pregabalin and gabapentin CD status. Medicines information staff continued to monitor external medicines updates, warnings and bulletins from a variety of sources, and disseminated them to pharmacists who in turn cascaded them to the relevant clinicians.

The team has continued to record queries received by the on call pharmacist out of hours on the Medicines Information database. These are then available to assist with similar future queries. A large proportion of on call enquiries are related to the neurology specialty, especially epilepsy management.

1.6 Drug expenditure information and analysis and cost improvements

Medicines expenditure for the year was £9,542,642 with a further £6,227,422 spent on homecare medicines. The majority of this expenditure was on high cost medicines excluded from tariff and therefore rechargeable to commissioners.

Detailed breakdowns of all medicines issued to The Walton Centre and their cost were produced monthly and submitted to Walton finance staff.

In order to reduce waste, the pharmacy department returned and credited unused high cost items from ward areas, so they could be reused. To maximise the efficiency of this process, high cost medicines are coded on the dispensing label. £31,319 of stock was re-credited to Walton this year.

Senior neurosciences pharmacists undertook analysis of medicines expenditure to identify any potential cost improvements as part of the annual pharmacy cost improvement programme (CIP). Potential savings strategies were then brought to the attention of relevant Walton staff for implementation. For example:

- The eye preparation routinely used in theatres was changed to one that was available in single dose units avoiding the need for a whole multidose tube of ointment per patient
- Lower priced generic preparations entering the market were purchased where medication patents expired e.g. fentanyl injection and nefopam tablets.
- A commissioned funding route was established for the use of fidaxomicin – a high cost antimicrobial used in the treatment of *C. difficile*

Medicines where an unavoidable price increase was anticipated were also highlighted. CIP progress was monitored and reported monthly, and CIP savings for the financial year totalled £46,749.

Pharmacy staff liaised with the finance team to advise on whether medicines were included or excluded from tariff, confirmed high cost medicine submissions to commissioners, and discussed anticipated changes in medicines expenditure. The Lead Pharmacist and Assistant Clinical Director of Pharmacy contributed to various individual funding request applications.

1.7 Clinical trials

In 2019-20, pharmacy staff dispensed and checked 112 clinical trial medicines at the Walton trials dispensary. Subsequent 'returns' of leftover trials medicines were managed as per protocols. Pharmacy staff took responsibility for the safe and appropriate storage of all trial medicines, delivery receipt, temperature monitoring and management of temperature excursions. They also maintained and held a code break list for all studies to allow ease of access and support out of hours. Seven new studies were opened, with pharmacy staff meeting with sponsor representatives from the various studies on average three times a month. A senior trials pharmacist was involved in the initiation process of all new studies to ensure that all legal and good practice requirements were satisfied and appropriate documentation was in place. Approximately 25 to 30 trials involving trial medicines were open at any one time during the year.

The Lead Clinical Trials Pharmacist attended the Trust Sponsorship Oversight Committee each month and met with the Neurosciences Research Centre manager on a regular basis.

1.8 Management of EPMA (Electronic Prescribing and Medicines Administration system)

EPMA has been in place for all Walton wards (excluding critical care) since April 2014.

The Pharmacy EPMA team provided day to day maintenance as per the service level agreement, for example keeping the medicine product list up to date, creating new users, merging duplicate records and routine maintenance tasks.

A senior pharmacist attended the Walton Clinical Safety Group for clinical IT systems meeting and undertook a full review of the EPMA risk register and hazard log.

Liverpool University Hospital Foundation Trust (LUHFT) have decided that they will no longer look to implement an electronic patient record (EPR) with an integrated EPMA module and will consequently be upgrading the current WellSky EPMA system (formerly JAC). LUHFT are awaiting quotes from WellSky and are planning to begin the upgrade within the next 12 months. The Walton Centre will not be able to continue on the previous version and will need to transition to the newer version along with LUHFT. It is important to note that the newer versions of the WellSky EPMA solution are web-based applications and will require extensive staff training due to differences between the versions.

Senior neurosciences pharmacists will attend and contribute to planning meetings with the EPMA team at LUHFT in the coming year to ensure that the Trust's requirements for EPMA are taken into account. A senior pharmacist was involved in preliminary discussions and scope out work involving integration of a view only record of EPMA into eP^2. Continuation of this project will depend on the outcome of the above.

1.9 On call pharmacist

An on call pharmacist service was available at all times outside of pharmacy opening hours, for advice and supply of urgent medicines, and was regularly accessed by Walton staff. In the last financial year the on call pharmacist service was utilised 295 times by staff from the Walton Centre.

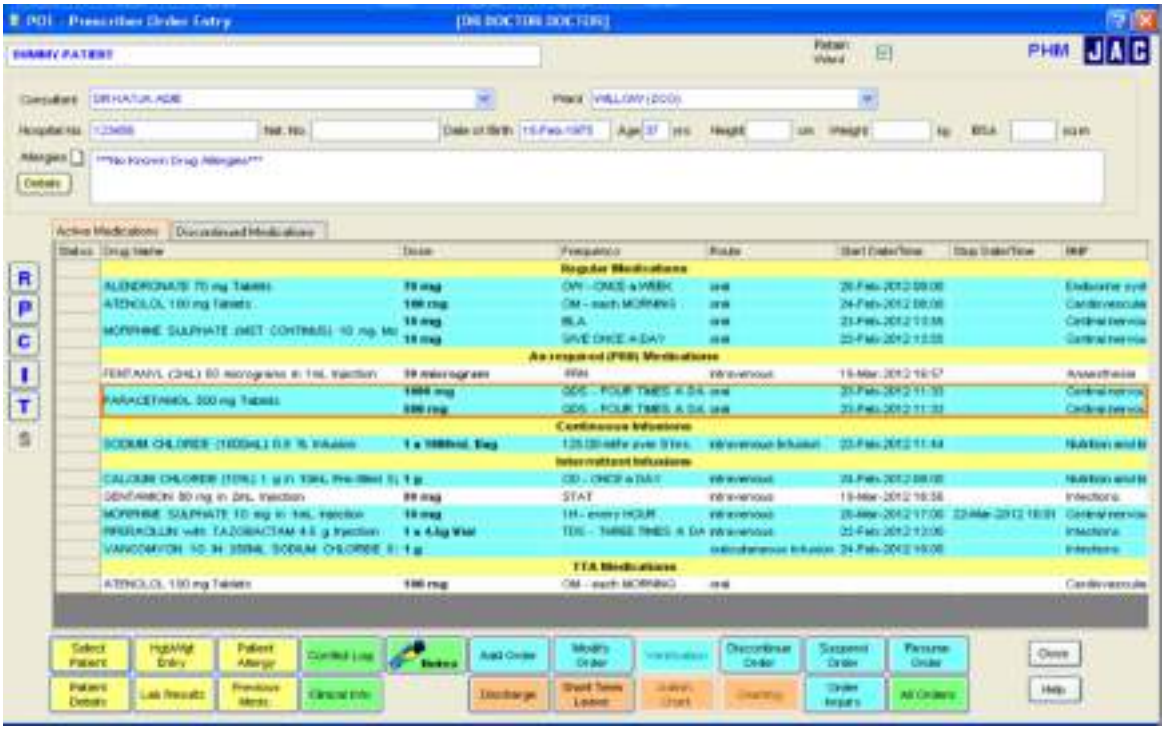
1.10 Clinical service

1.10.1 Ward pharmacy service

Ward pharmacists visited all wards daily Monday to Friday, and reviewed patients and their prescriptions, considering safety, efficacy and optimum individualised treatment for each patient. They ensured appropriate monitoring of bloods/observations were undertaken for specific medicines and were vigilant for side effects. They discussed medicines with patients, providing information and answering questions. The importance of this is paramount as demonstrated by an instance where a patient suffering with facial dystonia had inadvertently been taking half the intended dose. Once this was identified and corrected by the ward pharmacist the patient's symptoms improved to such an extent that surgical intervention was avoided. Acknowledgement of the significance of this intervention was recognised by awarding the pharmacist with the Pharmacy Department's 'Good Catch' award.

Medicines verification is the process whereby the pharmacist will 'verify' a medicine on the electronic prescribing system when they are satisfied that the medicine is safe and appropriate for that patient and correctly prescribed. They also ensure compliance with the

Pan Mersey formulary and local policies/guidelines where appropriate. Medicines verification was completed within 24 hours for an average of 70% of patients each month.



An example of an electronic JAC prescription illustrating a mix of unverified medicines (shaded in blue) and verified medicines (shaded in white)

It is a recognised problem that when patients are admitted to hospital there is a risk of miscommunication and unintended changes to patients' medication. As such, the pharmacy team undertook medicines reconciliation for all inpatients within the constraints of the ward service operational hours. Medicines reconciliation involves confirming the patient's usual medication regimen from a combination of sources then reconciling this against the hospital inpatient prescription to ensure all usual medicines are continued correctly, unless it is appropriate to stop or amend them. Medicines reconciliation was completed within the national target of 24 hours for an average of 74.8% of patients each month.

A new automated report was introduced in February 2020 that provides the percentage of all inpatients for whom medicines reconciliation was completed within 24 hours of admissions within the last month. This provides a more representative measure than the previous snapshot figure, which skews towards unplanned admissions. The new report shows that a greater percentage of The Walton Centre's patients benefit from medicines reconciliation within 24 hours than previously reported and therefore target compliance was increased to 75% from February.

Pharmacists worked closely with medical and nursing staff and other disciplines to resolve any errors, implement potential improvements in care, offer proactive advice and answer queries. They informally monitored day to day compliance with the Medicines Policy, raising any issues with senior nurses e.g. security of medicines or monitoring of fridge temperatures. Patients' own medicines were routinely checked and reused (if appropriate) both during admission and on discharge.

The EPMA web portal (as discussed under dispensary services) also pulls information from EPMA to produce a pharmacy dashboard for each ward, showing key information at a glance to aid the ward pharmacists in prioritising patients for review that day. For example, it highlights newly admitted patients, those with outstanding medicines reconciliation, those on

high risk medicines and those with nurse requests for supply of medicines. It displays certain notes written on EPMA, allowing it to be used as a handover tool for priority patients/issues, and enabling a list to be printed of issues highlighted by the ward pharmacist which require attention by a prescriber or doctor. The dashboard also highlights when a discharge prescription (TTO) has been written and if it has been sent to pharmacy.

Wherever possible, ward pharmacists verified TTOs on the ward, rather than by the duty pharmacist in the dispensary. This allowed the following benefits to be realised:

1. the ability to discuss medicines with the patient;
2. familiarity with the patient's history;
3. access to case notes, and;
4. easier access to nursing and medical staff in case of queries.

The average proportion of TTOs verified by the ward pharmacist was 82%.

1.10.2 Ward rounds and multidisciplinary team meetings (MDTs)

The pharmacy team contributed to a wide range of multidisciplinary patient reviews, including:

- Daily surgical registrar-led ward rounds. These are predominantly attended by senior prescribing pharmacists who in addition to reviewing medication, observations and test results during the ward round are able to initiate new therapies and modify prescriptions as required (within the remit of their agreed prescribing formulary).
- The daily neurology 'board round'
- The daily critical care ward rounds
- The daily critical care antimicrobial ward round (as often as possible)
- The weekly antimicrobial collaborative ward round
- Weekly critical care MDT
- Workload allowing, a junior pharmacist attended the weekly MDT meetings on Lipton and CRU.
- A senior pharmacist attended the weekly Multiple Sclerosis Disease Modifying Therapy (DMT) MDT (as often as possible)

The requirement to see all same day admission patients pre-theatre Monday to Friday can impact on surgical and critical care ward round attendance, as ward rounds may start before clerking on Jefferson ward is completed. Attendance can be further reduced by other competing demands.

Benefits of a pharmacist on the ward round include:

- A guarantee that for every patient seen, the prescription has been reviewed and any issues requiring medical input highlighted to the team for discussion, such as timely review of medicines such as antibiotics and corticosteroids.
- A check that any necessary monitoring for specific medicines is being undertaken and results reviewed, such as drug levels and blood tests to assess for adverse effects of treatments
- Proactive consideration of other medications that may be required, such as a low molecular weight heparin for prevention of clots or post-operative laxatives
- Pharmacist advice can contribute to clinical decisions in real time, preventing problems.
- The pharmacist is more involved with the patient and their care plan, so is better able to deal with any queries or prescribing requests

Participation at ward rounds is monitored as part of the monthly KPIs. In 2019-20 pharmacists participated in 982 ward/board rounds or MDTs, an average of 82 per month

(excluding the ITU daily antimicrobial ward round and DMT MDT for which attendance figures are not available).

1.10.3 Pharmacist independent prescribers

The pharmacist prescribing service at Walton was established in 2016-17. All of the permanent specialist neurosciences pharmacists are registered and active as prescribers, though due to other commitments, not all perform all roles below.

The pharmacists prescribe in three types of situation:

- Newly admitted patients admitted on the morning of elective surgery (also known as 'same day admissions'). The pharmacists check appropriate instructions about medicines in relation to surgery have been given in clinic and followed by the patient. They review and prescribe the patient's usual medicines, highlighting any potential problems in relation to surgery and making any appropriate amendments for the peri-operative period.
- On wards day to day, adding or amending prescriptions as necessary, within an agreed prescribing formulary. In most cases this takes place as part of the plan from daily ward round.
- Prescribing short-term leave and discharge medicines and completing the brief summary of the admission on the discharge prescription document. This ensures prompt action, saves junior doctor time, and audit data shows much lower risk of prescribing errors than medical colleagues.

Since same day admission started in May 2017, the pharmacists have reviewed and prescribed all appropriate medicines for every weekday same day admission patient. In 2019-20 this was an average of 125 patients per month. All pharmacist prescribers contributed to this service, with two required on most mornings to ensure all patients were reviewed and appropriate medicines prescribed in a timely manner pre-theatre. With a small pool of staff there is limited resilience for sickness, annual leave and vacancies.

2019-20 was a challenging year in this respect with periods of long-term sickness having an impact on ward based prescribing. Despite this, pharmacists prescribed 25% of discharge prescriptions – producing discharge prescriptions for an average of 66 patients per month.

Two evaluations of the pharmacist prescribing team were conducted during the year. One audit demonstrated a total of 211 interventions by prescribing pharmacists over an 11 day period; highlighting the level of contribution to improving prescribing practice and patient safety. The other, a qualitative audit collated the views of other heath care professionals of the service. This demonstrated overwhelmingly positive views of the service, including a 4.9 rating out of 5 for the service.

An ongoing challenge for the senior pharmacists is balancing the priorities of day to day clinical work, including the extended prescribing roles and attendance at ward rounds, against ongoing and increasing medicines management and governance work within the Trust (roles detailed in this report).

A regular peer support discussion session continued for the pharmacist prescriber team, which has proved useful to reflect on challenging situations encountered and improve consistency in practice amongst the team.

1.10.4 Pharmacy Technician service to pre-operative assessment outpatient clinics

Pharmacy Technician involvement in pre-operative assessment clinics started in early 2017, redeploying some of the pharmacy technician time previously assigned to inpatients. The technician uses a variety of sources to obtain a complete and accurate medication history, including GP records, discussion with the patient and/or carer, and where available, the patient's own medicines.

Having a complete and accurate list enables the specialist nurse to identify and counsel the patient about any medications that may need amendment pre-surgery. This is especially important for same day admission patients.

In some cases where there are multiple clinics running at the same time, particularly if they take place in both the main building and Sid Watkins, the technician may not be able to see all patients in person. In this case GP medication records were obtained where possible, and shared with pre-op nursing staff so that they have access to multiple drug history information sources. If time did not allow the technician to obtain the GP list at the time of clinic, then for same day admission patients, the GP list was obtained before admission to ensure the information is readily available on the morning of admission to enable safe prescribing.

From January 2020 - March 2020, pharmacy records indicate that 712 patients were due to attend pre-operative assessment clinics. The pre-op technicians discussed medicines with the patient and/or carer and thus documented a full medication history for 94% (n = 694) of these patients. In most of the cases where medicines were not discussed with the patient, this was because it was not physically possible or not appropriate: some patients did not attend for clinic, some were found to be attending for reasons other than pre-operative assessment, and some were seen in the nurse clinic in the Sid Watkins building at the same time as other pre-operative clinics in the main building (there is only ever one technician available for clinics at any one time).

The service helps to prevent medication errors on transfer of care and is much appreciated by the specialist nurses in clinic, and by the prescribing pharmacists who see same day admission patients when they arrive. The medication history is also available to the clerking doctor for non-same day admission patients via eP^2.

1.11 Pharmacy service level agreement

Monthly Pharmacy review meetings took place between Walton senior managers, the Assistant Clinical Director of Pharmacy and the Lead Pharmacist for Neurosciences. At times of significant staffing shortages (due to sickness, vacancies or other leave), Walton managers were kept up to date, and priorities discussed and agreed.

Funding was requested and agreed during the year for additional pharmacist service in two areas:

1. Homecare - band 8a pharmacist time to support the increasing homecare medicines workload (post filled from February 2020). This extra 8a resource, along with the previously agreed funding for antimicrobial stewardship, allowed the appointment of a new WTE band 8a pharmacist to join the permanent specialist neurosciences pharmacist team. The additional pharmacist also contributes to the pharmacist prescribing service, increasing resilience to maintain services during times of sickness or vacancies.

2. Critical care - bringing Walton in line with national standards for critical care staffing Monday to Friday (funding agreed Autumn 2019 with successful candidate to take up post from June 2020)

Roles and responsibilities within the team were reviewed and reallocated as appropriate to optimise delivery of services.

The agreed pharmacy key performance indicators (KPIs) were submitted monthly, and presented quarterly at the Quality Committee. Two pharmacy indicators (medicines reconciliation within 24 hours and discharge prescription turnaround time in the dispensary) were also reported as part of the monthly neurology divisional dashboard. The KPIs and their targets were reviewed during the year and changes agreed, to stretch the team and to reflect changes in data collection which improved accuracy.

A full review of the service level agreement will be undertaken during 2020-21.

1.12 Homecare medicines: administration and governance

Homecare medicine services deliver ongoing medicine supplies and, where necessary, associated care, initiated by a hospital prescriber, direct to patients' homes (with their consent). These treatments are often specialist therapies for chronic health conditions. The homecare medicines service improves patient choice and treatment convenience. It also benefits the health economy by saving VAT on the cost of the medication delivered by the externally registered pharmacy.

Senior pharmacists conducted a clinical check of each homecare prescription generated by the Trust, ensuring that:

- patients were prescribed the correct medication dose and (where appropriate) device
- prescriptions met all the legal requirements for dispensing
- a new prescription was due and that regular medication deliveries had occurred in the preceding 6 months (as a rough indication of patient compliance with the prescribed medication)
- all appropriate monitoring of blood counts had taken place, as per locally agreed policy, and that the results were within acceptable limits.
- the required NHS England Blueteq funding approval had been granted for patients registered with a GP in England

All homecare prescriptions and invoices were processed and recorded by a pharmacy assistant. A unique purchase order number was generated for each prescription before submission to the appropriate homecare company. All invoices were checked to ensure they correlated with the processed prescriptions, before forwarding to Walton finance for payment. KPI data from each company was reviewed to ensure the external homecare providers delivered the service expected. A senior pharmacist attended quarterly meetings of the Northwest Homecare Pharmacy Network to share good practice and work together, for example to produce regional homecare company SLAs.

The workload associated with homecare continues to increase. 913 patients were receiving medicines prescribed by Walton via homecare in March 2020 as opposed to 877 patients in March 2019. In addition to the day to day prescription processing, there were various significant homecare-related projects undertaken during the year including:

- The Homecare Self-assessment Audit was conducted in April 2019 in conjunction with the Regional Homecare Lead Pharmacist. The audit shows our performance against the Professional Standards for Homecare services published by the Royal Pharmaceutical Society in three domains: patient experience, implementation and

delivery of safe and effective homecare services and the governance of homecare services. In this audit, the Walton Centre had an overall score of 74.9%; a significant increase from 50.7% the previous year.

- One of the senior pharmacists attended the annual National Clinical Homecare Association (NCHA) conference. This conference brings together representatives from NHS Trusts, Homecare providers and Pharmaceutical drug companies across the UK. The NHCA aims to raise the awareness of the benefits of Clinical Homecare, and to ensure that high standards are maintained.
- A number of patients were successfully transitioned from one homecare provider to another in February 2020. This transition was mandatory because the previous homecare provider was discontinuing the homecare service for that drug.
- Agreement sought and gained to provide patient initiating therapy on fingolimod with a 14 day medication supply (rather than 7 day) to minimise risk of treatment disruption through delayed first homecare delivery

As per section 1.11, increased senior staffing for homecare services was in place from February 2020. This additional staffing resource will allow increased governance and improved provision of homecare services in line with the Royal Pharmaceutical Society (RPS) standards and National Homecare Medicines Committee recommendations.

2. Medicines Management and Clinical Governance at Walton

Medicines management services were provided by the designated Walton senior pharmacist team and/or the Assistant Clinical Director of Pharmacy, in collaboration with various Walton Centre staff.

An SLA review was conducted and following business case approval, 2 additional posts were agreed to further improve medicines management and governance processes at Walton. The Walton senior pharmacist team now consists of:

- six permanent senior pharmacists;
    - the lead pharmacist for neurosciences
    - four neurosciences specialist pharmacists (including a homecare and antimicrobial lead)
    - one neuro ITU specialist
- one annual rotational senior pharmacists (with a second joining the team in June 2020)
- three junior pharmacists at a time assigned to Walton on four monthly rotations

2.1 Medicines safety and learning from medication incidents at Walton

309 medication incidents were reported in 2019-20, making them one of the most common incident types reported within Walton. It is well established nationally that medication errors and incidents are common and often under-reported. The incidents reported mostly involved little or no actual patient harm, but many had potential for more serious harm if not identified and corrected promptly.

The multidisciplinary Safer Medication Group organised by the senior pharmacy team continued to meet on a monthly basis. The group reviewed all medication incidents, safety alerts, relevant audit results and concerns raised, to identify causes and plan/monitor actions to remove or reduce risk of recurrence. The group's work resulted in many changes to improve safety and quality of patient care in relation to medicines (see 2.16 for a list of improvements made by the Safer Medication Group and other parties).

The Safer Medication Group also reviewed compliance within the Trust against existing national safety alerts relevant to medication-related never events. In addition, the MHRA highlighted many safety warnings for specific medicines in its regular safety bulletins or warning letters to healthcare staff. Pharmacists ensured this information was disseminated to the appropriate staff.

Automated daily notification emails were sent to ward managers detailing omitted doses of critical medicines for patients on their wards within the last 24 hours (except ITU which does not use EPMA). A formal monthly audit was designed and implemented to monitor omitted doses. The results of the monthly missed doses audit were reported at Safer Medication Group and formed part of the quality account.

Senior pharmacists contributed to investigations and root cause analyses into incidents involving medicines.

The Lead Neurosciences Pharmacist continued to act as the designated Medication Safety Officer (MSO) for the Trust. There is a national network of MSOs with regular meetings. When time allowed, the monthly webinars and quarterly meetings were attended. The MSO received formal and informal medicines safety alerts and information from the network via email, and took appropriate actions where relevant to Walton.

The Lead Neurosciences Pharmacist produced quarterly reports on medicines safety, which were presented at the Drugs and Therapeutics Committee and then submitted to commissioners as part of the Quality Contract.

A senior pharmacist attended the Trust's daily Safety Huddle (subject to other commitments) to respond to any medication incidents or pharmacy/medicines-related safety issues in a timely manner and cascade to other members of the pharmacy team. A review of the medication categories within the Datix reporting system was conducted, mapping against National Reporting and Learning System codes. Changes to the Datix form were suggested to improve the ease of completion and clarity of reports received.

A generic mailbox was created to simplify the submission of Yellow Cards to the MHRA. Any healthcare practitioner at the Trust can submit brief details of the suspected adverse event to the inbox. The pharmacy team then complete the Yellow Card report through MIDatabank on their behalf, thereby reducing the barrier to adverse effect reporting for busy clinicians.

There is much further work, particularly more proactive work, which could be undertaken on an ongoing basis in relation to medicines safety if the MSO role was fully resourced, in terms of a dedicated medicines safety pharmacist. Following the national patient safety alert issued in 2014 which required Trusts to designate a MSO, a business case was submitted but at that time was not accepted. As a result the available time for this role is limited.

2.2 Specialist neuroscience pharmacist advice

The neuroscience pharmacist team responded to numerous queries on a day to day basis from a wide variety of clinical and non-clinical staff, internal and external. Common themes included:

- advice on commissioning issues or individual funding requests
- advice on formulary status and whether GPs could prescribe medicines
- availability of unlicensed medicines or different formulations
- queries over apparent shortages of specific medicines in primary care
- medicine interactions, cautions and contra-indications
- prices of medicines
- payment by results exclusions
- suitability of medicines formulations for intrathecal administration
- advice on unlicensed administration of medicines by Interventional Radiologists
- information regarding unusual or unlicensed medicines recommended by neurologists at satellite hospitals

The pharmacists also liaised proactively with Walton staff regarding issues arising, for example national shortages of medicines, significant price changes, and availability of generic versions of branded products.

2.3 Delivery of education and training

Senior pharmacists delivered medicines management training to staff at each of the regular training sessions below. Training talks were updated regularly to reflect recent incidents, notable changes in practice and national alerts.

- Trust induction (monthly)
- Trainee doctor induction (five times per year)
- Consultant health and safety mandatory training days (up to seven times per year)
- IV medicines study day
- Nurse preceptorship programme, including:
    - General medicines management sessions
    - Catheter associated infections
- ITU nurse training talk on antimicrobial stewardship
- Nurse NPSA study days
- Pharmacology study day for Liverpool John Moores University Neuro Masters Module and contribution of examination questions (commencing September 2019)

Senior pharmacists also delivered education in several ad-hoc scenarios including:

- Being shadowed by nurses and pharmacists undertaking the non-medical prescribing course.
- Pharmacy EPMA web portal training for ward staff.
- Medicines management for trainee nursing associates
- Glucose-potassium-insulin (GKI) infusions for clinical staff

The senior Pharmacy team were also involved in training Aintree pre-registration pharmacists and junior pharmacists on rotation to the Walton centre team, as well as tutoring junior pharmacists undertaking clinical pharmacy postgraduate diplomas.

2.4 Non-Medical Prescribing governance

Walton has long encouraged and supported appropriate clinical staff to become non-medical prescribers, but in recent years numbers have greatly increased. By March 2020, over 60 staff were either already registered independent prescribers or undertaking the training.

These include nurses, pharmacists and physiotherapists, who prescribe and give advice on medicines in inpatient and/or outpatient settings.

The Lead Neurosciences Pharmacist is one of two named Trust Non-Medical Prescribing (NMP) leads, together with the Deputy Director of Nursing. With support from another specialist neuroscience pharmacist, the NMP leads provided much informal support to NMPs, particularly during their training and initial prescribing practice.

Progress was made in transitioning from use of patient group directions or patient specific directions to use of non-medical prescribing for various medicines, such as botulinum toxins. Staff turnover however caused some delays in full transition.

All existing NMPs were encouraged to review their practice and formularies, and asked to submit annual review forms and reflective accounts in line with the NMP policy. A review of NMP governance within the Trust was commenced by the NMP leads, and the NMP subcommittee was dissolved. New governance processes will be introduced in 2020-21 and the annual review form updated.

Prescribing formularies of specialist nurses, pharmacists and physiotherapists were reviewed by the senior pharmacy team ahead of presentation at D&T for discussion and approval.

The Lead Pharmacist attended quarterly meetings for regional NMP leads when possible.

2.5 Patient Group Directions (PGDs)

PGDs are formal legal documents which authorise named individuals in specified staff groups to administer named medicines to patients without a prescription. During the year the Drugs and Therapeutics Committee reviewed and updated existing documents, and also commented on/approved new PGDs. For example, PGDs for administration of botulinum toxin by physiotherapists and nurses were updated.

In response to updated national guidance about administration of contrast by radiographers and publication of national template PGDs for contrast, the Lead Pharmacist supported radiology in reviewing the authorisation frameworks for administration of contrast at Walton. Advice was given on updating documentation and raising staff awareness to ensure all doses were legally authorised and it was clearly documented whether this was by patient specific direction or patient group direction. The Trust PGDs were updated in accordance with the national template PGDs.

2.6 Policies, guidelines and patient information

The senior pharmacy team continue to contribute to maintaining the Trust's wide range of medication related documents. During 2019-2020 the team collaborated with various colleagues in different divisions to update 5 clinical guidelines and 6 drug monographs. 5 new documents were also created to reflect new practices and address gaps in the Trust's guidance. These covered the patient pathway for initiation of cannabidiol (following a positive NICE opinion in December 2019) and mexiletine, the management of hyperkalaemia and anticoagulation initiation and bridging. Senior pharmacists are contributing to the development of the Trust's Status Epilepticus Guideline.

Senior pharmacists routinely attended meetings of the Drugs and Therapeutics Committee (see section 2.10 for details) and Clinical Effectiveness and Services Group. As part of this

membership, presented documents were reviewed and comments submitted where appropriate.

Pharmacy are responsible for maintaining the Trust's Medicines policies page via Sharepoint – uploading newly approved documents and sending notification to authors as their work reaches expiry. Pharmacy also kept the department's intranet pages up to date with practical information about the pharmacy service, and links to relevant external sites for information about medicines.

2.7 Freedom of information requests and complaints

Senior pharmacists, with support from the Pharmacy Computer Services Manager, responded wholly or partly to 38 freedom of information (FOI) requests during the year. Following roll out and training, responses were submitted via the Trust's new FOI database system. Requests were very varied, but the most common type was for information about usage of, or expenditure on, specified medicines or groups of medicines.

In addition senior pharmacists were involved in investigating and responding to a number of complaints from patients/relatives where medicines or Pharmacy were involved.

2.8 Liaison with primary and secondary care and commissioners / Prescribing formulary and new medicines

Senior neuroscience pharmacists represented The Walton Centre as required at the Pan Mersey Area Prescribing Committee subgroups for new medicines, formulary and guidelines, shared care and safety, and occasionally attended the Area Prescribing Committee (APC) meetings to present specific items. The Assistant Clinical Director of Pharmacy represented both Aintree and Walton routinely at the APC.

The team also received consultation documents monthly. Relevant documents were circulated to the appropriate clinicians at Walton for information and comment. Comments received were then collated and submitted.

Work requiring significant input from Walton pharmacists and/or clinicians during the year included:

- Review and update to apomorphine prescribing support statement
- Review and negotiation of amber sub classification for Sativex spray for spasticity in MS
- Production of prescribing support statement for Sativex
- Process agreed for everolimus prescribing to be done by Walton consultants, but dispensing to be facilitated by RLUH

A senior neuroscience pharmacist attended meetings of the North Wales Neuroscience medicines network where possible, via videoconferencing. Restricted videoconferencing facilities prevented attendance for all meetings.

Neuroscience pharmacists dealt with many ad hoc queries and informal complaints from CCG pharmacists and GPs about stock availability, funding requests and clinical recommendations from Walton consultants. Similar queries and complaints also arose from neurologists about responses from GPs/CCGs to their requests to prescribe or to fund medicines.

The Clinical Director of Pharmacy or the Assistant Clinical Director attended Northwest meetings of Chief Pharmacists, pharmaceutical advisors for CCGs, and pharmacists from NHSE on behalf of both Aintree and Walton.

2.9 Compliance with standards and targets from commissioners

The Quality Contract included various requirements relating to medicines management, and the Lead Pharmacist worked with the Quality Manager to prepare and submit data as required, including quarterly reviews of medicines related incidents.

There were no medication related CQUINs for Walton in 2019-20.

2.10 Drugs and Therapeutics Committee

Senior pharmacists collated agenda items for and at least two senior neuroscience pharmacists attended each of the year's Drugs and Therapeutics committee meetings and presented numerous documents to the committee. Due to the volume of work required for review by the committee, 6 meetings were held in the 2019-20 fiscal year, although only 5 are mandated in the committee terms of reference.

The committee considered, commented on and approved a range of medication related issues, including:

- Medication related clinical guidelines, policies, patient information leaflets & PGDs
- Applications to add new medicines to the formulary
- Medicines related audits including controlled drug quarterly audits.
- Medicines expenditure and potential cost improvements or cost pressures
- Homecare medicines' service level agreements
- Non-Medical Prescriber formularies
- Reports from subcommittees: Safer Medication group, Antimicrobial Stewardship group and the Immunoglobulin Advisory Panel
- Submissions to Pan Mersey Area Prescribing Committee subgroups
- New national guidance on medicines including safety alerts
- Significant miscellaneous issues arising relating to medicines, for example medication administration by nurse associates and supply of medication out-of-hours

Pharmacy committee members also assisted in the feedback of comments to authors unable to attend meeting and publication of approved documents.

2.11 Contribution to Walton committees and groups

In addition to the Drugs & Therapeutics committee the senior pharmacists attended/contributed to the following groups on a regular basis:

- ITU operational group
- Neurology Divisional Governance and Risk meeting
- Infection Prevention Control Committee
- Immunoglobulin Advisory Panel
- Safer Medication group
- Antimicrobial Stewardship group
- Clinical Audit group
- Team Brief
- Quality (CQC) Assurance Group
- Aintree Medication Safety Group (as the representative for Walton)
- Trust Sponsorship Oversight Board
- Clinical Systems Safety Group
- Neurology Divisional Assurance Group
- Digital Champions inpatient, outpatient and critical care user groups
- Safety huddle

- Quality Committee
- Quarterly homecare provider service review meetings
- Clinical Effectiveness and Services Group
- Patient flow/discharge planning Group
- OPAT group
- Patient Safety Group

Other groups were also attended on an ad hoc basis such as the Neurology Divisional CIP group.

2.12 Audit & Service Evaluation

Pharmacy staff undertook various audits and evaluations of service within Walton during the year including:

- Controlled drug quarterly audits
- Annual medicines storage audit – conducted across all ward and departments at The Walton Centre
- Antimicrobial prescribing quarterly point prevalence audit
- Review of pharmacist contributions on ward rounds
- Audit on compliance with valproate pregnancy prevention requirements. Audit results presented at the Audit Forum
- Evaluation of AED therapy post head trauma. Results presented at Trust audit half day in June 2019
- Collation of audits re. introduction of NMP pharmacists accepted for presentation in poster format at UK Clinical Pharmacy Association (UKCPA) Pharmacy Together conference in November 2019. Abstract published in the Rx, a Clinical Pharmacy Magazine in January 2020.
- Evaluation of interventions made by pharmacist independent prescribers at The Walton Centre
- Survey of Healthcare professionals' opinions of pharmacist independent prescribers at The Walton Centre

Results were reported and discussed at the most relevant forum.

There was regular senior pharmacist representation at the monthly clinical audit group meeting and contribution to the Trust's audit forward plan.

2.13 Antimicrobial stewardship

Antimicrobial stewardship from a multidisciplinary team of medical staff, microbiologists, pharmacists and specialist/ward nurses is essential for any NHS organisation. The risk of hospital acquired infections such as Clostridium difficile and development of resistant strains due to antibiotic use must be carefully balanced against the need to treat infections. Commonly treated infections at the Walton Centre range from relatively simple cases of urinary tract infections to highly complex infections involving deep structures in the central nervous system or retained metal work. Antimicrobial selection is often limited due to the site of infection as well as patient characteristics, and many complex infections require long courses of antibiotics. These factors make antimicrobial stewardship at the Walton Centre a particular challenge.

During 2019-20, the clinical pharmacist team at Walton were actively involved with microbiology and infection control teams and engaged with medical and nursing staff to maintain and improve antimicrobial prescribing.

Key activities conduced:

- Attendance at the weekly collaborative antimicrobial ward rounds; reviewing every patient prescribed antibiotics alongside a consultant medical microbiologist, medical teams and infection prevention and control (IPC) nurse specialists. Any identified themes were raised by a senior pharmacist at the Infection Control Committee and with the IPC lead neurosurgeon. Patients potentially suitable for outpatient antimicrobial therapy (OPAT) were identified by the pharmacist at the weekly ward round and highlighted to the OPAT team for weekly discussion.
- Monitoring of automated daily reports of restricted high-risk antimicrobials generated from the electronic prescribing system. Patients identified were reviewed by a senior pharmacist and flagged to ward pharmacists to discuss with the parent teams and microbiology.
- Monthly attendance at the IPC Committee and quarterly presentation of the point prevalence audits. The reports were also discussed at the antimicrobial stewardship group. All antibiotic prescriptions on a chosen day were reviewed against the Trust formulary and prescribing standards to establish if the appropriate medicine, dose, route, duration for the indication was prescribed. Data were compared between audits to identify any trends in prescribing within the Trust.
- A senior pharmacist commented on root cause analyses relating to infection as part of the IPC Committee. These included patients that developed C. difficile, MRSA, MSSA and E. coli infections.
- Reviewing and commenting on new or updated policies relevant to infection control, such as the new Trust flu policy and Trust antimicrobial formulary
- In response to an MHRA safety alert regarding fluoroquinolones, the antimicrobial stewardship group conducted a review of prescribing at Walton and circulated a Trust memorandum

New developments in 2019-20:

- A 0.4 WTE Antimicrobial pharmacist was appointed and in post from October 2019. Together with the Walton consultant microbiologists a list of key responsibilities was devised.
- Involved in the development of the new Trust OPAT policy and the relevant forms associated with the OPAT service.
- Attendance at weekly OPAT outpatient MDT clinics, producing clinic letters, and reviewing new OPAT referrals.
- The report for the quarterly point prevalence audit was reviewed following feedback from the Infection Prevention and Control Committee. The report now differentiates neurosurgical infections from the more simple infections making it easier to identify trends in prescribing. A RAG rating was also applied to key outcomes.
- The antimicrobial pharmacist discussed Datix reports associated with antimicrobials at the antimicrobial stewardship group so that trends could be identified and appropriate actions taken forward.
- In response to incidents in the region the antimicrobial pharmacist worked to improve the safety of antimicrobial prescribing in patients with myasthenia gravis. This was achieved by collaborative work with a consultant neurologist and the antimicrobial pharmacist at Aintree Hospital to produce an information bulletin and deliver training sessions to staff

2.14 CQC compliance

During the well-led inspection in April 2019, there was a well attended CQC focus group for pharmacy staff, and the Director of Pharmacy, Assistant Clinical Director of Pharmacy and the Lead Pharmacist for Neurosciences were formally interviewed. Pharmacy's contribution to the Trust's services helped The Walton Centre achieve its outstanding inspection result.

CQC highlighted the need for increased ITU pharmacy staffing to reach compliance with national standards. A business case for a Rotational Band 7 Pharmacist was submitted and approved. Concerns were raised over some aspects of medicines management on the wards, namely temperature monitoring and checking of expiry dates, and actions have since been taken to improve practice in these areas, in collaboration with the senior nursing team. Critical care liquid medication 'opened date' stickers have been introduced and drug expiry date monitoring is being recorded electronically by Pharmacy Staff. Electronic fridge temperature recording and monitoring has been developed and is awaiting implementation across the Trust.

As part of the Trust's routine monitoring to ensure ongoing compliance with CQC standards, the Lead Neurosciences Pharmacist attended meetings of the Quality (CQC) assurance group and contributed to six monthly self assessments against designated aspects of the updated CQC standards.

2.15 Immunoglobulin stewardship

A senior pharmacist worked with neurology managers, neurologists and the neuromuscular specialist nurse throughout the year to improve compliance with national guidelines for immunoglobulin, in order to ensure prescribing is safe and appropriate, that documentation is correctly completed and all data were entered on the national database. Failure to comply risks the Trust not being reimbursed for this frequently used and high cost medicine. Work included:

- Attending the national update meeting on the immunoglobulin database and national requirements
- Identifying outstanding reviews or documentation and ensuring completion
- Monthly attendance at the multidisciplinary immunoglobulin advisory panel meetings to review patients for which immunoglobulin had been requested or regularly given.
- Review of processes for prior panel review for urgent cases.
- Regular review of data dashboards from the database and actions to address areas of non-compliance.
- Pharmacist clinical check of immunoglobulin prescriptions before supplying.
- Managing shortages of specific immunoglobulin products, an increasing problem due to an international shortage of immunoglobulin.
- Responding to changes in the Trust's allocation of different brands/routes from NHS England. In particular, a change in the available subcutaneous products required preparatory work to allow safe use of new brands at Walton.

2.16 Other projects and developments

Miscellaneous improvements to practice were made during the year involving medicines management or pharmacy to enhance quality, safety and/or efficiency (in addition to those detailed elsewhere). Improvements marked with an asterisk were made in response to Walton incidents, audit results or anecdotal reports of problems. Others were proactive or in response to national alerts or problems in other Trusts, including Aintree.

- Porters record books introduced to allow for more robust documentation of medication transfer and receipt*
- Increased vigilance of controlled drug monitoring e.g. increased reporting of discrepancies and the introduction of weekly liquid checks
- Ongoing safety improvement with weekday review of the automated AKI report. The senior pharmacy team were nominated for the Good Catch aware in April 2019 due

to the impact of interventions including follow up of a outpatient with deranged renal function
- A senior pharmacist gave talks on Parkinson's disease medication to patients each month as part of the information day for people newly diagnosed with Parkinson's disease.
- A senior pharmacist delivered a presentation on the use of medication in brain tumour therapy as part of the 'Coping Better Together' day run in association with the Brain Charity
- Flowchart added to the 5-ALA guideline to provide nursing staff with a step-by-step guide to administration and monitoring of patients receiving the photodynamic therapy
- Trust's peri-operative medication management guide expanded and brought in line with national UKCPA Handbook of Peri-Operative Medicines. The guideline was extensively reformatted to include an alphabetised index of drugs to simplify use.
- SDA project expanded to include patients electively admitted for interventional radiological procedures. Senior pharmacists were involvement in the planning ahead of roll out in December 2019.
- Pharmacy team partook in a neurosurgery same day discharge trial, starting June 2019
- Intramuscular codeine product discontinuation in April 2019 – work with acute pain team conducted to ensure post-operative pain protocols and stock lists appropriately adjusted
- Adoption of a free-of-charge scheme for the supply of erenumab to patients with refractory chronic migraine in June 2019. As the homecare team was at capacity prior to recruitment of the new homecare lead, prescriptions were managed in house between the headache specialist team and pharmacy. 32 patients were enrolled on to the scheme before its closure by the drug manufacturer.
- Review of emergency drugs storage on Horsley ITU and in Theatres
- Horsley Pharmacy Bulletin was launched to provide information on changes in practice and feedback on specific medication related incidents to nursing and medical staff working in critical care. Three bulletins have been published to date.
- Introduction of an IV drug Y-site compatibility chart
- Re-design of the IV heparin chart
- Department rota adapted in September 2019 to included nominated daily homecare pharmacist to ensure timely processing of prescriptions
- Work with the Practice Educator to agree appropriate and legal roles and responsibilities of Nursing Associates in relation to medicines.

2.17 COVID-19

In March 2020, COVID-19 was declared a national pandemic by the World Health Organisation. To plan and prepare for the resultant changes in service delivery at the Trust the following changes were made implemented:

- SDA stopped the week commencing 23rd March as Jefferson ward was converted to accommodate additional ITU beds and following government advice elective surgery was cancelled. Pharmacy aided in the relocation of medicines and ordering process from Jefferson to Sid Watkins outpatient department.
- ITU cohort bay created and additional medication stock room created to facilitate segregation
- ITU/Jefferson overflow additional drug stock location set up and stock lists reviewed
- Development of alternative ITU sedation, vasopressor and neuromuscular blocking drug guidelines in anticipation of national critical care drug shortages

- The Walton Centre agreed to support Aintree Hospital's stroke service by relocating patients from Aintree Hospital to Sherrington ward. The pharmacy team prepared new stock lists and ordered medicines prior to patient arrival. Interim guidelines were produced for thrombolysis and labetalol infusion. The senior prescribing pharmacists helped with the transcription of medication from Aintree to Walton EPMA during the move of patients.
- The usual 6 daily neurosurgical ward rounds were disbanded and became ward based. As elective activity reduced in the Trust there were multiple ward closures. Pharmacist independent prescribers continued to support the adjusted ward round structures.
- Lloyds Pharmacy Clinical Homecare issued a statement that from 23rd March they would stop enrollment of new homecare patients. In response to this, alternative homecare providers were arranged and allocated by the Homecare Regional team for all Multiple Sclerosis patients requiring new disease-modifying therapy to reduce the risk of future relapses. This allocation was on request of the Lead Homecare pharmacist to help limit the additional workload required for in-house dispensing.
- A number of updates were made within the EPMA pharmacy web portal to reflect different ways of working throughout the COVID-19 pandemic. A drip rate infusion calculator was added to the portal to enable nurses to continue to administer intravenous medications in the event of a pump shortage. Within the pharmacist portal a function was added to be able to identify patients that had been reviewed remotely and flag any issues that would need to be handed over to the medical team responsible for the patient.
- The pneumonia section of the antimicrobial formulary was updated for COVID-19 patients in line with advice from the infectious diseases team at the Royal.
- The pharmacy clinical trials team supported the quick implementation of Public Health England COVID-19 studies such as the RECOVERY study. Pharmacy worked closely with Clinical Research Unit staff to ensure procedures ran smoothly, including the production of a RECOVERY trial information sheet
- A limited number of new patients were recruited onto non-COVID trials and some studies were put on hold during this period. The clinical trial service was adapted for existing patients to include arrangement of a courier service to deliver trial medication to patients' homes.
- An IV Medicines Guide was developed to facilitate access to information on administration of IV drugs without need to access Medusa guide on the intranet
- The Medicines Information team kept up to date with rapidly changing information/guidelines and situations. They summarised and disseminated useful medicine related information to the pharmacists at the Walton Centre where appropriate.
- Staff were fit tested to allow continued pharmacy presence in critical care areas treating COVID positive and suspected ventilated patients.

3. Future plans and areas for development

Some of the work described above is ongoing. Specific areas of focus for 2020-21 include:

- Upgrade to EPMA system at Aintree. Once timing known, discussions and planning at Walton will restart to consider options for EPMA at Walton including possible integration in to eP^2.
- Implementation of fridge temperature monitoring on the EPMA Web Portal for all nurses to record fridge temperatures electronically. Graphs will then be available within the portal showing trends in temperatures and will allow monitoring of ward compliance with temperature checks.

- Collection of monthly antimicrobial point prevalence data and collation of a quarterly report to try and capture more prescribing.
- Conduction of a manual audit of missed doses on critical care to capture data on the frequency of missed critical medicines (as paper medication charts preclude data capture via automated alerts)
- Systematic review of medicines expenditure to identify potential cost improvements.
- Ongoing scoping of options and feasibility of provision of ready prepared syringes for medicines to fill/refill implanted intrathecal pumps. This is a complex area but Aseptic preparation would reduce risk of microbial contamination, preparation errors and save time for specialist nurses.
- Further improvements in governance of homecare medicines. Commencement of a new homecare service for new migraine therapies (depending on outcome of SLA review) and a switch of provider for some medicines to improve service quality for patients.
- Ability for both Horsley multidisciplinary ward rounds to be simultaneously attended once additional critical care pharmacy staffing established. The additional staffing will also allow greater resource for audit and teaching as well as improving the safety of pharmacist independent prescribing on critical care through an independent second check process
- Agreement for teaching a safer prescribing session on a 4 weekly basis for 4th year medical students.
- Ongoing discussions regarding medication management following the UK's exit from the EU
- Review of the Medication Safety Officer's responsibilities and consideration of a business case submission to enable development of the role

REPORT TO TRUST BOARD

Date: 24 September 2020

Title	**Guardian of Safe Working Annual Report**
Sponsoring Director	Name: Dr Andrew Nicolson Title: Medical Director
Author (s)	Name: Dr Christine Burness Title: Guardian of Safe Working
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____

Executive Summary

There are currently 52 junior doctors on the new contract at the Trust. We have no vacant posts.

During the report period (August 2019 to July 2020), £2652,102 has been spent on covering junior doctors rota gaps.

We have had 9 exception reports during this period.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be financially strong • Research, education and innovation • Be recognised as excellent in all we do
Risks associated with this paper	Cost associated with rota gaps.
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – Completed in keeping with the Junior Doctors Contract Terms and Conditions
Any associated legal implications / regulatory requirements?	• Yes – European Working Time Directive, Junior Doctor Contract
Action required by the Board	Delete as Appropriate • To consider and note

Current Situation

During the reporting period, the coronavirus pandemic has impacted junior doctors at the Walton Centre in a number of ways:-

- The BMA and NHS Employers issued a joint statement suspending the 2016 T&C during the Coronavirus pandemic (Appendix 1). Adaptations to rotas will need to be considered and pragmatic The safety of junior doctors and minimising the risk of fatigue and burnout remains a priority.

- At the Walton Centre, rotas have had to be updated due to the changes and doctors are required to provide cover for colleagues, often at short notice. New rotas have been implemented across all specialties since 25th March and are continuously updated and adjusted in response to changing demands. Each rota includes a standby doctor for each shift and there are less junior doctors on site at any one time. In some cases, doctors working hours have actually reduced.

- Rotations for Foundation Year and Core trainees have been suspended in many specialties (at the Walton Centre, the only rotation that has taken place between February and August 2020 was of the F2 doctor in Neuroanaesthetics). That F2 post will stay within Neurocritical care until at least December 2020.

- Training has been impacted due to the cancellation of routine clinical work including face to face clinics and elective surgery. As routine specialty work resumes, the College Tutors and Training Programme Directors are supporting junior doctors to ensure that opportunities for training are optimised (for example via weekly online tutorials in anaesthetics). Specialist trainees have continued to provide telephone advice and a combination of face to face, telephone and video clinics. Core and foundation trainees will be encouraged to attend theatre sessions and clinics within the constraints of social distancing and infection control.

- The impact of coronavirus both professionally and personally is a threat to the wellbeing of all members of staff. Junior doctors require support during this time.
  The Trust regularly circulates details of how staff may access support via an internal Neuropsychology service and also external sources.
  The junior doctor's mess has been cleaned and a coffee machine has been provided. The Trust have also provided a breakaway area for staff to use.
  The GoSW has set up an online group for junior doctors to allow easy communication between colleagues who may not all be on site. Junior Doctor Forum Meetings will be held remotely during the pandemic and one-to-one meetings (in person with social distancing or by telephone or zoom) with the guardian of safe working are available on several days each week. The training programme directors and rota co-ordinators are working closely with junior doctors to ensure that they are supported and updated as the situation changes. The junior doctors forum took place weekly until July 2020 in order to provide additional support to junior doctors at the Trust. From August, the meeting has reverted to once monthly but the frequency can be increased at the request of the doctors or if the intensity of work increases.

Background

The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors' placed in the Trust have moved onto the new 2016 terms and conditions of service.

In June 2019, amendments to the 2016 were agreed as follows:

- Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am)
- Maximum of 72 hours to be worked within any 7 day period.
- Increased pay for weekend a night shifts (shifts ending between midnight and 4am)
- £1000 per year extra for LTFT trainees

- A fifth nodal point on the payscale when doctors reach ST6
- Transitional pay protection extended until 2015
- Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive)
- Exception reporting for all ARCP/ portfolio requirements
- Guaranteed annual pay uplift of 2% per year for the next 4 years
- *Fines to be levied by the GoSW for any breach of safe working hours*

The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue.

Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be;

- Differences in the total hours of work (including opportunities for rest breaks)
- Differences in the pattern of hours worked
- Differences in the educational opportunities and support available to the doctor
- Differences in the support available to the doctor during service commitments

We use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner.

Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust.

Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian.

During the report period, there have been 9 exception reports at the Walton Centre.
All have been resolved with time of in lieu (TOIL).

The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum alternating with to the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract.

The Annual Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

Report

High Level Data (requested by NHS Employers)

Number of doctors in training (total)	52
Number of doctors on 2016 T&C (total)	52
Amount of time in job plan for guardian to fulfil the role	1PA
Admin support provided to the guardian Support provided by Heather Doyle	0
Amount of job-planned time for educational supervisors	0.25 (for education and training)

Annual expenditure to cover junior doctor rota gaps (see Appendix 1 for breakdown by month)

Neurology	67,770
Neurosurgery	197,332

Total	**265,102**

a) Exception reports
There have been 9 exception reports during this period (and none during the last quarter).

b) Work schedule reviews
We have not had to undertake any work schedule reviews.

c) Vacancies
The Trust has 52 established training posts, currently none are unfilled.

d) Fines
No directorate within the Trust has received a fine.

Qualitative Information
The exception reports during this period have all been resolved by offering time of in lieu.

Issues arising
The change in the junior doctors contract will have the most impact on the senior neurosurgery registrar 24 hour on call rota. For the next 3-4 years, we will have 2 or 3 doctors on the new contract who must comply with the new T&Cs from February 2020.

Actions taken to resolve issues
The hours monitoring exercise is to be repeated annually for the Neurology Specialist Trainees in order to ensure that the rota accurately represents the hours worked. The senior neurosurgical registrar rota is also to be monitored. These plans have been put on hold due to the disruption in working patterns during the current pandemic.
Trainees are aware that they can request a work schedule review or hours monitoring exercise at any time of they have concerned. Potential rota changes to resolve any issues are reviewed in anticipation.

Summary
There are currently 52 doctors at the Walton Centre on the new 2016 terms and conditions. Overall, the feedback from junior doctors is very positive.

Since the introduction of the new contract in August 2016, there have been 16 exception reports. All have been resolved with TOIL.

The current coronavirus pandemic leads to new challenges for rota compliance and working patterns. Work schedules and working hours have not been changed (the latter were in some cases reduced at the height of the pandemic).Between March and August, all rotas had to be amended so that less junior doctors were on site at any one time and to allow for planned cover for absences.

We are trying to engage with broader junior representation across specialties at the JDF & encourage better teamwork within divisions between core trainees & specialist training grades to optimise working relationships & educational opportunities.

We are conscious of the potential impact of the current situation on junior doctors training and wellbeing and are taking all opportunities to offer support and educational experiences throughout this time.

Actions The Board is asked to receive, review and comment upon the Guardian's annual report.

Appendix 1

Locum agency expenditure to cover junior doctor rota gaps (by month)

	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	March 2020	April 2020	May 2020	June 2020	July 2020

Neurology	13,533	8,952	14,189	7,686	7,378	5,450	5,551	5,640	0	0	0	-690
Neurosurgery	28,470	9,130	22,389	25,330	15,884	17,305	14,581	16,778	18,171	5,025	11,413	12,857
Total	**42,004**	**18,082**	**36,578**	**33,016**	**23,262**	**22,755**	**20,131**	**22,418**	**18,171**	**5,025**	**12,248**	**12,248**

REPORT TO TRUST BOARD

Date: 24 September 2020

The Walton Centre NHS Foundation Trust

Title	**Annual Report 2019/20 : Senior Information Risk Owner (SIRO)**
Sponsoring Director	Name: Mike Burns Title: Director of Finance
Author (s)	Name: Mike Burns /Lorraine Blyth Title: SIRO/Digital Health Records and Information Governance Manager
Previously considered by:	Business Performance Committee 22nd September 2020

Executive Summary

In recent years compliance with developing information governance requirements has become a key concern for the public sector. The cabinet review of data security requires all public sector organisations to appoint a Senior Information Risk Owner (SIRO) whose role is to:-

"The SIRO will act as an advocate for information risk on the board and in internal discussions and will provide written advice to the Accounting Officer on the content of the annual Statement of Internal Control (SIC) in regard to information risk" *(Data Security and Protection Toolkit)*

Throughout the past year the Trust has strived to make improvements and to raise awareness as part of the Information Governance/Security Agenda which include:

- **Substantial Assurance -** gained for the 10th year in succession from internal audit on the Data Security and Protection Toolkit
- **Data Security and Protection Toolkit scores** – All assertions and mandatory evidence items were met for the new Data Security and Protection toolkit that was submitted to NHS Digital on 27th July 2020. The trust obtained Standards met again for the second year which was the second highest level available.
- **ISMS Review Group** – Regular audit and monitoring
- **ISO27001 accreditation** – Re accredited externally and there was no majors, minor or observations which is an excellent result.
- **FOI** – There have been 520 requests from April 2019 to March 2020 in comparison to 560 (7.14% decrease) in the previous year. There have been no Freedom of Information breaches ever to date which is something the Trust should be very proud of. This year has seen the trust receive one internal review request, this was dealt with within the relevant timeframe and there has been no correspondence since from the requestor or from the ICO. It is still imperative that the Trust continues to look at ways to improve the service and the level of information being made available to the public via the publication scheme with appropriate areas populating this regularly in the first instance in an attempt to reduce the number of FOI requests. The department will attempt to work with departments and improve this during 2020/21.
- **NHS Digital /CareCert –** (Computer Emergency Response Team). The Trust is also signed up to this cyber security alert service and receives weekly data and cyber security threat bulletins and risk notifications, which it acts upon. There has been 432 Carecerts received and completed in 2019/20.
- **Data Protection Impact Assessments –** The new DPIA screening and full assessments have both been reviewed in 2020 and combined in order to streamline the process and make it more user friendly. A list of completed DPIA's is regularly published on the trust external website in line with the new Data Security and Protection Toolkit requirements. There have been 15 full and 15 screening Data Protection Impact Assessments submitted to the forum throughout 2019/20.

- **Incidents –** There have been 212 incidents reported for this period against 209 in the previous year.

There have been 12 externally reportable Information Governance incidents which were reported to the Information Commissioner during this period. The ICO has now responded to all twelve incidents to advise that all appropriate remedial action had been taken and the Information Commissioner is satisified with the responses submitted by the Trust. However this figure has increased from 5 in 2018/2019. A lot of work has been undertaken to ensure that actions have been implemented following every externally reportable incident. Overall it does appear that the way the incidents are being acted upon and fed back to both managers and staff members, that lessons are being learnt as overall they are decreasing. It is hoped that with all of the actions taken this year the Trust will see less externally reportable incidents than it has during 2019/20.

- **Data Security Awareness Training -** The Trust successfully met the national 95% mandatory training target with 95% of staff completing training by 31st March 2020.

- **Cyber Security – Cyber Security –** The Trust has completed various exercises in relation to cyber security during the year such as: Cyber Desktop Exercise, NHSD Penetration Test, NHSD Internal Security Check, NHSD Risk Analysis and NHSD Internal Security Check. There are various different members from the Trust who are also now signed up to the Cheshire and Mersey Cyber group membership.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	As detailed in the report
Related Assurance Framework entries	As detailed in the report
Equality Impact Assessment completed	• **No** – The annual report is the report to show the Trust is meeting its statutory & regulatory requirements.
Any associated legal implications / regulatory requirements?	**Yes** – General Data Protection Regulation, Freedom of Information Act 2000, Access to Health Records Act 1990, Data Protection Act 2018, National Data Security Standards, Network and Information Systems Regulation.
Action required by the Board	• To consider and note

Report to Board of Directors
September 2020

Senior Information Risk owner (SIRO) Report

Background and Purpose

The purpose of this report is to:-

- Provide an overview of the Trusts compliance with legislative and regulatory requirements relating to the handling of information, including compliance with current Data Protection Laws and Freedom of Information Act (2000);
- Describe achievements relating to Information Governance within the Trust during the year 2019/20;
- To provide assurances on the progress and developments made in Information Governance/Security and to outline the strategic direction and priority areas for 2020/21;
- Present any Externally Reportable incidents within the preceding twelve months, relating to any accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

Executive Summary

In recent years compliance with developing Information Governance requirements has become a key concern for the public sector. The cabinet review of data security requires all public sector organisations to appoint a Senior Information Risk Owner (SIRO) whose role is to:-

"The SIRO will act as an advocate for information risk on the board and in internal discussions and will provide written advice to the Accounting Officer on the content of the Annual Statement of Internal Control (SIC) in regard to information risk" *(Data Security and Protection Toolkit)*

The Trust has again consistently performed well in relation to Information Governance and Information Security. This has resulted in meeting all 44 assertions, mandatory evidence items and achieving standards met for the Data Security and Protection Toolkit, which was submitted to NHS Digital on 27th July 2020.

Each year there are additional new requirements to meet, with increased focus on data security, introduced by NHS Digital for the Data Security and Protection Toolkit. This resulted in a number of additional actions being put into place. The Trust has worked throughout the year to ensure processes were implemented to enable the new requirements to be met, and for the Trust to remain compliant.

Having a strong Information Governance framework with robust processes and policies already in place has undoubtedly continued to contribute to the Trust being able to meet the new standards within the Data Security and Protection Toolkit.

The Trust successfully met the national 95% mandatory training target with 95% of staff completing Information Governance training by 31st March 2020. Additional classroom sessions were put on by the Information Governance Department as well as increased communication through regular attendance at

the Clinical Safety Huddle which is again thought to have helped this. The training is also solely managed through Information Governance, the only training function to sit outside the Training and Development Team. A lot of resource goes into email reminders on a weekly and monthly basis to both line managers and staff themselves in order to achieve this target.

The challenge over the past year has been to maintain and improve upon the standards, systems and processes already in place and to keep up with the changing legislation to ensure that the Trust continues to meet evolving Data Protection requirements. Work has been continually carried out throughout the year to meet the increasing amount of assertions within the Data Security and Protection Toolkit, the National Data Opt Out and preparing for Brexit. The National Data Opt Out has since been delayed to September 2020 however, due to the Covid 19 pandemic.

The GDPR Compliance Group that commenced in June 2018 has recently been combined with the Corporate Records Audit Group. It has continued to meet regularly throughout the year and has had good attendance. This Group has addressed many GDPR issues, increased communication and has ensured continuing compliance with GDPR. Outcomes and concerns have been reported to BPC during this time with any items to be reported by exception going forward.

After Covid-19 struck in the last month of the financial year, there has been a significant impact for the Information Governance Team as very different ways of working had to be implemented which led to new project/software and increased queries.

The IG Manager, the SIRO, the DPO and the Caldicott Guardian have continued to work closely together when advice or agreement is required on behalf of the Trust. The Information Asset Register within the Trust continues to ensure that the SIRO receives regular progress and summary reports from the IG Manager and Information Asset Owners (IAO's) on information risks, mitigations and on the progress of any associated Action Plans. The DPO will continue to monitor the Asset Register to ensure all processing arrangements and lawful basis's have been captured and recorded.

Throughout the past year the Trust has strived to make improvements and to raise awareness as part of the Information Governance/Security Agenda which include:

- **IG Toolkit Annual Review –** Resulted in Substantial Assurance being awarded by MIAA for the 10th year in succession.
- **IG Toolkit -** The final toolkit submission to NHS Digital on the 27th July 2020 resulted in a score of standards met with all 44 assertions and mandatory evidence items being completed.
- **ISO27001 accreditation -** The Trust had its external audit in July 2019 and successfully obtained the full ISO27001:20013 accreditation. There were no majors, minor or observations noted which is an excellent result.
- **The Information Security Management Systems (ISMS) Risk Group -** The Information Security Management Systems (ISMS) Risk Group manages risks that fall within the scope of the ISMS and is managed and reviewed in line with the ISO27001 standard. The IM&T department have internally developed a risk register which assists the group in managing risks and escalating where necessary as a plan, do, check, act methodology. A risk dashboard assists in confidence levels through use of weighting formula of an individual risk and as a collective score to assist in how risks are dealt with and prioritised. Solutions to continually improve Risk Management processes are reviewed within the group.
- **Cyber Security –** The Trust has completed various exercises in relation to cyber security during the year such as: Cyber Desktop Exercise, NHSD Penetration Test, NHSD Internal Security Check, NHSD Risk Analysis and NHSD Internal Security Check. There are various different members from the Trust who are also now signed up to the Cheshire and Mersey Cyber group membership.

- **NHS Digital /CareCert –** (Computer Emergency Response Team). The Trust is also signed up to this cyber security alert service and receives weekly data and cyber security threat bulletins and risk notifications, which it acts upon. There has been 432 Carecerts received and completed in 2019/20.
- **Freedom of Information** - There have been 520 requests from April 2019 to March 2020 in comparison to 560 (7.14% decrease) in the previous year. There have been no Freedom of Information breaches ever to date which is something the Trust should be very proud of. This year has seen the trust receive one internal review request, this was dealt with within the relevant timeframe and there has been no correspondence since from the requestor or from the ICO. It is still imperative that the Trust continues to look at ways to improve the service and the level of information being made available to the public via the publication scheme with appropriate areas populating this regularly in the first instance in an attempt to reduce the number of FOI requests. The department will attempt to work with departments and improve this during 2020/21.

  The SIRO is the Corporate Records lead for the sign off of all FOI requests. The FOI Annual Report was presented to IGSF in June 2020 and then to Business Performance Committee in July 2020

- **Corporate Records Management -** There have been eight Corporate Records audits carried out in 2019/20 in comparison to 9 in the previous year, however the results have remained very similar and positive. The Information Governance department has been the main point of contact for the group and continues to be responsible for setting up and arranging the audits with the responsible leads. All departmental audits reports are submitted to the Information Governance Deputy Manager to compile the annual report. All recommendations and actions are discussed through the Corporate Records Audit Group. The introduction of the audit schedule a few years ago has enabled the process to be managed internally and reported on more effectively. The 2019 NHS England Corporate Records Retention and Disposal Schedule was communicated through the group and to the wider Trust when this was introduced. The group also allows members to come and discuss any queries with retention periods and agree actions with all members. The Trust is still committed to deliver corporate records management via a digital tool. The current plan is to utilise Microsoft SharePoint to allow greater control over record retention. Under the new NHS Microsoft agreement there is an opportunity that is being investigated in utilising the latest version of SharePoint rather than the current Trust pilot which is using SharePoint 2010. This is being investigated with NHS Digital when national roll out of Office 365 starts in September. The annual audit report will be presented to IGSF in September. The SIRO has overarching responsibility for the Corporate Records Management function.
- **Data Flow Mapping -** is a mandatory requirement for all NHS Trusts. The Trust must adequately protect transfers/ flows of information. The Information Asset Register incorporates all the data flows and holds detailed information about the Trusts processing activities. The Trust has incorporated the capability to record the lawful basis for processing on the register in line with national requirements. Not only does it allow the Trust to remain compliant it ensures that the data remains secure in transit and that it reaches its destination promptly, securely and safely in line with the Data Protection laws. The Trust has ensured that all known data flows that leave the UK/EEA have been fully reviewed and meet DPA requirements. No high risks have been identified or reported.
- **Data Sharing Agreements -** The Trust has continued to see a steady number of Data Sharing Agreements being implemented. The Information Governance Department continue to work closely with all departments to ensure the agreements have been reviewed and a legal basis has been identified. Across the Trust the involvement of Information Governance at the beginning of projects is increasing which is a positive development.
- **Policies** – All Information Governance policies were agreed to be changed to a 3 yearly review date as this is no longer a requirement of the DS&P toolkit and is in line with the rest of the Trust policies. None of the policies were therefore due for review until 2021 but are being reviewed by the DPO during May – August 2020.

No new policies were introduced during 2019/20.

- **Data Protection Impact Assessments –** A DPIA policy and relevant guidance is in place which clearly defines how the Trust manages assurance in relation to privacy, data protection and confidentiality when developing and implementing policies, projects, systems and procedures initiated by the Trust. DPIA assessments are being carried out in line with the Policy and being monitored through IGSF. DPIA's have increased and show engagement from various different departments when initially introducing projects. The new DPIA screening and full assessments have both been reviewed in 2020 and combined in order to streamline the process and make it more user friendly. A list of completed DPIA's is regularly published on the trust external website in line with the new Data Security and Protection Toolkit requirements. There have been 15 full and 15 screening Data Protection Impact Assessments submitted to the forum throughout 2019/20.
- **Incidents -** There have been 212 incidents reported for this period against 209 in the previous year. There have been 12 externally reportable Information Governance incidents which were reported to the Information Commissioner during this period. The ICO has now responded to all twelve incidents to advise that all appropriate remedial action had been taken and the Information Commissioner is satisified with the responses submitted by the Trust. However this figure has increased from 5 in 2018/2019. A lot of work has been undertaken to ensure that actions have been implemented following every externally reportable incident. Overall it does appear that the way the incidents are being acted upon and fed back to both managers and staff members, that lessons are being learnt as overall they are decreasing. It is hoped that with all of the actions taken this year the Trust will see less externally reportable incidents than it has during 2019/20. The Information Governance department will continue to monitor where improvements can be made and will work with the Risk and Governance Department to identify trends and any additional training that may be required. The Annual incident report was presented to IGSF in July 2020.

Full details of the improvements made for 2019/20 can be found in the Information Governance Annual Report 2019/20.

IG/ Information Security framework in place

Senior Information Risk Owner SIRO

The current SIRO (Director of Finance and IT) has been in the role since November 2015. He is responsible for ensuring that there is an appropriate and effective framework of resources and support in place to provide assurance on the provision of Data Protection compliance. The SIRO is responsible for bringing Information Governance issues to the attention of the Board, and for providing a framework to identify and manage the risks associated with handling information under the control and ownership of the Trust.
He has undertaken training for the role by completing the NHS Digital training modules for Introduction to Risk management for SIRO's and IAO's in October 2017. Further SIRO training provided by Information Governance Limited was also attended in November 2018 and Legal Training for Caldicott Guardians and Senior Information Risk Owners provided by Hill Dickinson was attended on the 8th January 2020.
The SIRO is registered on the NHS Digital Register of SIRO's.

The SIRO is chair of the Information Governance Security Forum and works very closely with the Caldicott Guardian, the IG Manager, the Information Asset Owners and the ISMS Review Group to ensure the following:

- Develop, implement and monitor the processes that support information governance compliance and support a culture that values, protects and uses information for the success of the organisation and benefit of its clients;

- Know what information assets the organisation has, who owns them and understand the nature of information flows to and from these assets and any associated risks;

- Completion and timely submission of the Trusts Data Security and Protection Toolkit, identifying areas of risk and target improvement initiatives through action planning and progress monitoring;

- Owning the organisation's information incident management framework;

- ISMS compliance and re accreditation;

- Responsible for the Corporate Records Management Function.

Caldicott Guardian

The trusts Medical Director is the nominated Caldicott Guardian for the Trust and has undertaken this role since September 2016. He has undertaken Caldicott Guardian in Health and Social Care training in October 2017. Further training on Caldicott and Adult Safeguarding was also attended in November 2018 and Legal Training for Caldicott Guardians and Senior Information Risk Owners provided by Hill Dickinson was attended on the 8th January 2020. The Caldicott Guardian oversees the use and sharing of patient information, championing confidentiality and information sharing within and outside the Trust. The Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient-identifiable information. He is registered on the NHS Digital Register for Caldicott Guardians. He also plays an active part in the Information Governance and Security Forum and maintains a Caldicott log in which he records confidentiality queries and Information Governance issues on which he provides regular updates to the SIRO and Digital Health Records and IG Manager.

Digital Health Records and Information Governance Manager

The current Information Governance Manager has been in post since January 2018. She is responsible for coordinating the implementation of the Information Governance work programme within the Trust along with the Information Governance Team. The IG Manager has continued to develop, implement and monitor the processes that support information governance compliance and is responsible for promoting a culture that values, protects and uses information for the success of the organisation and benefit of its clients.
The IG Manager completed her Data Protection Foundation and Practitioner Qualifications in June 2019 and obtained a distinction in the Freedom of Information Practitioner course completed in March 2020.

Data Protection Officer

This role was introduced in January 2018. It shows the Trust recognises its obligations and accountability responsibilities with the new GDPR and Data Protection Laws.

Since the previous DPO left in December 2019 the Trust has bought into a 'DPO service' provided by an independent external organisation. The DPO is responsible for providing the Trust with independent risk-based advice to support its decision-making in the appropriateness of processing 'personal and Special Categories of Data' as laid down in the General Data Protection Regulation (GDPR) and any superseding Data Protection regulations. The DPO is required to provide advice and guidance on all data protection legislation queries to staff, patients and the board.

Business Performance Committee

The Business Performance Committee receives a monthly chairs report from IGSF and updates on performance against the Data Security and Protection toolkit. The Committee reviews any information risks identified through the Risk Assurance Framework before presentation at the Audit Committee. The Board of Directors and the Business Performance Committee receive exception reports on serious untoward incidents via the Corporate Performance report.

Information Governance Security Forum

The Forum continues as the organisational focus for all matters relating to information governance and security. The group has overseen the successful implementation of the IG action and improvement plans and has continued to be an effective forum for debate and decision making. The group considers all IG /Medical Records incidents reported, ensuring appropriate action and mitigation plans are in place as necessary and risk assessed and regular monthly updates of how the trust is progressing with GDPR have been provided to the group by the DPO. The DPO will continue to provide a monthly progress report through the group.

The DPO and IG Manager participate in the North Cheshire & Mersey IG Network, a local forum for IG specialist staff and give regular updates at the Information Governance Security Forum and attend National events to ensure they are up to date with current legislation and any changes which could impact on the Trust.

They also attend the newly introduced Information Governance Strategy Group which has been set up to review Information Governance processes with the aim of delivering them in a more collaborative and standardized environment across the Health Care Partnership. It consists of a set of professional network of experts such as SIRO, Caldicott and CIO representatives, IG Managers, DPO's, with patient and social care representatives also present. The group is currently looking at a collaborative Data Protection Impact Assessment for all organisations and the implementation of the Information Sharing Gateway.

Digital Systems Programme Board

This group was set up to replace the former EPR Programme Board and Health Records Strategy Group. The Digital Systems Programme Board constitutes six sub groups to deliver the Trust digital roadmap under authority of the Business Performance Committee. This programme board oversees the development and the operational stability and effectiveness of the digital infrastructure and systems that support patient care and corporate functions ensuring that the overall Clinical System functionality is managed alongside the defined Digital Strategy. The Group is a sub group of Business Performance Committee which it reports through to on a bi monthly basis. Regular updates are also fed into IGSF. During early 2020, given the challenges of the pandemic and the need to implement agile working the priorities have had to change within the strategy to accommodate the changes required and an updated strategy was presented to executives to facilitate this. The strategy will continue its focus on the delivery of clinical systems, however, there are likely to be some prioritisation choices that will need to be made by the Digital Programme Board over the next couple of years given the demands on the capital programme.

ISMS Review Group

The Information Security Management Systems (ISMS) Review Group was implemented in 2013 and is responsible for establishing, implementing, operating, monitoring, reviewing, maintaining and the improvement of the Information Security Management System (ISMS), ISO27001. The group has now been expanded to include representation from the Risk, Information and Procurement department and includes HR and Estates as and when required. The SIRO is responsible for signing off the ISMS documentation and function.

Strategic Direction

Throughout 2020/21 and beyond the Information Governance function will continue to work across all areas of the organisation to:-

- Actively support the delivery of the Trust's strategic plan;
- Identify and secure the resources, processes and skills required for the Trust to effectively deliver against emerging national NHS IG and Information security requirements;
- Continue to work towards maintaining or exceeding a "standards met" status for the Trust in the Data Security and Protection Toolkit;

- Work collaboratively with partner organisations to achieve continuous improvements in meeting national, statutory and good practice requirements;
- Implement effective mechanisms for achieving compliance with changing statutory requirements e.g. GDPR, DPA, FOI, Data Security, Ten National Data Standards etc;
- Work alongside IM&T and Information to ensure the Trust is ready for the mandatory National Data Opt Out Programme in March 2020;
- Undertake DPIA assessments and report on risks associated with information systems, data and processes through the established risk management mechanisms;
- Continue to work closely with IM&T staff and system implementation teams to assess, implement and provide continuing support to new clinical and corporate records systems;
- Continue to raise levels of awareness amongst staff of their IG/Information Security responsibilities through the delivery of effective training and communications and play a key role in supporting staff training and development;
- Ensure all policies and processes are reviewed ahead of the UK officially leaving the EU at the end of the year;
- Continue to ensure all staff where appropriate achieve training in the area of Information Governance and Data Protection and this is built into the Training Needs Analysis so is financially considered;
- Continue to contribute and work collaboratively with all at the external Cheshire and Merseyside IG meeting and the newly implemented Information Governance Strategy meeting;
- Maintain the status of “no breaches” within the Freedom of Information function and ensure the external publication scheme is reviewed with all departments;
- Maintain or exceed a “standards met” status for the Data Security and Protection Toolkit and “substantial assurance” for the eleventh year on the external MIAA audit.

Conclusion

The Information Governance Department continues to have robust monitoring and reporting arrangements in place which allows gaps to be identified quickly and actions to be taken where necessary. The results within this report should be seen once again as a significant achievement for the Department who consistently push to maintain and where possible exceed the same high standards with the aim to continue to provide the same levels of assurance.

The Trust has successfully attained standards met against the new Data Security and Protection Toolkit (DSPT) and substantial assurance for the tenth successive year following the external audit of the Toolkit by Mersey Internal Audit Agency. The Trust has been consistent in its Toolkit submissions over the past ten years and it is anticipated this will continue with the Data Security and Protection Toolkit each year.

Almost all actions from the 2019/20 Action Plan have been met, except for three - the National Data Opt out Programme which was delayed to September 2020 so is ongoing, the compliance check questions decreased slightly due to staffing and Covid 19 starting in March 2020, and the Data Protection Impact Assessment has not yet been made electronic due to other clinical system development priorities but this will be looked at for 2020/21. All other actions were met.

After Covid-19 struck in the last month of the financial year there has been a significant impact for the Information Governance Team as very different ways of working had to be implemented which led to new project/software and increased queries. Processes that were implemented quickly without full due diligence, and as advised by the Information Commissioner are now being retrospectively fully examined and documented. It is expected that this increased workload will continue with the extension of the COPI (Control of Patient Information Notice) until March 2021, virtual ways of working and the new agile working plan for the Trust.

The Department will continue to strive to make improvements and are already awaiting the increased mandatory assertions expected within the third version of the Data Security and Protection Toolkit in line with making cyber essentials mandatory by March 2021. Continuing work this year will also be required to ensure the Trust is ready for the delayed National Data Opt out Programme deadline by September 2020 and the impact on data protection legislation as the UK officially leaves the EU at the end of the year. All Privacy Notices, policies and procedures will have to then be reviewed again to ensure they are compliant with new legislation.

It is also expected that the annual external audit of the Toolkit will involve all assertions being audited over a three year period, so the workload is anticipated to increase for all those involved.

Improving staff training and awareness will continue to be driven forward by the IG Department each year. The 95% target was met again through consistent hard work by the IG staff and collaboration with line managers and staff across the Trust, which was a credit to everyone involved. Whilst there are still challenging times ahead, the Trust is in a very strong position to continue to remain consistent and deliver all requirements.

The high level actions plans outlined in the full Annual Information Governance Report for 2020/21 coupled with the continuous IG training and development should help to ensure the Walton Centre NHS Foundation Trust continues to improve and build on its Information Governance Framework to meet its statutory, regulatory and performance obligations for the forthcoming year.

Mike Burns
Director of Finance (SIRO)
August 2020

REPORT TO TRUST BOARD

Date: 24 September 2020

The Walton Centre NHS Foundation Trust

Title	**Workforce Race Equality Standards (WRES) Report 2020**
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	• Committee (please specify) __N/A • Group (please specify) __N/A • Other (please specify) __ N/A
Executive Summary The WRES requires Trusts to demonstrate progress against nine indicators of workforce race equality. It also requires the relevant Trust data to be submitted via the NHS England, Strategic Data Collection Service (SDCS) system to enable further comparisons to be made between NHS trusts, and to be published online in accordance with the public sector duties under Equality Act 2010. Please see attached summary.	
Related Trust Ambitions	• Be recognised as excellent in all we do • Equality, Diversity and Inclusion (ED&I) 5 Year Vision
Risks associated with this paper	Failure to consider and publish would risk compliance with the Trust's Public Sector Equality Duty (PSED).
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• Yes
Any associated legal implications / regulatory requirements?	Failure to consider and publish would risk compliance with the Trust's Public Sector Equality Duty (PSED).
Action required by the Board	• To consider and note

Workforce Race Equality Standard (WRES) Findings and Actions

Trust Board

2020

Contents

1. Introduction

The WRES requires Trusts to demonstrate progress against nine indicators of workforce race equality. The indicators focus upon Board level representation and differences between the experience and treatment of White and BME staff. In addition to producing and publishing the WRES PDF template and action plan on the Trust website and intranet, we are also required to submit a return via the NHS England, Strategic Data Collection Service (SDCS) system to enable further comparisons to be made between NHS trusts.

This reporting period covers 01 April 2019 to 31 March 2020. The 2019, 2018 and 2017 WRES Reports are also available on The Walton Centre Website:
https://www.thewaltoncentre.nhs.uk/175/equality-and-diversity.html

2. **Summary of Key Points**

Workforce Race Equality Standard (WRES) Findings and Actions, Trust Board 2020

This WRES report demonstrates the Trust's progress against the nine indicators of the NHS England Workforce Race Equality Standard.

Of the 9 WRES indicators the Trust is making progress on only 3 this year. This is a marked contrast to the previous year which saw the Trust progressing on 8 of the indicators.

Key to the Trusts own colour rating of performance regarding the WRES Indicators.	
Red a marked deterioration	
Pink indicates some level of deterioration	
Amber indicates no change	
Green Indicates improvement	

Indicator 1	Indicator 2	Indicator 3	Indicator 4	Indicator 5	Indicator 6	Indicator 7	Indicator 8	Indicator 9

Indicator 1) The percentage of BME staff in each of the AfC Bands 1-9.
This indicator has improved slightly in terms of the overall percentage of BME staff.

- As at 31 March 2020 there were a total of 1452 members of staff employed within the organisation.
- Of this total, the number of BME staff employed was 138 (9.5%).
- In March 2019 the total BME Staff recorded was 133 (9.41%).
- In March 218 the total of BME staff was 181 (12.95%)
- In March 2017 the total BME staff was 9%
- In March 2016 the total BME staff was 8.4%

(Note -The 2018 BME percentage appears to have been boosted by a temporary period in which there were higher numbers of junior medics at the Trust many of whom were BME.)

- If the 2018 figure is discounted as a fluctuation from the normal situation, we can see a small year on year increase in the numbers of BME staff at the Trust year on year from 2016 onward. .

Indicator 2) The relative likelihood of staff being appointed from shortlisting across all posts.
This indicator has deteriorated markedly.
The is now a 5.76% difference between the percentage of White candidates appointed from shortlisting and BME Candidates appointed from shortlisting in the preceding year to March 2019 the gap was insignificant.

The Trust is currently reviewing all aspect of the recruitment process to increase the numbers of BME staff at BAND 6 and above. This review will also include the introduction of Equality and Diversity Champions into the Interview process to ensure the elimination of any unconscious bias.

Indicator 3) The relative likelihood of BME staff entering the formal disciplinary process.
This indicator has deteriorated insignificantly.
There were 2 BME staff entering into this process in this period and 14 White staff. In the preceding year there were no BME staff entering disciplinaries. So this figure is a rebalancing towards what would be expected given the Trusts staff demographics. However the numbers involved are too small to draw any firm conclusions.

Indicator 4) The relative likelihood of staff accessing non-mandatory training and CPD.
This indicator has deteriorated very markedly.
Year to March 2020; 418 White staff accessed non-mandatory training and CPD = (94.57%)
24 BME staff accessed non-mandatory training and CPD = (5.43%)
BME staff 2019 = 17.41 times less likely to access such training. This is such a massive departure from the

Year to March 2019 at (9.77%) the percentage for BME staff is slightly more positive than the (7.02%) for White staff at the Trust.

The difference is very large between these two figures over a relatively short time period requires urgent investigation. It would be reasonable to hold judgement on these figures until they can be investigated further, to ascertain the reasons for such a marked difference. These figures will be discussed with HR, Training and BAME staff to identify the cause and remedial actions.

Indicator 5) The percentage of staff experiencing harassment, bullying or abuse from patients.

This indicator has deteriorated markedly.

	2017	2018	2019
White	21.8%	26.2%	25.3%
BME:	46.3%	29.3%	35.1%

There has been a 5.8% increase in percentage of BME staff experiencing harassment, bullying or abuse from patients. Steps have been taken to provide more support for BME staff when such incidents occur, however these figures will be discussed with BAME staff to identify the cause and find more preventative measures.

Indicator 6) The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
This indicator has improved slightly following the year on year trend.

	2017	2018	2019
White	17.7%	19.3%	16.4%
BME	24.4%	23.2%	21.6%

Indicator 7) The percentage believing that trust provides equal opportunities for career progression or promotion.
This indicator has deteriorated.

	2017	2018	2019
White	90.3%	92.8%	92.5%
BME	71.4%	91.7%	77.8%

There has been a 13.9% drop in the percentage of BME staff believing that trust provides equal opportunities for career progression or promotion. There is evidence from the BAME Staff Group meetings that this may be associated with greater awareness amongst BME staff of the disproportionately low numbers of staff (with the exception of Medical staff) at Band 7 and above, as reported in previous WRES reports. These figures will be discussed with BAME staff to identify the cause and remedial actions.

Indicator 8) In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues.

This indicator has deteriorated.

	2017	2018	2019
White	6.2%	4.3%	4.5%

BME	**15.4%**	**10.7%**	**13.5%**

This reporting period has seen a reverse in the previously downward year on year trend for BME staff expressing personally experienced of discrimination at work from a manager/team leader or other colleagues. These figures will be discussed with BAME staff to identify the cause and remedial actions.

Indicator 9) The percentage difference between the organisations' Board voting membership and its overall workforce.

This indicator has improves markedly

2018	2019	2020
-8.6%	- 0.1%	7.2%

Previous to 2019 this Indicator had remained relatively constant. Any slight changes in that period were due to changes in overall workforce numbers not changes to Board composition. As the Trust Board now has 2 (20%) BME membership this percentage is both higher than the percentage of BME staff in the workforce and the local and national demographics in terms of race.

3. Findings

WRES Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.
Indicator 1 narrative As of 31st March 2020 there were 1452 staff employed by the Trust. This figure comprised 1300 (89.5%) White staff and 138 (9.5%) staff with 14 (0.96%) unknown ethnicity. The percentage figure for BME staff rose a little in this reporting year from (9.41%) to (9.50%). This new figure remains approximately in line with the BME census figures for the North West and is well above the BME census figures for Merseyside. The current figure indicates that the Trust is not underrepresented in the overall numbers of BME staff. The highest percentage of BME staff measured against the total staff is to be found within the Clinical staff and stands at (4.89%). Medical BME staff make up (4.55%) of the whole workforce and Non Clinical BME staff constitute (0.69%). These figures provide no justification for further positive actions to boost the overall numbers of BME staff at the Trust. However, the comparatively low percentage of staff in the non-clinical workforce and the low numbers of clinical and non-clinical staff at Band 7 and above justifies further positive actions to boost BME staff numbers in these areas. In order to fully understand the significance of the percentages above they need to be examined alongside the, Non Clinical, Clinical and Medical staff figures and percentages. See tables below and comments for more details. As context for the all of the above staff race statistics, the Office of National Statistics, 2011 Census, states that 5.5% of the Merseyside population has a Black, Minority Ethnic background (BME) which is lower than the North West average (9.8%). Source: Census 2011, www.ons.gov.uk
Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective Actions completed: – Signed up to NHS Employers Diversity and Inclusion Partners Alumni – 30+ ED&I champions in place with role descriptor – Signed up to RCN Cultural Ambassadors programme – This measure has been – successfully tested regarding the recruitment of a Board member in 2018 and the exploration of the possibility of using Cultural

Ambassadors for this is continuing. This action will have to be further embedded before exploring the possibilities for clinical and other roles. However, appreciation must be given to the limited number of BME staff available to do this

- Board level ED&I lead is in post
- The appointment of a full-time Equality and Inclusion Lead post at the Trust
- Bespoke ED&I Cultural Competence and Cultural Confidence Training for ED&I champions delivered by a specialist consultancy
- ED&I Strategy has been refreshed with a new BAME strategic Group
- Engagement with BME staff has been improved via a new BAME staff group

Further proposed actions:

- Introduce an initiative whereby there must be a BME member of staff or Diversity Champion on any appointing panel.
- Further exploration is needed to understand any barriers BME staff feel they face when applying for more senior positions or the reasons why they do not apply.
- Continue to monitor this indicator.

2020 Whole Workforce

Total staff	White total	BME Total	Total unknown
1452	1300 (89.5%)	138 (9.5%)	14 (0.96%)

Non Clinical workforce Total: 383 Staff

1a) Non Clinical workforce	White Non Clinical staff numbers	White staff as a percentage of Non Clinical staff	White Non Clinical staff as a percentage of all staff	BME Non Clinical staff numbers	BME staff as a percentage of Non Clinical staff	BME Non Clinical staff as a percentage of all staff	Unknown/ null
Under Band 1	0	0.00%	0.00%	0	0.00%	0.00%	0
Band 1	0	0.00%	0.00%	0	0.00%	0.00%	0
Band 2	76	19.84%	5.23%	1	0.26%	0.07%	0
Band 3	72	18.80%	4.96%	5	1.31%	0.34%	0
Band 4	95	24.80%	6.54%	1	0.26%	0.07%	0
Band 5	39	10.2%	2.7%	1	0.3%	0.1%	0
Band 6	27	7.0%	1.9%	1	0.3%	0.1%	0
Band 7	17	4.4%	1.2%	0	0.0%	0.0%	0
Band 8A	17	4.4%	1.2%	1	0.3%	0.1%	0
Band 8B	13	3.4%	0.9%	0	0.0%	0.0%	0
Band 8C	6	1.6%	0.4%	0	0.0%	0.0%	0
Band 8D	5	1.3%	0.3%	0	0.0%	0.0%	0
Band 9	0	0.00%	0.00%	0	0.00%	0.00%	0
VSM	6	1.6%	0.4%	0	0.0%	0.00%	0
Totals	373	(97.4%)	(25.69%)	10	(2.61%)	(0.69%)	0

Of the 383 Non Clinical staff, 10 (2.61%) are recorded as BME. These figures indicate an increase of 1 Non Clinical BME staff since March 2019, i.e. The addition of 1 additional BME staff member is at Band 8A, which is significant as prior to this there were no BME Non Clinical staff above Band 7. However the majority of this BME staff group remain at Band 3 and below.

Though it is a undesirable the comparatively low numbers of Non Clinical BME staff does not currently present a risk to the organisation in terms of The Equality Act 2010. This is because there is no indication that this imbalance is caused by discriminatory practices on the part of the Trust and it is currently balanced by the overall number of BME staff at the Trust, which is roughly in line with regional and local race equality demographics. The Non Clinical BME staffing imbalance does, however warrant targeted action in terms of the Trusts commitments as set out in The Equality, Diversity and Inclusion (ED&I) 5 Year Vision and the Trusts general desire to improve equality of opportunity. The Trust intends to examine ways to better promote Non Clinical job opportunities to BME communities.

Clinical workforce Total: 930 Staff

1b) Clinical workforce	White Clinical staff numbers	White staff as a percentage of Clinical staff	White Clinical staff as a percentage of all staff	BME Clinical staff numbers	BME staff as a percentage of Clinical staff	BME Clinical staff as a percentage of all staff	Unknown/null
Under Band 1	0	0.00%	0.00%	0	0.00%	0.00%	0
Band 1	0	0.00%	0.00%	0	0.00%	0.00%	0
Band 2	152	16.34%	10.47%	13	1.40%	0.90%	1
Band 3	93	10.00%	6.40%	2	0.22%	0.14%	0
Band 4	14	1.51%	0.96%	1	0.11%	0.07%	0
Band 5	214	23.0%	14.7%	34	3.7%	2.3%	2
Band 6	150	16.1%	10.3%	15	1.6%	1.0%	1
Band 7	150	16.1%	10.3%	2	0.2%	0.1%	0
Band 8A	60	6.5%	4.1%	2	0.2%	0.1%	0
Band 8B	10	1.1%	0.7%	0	0.0%	0.0%	0
Band 8C	5	0.5%	0.3%	0	0.0%	0.0%	0
Band 8D	4	0.4%	0.3%	0	0.0%	0.0%	0
Band 9	0	0.00%	0.00%	0	0.00%	0.00%	0
VSM	3	0.3%	0.2%	2	0.2%	0.1%	0
Totals	855	(91.94%)	(58.88%)	71	(7.63%)	(4.89%)	4 (0.43%)

Clinical workforce

Of the 930 staff that currently make up the Clinical workforce 71 (7.63%) are recorded as BME, with the greater majority of these clustered around pay Bands 5 and 6 with a smaller spike in Band 2. There has been no significant change in the pay bands that this group of BME staff occupy within the organisation. In the 2019 WRES report there were 2 BME staff at Band 7, and 2 at Band 8A constituting (2%) of Clinical staff respectively. There remain no other BME Clinical staff above Band 6.

Medical workforce Total: 155 Staff

Medical	White Medical staff numbers	White staff as a percentage of Medical staff	White Medical staff as a percentage of all staff	BME Medical staff numbers	BME staff as a percentage of Medical staff	BME Medical staff as a percentage of all staff	Unknown/null
Consultants	58	37.42%	3.99%	42	27.10%	2.89%	9
of which Senior medical manager	7	4.52%	0.48%	9	5.81%	0.62%	0
Non-consultant career grade	3	1.94%	0.21%	2	1.29%	0.14%	1
Trainee grades	11	7.10%	0.76%	13	8.39%	0.90%	0
Other grades	0	0.00%	0.00%	0	0.00%	0.00%	0
Totals	79	(50.97%)	(5.44%)	66	(42.58%)	(4.55%)	10 (6.45%)

There are currently 155 Medical staff 66 (42.58%) of whom are recorded as BME. This relatively high number of BME Medical staff is a reflection of the national racial demographic of Medical staff which is currently very different from the National or regional racial profile of the general population. In short, the international nature of the medical labour market leads to a much larger representation of BME staff than the average proportion of BME people in the National population. Government figures for November 2018 indicate that 38.8 of the NHS Medical workforce is recorded as BME.

Source:
https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest

WRES Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.		
2018	**2019**	**2020**
Relative likelihood of White staff being appointed from shortlisting compared to BME staff = 1.50 times greater. The total number of applicants shortlisted was 1429. Of these 96 (13.7%) were BME. 26 (13.3%) of these BME shortlisted applicants went on to be appointed. 1233 (86.3%) of applicants were white. 245 (19.9%) of those white shortlisted applicants went on to be appointed.	The number of White applicants was 548. The total Number of BME applicants was 91. The number of White applicants shortlisted was 131. The number of BME applicants shortlisted was 22. The percentage of White applicants shortlisted was (23.91%) The percentage of BME applicants shortlisted was (24.18%) The relative likelihood of White staff being appointed from shortlisting compared to BME staff =(0.99%) less likely. This indicator has improved to such an extent that there is no longer a significant gap at the Trust between White staff and BME staff in terms of their chances of being shortlisted from appointment.	The number of White applicants was 394. The total Number of BME applicants was 66. The number of White applicants shortlisted was 154. The number of BME applicants shortlisted was 22. The percentage of White applicants shortlisted was (39.09%) The percentage of BME applicants shortlisted was (33.33%) The relative likelihood of White staff being appointed from shortlisting compared to BME staff = 7.10 more likely for white staff to be appointed.
Narrative This large percentage difference in favour of white applicants being shortlisted is unexpected as no changes took place in the recruitment process over this period which would easily explain the difference. The Trust is currently reviewing recruitment procedures to ensure that we understand and improve in relation to ensuring that there is no discrimination in the system.		
Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective Actions completed: – 30+ ED&I champions in place with role descriptor agreed		

- Board level lead identified
- E&D Policy uploaded to all adverts on NHS jobs to highlight equal opportunity expectations.
- Coaching programme includes BME staff to further support staff.
- Reciprocal Mentoring programme

Further proposed actions:
- The Trust is undertaking and Equality review of its recruitment procedures
- Explore the possibilities for ensuring that recruitment panels have current information about the ED&I profile of the Bands and sections of the workforce that they are recruiting too.
- Additional E&D training module will be mandatory for all recruiting managers, in addition to the basic module.
- Further explore the introduction of an initiative whereby there must be a BME member of staff on any appointing panel (as above).
- Explore additional advertising to reach BME groups
- Continue to monitor

WRES Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.		
2018	2019	2020
Relative likelihood of BME staff entering the formal disciplinary processes compared to White staff = 0.72 times less Total number of White and BME staff 1398 Total number of disciplinaries 32 Total disciplinaries of white staff 28. Total disciplinairies of BME staff 3.	For the year to March 2019 the Trust had 3 White staff entering into a formal disciplinary investigation. There were no BME staff entering into this process in this period.	For the year to March 2020 the Trust had 14 (87.50%) White staff entering into a formal disciplinary investigation. There were 2 (12.50%) BME staff entering into this process in this period. BME staff were 7 times less likely to enter into formal disciplinary than White staff.
The Trust is dealing with a relatively low number of disciplinaries overall, so unless there were sustained issues of discrimination we would expect random fluctuations to make the proportion of BME disciplinaries vary year on year. This seems to be what we are observing regarding this indicator. The low level of BME staff entering into this process in this period shows no indication of any discrimination in respect of this indicator.		

Further proposed actions:
- Continue with the Cultural Ambassadors Programme
- Continue to monitor

WRES Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.		
Year to March 2018	Year to March 2019	Year to March 2020
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff = 0.41 times greater	89 White staff accessed non-mandatory training and CPD = (7.02%) 13 BME staff accessed non-mandatory training and CPD = (9.77%) BME staff = (2.75%) more likely to access such training.	418 White staff accessed non-mandatory training and CPD = (94.57%) 24 BME staff accessed non-mandatory training and CPD = (5.43%) BME staff = 17.41 times less likely to access such training.
This indicator shows an unexpectedly large difference in the comparative numbers of staff accessing training and CPD compared with previous years. Work will be undertaken to understand these figures.		
Further proposed actions: - Review the data with Training and Development to identify wy the data is different from previous years and identify opportunities to improve BME uptake. - Discuss the figures with the BAME Staff Group to identify further ways to Increase BME participation - Continued communication of external training programme opportunities - Continue to monitor		

Staff Survey Questions: The Trust used a census which sends the survey to all staff.

WRES Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.			
	2017	**2018**	**2019**
W**hite**	**21.8%**	**26.2%**	**25.3%**
BME	**46.3%**	**29.3%**	**35.1%**
There has been a 5.8% increase in percentage of BME staff experiencing harassment, bullying or abuse from patients. Steps have been taken to provide more targeted support for BME staff when such incidents occur, however these figures will be discussed with BAME staff to identify the cause and find more preventative measures.			
Further proposed actions: – Gain further feedback from BME staff and explore with them what interventions the Trust can put in place to better support BME staff in this area. – Continue to monitor			
WRES Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.			
	2017	**2018**	**2019**
White	**17.7%**	**19.3%**	**16.4%**
BME	**24.4%**	**23.2%**	**21.6%**
This indicator has seen a slight increase for White staff and a slight decrease for BME staff. This is in line with the trend from previous years which has seen the indicator dropping for BME staff and increasing for White staff. The gap has now fallen to 3.87% from last year's 6.70% and the previous year's 11.07%. This is significant progress over the period covered.			
Action Competed: – Freedom to speak up guardian appointed and drop in sessions arranged Further proposed actions: – Continue to monitor			

WRES Indicator 7: Percentage believing that trust provides equal opportunities for career progression or promotion			
	2017	**2018**	**2019**
White	**90.3%**	**92.8%**	**92.5%**
BME	**71.4%**	**91.7%**	**77.8%**

There has been a 13.9% drop in the percentage of BME staff believing that trust provides equal opportunities for career progression or promotion.
There is evidence from the BAME Staff Group meetings that this may be associated with greater awareness amongst BME staff of the disproportionately low numbers of staff (with the exception of Medical staff) at Band 7 and above, as reported in previous WRES reports. These figures will be discussed with BAME staff to identify the cause and remedial actions.

Action Competed: The Trust has undertaken a BME staff Reciprocal Mentoring Programme

Further proposed actions:

- The Trust is undertaking an equality review of recruitment procedures.
- Gain further feedback from BME staff and explore with them what interventions the Trust can put in place to better support BME staff in this area.
- Continue to monitor

WRES Indicator 8: In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues			
	2017	**2018**	**2019**
White	**6.2%**	**4.3%**	**4.5%**
BME	**15.4%**	**10.7%**	**13.5%**

This reporting period has seen a reverse in the previously downward year on year trend for BME staff expressing personally experienced of discrimination at work from a manager/team leader or other colleagues. These figures will be discussed with BAME staff to identify the cause and remedial actions.

Actions completed:

- Freedom to speak up guardian appointed and drop in sessions arranged
- Berwick session around raising concerns
- Signed up to Tackling Bullying in the NHS campaign

Further proposed actions:

- Gain further feedback from BME staff and explore with them how the Trust can work to improve this indicator.

WRES Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.

2018	2019	2020
-8.6%	- 0.1%	7.2%

Previous to 2019 this Indicator had remained relatively constant because there were no Board Members. Any slight changes in that period were due to changes in overall workforce numbers not changes to Board composition. The Trust Board now has 2 (20%) BME members this percentage is both higher than the percentage of BME staff in the workforce and the local and national demographics in terms of race.

Action completed:

- Consideration has now been given to the previous lack of diversity when reviewing Non-Executive terms of office or appointing new members. This has improved the racial diversity of the Board.
- A BME member of staff now sits on any executive or non-executive appointing panel

Links to Equality Objectives:
All of the above actions relating to all WRES Indicators link to the Trusts EDI&I 5 Year Vision's commitment to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre. The actions are also relevant to EDS2 3.1 to 3.6: A representative and supported workforce.

End of report.

For more information, please contact:
Andrew lynch

Equality and Inclusion Lead
HR Department
The Walton Centre NHS Foundation Trust
Sid Watkins Building
Lower Lane
Liverpool
L9 7BB
Email: Andrew.Lynch2@thewaltoncentre.nhs.uk
Telephone: 0151 556 3396

4

Appendix - Equality Impact Assessment (EIA) Form

The Walton Centre NHS Foundation Trust

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part

1. Person(s) Responsible for Assessment: **Andrew Lynch** 2. Contact Number: **0151 556 3396**

3. Department(s): **HR** 4. Date of Assessment: **2.09.20**

5. Name of the policy/procedure being assessed: **Workforce Race Equality Standards (WRES) 2020 Findings**

6. Is the policy new or existing?
New Existing

7. Who will be affected by the policy (*please tick all that apply*)?
Staff Patients Visitors Public

8. How will these groups/key stakeholders be consulted with? N/A This document is the result of a consultation process.

9. What is the main purpose of the policy? This document sets out the findings of the Walton Centre Workforce Disability Equality Standards monitoring for 2020.

10. What are the benefits of the policy and how will these be measured? Improving race equality and reducing discrimination in Trust processes and staff, patient and visitor behaviour. This will be measured through the WRES metrics.

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes, The Equality, Diversity and Inclusion 5 Year Vision.

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? None, these findings are intended to promote and support equality for all staff.

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	

Sex	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Race	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Religion or Belief	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Disability	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Sexual Orientation	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Pregnancy / maternity	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Gender Reassignment	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Marriage & Civil Partnership	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Other	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) The purpose of this report is to set out how Workforce Race Equality will be promoted throughout the Trust in line with the Trust's Public Sector Equality Duty under the Equality Act 2010, therefore there is likely to be a positive impact on other protected characteristic, as according to this legislation all people are protected equally.

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? This report supports a Human Rights based approach to supporting staff.

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date
N/A	N/A	N/A	N/A

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken ✓

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Andrew Lynch Date: 02.09.20

Signed: Andrew Lynch

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ٠١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。

REPORT TO TRUST BOARD

Date: 24 September 2020

The Walton Centre NHS Foundation Trust

Title	**Workforce Disability Equality Standards (WDES) Report 2020**
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	• Committee (please specify) __N/A • Group (please specify) __N/A • Other (please specify) __ N/A
Executive Summary The WDES is a series of ten evidence-based Metrics that will provide NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, this information can be used to understand where key differences lie; and will provide the basis for the development of action plans, enabling the Trust to track progress on a year by year basis. The WDES also requires the relevant Trust data to be submitted to NHS England, to enable further comparisons to be made between NHS trusts, and to be published online in accordance with the public sector duties under Equality Act 2010. Please see attached summary.	
Related Trust Ambitions	• Be recognised as excellent in all we do • Equality, Diversity and Inclusion (ED&I) 5 Year Vision
Risks associated with this paper	Failure to consider and publish would risk compliance with the Trust's Public Sector Equality Duty (PSED).
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• Yes
Any associated legal implications / regulatory requirements?	Failure to consider and publish would risk the Trust's compliance with the Public Sector Equality Duty (PSED).
Action required by the Board	• To consider and note

The Walton Centre NHS
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Findings and Actions

Trust Board

2020

Contents

1. Introduction

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change. The WDES is a series of evidence-based Metrics that will provide NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, this information can be used to understand where key differences lie; and will provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis. The WDES is based on ten evidence-based Metrics which take effect from 1 April 2019. The data is taken from the 2019/20 financial year. The WDES is mandated in the NHS Standard Contract to enable comparisons to be made between NHS trusts and the WDES metrics data is reported to NHS England via the completion of the WDES online reporting form. This data is also for publication on The Walton Centre Website: https://www.thewaltoncentre.nhs.uk/175/equality-and-diversity.html

The 2091/20 WDES metrics data have been reported to NHS England in line with the required schedule. There were 1452 staff members employed within the organisation. Of those, the proportion of staff recorded as Disabled on the Electronic Staff Records system (ESR) was 40 (2.72%) this compares with the 2018/19 figure for Disabled staff of 43 which was (3.14%) measured against the then total staff number of 1414. So the number of Disabled staff at the Trust has fallen by 3 while the total number of staff has risen by 38 in this reporting period.

The Total number of responses to the 2019 Walton Centre Staff Survey was 619, which breaks down as 619 Non-disabled 121 Disabled and 483 Unknown.

2. Summary of key points

Metric 1) There are 7.6 million Disabled people of working age in the UK, which is 18% of the working age population. Of the total 1452 staff at The Walton Centre, 43 staff are recorded as Disabled (2.75%) this compares with a 2019. This compares to the 2019 (3%) average measured from trust's ESR records across England. The Trusts reported figures are the best data we have but they are unlikely to accurately reflect the true numbers of Disabled staff because we know from our conversations with staff on this subject that Disabled staff are often reluctant to share this information due to the general stigma in society around disability. The number of responses from Disabled staff to the Staff Survey stands at 121 (8.56%) which reflects the consistently higher response rate usually seen in the Staff Survey compared to ESR disability declaration rates, however because these two measures are incommensurate, it is impossible reach a definite figure for the number of Disabled staff at the Trust, however, the available data indicates a lack of non-clinical and clinical Disabled staff at pay Bands above 7 and 8a respectively. There are just 2 Medical staff recorded as Disabled on ESR. As a consequence the Trust incorporated information on this lack of disability diversity into Equality and Diversity Training for managers in 2019/20.

Metric 2)

The for the 2019/20 reporting period the number of Disabled candidates shortlisted was 11, the number appointed was 4. The likelihood of shortlisted disabled candidates being appointed was 0.36.

The number of Non-disabled candidates shortlisted was 389 the number appointed was 175. The likelihood of shortlisted Non-disabled candidates being appointed was 0.45.

Metric 3) There were no disciplinaries of Disabled staff in the reporting period. It is not possible to form firm conclusions from this figure other than to observe that, with only 40 staff recorded as Disabled it is not surprising to have low figures for the number of disciplinaries involving those few Disabled staff. To have greater confidence in this Metric the Trust will take steps to increase the numbers of staff recorded as Disabled on ESR.

Metric 4) The Disabled staff that responded were (12%) more likely to have experienced harassment, bullying or abuse from Patients/service users, their relatives or other members of the public.

- Disabled staff that responded were (2.6%) more likely to have experienced harassment, bullying or abuse from managers.
- Disabled staff that responded were (7.3%) more likely to have experienced harassment, bullying or abuse from other colleagues.
- Disabled staff were (3.7%) more likely to respond that any experience of harassment, bullying or abuse at work had been reported.

The Trust will introduce actions to better support Disabled staff who experienced harassment, bullying and explore ways to reduce the number of these incidents.

Metric 5) High numbers of both Disabled and Non-disabled staff believe that the Trust provides equal opportunities for career progression or promotion and there is no significant percentage difference in their responses.

Metric 6) Disabled staff were (7.1%) more likely to say that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The figures relating to this metric are high for both non-disabled staff and for disabled staff, so Trust actions to bring these figures down will target both Disabled and non-disabled staff.

Metric 7) In the Staff Survey (56.5%) of non-disabled staff and (50.8%) of Disabled staff answered that they are satisfied with the extent to which the organisation values their work. So, the Disabled staff who responded to this question were (5.7%) less likely to answer yes. The Trust will take action to understand and address the details of why these figures are not so high for either Disabled or non-disabled staff and what the cause of the (5.7%) difference in perception is caused by.

Metric 8) (80%) of Disabled Staff Survey respondents reported that the Trust has made adequate adjustment(s) to enable them to carry out their work. This figure requires further exploration by the Trust with our Disabled staff to establish its full significance, because the metric does not determine how many of the 75 respondents actually requested a reasonable adjustment.

Metric 9) At 7.3 the Staff Survey engagement score for Disabled staff was slightly lower than the 7.5 for non-disabled staff, however the difference is not a statistically significant one. The Trust has, however, taken other actions to facilitate the voices of Disabled staff to be heard .e.g. In July 2019 a Berwick session was held with Disabled and non-disabled staff to begin the dialogue and a staff Disability market place event took place the following day, where external organisations were available to talk to staff about disability support in employment. A WDES Disability Equality Working Group has been established to progress this work further.

Metric 10) There were 0 Trust Board members recorded as Disabled at the Trust. The Trust will take steps to check if this is due to under-recording of Disabled Board members of if actions need to be taken to increase the representation of Disable People at Board.

3. WDES Metrics and Findings

METRIC 1	Percentage of staff in AfC pay Bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

	Narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
Findings **2019/2020**	There are relatively few staff recorded as Disabled by the Trust. Unfortunately, this is not surprising as it reflects the National picture. National ESR data (analysed by Health Education England, as at June 2018) highlights that: 3% of staff in Trusts and CCGs are Disabled. 65% non-disabled and 32% unknown (staff either not declared or chose 'prefer not to say' to monitoring question). Non Clinical reporting of Disabled staff at the Trust indicates that there are 15 with most of these at pay Bands between 1 to 4 and none of these are at pay Bands above Band 7. Clinical staff disability reporting stands at 23 with most of these clustered between pay Bands 5 to 7, with only 1 recorded Clinical Disabled staff member at Band 8a-8b and none at Clinical Pay Bands above that. The Trust has a total of 2 Medical staff recorded as Disabled. These staff are at WDES Cluster 5 (Medical & Dental Staff, Consultants). There are no Disabled staff at the Trust recorded in WDES Cluster 6 (Medical & Dental Staff, Non-Consultants career grade) and there are no Disabled staff at the Trust recorded in WDES Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades). Data from the Trust and across the NHS suggests that a reasonable objective in relating to Metric 1 would be to increase ESR disability declaration levels. This step will help the organisation to identify to what extent the lower numbers of Disables staff at higher pay Bands is a feature of the workforce demographic and to what extent it reflects a reluctance of staff at those higher pay Bands to declare a disability.	**Actions completed:** (Please note: As this is the first year of WDES implementation there are fewer completed actions than there will be in future years.) – A Disability themed Berwick/engagement session was held on 6th July 2019. This session was used to introduce the WDES to staff and use this as a trigger for ongoing dialogue with Disabled and non-disabled staff about how we view and value colleagues with Disabilities and different abilities. – That meeting also relaunched disability networking at the Trust and has formed a group of Disabled staff and allies to champion Disability Equality at the Trust. – Signed up to NHS Employers Diversity and Inclusion Partners Programme

		30+ ED&I champions in pace with role descriptor – The appointment of a full-time Equality and Inclusion Lead post at the Trust **Proposed further actions:** – Further exploration is needed to understand any barriers Disabled staff feel they face when applying for more senior positions or the reasons why they do not apply. – ED&I Strategy Refresh – consultation with Disabled staff – Continue to monitor this indicator. **Links to EDS2 and Trust** **Further proposed actions:** – The WDES/Disability Equality Working Group will work with the Trust's Equality and Inclusion Lead to develop further actions to increase the recording of Disabled people at all levels of the workforce.

Tables showing the numbers and relative positions of Disabled staff and Non-Disabled staff at the Trust in relation to AfC pay Bands.

2020 Whole Workforce

Total staff	Disabled	Non-disabled	Unknown
1452	40 (2.75%)	970 (66.80%)	442 (30.44%)

1a) There are 383 Non Clinical staff comprising: 15 Disabled staff, 383 Non-disables staff and 168 Unknown.	Disabled Staff		Non-disabled staff		Total Unknown or Null		All Non Clinical Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 1 (Bands 1 - 4)	**13**	**5.2%**	190	76.0%	47	18.8%	250
Cluster 2 (Band 5 - 7)	**2**	**2.4%**	66	77.6%	17	20.0%	85
Cluster 3 (Bands 8a - 8b)	0	0%	30	96.8%	1	3.2%	31
Cluster 4 (Bands 8c - 9 & VSM)	0	0%	14	82.4%	3	17.6%	17

1b) There are 1067 Clinical staff comprising: 23 Disabled staff, 693 Non-disables staff and 244 Unknown.	Disabled Staff		Non-disabled staff		Total Unknown or Null		All Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 1 (Bands 1 - 4)	**6**	**2.17%**	208	75.36%	62	22.46%	276
Cluster 2 (Band 5 - 7)	**16**	**2.82%**	428	75.35%	124	21.83%	568
Cluster 3 (Bands 8a - 8b)	**1**	**1.39%**	45	62.50%	26	36.11%	72
Cluster 4 (Bands 8c - 9 & VSM)	0	0.00	12	85.71	2	14.26%	14

There are 139 Medical staff comprising: 2 Disabled staff, 107 Non-disables staff and 30 Unknown	Disabled Staff		Non-disabled staff		Total Unknown or Null		All Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 5 (Medical & Dental Staff, Consultants)	**2**	**1.83%**	78	71.56%	29	26.61%	109
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	0	0.0%	5	83.33%	1	16.67%	6
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	0	0.0%	24	100.0%	0	0	24

Metric 2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	The for the 2019/20 reporting period the number of Disabled candidates shortlisted was 11, the number appointed was 4. The likelihood of shortlisted disabled candidates being appointed was 0.36. The number of Non-disabled candidates shortlisted was 389 the number appointed was 175. The likelihood of shortlisted Non-disabled candidates being appointed was 0.45. The data show evidence of disability that in this reporting period None-disabled candidate were more likely to be appointed from shortlisting so, the data justifies the Trust exploring ways to encourage more applications from Disabled people as well as looking at measures to encourage more declarations of disability once staff are recruited. The Trust will also take this data into account in its current equality review of recruitment practices.	**Actions completed:** – The Trust is now currently participating in the DWP Disability Confident employer scheme at Level 2, Disability Committed Employer. **Further proposed actions:** – explore the possibility of moving on to achieve Level 3 Disability Confident Leader. – Equality Review Recruitment Practices.

Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric is voluntary in year one.	
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	In the period covered there were 2 non-disabled staff that entered the formal capability process and 0 Disabled staff. There is insufficient data regarding this metric to draw any useful conclusions about the formal capability process.	**Actions completed:** – Disability monitoring systems are in place with regard to the capability process, as measured by entry into the formal capability procedure. **Further proposed actions:** – Monitoring based on this will continue.
Metric 4 Staff Survey Q13	**National NHS Staff Survey Metrics.** For each of the following four Staff Survey Metrics, compare the responses for both Disabled and nondisabled staff. a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	

A1) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users.		
	2018	**2019**
Disabled Staff	**36.4%**	**32.5%**
Non-disabled Staff	**24.4%**	**24.2%**
A2) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers.		
Disabled Staff	**9.9%**	**5.9%**
Non-disabled Staff	**7.3%**	**7.5%**
A3) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues.		
Disabled Staff	**22.0%**	**15.1%**
Non-disabled Staff	**14.7%**	**13.4%**
B) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse at work and they or a colleague reported it.		
Disabled Staff	**56.7%**	**52.2%**
Non-disabled Staff	**53.0%**	**50.7%**

Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence**

		and/or a corporate Equality Objective
	A1) The metric has improved a little for both Disabled and Non-disabled staff, however the metric continues to show higher rates for Disable than for Non-disablesd staff. A2) This metric shows a marked improvement for Disabled staff who are now less likely to harassment, bullying and abuse from Managers than Non-disabled staff. A3) This metric has improved for both Disabled and Non-disabled staff, however the improvement for Disabled staff is larger, bringing them closer to the figure for Non-disabled staff. B) This metric has changed to for Disabled staff to become closer to that reported by Non-disabled staff, however the metric is deterioration for both Disabled and Non-disabled staff. In order to understand what is behind this change the Trust will discuss this topic with Disabled staff.	**Actions completed:** – General measures to counteract the various forms of bullying and harassment related to Metric 4 are in place e.g. the Bullying and Harassment policy and freedom to speak up Guardian and information. **Further proposed actions:** – The Trust plans to explore with Disabled staff what extra steps can be taken to support disables staff in this respect. Volunteer Staff Disability Support Advisors are to be recruited to help with this and The WDES Disability Equality Working Group will guide their development and role within the Trust.

Metric 5 **Staff Survey** **Q14**	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	
	2018	**2019**
Disabled Staff	**90.1%**	**90.4%**
Non-disabled Staff	**92.9%**	**91.8%**
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	Of the 91 Disabled staff that responded to this question (90.1%) answered Yes. Of the 435 non-disabled staff that responded to this question (92.9%) answered Yes. Disabled staff that responded were (1.8%) less likely to respond that they do believe that the Trust provides equal opportunities for career progression or promotion, but because this small percentage difference is in the context of a high satisfaction score on this question the difference is not likely to be very significant as a guide to if there are any real barriers to equal opportunities for career progression or promotion at the Trust.	**Actions completed:** – (No specific disability targeted actions relating to this indicator have been implemented yet.) **Further proposed actions:** – The staff WDES Disability Equality Working Group will consider the possibility of introducing a Disability Reciprocal Mentoring Scheme to help Senior Leaders within the Trust to better understand the barriers Disabled staff perceive in their way regarding progressing their career and to help disabled staff to network within the organisation and learn more about the possibilities for advancement.

Metric 6 Staff Survey Q11	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	
	2018	**2019**
Disabled Staff	**29.8%**	**24.4%**
Non-disabled Staff	**22.7%**	**14.9%**
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	Of the 94 Disabled staff that responded to this question (29.8%) said that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. Of the 282 non-disabled staff that responded to this question (22.7%) said that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The Disabled staff who responded were (7.1%) more likely to say that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The figures relating to this metric are high for both non-disabled staff and for Disabled staff, so actions to bring these figures down should target both Disabled and non-disabled staff. Targeted action will also be undertaken to close the gap between the experience of Disabled and non-disabled staff.	**Proposed actions:** – Use Walton Weekly to: Publicise the figures to managers and staff. – Provide information on what presentism is and why it is better to be off work and get better properly than to come to work when this hinders recovery. – Remind managers and staff that being off work in relation to a disability is not to be viewed and dealt with in the same way as standard sick leave. – Give guidance on reasonable adjustments – Put this topic on the agenda for the WDES Disability Equality Working Group to identify actions to reduce incidents where disabled staff feel pressured to work when sick.

Metric 7 **Staff Survey** **Q5**	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	
	2018	**2019**
Disabled Staff	**50.8%**	**51.7%**
Non-disabled Staff	**56.5%**	**61.8%**
Findings 2019/2020	**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	Of the 132 Disabled staff that responded to this question (50.8%) responded that they are satisfied with the extent to which the organisation values their work. Of the 602 non-disabled staff that responded to this question (56.5%) responded that they are satisfied with the extent to which the organisation values their work. Disabled staff who responded to this question were (5.7%) less likely to say they are satisfied with the extent to which the organisation values their work. The Trust needs to understand the details of why these figures are not so high for either Disabled or non-disabled staff and what the cause of the (5.7%) difference in perception is caused by and what more the organisation needs to do to show that we value our Disabled and non-disabled staff.	**Actions completed:** – The Berwick session of 9th July 2019 commenced the conversations with Disabled staff that will help the Trust to identify specific disability targeted actions relating to this indicator. **Further proposed actions:** – This metric will be put on the agenda for the WDES Disability Equality Working Group. – Work with staff to Celebrate Disability History Month raise awareness and foster a conversation about what it means to be Disabled. – Network with external Disability organisations to help to change the culture within the organisation to break down stigma about what it means to have a Disability at the

Metric 8 Staff Survey Q28b	The following NHS Staff Survey Metric only includes the responses of Disabled staff Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	
	2018	**2019**
	80.0%	**86.1%**
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	86% of Disabled staff respondents to this question reported that the Trust has made adequate adjustment(s) to enable them to carry out their work. These figures require further exploration to establish their full significance. Many Disabled staff will never require a reasonable adjustment and only a limited number of Disabled staff will require a reasonable adjustment in any given 12 month period. So the (86%) figure could reflect that only (86%) of requests in that period have been dealt with satisfactorily or that 100% of requests in that period were dealt with satisfactorily but only (80%) of Disabled staff required reasonable adjustments in that period. Many other scenarios, both positive or negative could fit the data as recorded. Source: 2018 NHS Staff Survey Benchmark Report	**Actions completed:** – Information on reasonable adjustments is given during induction training and information on them and how to access them is also made available via the staff intranet. **Further proposed actions:** – This Metric will be put on the agenda for the WDES Working Group. – Action will be taken to better Determine if all disabled staff at the trust know about reasonable adjustments and are getting them when requested.

Metric 9 a)	NHS Staff Survey and the engagement of Disabled staff. For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score. For part b) add evidence to the Trust's WDES Annual Report: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.	
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	The Total number of respondents to the relevant parts of the Staff Survey was 619 (52.63%) as measured against the total of all staff employed at the Trust 1452. Of these 619 staff who responded 121 (19.55%) were Disabled and 483 (87.3%) were non-disabled. There were 15 unknowns. The engagement score for all staff was 0.10 The engagement scores are auto-calculated on the WDES submission template. Following on from the original engagement activity for the WDES 2019 the Trust has needs to take more action to facilitate the voices of Disabled staff to be heard. https://www.england.nhs.uk/about/equality/equality-hub/wdes/ https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/	**Actions completed:** – The Trust has started the process of engaging with Disabled staff to facilitate the hearing of a powerful Disabled staff voice. It is anticipated that this will help to close the 15% gap in declaration rates between ESR and the Staff Survey. On Tuesday 9th July a Berwick session was held with Disabled and non-disabled staff to begin this dialogue. This was followed by a staff Disability market place event the following day where external organisations were available to talk to staff about disability support in employment. **Further proposed actions:** – A WDES Disability Equality Working Group has been established to progress this work further.
Metric 9 b)	b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what	

	action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.	
	Yes - A Disability themed Berwick/engagement session was held on 6th July 2019. This session was used to introduce the WDES to staff and use this as a trigger for ongoing dialogue with Disabled and non-disabled staff about how we view and value colleagues with Disabilities and different abilities. That meeting also relaunched disability networking at the Trust and has formed a group of Disabled staff and allies to champion Disability Equality at the Trust.	
Metric 10	Board representation Metric – For this Metric, compare the difference for Disabled and non-disabled staff. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board	
Findings 2019/2020	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	There were 0 Trust Board members recorded as Disabled at the Trust. The Board has discussed the 2019 WRES and is informed on the reasons for Board members to declare if they have a disability, so it is reasonable to take the figure of 0 at face value. The disproportionately low representation of Disabled Board members will be taken into account of in the process of recruiting future Board members.	**Actions completed:** – The Trust Board has appointed one of its members as Board Equality Lead in order to ensure that the Board provides adequate leadership regarding disability and other equality related matters. No other specific disability targeted actions relating to this indicator have been implemented yet. **Further proposed actions:** The Board should consider taking further positive actions to increase its disability make up when recruiting new Board members e.g. by advertising future Board recruitment opportunities at organisations that support Disabled people. **Links to Equality Objectives:**

		– All of the above actions relating to all WDES Metrics link to the Trusts EDI&I 5 Year Vision's commitment to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre. The actions are also relevant to EDS2 3.1 to 3.6: A representative and supported workforce.

End of report.

For more information please contact:
Andrew lynch, Equality and Inclusion Lead, HR Department, The Walton Centre NHS Foundation Trust, Sid Watkins Building, Lower Lane, Liverpool, L9 7BB
Email: Andrew.Lynch2@thewaltoncentre.nhs.uk
Telephone: 0151 556 3396

Appendix A - Equality Impact Assessment (EIA) Form

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Par

1. Person(s) Responsible for Assessment: **Andrew Lynch** 2. Contact Number: **0151 556 3396**

3. Department(s): **HR** 4. Date of Assessment: **14.09.20**

5. Name of the policy/procedure being assessed: **WDES Findings 2020**

6. Is the policy new or existing?
New Existing

7. Who will be affected by the policy (*please tick all that apply*)?
Staff Patients Visitors Public

8. How will these groups/key stakeholders be consulted with? N/A This document is the result of a consultation process.

9. What is the main purpose of the policy? **This document sets out the findings of the Walton Centre Workforce Disability Equality Standards monitoring for 2019.**

10. What are the benefits of the policy and how will these be measured? **Improving disability equality and reducing discrimination in Trust processes and staff, patient and visitor behaviour. This will be measured through feedback, including but not limited to complaints, grievances and concerns raised.**

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? **Yes, The Equality, Diversity and Inclusion 5 Year Vison.**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **None, these findings are intended to promote and support disability equality for all staff.**

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Sex	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Race	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Religion or Belief	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Disability	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Sexual Orientation	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Pregnancy / maternity	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Gender Reassignment	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Marriage & Civil Partnership	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Other	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) **The purpose of this report is to set out how disability equality as defined within the context of the Equality Act will be promoted throughout the Trust and therefore there is likely to be a positive impact on other protected characteristic, as according to this definition anybody can become. Disabled.**

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? **This report supports a Human Rights based approach to supporting staff with disabilities.**

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date
N/A	N/A	N/A	N/A

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

✓

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Andrew Lynch Date: 20.09.20

Signed: Andrew Lynch

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواببکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。

REPORT TO TRUST BOARD

Date: 24 September 2020

Title	Revalidation Annual Report
Sponsoring Director	Name: Dr Andy Nicolson Title: Medical Director/Responsible Officer
Author (s)	Name: Dr Andy Nicolson Title: Medical Director/Responsible Officer
Previously considered by:	None

Executive Summary

The headlines of the Trust's annual report are:

a. 148 doctors had a prescribed connection with the Trust. This had increased by 6 from the previous year.
b. Of the 148 who would have expected to have an appraisal, 133 have done so. These were all 'approved' missed appraisals (2 were on sickness absence and 13 were due to the restrictions from Covid-19).
c. 47 doctors successfully revalidated, in 6 cases there was a recommendation to the GMC to defer revalidation due to insufficient evidence being presented. In one of these cases the doctor who had been deferred was subsequently successfully revalidated.
d. Deferral is regarded as a neutral act, and does not carry negative connotations.
e. No doctors were referred to the GMC for non-engagement in the appraisal process.

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
Related Assurance Framework entries	None
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) ____N/A_____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____None_____
Action required by the Board	• To consider and note • To confirm compliance with the Responsible Officers Regulations 2010.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: Currently we are awaiting a revised template from NHS England in order to submit this. Action from last year: To maintain completed appraisal percentages above 90%. Comments: Achieved 90% of completed appraisals, despite the disruption to appraisals caused by the Covid-19 pandemic. Action for next year: Await guidance on how quarterly reports are required for 20-21.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Continue current process. Comments: The Trust RO is also the Medical Director. He undertakes annual appraisals by appointed NHS England appraiser which includes his role as Responsible Officer. The RO has attended the required number of regional RO network meetings. Action for next year: Continue current process.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: The Trust is exploring the option of using a different electronic appraisal system. An alternative is currently being trialled by several Consultants. Comments: The company who were providing the existing electronic system relinquished that part of their services. We have taken the opportunity to trial 3 systems to find the most appropriate for our Trust. Action for next year: To embed the new system into the Trust and look at the introduction of an electronic job planning system that will also be available on the new system.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Ensure the system is maintained.

Comments: GMC Provides a list of all Doctors with a prescribed connection to the Trust. The list is maintained by the Appraisal and Revalidation Co-ordinator who also receives a monthly list of starters and leavers via the HR Department.

Action for next year: Continue current process.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Remediation Policy and Maintaining Higher Professional Standards Policies to be reviewed 2019. Consultant Job Planning Policy in review.

Comments: The MHPS policy has been reviewed and approved through LNC. The remediation policy review will be completed in 2020. The Consultant job planning policy will be formally reviewed when the new electronic process is in place, anticipated to be in late 2020.

Action for next year: Whistleblowing Policy (now raising concerns) review date 2021. Complete reviews of the remediation policy and Consultant job planning policy.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None required

Comments: The last review was conducted by the MIAA in 2015. It is recommended that a peer review takes place in each 5 year revalidation cycle. As the Trust is due to embed a new electronic appraisal system in late 2020 it was not considered appropriate to review this year.

Action for next year: MIAA to review in late 2021 / early 2022.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue current process.

Comments: Locum and Short Term Doctors are provided with an opportunity for an appraisal whilst at the Trust including those with a prescribed connection to another organisation eg GP with a specialist interest. Data relevant to appraisal is available to them on request if they have their appraisal at their Designated Body. This group of doctors also have access to Educational events within the organisation and receive a Local Trust induction.

Action for next year: Continue current process.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: To maintain and review systems in place and continue achieving over 90% compliance. Comments: 148 Doctors had a prescribed connection with the Walton Centre NHS Trust as at 31.03.20. This has increased by 6 from the previous year and by 44 from 2014. 133(90%) completed an annual appraisal. 15 missed an appraisal – 2 due to long term sickness, 1 new to UK commenced the Trust 18.03.20 and 12 due to Covid-19 restrictions. Action for next year: To restart appraisals when advised by the GMC.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None. Comments: Covid-19 had an impact on the figures for 2019-2020 for those that were due 1st part of 2020. Action for next year: None required.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None required. Comments: To revise if and when required. Action for next year: None required.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To maintain an adequate number of appraisers. Comments: Medical appraisers have reduced from 29 to 26 over the last year mostly due to retirements. New appraisers were identified but training was put on hold due to Covid-19. Action for next year: Training required for new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to apply the current process and maintain the QA of appraisals. Comments: All appraisals are reviewed by either the RO or the Trust medical appraisal lead. All appraisees provide feedback on the appraisal and this feeds in to the appraiser's own appraisal. The feedback scores are analysed by the Medical Appraisal lead and the appraisals of any outliers are reviewed in detail. Action for next year: Continue to apply the current process and maintain the QA of appraisals.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue current process. Comments: Monthly appraisal percentage is collated for NHSI and reported to the Quality Committee as part of the Trust's performance report. Action for next year: Continue current process.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: There were 52 doctors due for revalidation in 2019-20. Comments: There were 47 positive recommendations for revalidation in 2019-20 until the suspension of appraisals. There were 6 deferrals due to insufficient evidence provided. The majority of Revalidation dates due in 2020 were moved to 2021 due to Covid-19. Action for next year: There are 42 Doctors due for revalidation 2020-21.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue Current Process.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: All revalidation recommendations are confirmed promptly in writing to the doctor from the RO, with a summary of the evidence from appraisals during the revalidation cycle. If the recommendation is for deferral then there is also a discussion with the doctor with a clear written action plan agreed. There have been no recommendations of non-engagement but this would not take place without a discussion with the doctor.

Action for next year: Continue Current Process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue Current Process.

Comments: The RO / Medical Director is also personally responsible for clinical governance for doctors. The "monitoring" aspects required for this part of the RO's role are through the normal reporting processes to the Divisions, Executive, Quality Committee and Trust Board. This provides the formal assurance structure.

Action for next year: Continue Current Process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To monitor serious untoward incidents reported to the ARC to ensure that all are reported.

Comments: The Clinical Governance Teams provide data relating to legal claims, complaints, datix incident forms and serious untoward incidents to the Appraisal and Revalidation Co-ordinator (ARC). This data is then redacted and provided to the Doctor or directly uploaded onto their portfolio on the electronic appraisal system.

Action for next year: To work with the governance and divisional teams to ensure that all SUIs with involvement of doctors are reported to the ARC.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue current process.

Comments: The Trust's process for responding to concerns about a doctor follows Maintaining High Professional Standards (MHPS). The Trust has an approved MHPS policy that has been discussed and agreed with relevant stakeholders.

Action for next year: Continue current process.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Continue current process. Analysis of this information is to be included in the Trust's Integrated Performance Report. Comments: If a doctor is investigated with regard to capability or conduct then this is carried out in accordance with MHPS, and as such is reported to Trust Board. This information is not included in the Trust's IPR, and following recent review we consider that this would not add anything to the current process so we do not plan to implement this. Action for next year: Continue current process.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Continue current process. Comments: The Trusts uses NHS England's Medical Practice Information Transfer form (MPIT) to transfer information to and from other NHS organisations for new starters. Section 2 of the 'Professional work outside the WCFT' is used annually for existing staff who also work outside the Trust. Action for next year: Continue current process.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue current process. Comments: All Trust Policies have an appropriate Equality Impact Assessment, these are quality checked by the Equality, Diversity and Inclusion Lead of the Trust for HR policies. Action for next year: Continue current process.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: The Trust currently uses the 'staff flow' electronic system provided by Liaison Group which is a platform for direct engagement. The Trust is upgrading to their 'TempRe' system which will provide more robust reporting. The ARC will introduce a checklist to the system which the agencies will complete, as well as confirmation of pre-employment checks for each doctor it will also provide details of RO, appraisal and revalidation as this information has not always been provided before employment and has to be chased up with individual agencies.

Comments: The HR Recruitment team have a robust system in place for pre-employment checks and is subject to external Audits in line with NHS 'Safer Recruitment'. The Trust is provided with locum doctors from agencies through the HTE framework who provide written confirmation of their processes as part of monitoring of the contract.

Action for next year: Review use of Agency checklist.

Section 6 – Summary of comments, and overall conclusion

This has been another successful year for the medical revalidation process at The Walton Centre. Prior to the Covid-19 pandemic the Trust were on target to achieve the target of no unapproved missed appraisals. Due to Covid-19 appraisals were halted in March 2020 as advised by the GMC. As a result there were some doctors who missed their appraisal that was due that month. Despite this we still achieved the national target of 90% completed appraisals, the majority of missed appraisals being due to Covid-19. There were no unapproved missed appraisals.

During this year there were 47 positive revalidation recommendations were made to the GMC, and 6 recommendations for deferral were made. There were no recommendations for non-engagement.

The appraisal and revalidation process is well embedded, with robust systems in place. The Responsible Officer is well supported in his role by the Medical Appraisal Lead and the Appraisal and Revalidation Coordinator. There are systems in place for peer support of appraisers and Quality Assurance of appraisals.

Clearly the Covid-19 pandemic has dominated this year, and this had had a significant impact on this process. Alternative electronic appraisal tools to our current system have been trialled by a group of appraisers and we will be switching to a new system in time for the resumption of medical appraisals in November 2020. This date to restart appraisals is in line with recent guidance from NHS England.

Overall conclusion:

The Trust's systems for medical appraisal and revalidation are working well. The Trust has a high rate of completed appraisals within the required timescale, even taking into account the impact of Covid-19. The appraisal and revalidation team will ensure that this is continued through this year, and the new electronic system will be embedded. There are no areas of concern.

Section 7 – Statement of Compliance:

The Board of The Walton Centre NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Walton Centre NHS Foundation Trust

Name: Ms Hayley Citrine Signed:

Role: Chief Executive

Date:

REPORT TO TRUST BOARD

Date: 24 September 2020

Report Title	**Chair's Assurance Report – RIME Committee 02/09/20**
Sponsoring Director	Seth Crofts – Non-Executive Chair
Author (s)	Dr Nicolson, Executive Lead for Research and Development
Purpose of Paper:	
The Research, Innovation and Medical Education 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 Research, Innovation and Medical Education Committee held on 2 September 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's Attention

a) MHRA Corrective and Preventative Action Plan

A report was brought to the Committee to update on areas identified within the Corrective and Preventative Action (CAPA) Plan from the findings of the Medicines and Healthcare products Regulatory Agency (MHRA) Inspection Report of November 2016. The Committee was informed that there were no outstanding actions. The key area of note was the measures that had been implemented through the Sponsorship and Governance Oversight Committee which would prevent the need for the Trust to have a CAPA Plan in the future. It was also noted that the EDGE data system was being utilised more consistently by the Neuroscience Research Centre.

Committee was informed that a formal audit procedure had not been implemented by the Neuroscience Research Centre due to staffing constraints but that it would be instigated in 2021.

b) Intellectual Property Update

To-date, the commercialisation of Trust intellectual property (IP) and data deriving from research and innovation projects had not been undertaken on a significant scale. The Trust may also be losing potential financial and other benefits as processes for intellectual property management and data commercialisation were not in place. A discussion paper was presented to the Committee outlining approaches that could be taken. Key areas of focus were highlighted as being investigator led research and innovation projects. With regards to commercial research projects, IP and data issues were primarily included within the contracts.

External consultation and the review of other trust's IP policies would be undertaken to inform the development of IP policy and guidance for The Walton Centre.

2.0 Items for the Board's Information and Assurance

a) Innovation Strategy Quarterly Update

A comprehensive report was presented to the Committee on the progress of implementing the Trust's Innovation Strategy which included an overview of the short term (2019-2020) and medium term (2020-2022) objectives. It was noted that the majority of the short term objectives were on track and although there had been some time delays incurred due to the COVID-19 pandemic, actions were in place to address them. Committee was also informed of the progress had been made with regards to achieving the medium term objectives. A review of all of the innovation pipeline projects/initiatives was due to be undertaken in Q3.

The COVID-19 pandemic had been a catalyst for innovation both in terms of conception and spread and adoption. The Committee was apprised of the key role that innovation had had in the Trust's response to the challenges posed during these times in the areas of patient care, medical education and new/innovative ways of working.

b) Medical Education Committee

A summary of the Medical Education Committee's current activity:

- A key area focus had been the preparation of the Medical Undergraduate Working Group for the year 4 students that were due to arrive at the Trust week commencing the 7 September 2020. Dr Davies and Dr Smith are involved and there was an identified core group of consultants supervising the undergraduate students. There was a review being undertaken of the Medical Education PAs to support the additional consultant input requirement
- A meeting was being held week commencing the 7 September 2020 between Dr Dougan, Dr Nicolson and the Director of Finance and IM&T to look at the Medical Education finances in more detail and to gain a greater understanding
- Medical Education currently had a fragile administration infrastructure which was attributed to absence of the Medical Education Manager in 2020. Dr Dougan was liaising with Mr Gibney regarding this
- Positive feedback was being received for the majority of the education programmes. It was noted that there some difficulties with the IMT group but that these were being addressed
- Proposal to broaden the scope of the undergraduate intake. It was felt that there was the will and capacity for this
- The following feedback was received following the most recent GMC survey:
  - The Neurology division had been listed as an exemplar for education
  - Although Neurosurgery had previously been an outlier, it had been rated as 'green'. Mr Nick Carleton-Bland had been awarded an Excellence in Education from the School of Surgery
  - With regards to Neurosurgical higher training, there were many out of programme at the moment therefore the Trust is supporting Neurosurgery by employing trust doctors
  - Very good feedback for Anaesthetics
  - Pain was highlighted as an area of improvement
  - Overall, the quality of education received at The Walton Centre was reported as very good.
- One area for future collaborative working was identified as looking at how to encourage junior doctors to participation in research. This was not only supportive of the potential benefits of research in career development but also in succession planning for the Trust.

3.0 Progress Against the Committee's Annual Work Plan

The Research, Innovation and Medical Education (RIME) Committee Terms of Reference were ratified by the Trust Board on the 30 July 2020 following which a revised cycle of business commenced at the Committee meeting held on the 2 September 2020. A detailed review of the work plan would be undertaken at the January 2021 meeting to ensure proportionate representation was reflected across the areas of Research and Development, Innovation and Medical Education.