The Walton Centre
NHS Foundation Trust

TRUST BOARD MEETING

OPEN SESSION

Thursday 30th January 2020

09:30 – 13:10

Board Room

OPEN TRUST BOARD MEETING
AGENDA
The Boardroom, WCFT Thursday 30 January 2020
09:30 – 13.10pm

V = verbal, d = document p = presentation

Item	Time	Item	Owner	Purpose	Reference
1	09.30	Welcome and Apologies	J Rosser	N/A	TB138/19-20(v)
2	09.30	Declaration of Interests	J Rosser	N/A	TB139/19-20(v)
3	09.30	Minutes and actions of meeting held on 28th November 2019	J Rosser	Decision	TB140/19-20(d)
PATIENT STORY					
4	09.40	Patient Story	J Ross A Sule	Information	TB141/19-20(p)
STRATEGY					
5	10.10	Chair and Chief Executives Report	J Rosser H Citrine	Information	TB142/19-20(p)
6	10.25	Innovation Strategy	M Gibney	Decision	TB143/19-20(p)
7	10.35	Research and Development Strategy	M Gibney	Decision	TB144/19-20(d)
8	10.50	Digital Strategy	M Burns	Decision	TB145/19-20(d)
BREAK 10 mins					
PERFORMANCE					
9	11.10	Integrated Performance Report	CEO/NED Chairs	Assurance	TB146/19-20(d)
QUALITY					
10	11.25	Governance Quarterly Report	L Vlasman	Assurance	TB147/19-20(d)
11	11.35	Pharmacy and Medicine Management Annual Report	D Thornton	Assurance	TB148/19-20(d)
12	11.45	Accountable Officer for Controlled Drugs Annual Report	D Thornton	Assurance	TB149/19-20(d)
13	12.00	Mortality and Morbidity Quarterly Report	A Nicolson	Assurance	TB150/19-20(d)
14	12.15	Guardian of Safe Working Report	C Burness	Assurance	TB151/19-20(d)
PEOPLE					
15	12.30	DBS Checks Update	M Gibney	Information	TB152/19-20(d)
CHAIRS ASSURANCE REPORTS					
16	12.35	BPC Chairs Report	S Samuels	Assurance	TB153/19-20(d)
17	12.40	Quality Committee Chairs Report	S Crofts	Assurance	TB154/19-20(d)
18	12.45	RD&I Chairs Report	S Crofts	Assurance	TB155/19-20(d)
19	12.50	Audit Committee Chairs Report	S Rai		TB156/19-20(d)
20	13.00	Neuro-science Programme Board Chairs Report	M Burns	Assurance	TB157/19-20(d)
CONCLUDING BUSINESS					
21	13:05	AOB	J Rosser		TB158/19-20(v)
22	13.10	Meeting Review	J Rosser	Verbal	TB159/19-20(v)

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

Date and Time of Next Meeting: March 28TH 2020, The Boardroom, WCFT

UNCONFIRMED

Minutes of the Trust Board Meeting
Thursday 28th November 2019

Present:	Chair
Ms J Rosser	Non-Executive Director
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
Mr M Burns	Director of Finance
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Vlasman	Acting Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation
In attendance:	
Lisa Gurrell	
Ms J Hindle	Head of Patient Experience (item 2)
Observing	Corporate Secretary
Doreen Brown	
Ella Pereira	Public Governor
Michael Pridgeon	Partner Governor
	Staff member - Chartered and Clinical Scientist in Neurophysiology
Apologies	
Ms Citrine	
Ms Salter	Chief Executive
	Director of Nursing & Governance

Trust Board Attendance 2019-20											
Members:	Apr	May	Ext May	Jun	Jul	Sept	Ext Oct	Nov	Jan	Feb	Mar
Ms J Rosser	✓	✓	✓	✓	✓	✓	✓	✓			
Mr S Crofts	✓	✓	✓	✓	✓	✓	✓	✓			
Ms A McCracken	✓	✓									
Ms S Samuels	✓	✓	✓	✓	✓	✓	✓	✓			
Mr A Sharples	✓	✓	✓	✓	✓						
Ms B Spicer				✓	✓	✓	A	✓			
Ms S Rai						✓	A	✓			
Prof N Thakkar	A	✓	✓	✓	✓	✓	✓	✓			
Ms H Citrine	✓	✓	✓	✓	✓	✓	✓	A			
Mr M Burns	✓	✓	✓	✓	✓	✓	✓	✓			
Mr M Gibney	✓	A	✓	✓	✓	✓	✓	✓			
Dr A Nicolson	✓	✓	✓	✓	✓	✓	A	✓			
Ms J Ross	A	✓	✓	✓	✓	✓	A	✓			
Ms L Salter	✓	✓	✓	✓	✓	✓	✓	A			

TB117/19 Welcome and apologies

Ms Rosser welcomed those present to the meeting.
Apologies were noted from Ms Citrine and Ms Salter and quoracy was confirmed.

TB118/19 Declarations of interest

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

Minutes and matters arising from the meetings of 26th

The minutes were agreed as an accurate record of the meeting subject to the following amendments

- Pg 1 Su Rai to be included in attendees and Alan Sharples to be removed
- Item 108 & 109 – should read as Workforce

The following items were agreed as complete and would be removed from the action log:

TB 28/19 Staff Survey Results
TB 79/19 Equality and Diversity and Inclusion Report – item closed
TB97/19 Integrated Performance Report – item closed

TB106/19 Freedom to Speak up Guardian Report -item was on the agenda

An update was provided on the following items.

TB99/19 RDI Chairs report – consideration was being given to this but the balance of Board business would influence the timing of this item.

TB78/19 – Safeguarding/DBS Checks

Discussion were ongoing at a system level regarding this matter. Mr Gibney agreed to produce a paper for January's meeting.

Minutes of the meeting on 30th October 2019

The minutes were agreed as a true and accurate record.

TB119/19 Patient Story

Lisa Gurrell newly appointed Head of Patient Experience presented a story that she had captured in her first week in the Trust. During her introductory tour of the Trust it had been possible to hear directly from a patient who was attending an outpatient appointment and the patient had willingly shared her positive experience.

The patient was an elderly lady who had been diagnosed with an aneurism. Having travelled from the Isle of Man she and her friend arrived for her appointment several hours early. A member of staff made them a drink and made sure that they were comfortable. Having checked the time of her appointment the member of staff made

arrangements for her to be seen earlier than scheduled. As she waited several members of staff greeted her and checked that she was in the right place and due to be seen. The patient also had the opportunity to talk with another patient who had received surgery. Their experience had been positive and they were complimentary of the caring nature of all staff.

Ms Gurrell advised members that she was keen to ensure that patients were enabled to provide feedback, both positive and negative in a timely manner. By providing opportunities for informal feedback to be captured it was expected that concerns would not escalate into formal complaints.

The Chair thanked Ms Gurrell for attending the meeting and sharing her early experience of the Trust.

TB120/19 Nurse Staffing Bi-annual Review

Ms Vlasman presented the updated position in relation to nurse staffing in line with NICE guidance. The review had been expanded to include the wider workforce as outlined within the NHSI document "Developing Workforce Safeguards"

It was noted that recruitment and retention of staff remains a challenge and that whilst staff at Band 6 and Band 7 are likely to stay with the Trust staff at Band 5 are more likely to leave to pursue opportunities elsewhere. This was disappointing given that they had received training and support for 12 months however it was recognised that other Trusts were offering a more attractive package which incentivised staff to stay. A discussion took place regarding the system wide challenges and the need for agreement in order to reduce competition amongst Trusts. It was agreed that Ms Rosser should raise the matter with the Cheshire and Merseyside Partnership Board.

ACTION: Ms Vlasman to provide Ms Rosser with details of the nurse recruitment packages of other Trusts. DUE: January 2020

Ms Samuels queried if it was appropriate for the Trust to benchmark itself against acute Trusts given the complex nature of its patients or whether it would be more helpful to make a comparison with Trust's providing the similar services. Ms Vlasman agreed to look at the turnover of Trust's delivering similar services and include in future reporting.

The Board:

a) **noted that nurse staffing levels remain safe in line with national guidance**
b) **supported the changes to the report**

TB121/19 Quarterly Governance Report

Having previously been considered by the Quality Committee the Quarterly Governance report was provided for assurance. Ms Vlasman highlighted the following:

- 1 Serious Incident had been reported to Commissioners in quarter 2 which related to a complex patient. A root cause analysis was underway and the outcome would be reported in quarter 3.

- There had been an increase in the Deprivation of Liberties incidents. This is believe to be because the Trust had previously not reported them via Datix.

- The Friends and Family Test results remained positive with inpatients rates at 96 to 98% each month

- An increase in complaints has been seen, the key theme of complaints is around appointments and the Trust is looking to perform a deep-dive into this.

A discussion took place regarding referral pathways for Neurosurgery and it was noted that this had been discussed at both Quality Committee and BPC and how the Trust could make appointments more efficient. Complaints appeared to be around short-notice changes to appointments.

This would be addressed through the Out Patient improvement work.

The Board:

- **noted the report**

TB122/19 Integrated Performance Report

A copy of the integrated performance report as at 31 October 2019 had been circulated with the agenda. Members noted that the Safe and Caring domains remained green and the following points were highlighted:

- C.Diff, MRSA, MSSA and EColi remain below the YTD threshold, there had been zero Grade 3 and 4 pressure ulcers in October and zero falls of moderate harm.

- Daily average delays remain an issue although there had been a reduction from 13.4 in September to 11.39 in October against a 5.85 day target.

- The Trust achieved all applicable cancer targets in October 2019 with the exception of the Two week rule Urgent GP referral and 31 day diagnosis. It was noted that there had been no quality issues linked to this.

- The Trust had delivered an in month surplus of £361k against a plan of £645k and therefore the Provider Sustainability Funding (PSF) would not be available

to the Trust.

- Nursing turnover for a rolling 12 month period was 17.22% compared to 17.34% in September 2019.

- Follow up waiting list (FOWL) the Neurology overdue follow-up waiting list for October was at 14,083 which was a reduction of 736 from September.

Ms Ross advised members that future reports would contain Statistical Process Charts (SPC) to provide improved detail of trends in performance. The new Head of Business Intelligence had developed a revised IPR and dashboards relevant to the Committees and it was suggested that it would be helpful if members had the opportunity to comment on these before they were finalised. Ms Ross would organise a meeting with the Non-Execs to present the revised reports.

ACTION: J Ross to meet with NEDs to present the revised reports for comment: DUE: Jan 2020

TB123/19 Freedom to Speak Up Strategy and Guardian's Report

The Freedom to Speak Up Strategy was circulated with the agenda for approval together with the quarterly Guardian's report. Ms Vlasman highlighted the following

The Strategy summarised the Trust's vision for raising concerns and the "Speak Up" culture it wishes to embed.

The Freedom to Speak Up Guardian had recently issued a questionnaire to staff in order to establish if staff feel comfortable raising concerns and whether more could be done to support them.

Mr Crofts advised members that as the Non-Executive lead for Raising Concerns he continued to meet with the Guardian on a monthly basis and noted that the Guardian had been focussed on training staff including the 3 new champions who would promote the role.

A discussion took place regarding the level of work involved for the Guardian and whether the report adequately reflected this. It was noted that the number of concerns reported would not necessarily reflect the cases that were avoided through the Guardians advice and support; it was not possible to measure this accurately.

It was noted that the relationship between the Guardian and HR Team was extremely positive with both functions signposting staff to the other when required.

Ms Rosser requested that the Board's appreciation and thanks were passed on to the Guardian.

The Board

a) **approved the Freedom to Speak Up Strategy**
b) **took assurance from the Guardian's quarterly report**

TB124/19 Walton Centre Charity Annual Report and Accounts

Mr Burns referred to the Annual Report and Accounts of the Walton Centre Charity for the year ending 31st March 2019 which had been considered by the Charity Committee in July 2019 and highlighted the following:

- The charity has 28 earmarked funds shown in appendix 1
- Cash reserves of approx. £60k which equates to 3 mths expenditure
- The value of the fund at year end was arisk has been
- In 18/19 the income was £697,000 which was an increase of £231,000 on the previous year
- Expenditure of £277,000 on charitable objectives of which £143,000 was spent on patient welfare and amenities
- Expenses of £538,000
- No errors in relation to the accounts had been found by the auditor.

Ms Rai advised members that she was keen to promote the profile of the Charity and wanted to make clear the Trust's position in relation to other charities involved in the work of the Trust.

The Board:

- **approved the annual report and accounts for the Walton Centre Charity**

TB125/19 Standing Financial Instructions and Scheme of Reservation and Delegation

Mr Burns advised members that in line with the Board's annual cycle of business the documents had been reviewed and revised and were presented to members for approval. Having been reviewed and accepted by the Audit Committee at its October meeting the following amendments were highlighted:

- Changes in job roles and titles for the Director of Finance & IT and the Director of Operations and Strategy.
- Duties that had previously been held by the Deputy Director of Governance were now the responsibility of the Director of Nursing and Governance.
- Amendments to policies that should be reserved for the Board to approve which included the Freedom to Speak Up Policy and Learning from Deaths Policies in line with national guidance.

A number of minor amendments were requested specifically to include the Deputy Director of Nursing job title and remove the title of the Deputy Director of Governance and to remove the amendment under section 4.1.1 regarding delegation to Committees.

The board

a) **approved the Standing Financial Instructions and Scheme of Reservation and Delegation**

TB126/19 Committee Terms of Reference

As part of the Annual Cycle of Business the Committee Terms of Reference had been reviewed and agreed by each Committee and were presented to members for approval. Changes had been made to the membership and Ms Hindle highlighted the following key changes:

- Approval of primary enabling strategies e.g People, Quality, Digital etc is reserved to the Trust Board with the Committees providing oversight once approved
- The role of the Committees' in relation to their oversight of the Board Assurance Framework and operational risks is now explicit
- The Transformation Programme will be overseen by the Business Performance Committee

The Board:

a) **approve the membership of the Committees**
b) **approve the revised terms of reference**

TB127/19 Fit and Proper Persons Procedure

Mr Gibney advised members that new procedure had been developed in order to strengthen the existing process relating to the Fit and Proper Person requirements. It was presented to members for approval.

The procedure outlined the responsibilities for performing pre-employment checks when recruiting Board members and also the process for dealing with any matters that may arise after appointment. The procedure extended the process to include Deputy Directors as it was possible that a situation could arise when they would be required to formally act up.

Ms Rosser stated that there were a number of areas of the document that required amendment and she would meet with Mr Gibney and Ms Hindle to formalise this on behalf of the Board.

ACTION: Ms Hindle to arrange a meeting to finalise the procedure. DUE: January 2020

The Board:

a) **approved the procedure subject to the Chair's amendments**

TB128/19 Board Assurance Framework

Ms Hindle presented the paper that had been circulated with the papers highlighting the following:

2 new risks had been added

- **Risk ID 041** Cyber Security currently rated as 16
- **Risk ID 42** – Quality**-** around the delivery of the Quality Strategy

1 risk would be removed

- **Risk ID0025** had achieved its target score and would be removed from the BAF and monitored via the operational risk register.

The following risks had reduced in score

- **Risk ID 0031** Risk of breaching the NSHI Agency Cap
- **Risk ID0037** Potential impact on business continuity due to an aging estate
- **Risk ID0** Lack of assurance on quality of data

Mr Crofts commented on the risk regarding violence and aggression to staff and that the risk seemed out of line with risks at an operational level. Ms Hindle agreed to review the wording and scoring of the risk.

The Board

a) approved the changes to the Board Assurance Framework

TB129/19 Chairs Assurance Reports

TB129/19 Business Performance Committee

Ms Samuels presented the report from the Committee and highlighted the following matters:

- The Committee received the Draft Digital Strategy and has requested information regarding resource allocation prior to it being presented to Board
- The Committee agreed a change to the capital programme – to include in an MRI scanner
- The Committee received an update on the Clinical Utilisation Review and it demonstrated that a number of issues were external to the Trust. Where issues were identified actions were being taken.

TB130/19 Quality Committee

Mr Crofts presented the report from the Committee and highlighted the following matters:

- The Committee had received an insightful presentation from the Speech and Language Therapy Service which demonstrated the proactive work of the team
- The Committee had received feedback from the GIRFT visit. Positive feedback

was provided in relation to patient information.
- The Committee reviewed the quarterly risk register and this highlighted a risk around legionella
- Making every contact count – the Committee had a discussion regarding the issues with recording on EP2 and the plans for the CQUIN linked to alcohol and tobacco.

TB131/19 **Trust Charity Committee**

Ms Rai presented the report from the Committee and highlighted the following matters:

- The Committee had received an update in relation to the refurbishment work and the costs of the proposed works.
- The Committee received and reviewed the annual reports and accounts of the Charity and were agreed
- The Committee noted the success of the Jan Fairclough Ball and generosity of those who donated. Future plans will consider if the event can be expanded.
- The Committee considered a number of applications
- The Committee considered a £6,748 donation from a patient who wanted to improvement the environment for patients and staff. The Committee supported the request from Theatres but noted that it was unusual not to receive a request in writing.

TB132/19 **Audit Committee**

Ms Rai presented the report from the Committee and highlighted the following matters:

- External auditors continue to meet with the Trust to ensure they are aware of any matters that may be relevant to their work
- Internal Auditor reviewed the Trust's Year End Forecasting Process and gave an opinion of substantial assurance
- The Committee would be looking at re-tendering the external audit contract in 2020/21

Consent Agenda

TB132/19 to TB134/19 The Board approved items presented within the consent agenda with no questions from members

- Healthcare Worker Vaccination Self-Assessment
- Modern Slavery Act Statement
- Emergency Planning Resilience and Response self-assessment

TB135/19 **Seven Day Hospital Services**

Dr Nicolson provided an update to members noting that the Trust was required to provide an update to NHS England on a bi-annual basis.

The process has changed and now requires Trusts to self-assess against the 10 clinical standards for 7 day Services with a focus on 4 of the 10.

The Trust has previously reported compliance with 3 of the 4 which cover availability of investigations out of hours, ward round reviews out of hours and access to other services.

The Trust continues to find the consultant review within 14 hours difficult as it is focussed on A&E Departments. NHS England recognise the challenge around this. The Trust has said that they will aim to comply with it. When the Trust first audited this standard the compliance rate was approx. 50%. A recent audit has shown the Trust is at 79% against a 90% target. Dr Nicolson had reviewed all of the cases and there was no evidence to suggest that patients had received less than appropriate Consultant input.

TB136/19 AOB

Brexit update

The Trust has been advised that daily SIT Rep reports are no longer required however the Trust is required to maintain its Business Continuity Plans and the escalation of any gaps in the plans. The Trust has no new risks related to this matter.

TRUST BOARD
Matters arising Action Log
January 2020

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
25.07.2019	TB99/19	**RDI Chairs Report** To invite the Chair of LHP to present to Board	J Rosser	LHP invited to attend January 2020's meeting.	Sept 2019	
27.06.2019	TB 78/19	**Annual Safeguarding Report** 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.	~~Oct 2019~~ Jan 2020	
25.07.2019	TB 96/19	**Quality Committee Terms of Reference** To review the membership and Terms of Reference for all of the Board Committees	J Hindle	Quality Committee, BPC and Audit Committee complete. **Jan 2020** RDI, Charity and Rem Com to be agreed by each committee before approval by Board.	~~Nov 2019~~ March 2020	
28.11.2019	TB120/19	**Bi-annual nurse staffing review** Executives to provide the Chair with details of the recruitment approach being adopted by other Trusts.	M Gibney	Information regarding the Liverpool Nurse model shared with the Chair.	Jan 2020	
28.11.2019	TB121/19	**Quarterly Governance Report** Members to provide feedback on whether the report is required in full for the Board given that Quality Committee review the report in detail.	L Vlasman	The report has been condensed following feedback and now contains less narrative.	Jan 2020	
28.11.2019	TB122/19	**IPR** To arrange a telecom with NEDs to discuss the revised format of the IPR and respective dashboards prior to January's meetings.	J Ross	Revised dashboards and report circulated for comment on 19.12.2019 **January 2020**	Jan 2020	

				Item on the agenda		
28.11.2019	TB127/19	**Fit and Proper Person Procedure** To arrange a follow up meeting with the Chair to finalise the procedure.	J Hindle	Meeting took place on 7th Jan 2020.	Jan 2020	

REPORT TO THE TRUST BOARD
Date30th January 2020

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

1.0 INTRODUCTION

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

2.0 UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

2.1 NHS People Plan - Nursing and Midwifery Workforce

The NHS 'We Are the NHS, We Are Nurses' campaign, backed by the Health Secretary, targets teenagers who are about to choose their degrees as well as career switchers considering going into nursing.

NHSI Nursing students will benefit from guaranteed, additional support of at least £5,000 a year to help with living costs. with up to £3,000 further funding available for eligible students

The funding will be given to all new and continuing degree-level nursing, midwifery and many allied health students from September 2020. It is expected to benefit more than 35,000 students every year.

The funding comes as part of the government's pledge to increase nurse numbers by 50,000 over the next 5 years. The measures will be part of the upcoming NHS People Plan, which will set out work to reduce vacancies across the NHS and secure the staff needed for the future.

2.2 NHS National Contract and tariff

National tariff – there are some changes to tariff proposed for 2020/21, with the financial impact for the Trust being calculated. There was a national consultation around proposed tariff changes of which the Trust has responded (consultation ended 22nd January 2020).

National contract – a national consultation is underway for changes to the national contract with a deadline of 31st January 2020. The Trust will be providing feedback on the national consultation.

2.3 Pensions and Tax Implications update

NHS England issued a letter on pensions before Christmas. They are guaranteeing that tax charges as a result of the pensions issue will be covered by 'scheme pays' for the current tax year (2019/20). This offer has been promoted to consultants and senior managers with direct patient contact and will be shared with all other relevant staff at 8a and above from mid-January 2020. This means that The Walton Centre now offers both the national pension option and also time off in lieu (toil).

There is some anecdotal information that some consultants now intend to take on additional clinics again (mainly in Neurology). NHSE is looking to monitor uptake and NHS Employers are launching a pensions tax calculator in March 2020.

2.4 EU exit no-deal preparations to stop

Following the vote at second reading of the Withdrawal Agreement Bill on 20 December, the government has stepped down preparations for a no-deal exit from the European Union. The Department of Health and Social Care has informed NHS England and NHS Improvement that for the health and care system this means that no-deal preparations should cease. As a result, staff previously working on no-deal preparations are being redeployed.

NHS organisations have been asked to retain a key point of contact who would act on behalf of the trust if an operational response is required later in the year

2.5 NHS RightCare Headache and Migraine Toolkit

In conjunction with the Neurological Alliance, the Trust has informed the development of the NHS RightCare Headache and Migraine Toolkit which is due to be rolled out in January.

The Toolkit could help prevent 16,500 emergency hospital admissions every year if every local health group matches the performance of the best-performing areas with similar populations to their own.

3.0 INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

3.1 North Mersey CCG Merger

A paper setting out a case for change for a potential merger of the four North Mersey Clinical Commissioning Groups – NHS Knowsley CCG, NHS Liverpool CCG, NHS Southport and Formby CCG and NHS South Sefton CCG – will be presented to NHS Liverpool CCG's governing body in mid-January. A briefing note is attached at appendix A.

3.2 New Year's Honours

It was satisfying to see a number of NHS staff recognised in the New Year's Honours. Colleagues from the North West include Joe Rafferty, CEO Merseycare who received a CBE and Ann Marr, CEO St Helens and Knowsley received an OBE. I have written formally to both to offer congratulations on behalf of the Board.

3.3 One Liverpool

Chairs and Chief Executives from the region attended the One Liverpool Workshop in early January. The purpose of the event was to agree how to implement the agreed Liverpool priorities. The key points were:

- Initial Year 2020/21 -concentrate on achievable goals, alcohol, substance misuse, childhood mortality
- Children's health and prevention of inequality is a major strand of the strategy.
- Some concerns about how external regulation (ie NHSI/E CQC etc) maps against One Liverpool objectives
- Board of providers need a very clear steer (backed up by evidence) of what

One Liverpool is seeking to achieve and how it fits with individual Trust's Strategies

By the end of January the rationale and evidence for priorities will be mapped out and circulated.

3.4 Cheshire and Merseyside Acute Sustainability Board

Following meetings with Bill McCarthy (NHSI Regional Director) and discussions with key stakeholders the programme is currently being reviewed to ensure that it focusses on defined future priorities for Acute Sustainability. This will incorporate an analysis of available Cheshire and Merseyside hospital and system data such as Model Hospital, GIRFT, RightCare, HES, Performance and Reference Costs in order to understand current performance and use this to triangulate the 'highest risk' services.

The programme will be re-launched in April 2020.

4.0 INTERNAL MATTERS

4.1 Staff Awards

The Trust held its annual Staff Awards event in December recognising the hard work and dedication of our staff.

There were five awards in total, including an award exclusively nominated by patients and their families. In total over 120 nominations were received, half of which came from the general public.

The shortlist and winners were decided by a judging panel comprising of a Non-Executive Director, our Lead Governor, and a representative from Staff Side.

Winners included a consultant, nurses, and corporate staff, and each received a certificate and voucher.

4.2 Consultant Appointments

In December 2019 the Trust welcomed a number of candidates who applied for a consultant Neurologist post. An offer was made and the successful candidate is expected to join the Trust in April 2020.

4.3 Council of Governors

The Council of Governors met on 13th January. Items on the agenda included a regular performance update and highlights from the NEDs of board committees. The Council also considered a proposal to establish a Membership Committee and knowledge and effectiveness review.

The Council thanked Colin Cheesman for his contribution as Lead Governor and welcomed Barbara Strong, who will replace Colin in the role.

A number of governors attended Lunch with the Chair in mid-January and were also given a tour of the hospital. Chris Sutton, Public Governor for Rest of England,

Nanette Mellor, Partner Governor, and Ruth Austen-Vincent, Partner Governor attended and were shown round the hospital by Pippa Fisher, Divisional Director of Nursing.

4.4 Holocaust Memorial event

On 27 January an event will be held to mark Holocaust Memorial Day in conjunction with Mersey Care. The Trust was happy to welcome Beatrice Fraenkel, Chair of Mersey Care, to visit Jefferson Ward to unveil a plaque commemorating the kindness of the Jefferson family in housing her mother, a young Jewish woman who left Germany in 1939.

A minute's silence will be held as part of the event, and Andrew Lynch, our Trust's Equality and Inclusion Lead, led on staff engagement work during the week.

4.5 Press Releases

- Award-winning BBC Two documentary Hospital returns to The Walton Centre
- BLOG: Playing to our strengths (piece from Suzanne Simpson about social prescribing as part of Occupational Therapy Week)
- Walton Centre Director wins international lifetime contribution award
- Staff health and wellbeing app highly commended in prestigious Engage Awards
- Walton Centre Finance Director wins top industry award
- Leading light celebrated in Healthcare Finance Award
- Top Professor's Festive University Challenge

REPORT TO TRUST BOARD
Thursday 30 January 2020

Title	Innovation Strategy 2019-2024
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Dr Shagufay Mahendran, Clinical Lead for Innovation Rachel Saunderson, Innovation Co-ordinator
Previously considered by:	• Committee - Presentation overview to the Research Development and Innovation Committee (17/07/19) Final Draft to Research Development and Innovation Committee (11/09/19) • Other - Presentation overview to the Board Development Session (14/06/19)

Executive Summary

This is the Trust's first innovation strategy and it seeks to lay out the organisation's approach to innovation, the key cultural enablers and the direction of travel. This strategy has been agreed by the Trust's Research Development and Innovation Committee on the 11 September 2019. Given the nature of innovation, the focus is upon promoting shared dialogue, constructive challenge and establishing the internal infrastructure.

This strategy also identifies the key external/contextual challenges that have to be navigated but will be critical to the delivery of the Trust's aspirations - this is likely to involve the development of new partnerships. There is a short term focus upon establishing a framework of the right groups, individual roles and processes that enable innovation.

The medium term aspirations are centred on the concrete delivery of major innovative projects, establishing the brand and the subsequent diversification of income.

The long term goal is to have a tangible culture of innovation, a raft of successful initiatives and an international profile as world leaders in key service areas.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	There are a number, however the key risk is not delivering upon this agenda.

Related Assurance Framework entries	N/A
Equality Impact Assessment completed	EIA assessment attached at appendix a
Any associated legal implications / regulatory requirements?	• Yes –Those associated with new ways of working, services and products e.g. Intellectual Property
Action required by the Board	The Board is requested to: • approve the Innovation Strategy • note that the objectives will be monitored by the RD&I Committee

INNOVATION STRATGY

EXECUTIVE SUMMARY

Thursday 30 January 2020

The purpose of The Walton Centre is to provide the best neuroscience patient outcomes both nationally and internationally. To achieve this, we need to be at the cutting edge of innovation shaping the future of new treatments, care and support in neuroscience. Through innovation the Trust can not only fulfil the ambitions of our staff, but also establish The Walton Centre as a brand both nationally and internationally.

Therefore we have developed the Trust's first Innovation Strategy to ensure that we promote a dynamic culture of innovation, curiosity and creativity across all service areas. This strategy puts in place many of the basic building blocks for innovation that enable our talented employees to fulfil their potential and to develop shared system wide priorities. The strategy was agreed by the Research Development and Innovation Committee on the 11 September 2019.

The main benefits and deliverables are as follows:

- Create a pipeline of sustainable innovative projects for neuroscience
- Promote, deliver and monitor innovation projects that meet our patients' and workforce needs
- Ensure the strongest possible integration of the innovation agenda with Medical Education and Research at the Trust
- Accelerate the implementation of innovations across the Trust/local health system through a structured network of support
- Shape the local, national and international agenda including grants/incentives
- Generate new and additional income streams

The governance arrangements for the implementation of this strategy will principally be conducted through the Research Development and Innovation Committee. However given the nature of this agenda, there will be specific initiatives that will be subject to oversight from other internal committees, notably the Walton Charity Committee. Ultimately, major innovations will be endorsed by the Trust Board.

Implementation may be subject to external assurance as the system infrastructure evolves potentially through Liverpool Health Partners, Liverpool Health Ventures and the North West Innovation Agency.

This document describes the strategic direction for innovation at The Walton Centre and the subsequent objectives set out for the short, medium and long term. Some deliverables are very tangible (e.g. database) however, as is the nature of

innovation, specifics are not possible in the more ambitious and ground breaking aspirations.

Recommendation

The Board is requested to:

- approve the Innovation Strategy
- note that the objectives will be monitored by the RD&I Committee

LEAD

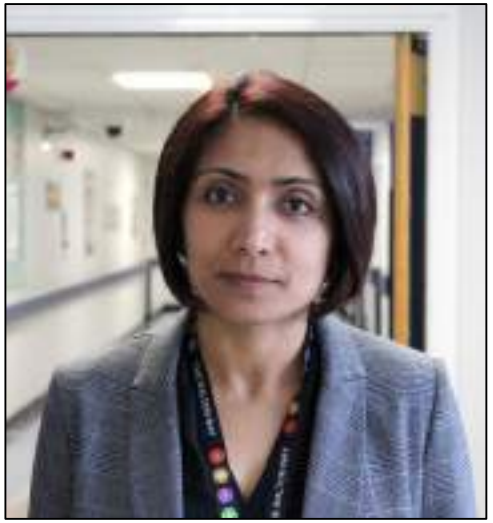
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Innovation Strategy 2019 – 2024

Contents

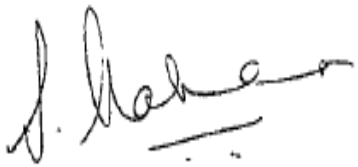
Introduction from Clinical Lead of Innovation

I am proud to share The Walton Centre's first innovation strategy as the designated Clinical Lead. Put simply, innovation has to be at the core of what we do at this Trust otherwise we will not remain the outstanding centre of excellence for neuroscience in England.



Given the national challenges to the NHS and the various local system redesigns, it is difficult to make the space to think, develop and introduce creative new solutions for our patients. However, these conditions provide a great opportunity to transform services capitalising upon the radical improvements in technology, medical equipment and treatments. The purpose of this strategy is to signal the direction for the Trust but it is not set in stone rather, it is the art of the possible!

This aspires to formalise the conditions needed across the Trust to ensure that we have a democratic but focused approach to innovation by building a strong culture throughout all the services we offer. To deliver new solutions for our patients we will have to enter into new partnerships at local level, nationally and internationally. Therefore, we will have to work with a much wider set of stakeholders than has been traditional, be open to new discussions and ultimately engage with partners who share our values. Success looks like a broad portfolio of innovations, both big and small, across all the services we offer.



Dr Shagufay Mahendran
Consultant in Neurorehabilitation &
Clinical Lead for Innovation

Innovation Strategy Overview

The Innovation Strategy is based on the Trust's six strategic priorities. A culture of open innovation will underpin the achievement of all the Trust's strategic ambitions. However, it is fundamental to leading new treatments, adopting advanced technology and generating additional income to invest in service improvements. Recognition as a centre of excellence has innovation at its core.

Deliver	• Deliver best practice care and treatments in our specialist field.
Provide	• Provide more services closer to patients' homes, driven by the needs of our communities, extending partnership working.
Invest	• Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff
Lead	• Lead research, education and innovation, pioneering new treatments nationally and internationally.
Adopt	• Adopt advanced technology and treatments, enabling our teams to deliver excellent patient and family centred care.
Recognise	• Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing.

Introduction

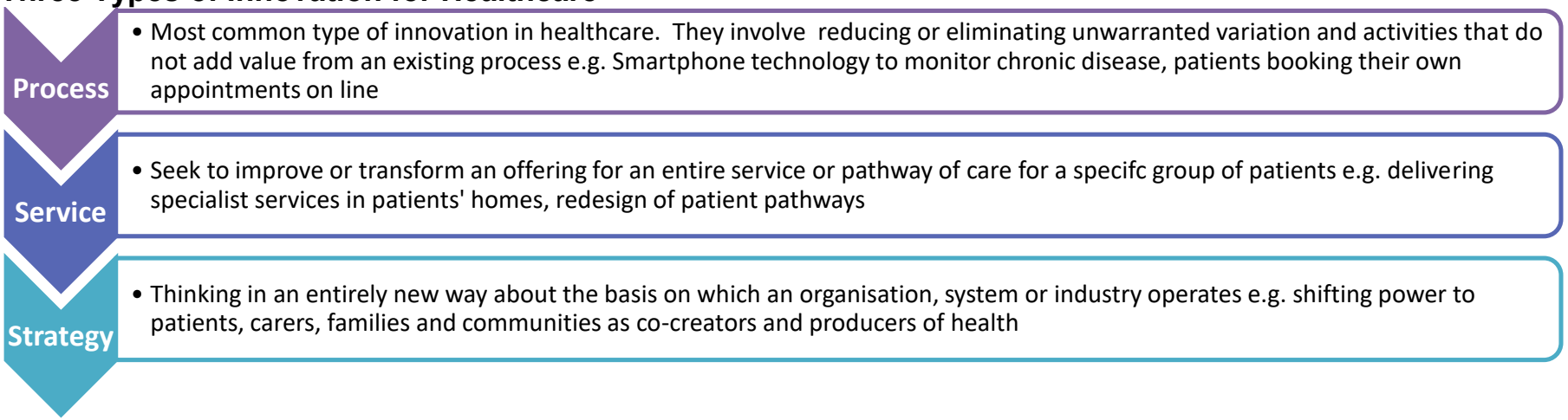
THE TRUST

The purpose of The Walton Centre is to provide the best neuroscience patient outcomes both nationally and internationally. To achieve this, we need to be at the cutting edge of innovation shaping the future of new treatments, care and support in neuroscience. The organisation is made up of many talented, dedicated and passionate health professionals who all share this compelling vision.

At Trust level, we need to ensure that we promote a dynamic culture of innovation, curiosity and creativity across all service areas. However, the danger is that we end up with too many initiatives that fail to be implemented internally and adopted by the wider health economy. Therefore, this strategy puts in place many of the basic building blocks for innovation that enables our talented employees to contribute but ensures that we have a clear set of shared priorities.

The starting point is having a shared view of what innovation looks like.

Three Types of Innovation for Healthcare

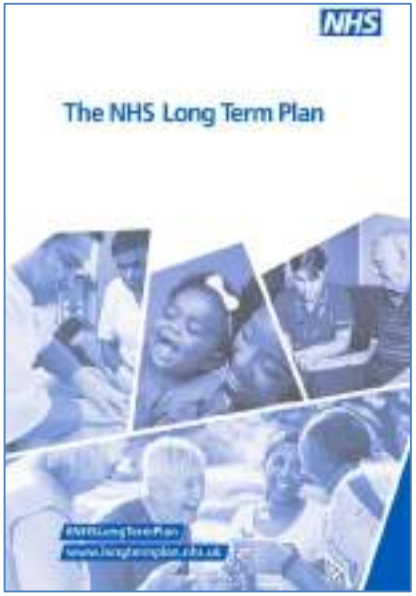


HSJ 2013, Helen Bevan: Three steps to a new innovation strategy

INTERNATIONAL, NATIONAL AND REGIONAL CONTEXT

The Global Innovation Index (GII) analyses global innovation trends and performance of 129 economies with the aim to place innovation firmly on the map, allow countries to assess their performance and provide an incentive for countries to collect innovation metrics. The GII ranks the UK as the 4th innovative economy. Medical fields where major advancements were expected in the next decade include:

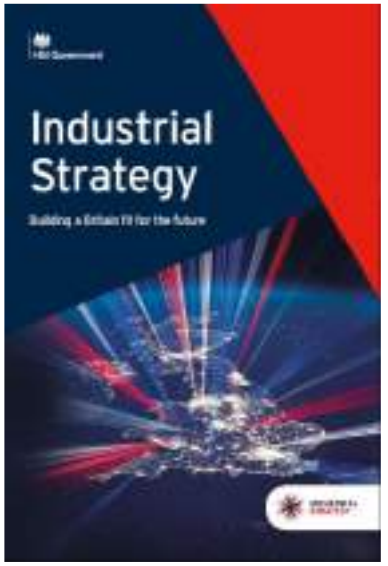
- Mapping of the brain – Improved understanding of brain cells and circuitry means earlier diagnosis of common neurological conditions
- Alzheimer's disease – Better imaging techniques allow for disease diagnosis in living patients instead of post-mortem identification
- Spinal cord injuries – Cutting-edge non-invasive spinal stimulation techniques can help people with paralysis improve range of motion
- Pain management – Advancements in Genomics, neuroscience and structural biology mean targeted, non-addictive, non-opioid pain relief
- Cancer Immunotherapy – New methods of using a patient's own immune system to help fight cancer



The NHS Long Term Plan was launched by NHS England in January 2019 and sets of the NHS priorities for the next ten years. The plan recognises the critical importance of research and innovation to drive future medical advancements and the benefits they can bring to both patients (breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery) and the economy .e.g. creation of jobs and services. It also cites the expansion of medical science and innovation as one of the reasons for continuous growth within the NHS as enables the introduction of new treatments which a modern health service should be providing. The plan pledges to:

- Focus targeted investment in areas of innovation that will be transformative
- Speed up the pipeline for developing innovations in the NHS so that proven and affordable innovations get to patients faster
- Accelerate uptake of proven, affordable innovations through a new Medtech funding mandate
- Invest in spreading innovation between organisations
- Support global export of innovations that are proven as ‘ready for spread’ in England through the work of Healthcare UK.

Published in November 2017, the strategy sets out the aspiration for Britain to be the world's most innovative economy and ensure the UK is the best place for innovators, whilst maintaining its position as a global leader in science and innovation. Key areas of note for health are:



- Higher Education Innovation Funding in England enabling universities to engage with businesses and improve the commercial skills of their staff
- Continue to recruit and retain the best talent and ensure the UK remains a world-leader in science and innovation through the Rutherford Fund - £118m investment over four years (from 2017/18) in fellowships for early-career to senior researchers
- Develop age-related innovative products and services to meet the needs of an ageing society – would make a significant difference to UK productivity and individuals' wellbeing, and will find a growing global market.
- Make the UK a global centre for artificial intelligence and data-driven innovation - invest to enhance the power of health data to diagnose life-changing diseases at the earliest possible stage and develop precision treatments to cure them.

The strategy is currently going through an engagement process with the final version due to be published in March 2020. It will set out the long term economic vision for the Liverpool City Region and focus across four key priorities:

- Good work, health and wellbeing for all
- Vibrant and connected communities
- More businesses innovating and growing
- Clean growth.

Innovation is an underlying theme across the strategy. It commits to further work being undertaken to understand supply chains, sectoral 'deep dives' and fore-sighting, plus the wider innovation ecosystem in the City Region.

A key challenge within the strategy is to bring together innovative businesses, communities and higher education bases within the City Region to build collaborative relationships centred on innovation and commercialisation. The University of Liverpool is cited as one of the top three centres in the UK for Computer Science-related research publications. Therefore the sector and its assets would be key in driving productivity and innovation led growth across all sectors of the City Region economy.

Liverpool City Region Health Matters is a new collaborative programme that is part-funded by the European Regional Development Fund and is designed to connect the City Region businesses with world-class healthcare and technology partners to support company scale-up. It aims to accelerate innovation and growth by supporting ambitious businesses to better understand, work with and sell to the health and social care markets.

HEALTH MATTERS
Liverpool City Region

European Union
European Regional Development Fund

The Cheshire and Merseyside Population Health Framework has been produced by the Cheshire and Merseyside Health and Care Partnership to provide guidance to support the delivery of the prevention challenge within local place based settings. The Trust's Innovation Strategy has a supportive and enabling role across this whole agenda.

At the time of writing, there are a number of system level initiatives that seek to redesign service delivery across the local health economy including the whole of the public sector and even beyond. Working across organisational boundaries is at an early stage and it will take time for a mature and integrated health/social care system to be established. However, throughout all this work the focus is upon prevention and early detection of conditions, especially diseases of inequality.

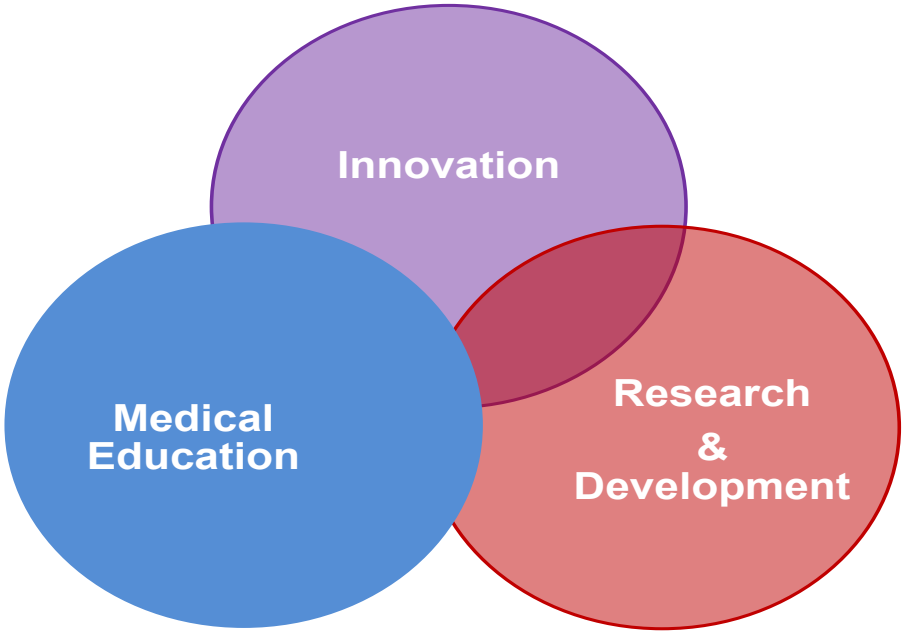
Vision and Goals

- Create a pipeline of sustainable innovative projects for neuroscience
- Promote, deliver and monitor innovation projects that meet our patients' and workforce needs
- Ensure the strongest possible integration of the innovation agenda with Medical Education and Research at the Trust
- Accelerate the implementation of innovations across the Trust/local health system through a structured network of support
- Shape the local, national and international agenda including grants/incentives
- Generate new and additional income streams

INTERDEPENDENCIES

Any innovation strategy within a trust is incomplete without reference to the closely aligned areas of research and medical education. We lead in innovative developments that are tested through our own research trials and ultimately become part of our medical education curriculum. This is acknowledged in this Trust's strategic ambition to: "**Lead** research, education and **innovation**, pioneering new treatments nationally and internationally."

As the strategy and culture of innovation matures, we will expect its impact and influence across research and medical education agendas to emerge and become increasingly interdependent.



STAKEHOLDERS

Innovation Priorities & Delivery

Timescale	Objective	How to get there…	Trust Objective (s)
Short Term (2019-2020)	Prioritise a pipeline of innovative projects (initially rehabilitation) that can fundamentally improve diagnostic and treatment options for patients	• Continue to work with clinical and non-clinical staff to develop and establish a project pipeline - updates to be shared with the Medical Innovation Group • Establish a support and signposting service to progress innovative projects • Work with internal and external stakeholders to explore funding opportunities	
	Establish a pipeline of projects held on a central database	Project pipeline databased to be designed, implemented and maintained by Innovation Co-ordinator	
	Actively engage key internal stakeholders in developing and promoting the Trust's culture of innovation	Co-produce with consultant leads and wider teams, The Walton Centre's model of innovation to underpin/promote the cultural change	

Timescale	Objective	How to get there…	Trust Objective(s)
Short Term (2019-2020)	Raise awareness internally and externally through communications strategy	Strategy to be developed in collaboration with the Communications function to utilise internal and external communication methods inclusive of social media platforms	
	Single point of contact for projects and ideas including commercial proposals	Explore software options to develop an internal system	
	Establish an innovation space to cultivate a creative environment, promote interaction and communication, and update on current activity.	Work with internal stakeholders and the Estates function to develop an innovation space in the Trust	
	Establish new partnership working arrangements to progress innovation ambition working closely with The Walton Centre Charity	Continue to work with the Walton Centre Charity to identify new partnerships	
	Develop an appropriate process to express the voice of the patient in decision making	Work with internal stakeholders to form the group to be the patient voice in medical innovations. Group to be aligned with key change management processes and groups	

Timescale	Objective	How to get there…	Trust Objective(s)
Short Term (2019-2020)	Establish a Workforce Innovation Group	Work with internal stakeholders and staff side to form the group to look at new ways of working. Group to be aligned to the Medical Innovation Group	
	Scope, develop and implement the Posture Programme - Multi-tom Rax	Dedicated resource to deliver the programme led by Radiology Service Manager and Assistant Medical Director	
	IT engagement	Initial meeting to be held with the Head of IM&T with a view to exploring options for future working and identifying an IT Innovation Lead	
	Audit of innovation initiatives across the Trust/partnerships	Annual review of projects undertaken - findings to be reported into the Research Development and Innovation Committee	

Timescale	Objective	How to get there…	Trust Objective(s)
Medium Term (2020 – 2022)	Scope, develop and implement Movement Analysis Programme – CAREN/Gait Lab	Dedicated resource to deliver the programme led by the Divisional Director of Operations for Neurology and the Neurorehabilitation Consultant /Clinical Lead for Innovation	
	Understand and articulate the relationship between innovation, medical education and research developing integrated funding bids	Work with the Head of Research, Medical Education Development Manager and Clinical Leads to: • Explore synergies • Explore and identify the research potential at the start of each innovation development and opportunities for joint grant applications • Identify and develop internal and external stakeholder crossover • Develop innovation relationships with research and medical education partners	

Timescale	Objective	How to get there…	Trust Objective(s)
Medium Term (2020 – 2022)	Celebrate successful initiatives and raise profile internally and across a wider external footprint	• Work with the Communications function to incorporate into the Innovation Communication Strategy utilising internal and external communication methods inclusive of social media platforms • Award entries to be submitted where appropriate	
	Ensure alignment to and shaping of, system wide priorities	Working with external stakeholders and building relationships with external partners	
	Promote, enable and genuinely commit to wider system collaboration where appropriate	Through engaged partnership working with external stakeholders	
	Establish new/additional income streams based on a new business model e.g. commercial partnership, new organisational structure or form etc.	Appointment of Head of Commercial Engagement and Marketing	

Timescale	Objective	How to get there…	Trust Objective(s)
Long Term (2022 – 2024)	The Trust emerging as financially independent with growing income generated from the private sector	• Establishing new partnerships with expert organisations to provide new products and services • Commercialisation and monetising assets e.g. Striker and Medtronic	
	Appropriate collaboration across the local health economy with minimal reputational damage	• Liverpool City Region Local Enterprise Partnership • Academic Health Science Network Innovation Agency • Liverpool Health Partners	
	Clearly established a culture of innovation across the Trust	• Neuroscience hackathons • Celebratory exhibitions of success stories • Innovation Agency Coaching Academy programmes/resources	
	Well established and integrated relationships between innovation, medical education and research with centralised leadership	Work with the Head of Research, Medical Education Development Manager and Clinical Leads to established prospective data collection/ product surveillance data to validate innovation initiative outcomes	

Timescale	Objective	How to get there…	Trust Objective(s)
Long Term (2022 – 2024)	New (and unimagined) business opportunities on offer from the Walton Centre in different sectors, overseas etc.	• High profile and levels of engagement with the Merseyside business community • Established dynamic culture of creativity and innovation • New ways of developing solutions with new partners from across the international health sector and beyond	
	Track record of successful project implementation (both big and small) with related/funded research trials	• Develop a book/publication of innovation achievements/successes • Publicise achievements via social media platforms • Exhibit in the Trust's innovation space • Regional and national spread and adoption via Academic Liverpool City Regions Local Enterprise Partnership, Health Science Network (Innovation Exchange Network) and NHS England	

Timescale	Objective	How to get there…	Trust Objective(s)
Long Term (2022 – 2024)	Demonstrably influencing the international agenda in priority service areas	• Campaign to raise profile of key consultants, innovations and research projects in targeted countries • Working with partners (especially the LEP and Department for International Trade) to expand business opportunities/joint working • Leading, exhibiting and presenting in selected medical/academic forums e.g. European Neuroconvention	
	'Walton' brand established for innovation both nationally and internationally within healthcare and relevant commercial sectors	• Trust clear on priority services and aligned to regional population health needs • Key consultant work celebrated, research promoted and a number of prestigious partnerships established • Clear evidence of golden thread with credible brand testing	

Risks to Delivering the Strategy

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

On a practical level the key risks are as follows:

- Ensuring sufficient workplace capacity to maintain innovative practices, treatments and boundary scanning
- Ensuring that the inevitable financial pressures don't distract from the Trust's commitment to innovation
- Challenging complacency and the status quo where employees become demotivated
- Too many innovations that are not fully implemented, acknowledged and celebrated
- The Walton Centre's innovation agenda becoming weakened in an environment of competing/emerging system change
- Local and national political drivers e.g. Brexit, Ministerial changes etc.

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

Associated Documents & Strategies

The documents and strategies associated with the Innovation Strategy are:

- The Walton Centre's Strategy 2018-2023 and its five enabling strategies:
  - Research and Development Strategy
  - Quality and Clinical Services Strategy
  - Workforce Strategy
  - Estates Strategy
  - Finance Strategy
  - Digital Strategy
- The Global Innovation Index 2019: Creating Healthy Lives – The Future of Medical Innovation
- The NHS Long Term Plan, NHS England
- Industrial Strategy: building a Britain fit for the future, HM Government
- Liverpool City Region Industrial Strategy, Liverpool City Region
- Cheshire and Merseyside Population Health Framework, Cheshire and Merseyside Health and Care Partnership

"If you can see the endpoint, it's not innovation."

Appendix 3 - 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

1. Person(s) Responsible for Assessment: **Mike Gibney**

2. Contact Number: **0151 556 3474**

3. Department(s): **Workforce & Innovation**

4. Date of Assessment: **20/01/20**

5. Name of the policy/procedure being assessed: **Innovation Strategy**

6. Is the strategy new or existing?

(New) Existing

7. Who will be affected by the strategy (*please tick all that apply*)?

(Staff) (Patients) Visitors Public

8. How will these groups/key stakeholders be consulted with? **Through review committees; SPC, LNC, RD&I and Medical Innovation Group and Workforce Innovation Group. Also patient experience groups/ideas laboratory as necessary.**

9. What is the main purpose of the strategy? **To create the conditions for genuine innovation for patients outcomes. This will fulfil the ambitions of our staff and promote the Trust brand at a national and international level.**

10. What are the benefits of the strategy and how will these be measured?

- **Create a pipeline of sustainable innovative projects for neuroscience - establish database**
- **Promote, deliver and monitor innovation projects that meet our patients' and workforce needs - projects developed and implemented across the Trust's portfolio**
- **Shape the local, national and international agenda including grants/incentives – the tangible outcome will be that these agendas reflect the Trust's agreed ambitions**
- **Generate new and additional income streams – achieving new income targets**

11. Is the strategy associated with any other policies, procedures, guidelines, projects or services? **Yes, see pages 5-10**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **Yes – supporting the research agendas of individual members of staff (especially at consultant level) can have both a material and reputational benefit to those individuals. The risk is of a disproportional negative impact to some staff groups with protected characteristics notably race, gender and age.**

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 risk is of a disproportional negative impact to some staff groups with protected characteristics notably age.	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Sex		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably gender.	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Race		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably race.	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Religion or Belief			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to religion or belief in the recruitment of clinical staff that may benefit from this strategy	
Disability		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably disability	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim

Sexual Orientation			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to sexual orientation in the recruitment of clinical staff that may benefit from this strategy	
Pregnancy / maternity			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to pregnancy/maternity in the recruitment of clinical staff that may benefit from this strategy	
Gender Reassignment			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to gender reassignment in the recruitment of clinical staff that may benefit from this strategy	
Marriage & Civil Partnership			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating marriage & civil partnership in the recruitment of clinical staff that may benefit from this strategy	
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.) **N/A**

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: Mike Gibney & Andrew Lynch Date: 20/01/20

Signed: Mike Gibney & 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 داوابکرێت 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 THE TRUST BOARD
Thursday 30 January 2020

Title	Research and Development Strategy 2019-2024
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Gill Hamblin Title: Head of Research Name: Dr Rhys Davies Title: Interim Clinical Director of Research and Development Name: Dr Andrew Rose Title: Head of Commercial Engagement and Marketing
Previously considered by:	• Committee - Research Development and Innovation Committee on 08/01/20 • Group (please specify) _____ • Other - Presentation overview to the Board Development Session on 14/06/19

Executive Summary

The Walton Centre NHS Foundation Trust's role as a specialist neuroscience centre is to be active in clinical research. The Trust has invested in a dedicated Neuroscience Research Centre to deliver clinical trials and support research across the Trust involving all disciplines of clinical staff. The Trust's long term strategy places a critical emphasis upon this Trust leading in the field of research, innovation and education. The reputation, profile and brand of the organisation is intrinsically linked to its academic and commercial research offer and function. It may seem obvious, but it is clear that leading consultants have a genuine drive to improve patient outcomes through research in their specialist field.

It is important to note that this strategy has been developed in collaboration with key stakeholders and that it reflects a broad spectrum of specialist areas across the Trust. The desired outcome is to embed research, development and innovation into our everyday business as usual and at the centre of the organisation's culture. Ultimately, the Trust wants research outputs to deliver tangible benefits across the widest possible patient pathways.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	There are a number of risks related to reputation, brand, recruitment and retention. These emerge if the Trust fails to delivery upon this strategy.
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	A full Equality Impact Assessment is attached at appendix a
Any associated legal implications / regulatory	• Yes – Many related to individual pieces of research/trials.

requirements?	
Action required by the Board	The Board: a) approve the Research and Development Strategy b) note that a full implementation plan will be monitored by the RD&I Committee

REPORT TO TRUST BOARD

RESEARCH AND DEVELOPMENT STRATGY

EXECUTIVE SUMMARY

Thursday 30 January 2020

The development, resourcing and growth of Research and Development is a fundamental mainstay of the overall Trust Strategy 2018 – 2023. A more focused and targeted expansion of research capacity is at the core of maintaining our centre of excellence status/reputation. It is also central to fulfilling the career ambitions of our most senior clinical staff and provides the opportunity to diversify income through commercial relationships.

To this end, we have developed a Research and Development Strategy in consultation with clinical colleagues (including consultants, Allied Health Professionals and nurses) over a period of six months. There was overwhelming support to increase research activities. This strategy was agreed by the Research Development and Innovation Committee on the 8 January 2020.

The main benefits and deliverables are as follows:

- Redesign key aspects of the service with an emphasis upon developing staff to expand skillsets, increase delivery and ensure consistency in practice
- Ensure leadership of neuroscience research across the system developing new partnerships with universities, other NHS trusts and system level collaborations, in particular Liverpool Health Partners
- Optimise grant applications and recruitment of patients through local/national collaborations (including the National Institute for Healthcare Research and the North West Coast Clinical Research Network)
- A renewed focus upon commercial trials to maximise income and ensure the financial sustainability of the service through commercial partnerships
- Ensure the successful development of Liverpool's first Neuroscience Faculty in partnership with the University of Liverpool
- Establish mechanisms to improve the engagement of patients, carers and staff in the prioritisation of our research agenda

The governance arrangements for the implementation of this strategy will principally be conducted through the Research Development and Innovation Committee. However, it is important to note that implementation is subject to considerable external assurance notably through the Medicines and Healthcare products Regulatory Authority (MHRA), the North West Coast Clinical Research Network (NWC: CRN) and Liverpool Health Partners (LHP).

Recommendations

The Board is requested to:

c) approve the Research and Development Strategy
d) note that a full implementation plan will be monitored by the RD&I Committee

LEAD

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Research & Development Strategy 2019 – 2024

Contents

Research & Development Strategy Overview

Our Research and Development Strategy is developed based on the Trust's six strategic priorities. Realising those priorities will ensure we achieve consistently well led, fully staffed teams, where individuals' wellbeing and identity is nurtured, enhancing our excellent care to patients.

Deliver	• Deliver best practice care and treatments in our specialist field.
Provide	• Provide more services closer to patients' homes, driven by the needs of our communities, extending partnership working.
Invest	• Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff
Lead	• Lead research, education and innovation, pioneering new treatments nationally and internationally.
Adopt	• Adopt advanced technology and treatments, enabling our teams to deliver excellent patient and family centred care.
Recognise	• Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing.

Introduction

The Walton Centre NHS Foundation Trust's role as a specialist neuroscience centre is to be active in clinical research. The Trust has invested in a dedicated Neuroscience Research Centre to deliver clinical trials and support research across the Trust involving all disciplines of clinical staff. To support research and innovation activities, we will work with clinicians and patients/families to understand areas of need and where improvements in practice can be made. This Trust has a proven and consistent track record in delivering high quality research in significant volumes to make it one of the largest research active trusts across the whole of Cheshire and Merseyside.

The Trust's long term strategy places a critical emphasis upon this Trust leading in the field of research, innovation and education. The reputation, profile and brand of the organisation is intrinsically linked to its academic and commercial research offer and function. This is especially important during a time of regional reconfiguration and helps define the unique purpose of this centre of excellence. It may seem obvious, but it is clear that leading consultants have a genuine drive to improve patient outcomes through research in their specialist field.

It is important to note that this strategy has been developed in collaboration with key stakeholders (including the consultant body) and that it reflects a broad spectrum of specialist areas across the Trust. The desired outcome is to embed research, development and innovation into our everyday business as usual and at the centre of the organisation's culture. Ultimately, the Trust wants research outputs to deliver tangible benefits across the widest possible patient pathways.

National Context

The NHS Long Term Plan has been published by NHS England setting out an overall vision for how the NHS should change over the next ten years. The plan recognises the critical importance of research to drive future medical advancements and the benefits they can bring to both patients and the economy. The key areas of note for research are:

- To link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services

- The use of de-personalised data extracted from local records, in line with information governance safeguards, will enable more sophisticated population health management approaches and support world-leading research
- To increase the number of people registering to participate in health research to one million by 2023/24.

The Plan references the Government's Industrial Strategy which highlights that there is an ambition to treble industry contract and research and development collaborative research in the NHS over ten years, to nearly £1 billion. It also recognises the outstanding capabilities for research in the UK e.g. universities, NHS providers, UK Biobank etc.

The UK Policy Framework for Health and Social Care Research was published in 2017 and sets out principles of good practice in the management and conduct of health and social care research in the UK. It applies to research involving patients, service users or their relatives or carers.

Local Context

This strategy is being developed at a time of wide spread change across the local health economy and at a point where many stakeholders (notably local universities) are recognising their civic responsibilities to the Merseyside region. In addition, research is not developing in a vacuum and has to take note of the many local collaborations/initiatives to redesign the provision of both health and social care. These include the Cheshire & Merseyside Health & Care Partnership, the Liverpool City Region Mayoral agenda and the One Liverpool commissioning plan.

The Trust is a key stakeholder of NIHR Clinical Research Network North West Coast (CRN NWC) and Liverpool Health Partners. As such, we are actively collaborating to deliver research and education programmes for implementation into services designed to address the needs of the local population, create wealth and thereby positively impact the lives of many locally, nationally and internationally. It should be noted that the recent development of a Single Point of Access to Research and Knowledge (SPARK) brings together the Liverpool Health Partners (LHP), NHS trusts and universities research support functions to facilitate and deliver high quality, world-class health research, capitalising on the commitment locally to drive research based on population need.

Deliver

Objective: To deliver high quality safe research that is underpinned by robust governance systems and processes, and is accessible to all patients who wish to participate in clinical research	
Links to: Trust Strategy 2019-2024	**Key Measures:** NIHR CRN metrics Increase numbers of studies supported Increase research income Increased numbers of investigators Increased numbers of trained staff

Where we are now?	Where we want to be?	How to get there…
• High quality delivery of research is underpinned by governance processes	• Aligning to Trust strategy, increase research activity, while continuing to provide high quality, safe clinical research within the relevant governance framework	• Review and improve governance processes, specifically regarding sponsor oversight • Provide alerts to Principal Investigators (PIs) to ensure all reporting takes place at the required time points

• All research active staff are trained in Good Clinical Practice (GCP) • Staff are skilled in the delivery of clinical research • Workforce capacity is limited to be able to take on additional studies	• Demonstrate and practise accountability and transparency in clinical research • Appropriate levels of workforce capacity to deliver clinical trials which reflect the commitment from PIs to conduct research which is relevant to our patient population	• Continue to direct staff to GCP training • Hold an internal Principal Investigator Forum annually for PI's to share best practice and identify areas for improvement and new topics for clinical trial development • Increase the number of PIs • Increase number of Chief Investigators • Create an additional 2 NIHR Senior Investigators • Increase nurse workforce capacity initially with the creation of a Band 5 Research Nurse post to support the Band 7 Research Nurses • Review team roles • Be innovative when creating new roles
• MHRA Corrective and Preventative Action Plan (CAPA) is in place following an MHRA inspection in 2016	• All actions identified in the MHRA CAPA plan are completed	• Develop and implement a quality management system to ensure appropriate oversight and governance

• CRN NWC recruitment target was met and overachieved for 2018/19	• To sustain patient recruitment and meet the CRN NWC target annually • To boost the CRN NWC regional recruitment target • To conduct more clinical research	• Work closely with CRN NWC to address research nurse capacity issues for the delivery of non-commercial trials • Identify suitable studies which will contribute to meeting the target • Identify large scale observational studies which will be relatively straight forward in meeting our recruitment targets
• Poor links with trust laboratories; research activity in labs is not part of overall research function	• To fully collaborate with lab staff on each research trial • To ensure quality measures are delivered in line with UKAS measures	• Review need for separate mini research lab in NRC • Develop robust relationship with lab staff

Provide

Objective: To provide maximum opportunities for patients to participate in clinical research trials To provide a workforce that is stable and that staff wellbeing is a priority	
Links to: Trust Strategy 2019-2024	**Key Measures:** NIHR Patient Survey ratings Increased patient recruitment Increased promotion of activities

Where we are now?	Where we want to be?	How to get there…
• Provide a positive experience for the patient taking part in clinical research	• Patients have a positive experience of taking part in clinical research	• Proactively scan the environment for clinical research trials that are relevant to our patient population • Use the NIHR National Research Patient Survey as a baseline to satisfaction and a positive patient experience
• Patients are invited to participate in clinical research	• All patients have the opportunity to participate in clinical research trials • For research to be an integral part of The Walton Way	• Encourage the development of new PIs in clinical areas which are not research active

• Environment does not encourage patients to participate in clinical research	• It is clear from the Trust environment that we are research active and that we positively encourage patients to participate in clinical research	• Plan, agree and deliver a programme for the circulation and display of publicity materials for taking part in research • Collaborate with NIHR on national campaigns • Share research opportunities with wider Trust as relevant e.g. Professional Nurse Forum, Clinical Audit meetings, Divisional Governance meetings
• Information on the availability of clinical research studies is sparse across the Trust	• Availability of appropriate clinical trials is easy to obtain and is kept updated • Positive publicity and good news stories being shared across multimedia platforms	• Include current clinical trial availability and recruitment activity on the Trust website and update monthly • Increased coverage across internal and external publications and across social and other forms of media • Promotion and publicity internally and externally on International Clinical Trials Day (annually in May) • Applications for research and innovation awards i.e. Dedicated Annual Research Comms Plan

• No forum exists for patients and carers to get involved and engage with the research pipeline	• Dedicated Patient and Carer Forum for research and innovation	• Look to colleagues in the Trust, Public Governors and The Brain Charity to encourage involvement by patients • Create a guide for patients to get involved in research • Explore the use of Living Lab approaches with Liverpool John Moores University
• We are ending a period of flux within the research team that has lasted 2 years • Staff turnover has been high	• Cohesive, strong motivated workforce, that are empowered, with secure jobs, with an opportunity for career progression	• Engage with and seek the opinion of all members of the research team in developing and improving the overall research function for the Trust • Provide a welcoming environment and 'can-do' approach to all visitors to the department
• Excellent AHP research	• To increase the number of Chief Investigators from the AHP workforce	• Circulate NIHR Research Fellowship Opportunities • Support applications that follow

Invest

Objective: To be financially strong, aiming for financial balance.	
Links to: Trust Strategy 2019-2024 Trust Financial Strategy	**Key Measures:** Increased research income (to point of sustainability)

Where we are now?	Where we want to be?	How to get there…
• Income generation via delivery of commercial trials has been declining year on year since 2014	• In financial balance as a minimum and ideally generating a surplus	• Accurate costing of commercial trials in line with national costings framework • Maintaining dialogue with CRN NWC Financial Accountant • Keep dialogue open with Trust Director of Finance and Executive Team • Provide updates at Research Development & Innovation Committee • Understand future UK/international trends to support planning

• We actively pursue grant applications and other alternative sources of funding	• In receipt of large grant funding for the delivery of trials	• Encourage and support grant applications • Provide support from experienced Chief Investigators in achieving successful grant applications • Scan for funding opportunities • Collaborate with partners such as the ARC and Liverpool Health Partners • High level discussions with relevant industry partners and clinicians • Ensure DPO is involved • Proactively seek opportunities to open registry studies
• NIHR funding for non-commercial trials has also been cut year on year	• Secure funding to ensure continued viability of the research function	• Maintain open dialogue with NWC CRN

• Lack of commercial financial model is unsustainable	• Align research with plans to commercialise Trust registry datasets	• Business case to Executive Team Meeting for consideration • Conduct cost benefits exercise to demonstrate need and link to income generation
• No dedicated Data Analysis Statistician	• Trust funded Data Analysis Statistician	• Demonstrate need • Provide data showing funds that have been used to employ statistician on a trial by trial basis • Support applications for SI awards • Potentially consider alignment with wider health economics requirements of Trust
• Only 1 x NIHR Senior Investigator (SI) is eligible for the annual award of £75k	• 2 x additional NIHR Senior Investigator posts, eligible for £75k each SI annually • Research Capability Funding (RCF) is used to grow research active clinicians/increase number of PIs/CIs	• Work with current PIs to encourage application to Senior Investigator Award
• Poor understanding of current Research PAs	• Accurate research PAs allocated to reflect workload • Increased number of PAs allocated for research	• Review research activity per consultant using EDGE database • Provide this information to each Divisional Clinical Director to use at consultant annual reviews

Lead

Objective: We will lead the implementation of clinical research trials that are pioneering novel treatments nationally and internationally	
Links to: Trust Strategy 2019-2024	**Key Measures**: Establishment of new Neuroscience Faculty Development of new Chair(s) in Neuroscience, investigators and research staff

Where we are now?	Where we want to be?	How to get there…
• We deliver high quality clinical research trials	• Lead on the delivery of early phase clinical research trials in collaboration with LHP partner organisations • Additional Chairs of Neuroscience, investigators and research staff • Ensure that studies supported are informing national and international practice	• Develop new relationships with commercial and non-commercial partners to facilitate delivery of early phase trials • Develop the City's first Neuroscience Faculty (with the University of Liverpool) • Develop new investigators • With lead investigators, audit the impact of studies conducted to ensure that practice is being informed

• Leading on the delivery of multi-centre clinical research trials e.g. NERVES to explore changes in clinical practice	• Continue to lead on the delivery of multi-centre clinical research trials in order to influence changes in clinical practice • Develop more treatment based research • Widen scope to collaborate with international neuroscience experts • To be world-class leader with our research portfolio	• Promote the findings of research nationally and internationally, including international conferences • Increase the number of publications in high impact journals such as New England Journal of Medicine and the Lancet • Host international research consensus meetings

Adopt

Objective: We will work to adopt new technologies and innovative treatments that have been supported by studies supported by The Walton Centre	
Links to: Trust Strategy 2019-2024	**Key Measures:** Initially, baseline the number of interventions evaluated positively by the Trust that have been implemented

Where we are now?	Where we want to be?	How to get there…
• The usage of interventions that have been positively evaluated in studies supported by The Walton Centre is unclear	• Working within Procurement rules and financial constraints, we will work to ensure that interventions evaluated positively in Walton Centre studies will be implemented	• Linked auditing impact, confirm with lead investigators if interventions evaluated positively have been implemented by the Trust • Work with investigators and Innovation, Procurement and other teams to explore if appropriate products can be implemented

Recognise

Objective:	
Links to: Trust Strategy 2019-2024	**Key Measures:** Number of research publications Number of communications activities related to research published

Where we are now?	Where we want to be?	How to get there…
• Limited promotion of studies supported by the Trust, investigators, research staff and patient research stories • Recognise the importance of developing new researchers	• Ensure that studies supported by the Trust, investigators, research staff and patient stories related to research are promoted • Develop new researchers pipeline (medics/AHP/ nurses)	• Develop communications approach to ensure that studies supported by the Trust, investigators, research staff and patient stories related to research are promoted • Increase the number of high profile publications • Develop plan to resource and develop new researchers covering all professional groups

Risks to Delivering the Strategy

The delivery of the Research and Development Strategy is dependent upon a number of internal and external factors. It needs to be integrated into the ambitions for the region and UK. As such, structures and delivery mechanisms will need to adapt to the emerging research landscape.

The key risks identified for the delivery of the strategy are as follows:

- Ensuring sufficient workplace capacity and capability to maintain, grow and develop the research function
- Establishing a sustainable financial model that balances income streams, notably commercial income
- Inability to secure sufficient grant based funding
- The Walton Centre brand not aligned to research ambitions and/or not strong enough to attract commercial sponsors
- Portfolio of research not aligned to key strategic priorities for the Trust (e.g. spinal centre of excellence developments) or for the region given key needs in neuroscience related ill health (e.g. neurological disability in early life, chronic pain, neurodegeration)
- Competing and emerging system change
- Local and national political drivers and in the short term, the implications of Brexit negotiations on promoting/ attracting research

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

Associated Documents & Strategies

The documents and strategies associated with the Research and Development Strategy are:

- The Walton Centre's Strategy 2019-2023
- The NHS Long Term Plan, NHS England
- The UK Policy Framework for Health and Social Care Research, NHS Health Research Authority
- Industrial Strategy: building a Britain fit for the future, HM Government
- One Liverpool Strategy 2019 – 2024, Liverpool City Council
- Better Lives Now, Cheshire & Merseyside Health & Care Partnership

Appendix A - 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

1. Person(s) Responsible for Assessment: **Mike Gibney** 2. Contact Number: **0151 556 3474**

3. Department(s): **Research & Development** 4. Date of Assessment: **20/01/20**

5. Name of the policy/procedure being assessed: **Research & Development Strategy**

6. Is the strategy new or existing?

(New) Existing

7. Who will be affected by the strategy (*please tick all that apply*)?

(Staff) (Patients) Visitors Public

8. How will these groups/key stakeholders be consulted with? **Through review committees; SPC, LNC and RD&I. Also patient experience groups/ideas laboratory as necessary.**

9. What is the main purpose of the strategy? **The purpose of this strategy is to support members of staff in their research ambition and to increase the level of research activity across the Trust.**

10. What are the benefits of the strategy and how will these be measured?

- **Redesign key aspects of the service with an emphasis upon developing staff to expand skillsets, increase delivery and ensure consistency in practice – Through supervision, appraisal customer feedback**
- **Optimise grant applications and recruitment of patients through local/national collaborations (including the National Institute for Healthcare Research and the North West Coast Clinical Research Network) – successful applications and increased revenue.**
- **A renewed focus upon commercial trials to maximise income and ensure the financial sustainability of the service through commercial partnerships – Increased commercial income directly related to research**
- **Ensure the successful development of Liverpool's first Neuroscience Faculty in partnership with the University of Liverpool – Build key partnerships, lead system development and influence the Neuroscience agenda for Liverpool**

11. Is the strategy associated with any other policies, procedures, guidelines, projects or services? **Yes, see pages 4-5**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **Yes – supporting the research agendas of individual members of staff (especially at consultant level) can have both a material and reputational benefit to those individuals. The risk is of a disproportional negative impact to some staff groups with protected characteristics notably race, gender and age.**

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 risk is of a disproportional negative impact to some staff groups with protected characteristics notably age.	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Sex		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably gender.	Monitored/evidenced through the Clinical Excellence Awards scheme which is actively promoted to female consultants (see gender pay gap)
Race		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably race.	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Religion or Belief			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to religion or belief in the recruitment of clinical staff that may benefit from this strategy	

Disability		✓		The risk is of a disproportional negative impact to some staff groups with protected characteristics notably disability	We believe that any disproportional impact can be justified as a proportionate means to a legitimate business aim
Sexual Orientation			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to sexual orientation in the recruitment of clinical staff that may benefit from this strategy	
Pregnancy / maternity			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to pregnancy/maternity in the recruitment of clinical staff that may benefit from this strategy	
Gender Reassignment			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating to gender reassignment in the recruitment of clinical staff that may benefit from this strategy	
Marriage & Civil Partnership			✓	Demographic monitoring has demonstrated no disproportionality or discrimination relating marriage & civil partnership in the recruitment of clinical staff that may benefit from this strategy	
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.) **N/A**

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: Mike Gibney & Andrew Lynch Date: 20/01/20

Signed: Mike Gibney & 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 الطّلب 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。

REPORT TO TRUST BOARD
30th January 2020

Title	**Digital Strategy**
Sponsoring Director	Name: Mr M Burns Title: Director of Finance and IT
Author (s)	Name: Mr J Griffiths Title: Head of IM&T
Previously considered by:	• Executive Team • Business Performance Committee • Quality Committee • Neurology Consultants discussion • Digital Workstream Groups

Executive Summary

Our digital strategy places our staff and patients at the centre of our vision. We recognise the adoption of technology will create a digitally enabled organisation that will have a positive impact on the overall experience of all staff and patients.

The Digital 2020 strategy set out the 3 year vision of the Trust and this addendum strategy sets out the key strategic themes and objectives to support the organisation and what is required to fulfil the Digital 2020 strategy.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	N/A
Related Assurance Framework entries	
Equality Impact Assessment completed	Yes – attached
Any associated legal implications / regulatory requirements?	• Delivery of this strategy will help underpin all current requirements. E.g. GDPR
Action required by the Board	The Board is requested to: • approve the strategy

The Walton Centre
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Excellence in Neuroscience

Digital Strategy Addendum to Digital 2020 Strategy

Our digital strategy places our staff and patients at the centre of our vision. We recognise the adoption of technology will create a digitally enabled organisation that will have a positive impact on the overall experience of all staff and patients.

The Digital 2020 strategy set out the 3 year vision of the Trust and this addendum strategy sets out the key strategic themes and objectives to support the latest organisation 5 year strategy and also what is required to fulfil the Digital 2020 strategy.

Trust's six strategic priorities

Deliver	• Deliver best practice care and treatments in our specialist field.
Provide	• Provide more services closer to patients' homes, driven by the needs of our communities, extending partnership working.
Invest	• Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff.
Lead	• Lead research, education and innovation, pioneering new treatments nationally and internationally.
Adopt	• Adopt advanced technology and treatments, enabling our teams to deliver excellent patient and family centred care.
Recognise	• Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing.

Deliver

Objective: *To provide the right systems, processes and paper-lite environment enabling our clinical workforce to be digitally enabled to help with the delivery of high quality care to patients' and reduce duplication and repetition of patient information allowing efficiencies and freeing time for clinical needs.*

Where we are now?	Where we want to be?	How to get there…	Costings where applicable…	When will this be delivered?
Well led and enthusiastic clinical systems team (winner of WCFT team of the year 2019) supporting over 30+ digital systems	Continue to expand knowledge and expertise within the team with leadership and depth of information for guidance	Maintain quality relationship between IT teams and strengthen leadership with 3rd party Suppliers for knowledge base	Within existing training, T&D and HR Wellness Programmes.	Continual Service Improvement; business as usual
Exceptional reputation of an undergraduate placement scheme within our software development team	Continue the peer-to-peer simulation programme as a way of mastering learning	Active engagement in Universities annual Career Fair in Computer Science		Continual Service Improvement; business as usual
Our inpatient wards are a mix of paper and digital patient records	Digitisation of paper forms across our wards (excluding Critical Care in phase 1) and sign off those that need to remain on paper	Continue to engage with our clinical teams across all specialities for maximum effort to go paper-lite	Within the capital staffing budget forecast for 20/21 £352,000	Q4 20/21 for full development and go live Sprints throughout year
Our outpatient areas are a mix of paper and digital patient records	Digitisation of paper forms across our outpatient sites (excluding Pain Management) and agree a	Continue to engage with multiple stakeholders including health records and Divisional		To be mapped out in-line with the Trusts Outpatient Transformational Programme

	sign off process for those that need to remain on paper	service leads for maximum effort to go paper-lite		being delivered from Q1 20/21
Established staff engagement with task groups for digital systems	Release system upgrades with depth of improvements aligned to the paper-lite and interoperability work-stream	Continue to engage with our clinical staff to provide focussed modular themes		Continual Service Improvement; business as usual via the delivery groups and clinical reviews
Reliance on green paper case-notes for admitted patient care	Implement digital transformation programme that brings focus to digital case-notes and minimal reliance to paper	Set trajectory on paper-lite program where temporary set of case-notes can be justifiably implemented		Physical case note reduction is ongoing and change to Electronic Document Management system first , casenote second will be pushed in Q3 20/21 with clinical approval
On site Exchange infrastructure providing email services in and out of the Trust	Migration of the Trusts email services to the new NHS Mail platform, along with utilising the latest Office 365 application suite by end of 2020.	Plan the migration of services utilising best practice to ensure continuity of service and adhere to essential cyber security standards	Capital plan is additional to current resources to migrate accounts (£48,000)	Q4 20/21 all accounts will be on NHS mail.
Utilisation of Microsoft Windows 7 & 10 Operating Systems across the Trusts IT estate	Replacement of all Windows 7 in order to have solely a Microsoft Windows 10 Operating System across the organisation	Continue the migration of Operating Systems on all clients including upgrade of hardware such as memory and solid state drives	Capital plan is additional resources to migrate accounts within above budget of £48,000	Q1 20/21 but additional work around legacy systems ie pathology/neurophysiology to allow Windows 10 environment is ongoing with 3rd parties

Provide

Objective: *To provide an inclusive digital environment delivering system accessibility to those working in the community and in the Trust as a reliable source of information at the point of patient care*

Where we are now?	Where we want to be?	How to get there…	Costings where applicable…	When will this be delivered?
Active engagement in Employer Advisory Panel at Edge Hill university as part of wider industry stakeholder partners	Expand knowledge and expertise between Senior and Deputy Software Developer for both succession planning and wider IT digital system support	Continue the peer-to-peer development with exposure to complex programming skills, in-depth wiki guidance and training courses		Continual Service Improvement; business as usual. ISO and MIAA audits as evidence of compliance
Involvement on the Equality, Diversity & Inclusion programme to aid data capture important to staff, patients, community	Develop our digital systems to support community led outcomes	Integrate process and outcomes set out in the Trust Equality, Diversity & Inclusion visions		Continual Service Improvement; business as usual
Access to eP2 digital records system is across both sites of the Trust	To provide clinical staff access to our internal systems whilst at satellite clinics both within Cheshire & Merseyside and cross boundaries	Engage with external organisations and respective IT leads to initiate firewall rules to be opened for remote desktop connection	Currently unknown as solution not agreed with external organisations	Satellite requirements have been gather in Q4 19/20 with a roll out plan to be completed by

				Q3 20/21
Partnership working with Emergency Services as part of the PED4PED project (patients with epilepsy through Emergency Departments)	Allow North West Ambulance Service paramedics to launch Walton clinical correspondences from mobile devices situated within the ambulances	Replicate our Share2Care instance on the NWAS domain with certifications and firewall rules	Currently centrally funded	Systems in-place and further expansions in partnership with Informatics Merseyside led by STP during 20/21
Maintaining a suite of external systems access from our eP2 system as part of the interoperability agenda	Expand this suite of 3rd party systems to include for example Share2Care, NWAS EPR	Engage with Suppliers and ensure due diligence achieved on safe release of connected systems	Each external system has a combined circa £10,000 integration cost for both our Integration Engine and the suppliers cost. Currently all know systems are budgeted for	Continual monitoring via interoperability needs and requirements
Our extensive patient alert markers have interactions in a number of key areas; notably the orange alert card, our Patient Administration System and e-prescribing	Build on the philosophy that all objects are recursively reusable as part of a universal metalanguage approach	Develop a data entry point in the eP2 system for clinical users to enter and view risk markers, as the primary source, allowing administrative systems to be automatically populated		Ongoing Risk and Alert meetings have been start Q3 19/20 with a proposed agreed single risk/alert system to be integrated into the Master Patient Record in Q3 20/21

Invest

Objective: *To provide a suite of innovative products for our workforce and as a commercial solution for delivery of quality outcomes*

Where we are now?	Where we want to be?	How to get there…	Costings where applicable…	When will this be delivered?
Well established university placement programme in collaboration with Edge Hill University to bring Computer Science students into our software development team	Continue to work in partnership with our Universities to increase our software developer skill-mix and bring post graduate talent into the Trust	Advertise posts onto university portals through their careers support services		Continual Service Improvement; involved in career fairs and events with Edge Hill. Liaising with new Head of Commercial engagement and Marketing for synergy with external universities
Case-note scanning is completed off-site through a 3rd party company though with a significant cost model	Have all new patients mapped to a digital journey removing the need to create a set of paper case-notes reducing the need to prepare, transfer and store sets of physical	Bring a technological innovation process of scanning directly into eP2 system, ensure the majority of letters being sent to GP's electronically – with significant cost savings and	Capital cost for scanning equipment and software to allow optical barcode recognition is £15,000;	Scanning solution to be introduced within Trusts Outpatient Transformational Programme being

	case-notes	quicker information to GP's' Internal correspondence and referrals – significant benefits in reduction of printing, case note retrieval, filing, speed of responses' and so on	this would be cost beneficial against off site scanning in the future; although initially would require both to cover casenote backlog.	delivered from Q1 20-21
Implementation of in-house clinical systems ie Self checkin at a regional Trust has proven our product is a working commercial solution	Promote to a wider audience whilst adopting new features both in terms of customer and market needs	Dedicated commercial team focusing on selling, promoting, enhancing and finding routes to market as well as embracing Open Source / NHS sharing,		Meetings with the Trusts new Head of Commercial engagement and Marketing currently taking place Q4 19/20 discussing options
Implementation of information asset registry at a number of regional Trusts has proven our product is a working commercial solution	Promote to a wider audience whilst adopting new features both in terms of customer and market needs with opportunity to showcase the new Freedom of Information and Subject Access Request registries	Dedicated innovation post and support focusing on income generation, promoting, enhancing and finding routes to market and the wider NHS audience		Meetings with the Trusts new Head of Commercial engagement and Marketing currently taking place Q4 19/20 to discussing options
Developed a suite of software within eP2 to improve efficiencies and help reduce duplication and create rich data to help	Expand eP2 and integrate into the new Business Intelligence warehouse to improve rich data which will help increase efficiencies throughout the organisation	Implement new BI server and EPR server to feed rich datasets to allow a complete digital view of the organisation		The Business Intelligence server was commissioned in Q2 19/20 and the EPR server is due to be commissioned in Q4 19/20 . This project will then be led by the informatics strategy

Lead

Objective: *To incorporate digital innovation and the application of new technology in systems and processes through agile framework and connecting communities for scalability, speed and growth*

Where we are now?	Where we want to be?	How to get there…	Indicative costings where applicable…	When will this be delivered?
Evolution of a digital platform as we expand to new disciplines and services	Adopt innovation in smarter digitisation of our paper records as a common approach	Use design principals to harness digital technology within the eP2 platform		Continual Service Improvement; business as usual
Have an active role engaging with local and regional Trusts, partners, academia, and research as collaborative partnerships	Bring assistive technology through citizenship engagement for localised management of care and wellbeing	Involvement with NHS X digital advancement as key driver to the future digital landscape		Continual Service Improvement; business as usual
Core building blocks for an integrated electronic patient record system	Enable digital pathways to be standardised across our services	Customise clinical pathways enabling quality, patient safety, and efficiency		Continual Service Improvement; business as usual though workstream groups and Clinical Safety Group
Maintain access to primary care data through EMIS Web and Cheshire	Integrate EMIS and Cheshire both systems within the Share2Care	Collaborate with Informatics Merseyside on governance agenda		Continual Service Improvement; business

Care records as the first Trust in the Cheshire & Merseyside region to launch both systems in patient context	platform offering our staff a single point of access to regional primary and secondary care data	and the regional consent model to ensure there is alignment to national standards of opt-out		as usual through Regions Clinical Design Group chaired by WCFT Chief Clinical Information Office.
Electronic prescribing medication data is maintained within the EPMA module and accessible solely through Aintree JAC system	Enable patient medication data to be accessible within eP2 as a replication of e-prescribing data	As part of the interoperability agenda, connect to the EPMA mirrored database to pull through accurate patient medication data and present in patient context	Capital cost of £5,000 to finalise system interoperability	Within existing programme plan for Q1 20/21

Adopt

Objective: To bring a digital innovation to clinicians through our EPR and to ensure that all of our workforce are underpinned by reliable and innovative digital service

Where we are now?	Where we want to be?	How to get there…	Indicative costings where applicable…	When will this be delivered?
Medical staff and Advance Nurse Practitioners using paper case-notes to record information at the point of admission and for regular daily noting	Incorporate a module within the eP2 digital system allowing medical staff to have the tools necessary to capture key information electronically	Develop a medics module thorough a task and finish group consisting of digital functions for use at patient admission and daily ward checks	Within current development/PMO resource against current roadmap	Pilot Neurology Q3 19/20 in Chavasse Ward, pilot Neurosurgery Q4 in Dott Ward. Due to go live Q1-2 20/21
Staff recording clinical notes for admitted patient care are completed either in digital or paper format	To have all clinical noting completed in the eP2 digital system only by bringing Medics, Nurse Practitioners, Dietitians and Pharmacy with existing users	Expand on the current clinical noting function in eP2 to assist with various type of ward round noting	Within current development/PMO resource against current roadmap	Pilot Neurology Q3 19/20 in Chavasse Ward, pilot Neurosurgery Q4 in Dott Ward. Due to go live Q1-2 20/21
Advance Nurse Practitioners interaction with patients post-	Innovate a process to allow digital capture of this activity from request	Utilise the current planned nurse advice telephone consultation model	Within current development/PMO	Within 20/21 programme requires

discharge can be exhaustive and not always captured due to the nature of current processes	to contact a patient through to actual interaction		resource against current roadmap	workstream decision points to be agreed
Staff running outpatient clinics record clinical noting in digital or paper format	To have all clinical noting completed digitally during outpatient consultation with minimal use of continuation sheets as part of the paper-lite work-stream	Promote the digital noting function within the eP2 system and scan copies for those completed on paper		To be mapped out in-line with the Trusts Outpatient Transformational Programme being delivered from Q1 20/21
Health Care Assistants are not Users of the digital record system as their documentation predominantly resides at bed side	Bring a digital function for this staff group whilst having the assurance data is recorded in a timely manner and is accessible to those who need to view at bedside/ward rounds	Have dedicated hardware in place to accommodate the much regular use of data collections and through a task and finish group bring an innovative model of care. Increase the hardware provision on wards to meet clinical needs	Capital £15,000 for outpatient and wards. ITU to be cover 21/22 when programme extends to ITU and finishes EPR within other areas.	Phase 1 of the expansion of hardware completed Q3-Q4 19/20. Phase 2 in-line with medics module Q1-2 20/21
Theatre documentation are paper based records whist theatre journey data collections is digitally captured	Expand the eP2 system to incorporate theatre documentation whilst maintaining TIMS system solely for patient journey data	Digitise theatre forms within the eP2 system aligning them with all other digital patient case-notes	Within current development/PMO resource against current roadmap	Q4 20/21 to Q2 21/22 to integrate TIMS fully into eP2
Process and management of patient operation notes are within the MD Analyse database	Expand the eP2 system to harness operation note reporting	Develop an integrated Operation Note function in eP2 Consultant View, pilot with Neurosurgery and release as a system upgrade		Piloted Q3 2019 and went live Q4 19/20.
Patient Consent is captured through a paper based copy provided to the patient prior to surgery	To have consent signed digitally on day of surgery and be part of the same day admission process	Develop innovative way of allowing a patient to sign on a digital canvass within the eP2 system whilst maintaining legal requirements and	Within current development/PMO resource against	Q4 20/21

		Clinical Safety standards	current roadmap	
Support our Neuroscience laboratory who are accredited to ISO15189 in their maintenance contract due to expire in September 2021	Upgrade the server architecture and desktop operating systems in line with future state plans highlighted in the latest LIMS business case	Representation at regional pathology network meetings as part of the digital transformation strategy	Capital allocated 19/20 £288,000. This is a cost avoidance against the original capital forecast for 20/21 due to staying with existing supplier and upgrading software, and investigation Pathology OCS as part of regional unification.	Server and software upgrade Q4 19/20 to Q1 20/21. Senior Biomedical Scientist & IT Systems Lead attends regional meetings and Digital monthly meetings
Support our Neurophysiology service with mix of paper/digital processes in line with their maintenance contract due to expire end 2020	Risk-free digital system with a need to mix integration, additional software and process change	Implementation of an end to end order communications system a replacement reporting system	Capital still being calcualted at approx £40,000 . This is a cost avoidance over the original capital forecast for 20/21 due to staying with existing supplier and upgrading software/hardware,	Server and software upgrade Q4 19/20 to Q1 20/21.. Order comms implemntation Q3-4 20/21 based on current resources
Appropriate Information Technology deployed on wards to enable clinical staff to provide efficient care	Additional mix of computer, laptop and hand held devices to be installed to accommodate the expansion of EPR modules	Asses hardware requirements by liaising with end users and stakeholders and purchase accordingly	Capital £15,000 for outpatient and wards. ITU to be cover 21/22 when programme extends to ITU and finishes EPR within other areas.	Phase 1 of the expansion of hardware completed Q3-Q4 19/20. Phase 2 inline with medics module Q1-2 20/21

Mobile devices utilised to allow agile working in the workplace	Further expand mobile working in the workplace and off campus through modern VPN technologies and additional equipment such as laptops to be used in the office, in meetings and at home	Invest in back-end networking infrastructure to increase capacity of Internet circuits aligned to demand on remote teleworking and upgrade hardware where applicable	£25,000 Capital planned for expansion of current VPN systems	Internet circuits increased and tested resilience Q4 19/20. Expansion of VPN service throughout the year
In-house EPR solution located and delivered on shared datacentre infrastructure	Migrate the EPR solution into a dedicated EPR infrastructure in line with system maturity to ensure a robust, resilient and performance metric platform is set up	Implement the latest Windows Server Operating Systems utilising solid state drives, virtual optimisation to provide reliability and essential cyber security updates	Procured Q2-Q3 19/20	Q4 19/20 to be fully commissioned. Governance and project plans audited by MIAA to ensure good practice
Variation in printers used across the Trust from LaserJet to multifunctional(MFD) devices	Rationalise the printing fleet to reduce Trusts carbon footprint and improve the data security associated with this	Asses printing requirements of departments to consolidate and improve the printer estate where possible	Within several budget lines as underpins several projects and workstreams. All budgets are covered for planned work via Digital and Transformation team	Continual Service Improvement; This will be in conjunction with Transformation team as we are introducing off site printing for patient letters, electronic GP letters in partnership with the community. Electronic documentation direct to share2care. Removal of faxes and introduction of electronic case notes

Recognise

Objective: To bring recognised technological infrastructure solutions for our staff as effective and efficient ways of delivering secure data management

Where we are now?	Where we want to be?	How to get there…	Indicative costings where applicable…	When will this be delivered?
Well established and highly recognised Information Security Management documentation library	Maintain our full ISO27001 certification and compliance in annual accreditations ensuring our patient and staff data is secure	Continue to embed standards with interested parties across the Trust through actively monitored controls		Continual Service Improvement; business as usual
A managed and well supported Clinical Design Authority group on behalf of regional Share2Care program	Continue providing leadership and expertise in developing the platform through clinical needs	Continue to monitor and evaluate resource as the regional platform matures and ensure a commitment to adhering to Clinical Safety standards		Continual Service Improvement; business as usual
Maintain partnership working with the regional Share2Care platform for system connectivity and data maturity	Be responsive through wider publication of patient data as a move towards our staff accessing external correspondences from local Trusts and visa-versa	As part of the interoperability agenda, connect the Share2Care platform within the eP2 system to automatically launch in patient context		Continual Service Improvement; business as usual

Maintain partnership working with Informatics Merseyside on e-correspondences sent to GP practices through the MESH solution	Include inpatient discharge summaries as part of the outpatient correspondences sent to GP practices	Collaborative working with external organisations to adopt a feasible solution and ensure partnership to develop a patient portal with the community		Engaged with Transformation team around solutions and will support and guide throughout this process
On-site datacentres provisioning storage and server resources to end users and critical systems	Continuing to update and increase the capacity to maintain the ever increasing demand of on site and cloud storage	Invest in additional hardware and updated virtualisation software and Operating System Licenses, in line with the NHSX "Internet First" policy		Continual Service Improvement; mapping of existing services with datacentre is ongoing 19/20 Q4 and phased investment to ensure all near future end of life equipment/software is replaced within next 24 months, based on risk assessments. All long term end of life equipment/software will be revisited and put on future plans and cpital plans.
Utilising Video Conferencing tools to facilitate the remote collaboration between sites & services within and outside of NHS England	Incorporate the latest video technologies and tools into corporate office areas to expand this functionality to all staff	Plan installation of applications to required areas including additional audio and visual technologies to accompany the new product		Engaged with Transformation team around solutions and will be piloting in Q4 19/20
Both digital and legacy analogue systems are utilised across the Trusts buildings to facilitate voice communication services	Full digital infrastructure and introduction of unified communication, remote teleworker applications and voice conferencing with collaboration screen sharing functionality	Plan migration of remaining services and introduce additional functionality provided by the system		Work has been completed during 19/20, piloting full unified communications during Q4 19/20 with roll out through organisation Q1-2 20/21. Mitel call centre to be installed within Patient Access Centre Q4 19/20

Risks to Delivering this Strategy

Delivery of the Digital strategy is dependent on the appropriate planning needs and key risks associated in its delivery are as follows:

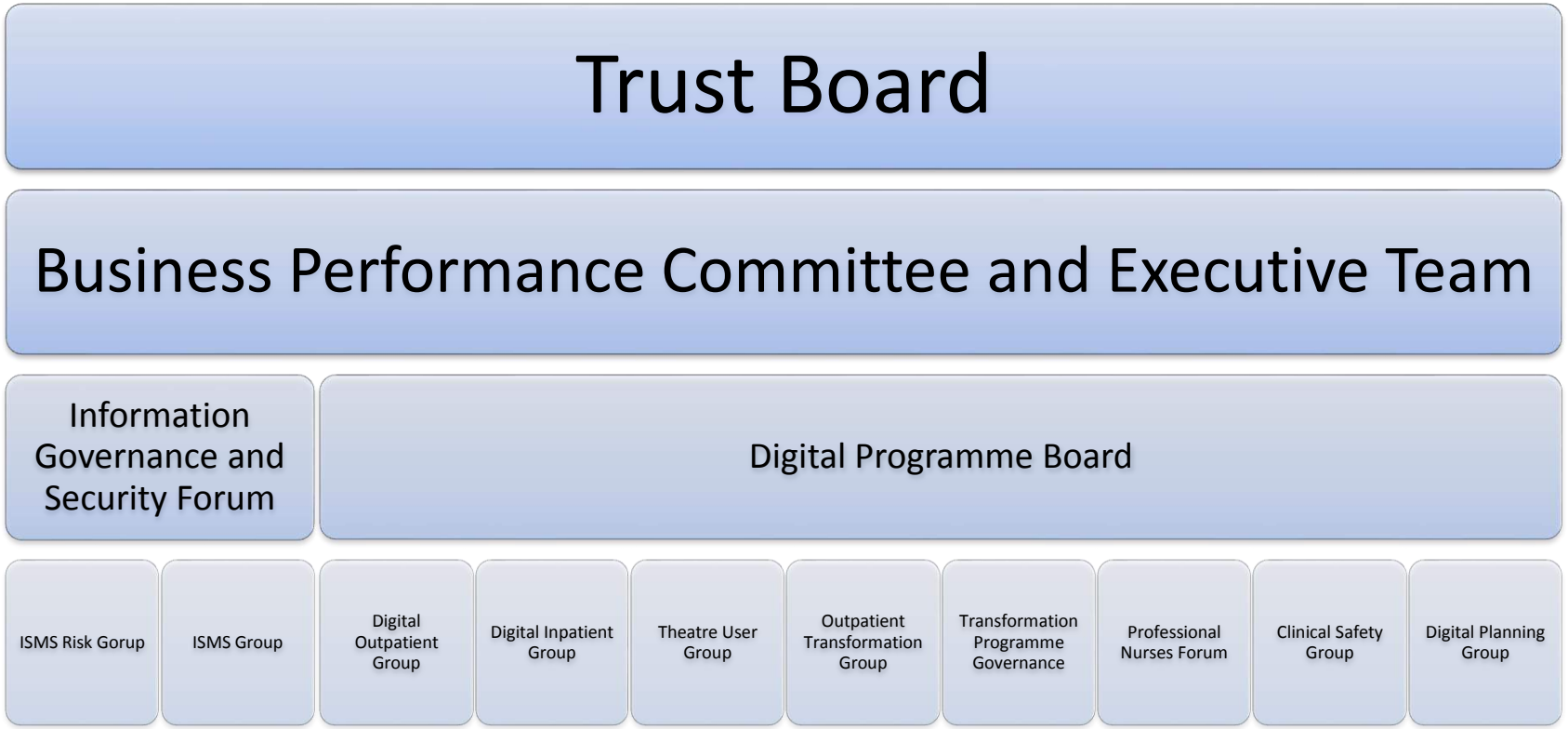
- **Investment to drive forward the commercial opportunities**
- **NHS Digital Windows 10 migration deadlines (currently extended to 20/21)**
- **Pressures in resource for regional collaborative working**
- **Experienced Digital limited resources competing with private sector**
- **Skill shortages of specialist roles within the NHS; Software Development, Information Governance, Digital Leaders**
- **Dependencies with 3rd party Suppliers on interoperability and systems integration**
- **Financial pressures within the Organisation for resources and hardware/software innovation and upgrades**
- **Capacity / Resource associated with system upgrades and product lifecycle testing**
- **Changes and transition of the NHS X strategy and vision**

The above risks have/ will be continually reviewed and where possible mitigations plans in place for delivery of this strategy.

A group meets monthly to review all Digital risks and mitigation plans to support and supply evidence to the organisations ISO27001 certification, all transient risks that relate to digital are logged onto the ISO risk register and it is the duty of the group manage those risks and escalated to corporate risk register (Datix /BAF) if mitigation isn't deemed sufficient . This risk register is then are reviewed at the bi-monthly Corporate Governance and Risk Meeting.

Programme Management / Governance

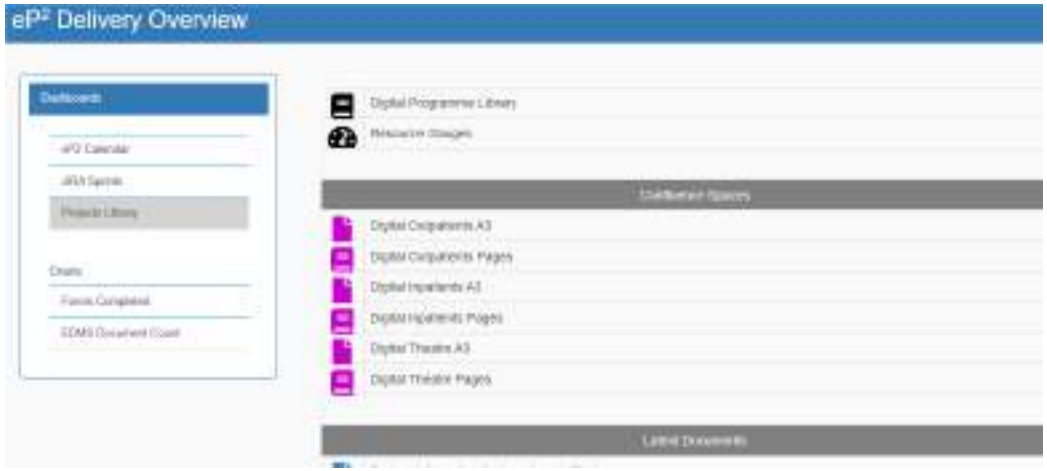
Forum	Purpose
Trust Board	To support and oversee the Digital Strategy implementation plans; providing overarching investment decisions which balance improvements in core business platforms with ongoing innovation.
Business Performance Committee	To provide Governance that the Digital programme is being delivered within constraints of Budget, time and resources and request any additional evidence it sees fit to ensure that the programme is delivering its strategy, Any strategy updates will go to this forum and in the case of larger strategy update move onto Trust Board
Executive Management Team	To provide ongoing senior management support and oversight to the Digital strategy and implementation plans ensuring alignment of digital strategy with the Trusts overall strategy. To act as a point of escalation for emerging issues, risks as well as agree and support any mitigation actions; both from any programme or Cyber security. The Director of Finance and IT (SIRO) will keep the Executive team fully up to date with all Digital issues.
Digital Programme Board	To act with delegated authority to manage the Digital Strategy plan on behalf of Trust. To oversee the implementation of the digital services required to achieve strategic ambitions. To accept accountability for: 1. Ongoing development and delivery of the Digital strategy 2. Act as point of escalation for any operational or programme risks and issues; to Executive Team or Trust Board 3. Make decisions based on resources and timescale in relation to change of deliverables from Digital Workstreams
Digital Workstream Groups	To shape the design of digital delivery within each workstream to move the Trust to an Electronic Patient Record safely and in a timely manner to reduce the duplication of paper and electronic. To highlight or provide any concerns and requests to the Clinical Safety Group.
Digital Operations	To lead on operational delivery of digital services across the Trust including; proactive management of risk and renewal roadmap, capacity and planning, digital system capability and functionality, skills development and training, forward planning of work and modelling impact to business continuity, management of security (cyber and information) and information governance, disaster recovery planning and critical systems maintenance; as well as software delivery and maintenance all in-line with the ISO27001 standard

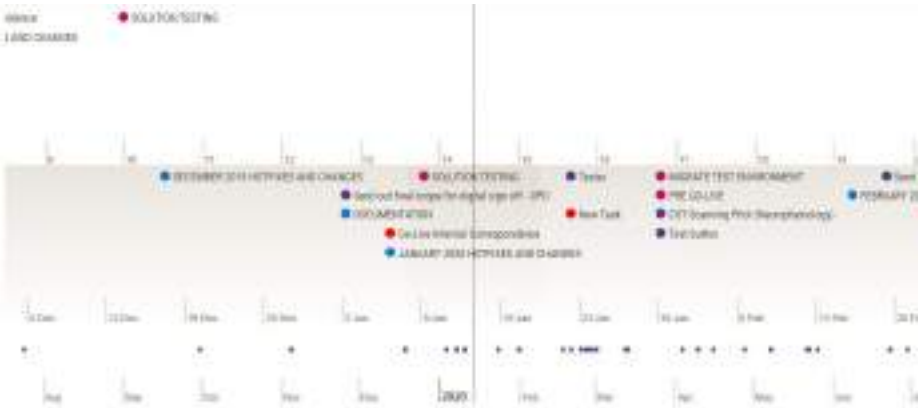

Trust Board
Business Performance Committee and Executive Team
Information Governance and Security Forum
Digital Programme Board
ISMS Risk Gorup
ISMS Group
Digital Outpatient Group
Digital Inpatient Group
Theatre User Group
Outpatient Transformation Group
Transformation Programme Governance
Professional Nurses Forum
Clinical Safety Group
Digital Planning Group

- ## Programme and Project Library

The organisation uses JIRA for agile development and working, and confluence for all documentation and planning.

To enable an overview for all managers in the organisation a web portal displays a live dashboard the status of all work and all libraries used within this programme, http://dashboards/epx/ This allows any user to drill down into each components of work if required in a completely granular view. This also includes full Gantt, PERT and milestone charts for all projects within the Programme





• Change Control

The programmes change control process has passed ISO 27001 certification and completely follows the recognised ITIL process (Information Technology Infrastructure Library, is a set of detailed practices for IT service management that focuses on aligning IT services with the needs of business) of "*to ensure that no unnecessary changes are made, that all changes are documented, that services are not unnecessarily disrupted and that resources are used efficiently."*

All changes are logged and approved through the Trusts Change Control System (http://forms/it/change/) and is agreed by the group. Changes are discussed within Weekly Team 60 meetings and reported to ISMS Monthly Group (the group that maintains the ISO27001 standards on behalf of the organisation) as well as escalation to Information Governance and Security Forum as required

• Clinical Safety Group

The Digital Systems Clinical Safety Group is constituted as a sub group of the Clinical Effectiveness and Services Group, under authority of the Quality Committee. The group oversees and provides assurance on the clinical risks associated with current and proposed clinical IT systems, in order to maximise the benefits to safe & effective patient care. The group addresses, with those who are responsible for the manufacture of clinical systems, any potential clinical risks and do so through the application of a risk management approach using documentation guidance as illustrated in standards :

- DCB 0129 Clinical Risk Management: its application in the manufacture of Health IT systems
- DCB 0160 Clinical Risk Management: its application in the deployment and use of Health IT systems

• ISO 27001:2013

The trust is certified in ISO27001 until 18th Feb 2023 and will be externally audited every year for inspection until full recertification is due. The last recertification was Q2 2019 and the trust received full certification with no Majors, no Minors and No Observations against the standard and was commended for the systems and controls in place to deliver a secure and effective use of IT via the plan–do–check–act process.

ISO 27001 requires that management:

- Systematically examine the organization's information security risks, taking account of the threats, vulnerabilities, and impacts;
- Design and implement a coherent and comprehensive suite of information security controls and/or other forms of risk treatment (such as risk avoidance or risk transfer) to address those risks that are deemed unacceptable; and
- Adopt an overarching management process to ensure that the information security controls continue to meet the organization's information security needs on an ongoing basis.

Scope of registration – The information Security Management of the development, management, delivery and support of the IT infrastructure within the Walton Centre

Appendix 3 - 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.

Par

1. Person(s) Responsible for Assessment: **Justin Griffiths** 2. Contact Number: **0151 556 3000**

3. Department(s): **IM&T** 4. Date of Assessment: **23/01/20**

5. Name of the policy/procedure being assessed: **Digital Strategy (Addendum to Digital 2020 Strategy)**

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? **Through review committees, BPC and Quality; Also through the 6 Digital workstream groups**

9. What is the main purpose of the policy? **The strategy sets out the delivery of an Electronic Patient Record within the organisation and the implementations within the IT Technical area e.g. Servers, software upgrades, Mail migration**

10. What are the benefits of the policy and how will these be measured? **Improving patient care, by delivering the right information to the right person at the right time and improving digital tools for user to complete their day to day jobs**

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? **Yes, it underpins several Trust initiatives including Transformation/Service Improvement**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **None,**

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 age within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Sex			✓	Defines sex within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Race			✓	Defines race within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics. It also specially discusses the WRES.	
Religion or Belief			✓	Defines religion or belief within the context of Equality Act and discusses promotion of equality relating to all protected characteristics.	
Disability			✓	Defines disability within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics. The policy also specifically refers to adjustments being made for recruitment or training purposes.	
Sexual Orientation			✓	Defines sexual orientation within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Pregnancy / maternity			✓	Defines pregnancy and maternity within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Gender Reassignment			✓	Defines trans/gender reassignment within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Marriage & Civil Partnership			✓	Defines marriage and civil partnership within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Other			✓	Makes reference to the inclusion of other, non-defined 'protected characteristics' such as carers and other vulnerable groups within the process of equality analysis/equality impact assessments (EIA's).	

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 systems all comply with all the protected characteristics within the context of the Equality Act**

13. Does the policy 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: Date:

Signed:

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。

REPORT TO TRUST BOARD

Date 30TH JANUARY 2020

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Director of Strategy and Operations
Author (s)	Name: Mark Foy - Head of Business Intelligence
Previously considered by:	Quality Committee – January 2020 Business Performance Committee January 2020

Executive Summary

This report gives assurance on all Integrated Performance Report measures aligned to the Trust Board. 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.

This is the first time that SPC charts have been used in this performance report. As well as providing an overview of which measures are above or below target in month, assurance will be given for those measures that are in or out of control or not within normal variation in order to provide early warnings of any issues or to highlight significant improvements in metrics so learning can be shared.

Related Trust Ambitions	• Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Related Assurance Framework entries	ID0024 Performance
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____

	• No – (please specify) _____
Action required by the Board	The Board is requested to: • consider and note

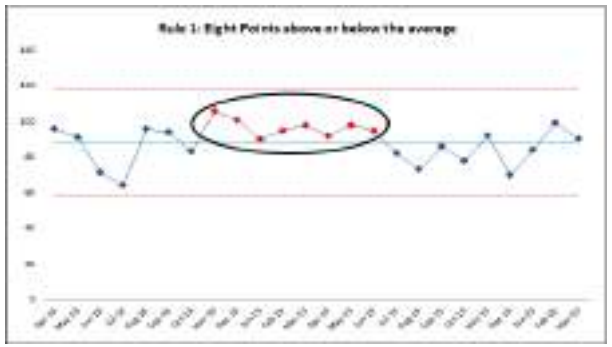
NHS
The Walton Centre
NHS Foundation Trust

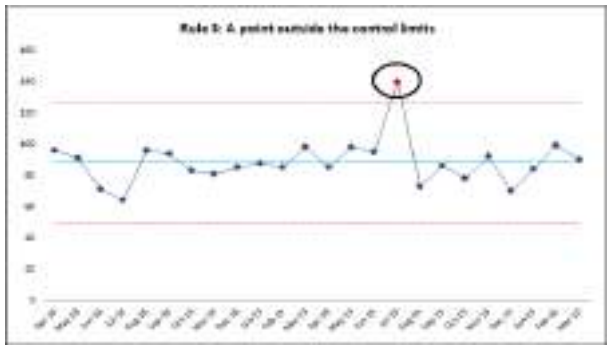
Board KPI Report
January 2020

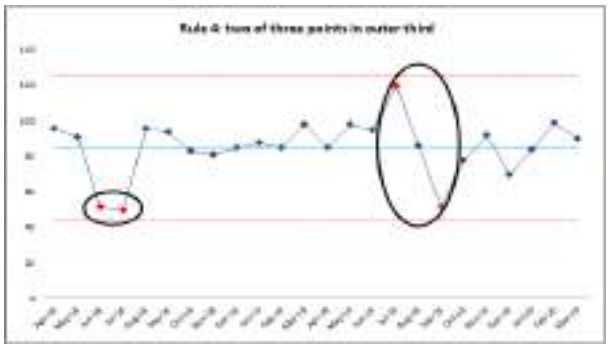
Data for December 2019 unless indicated

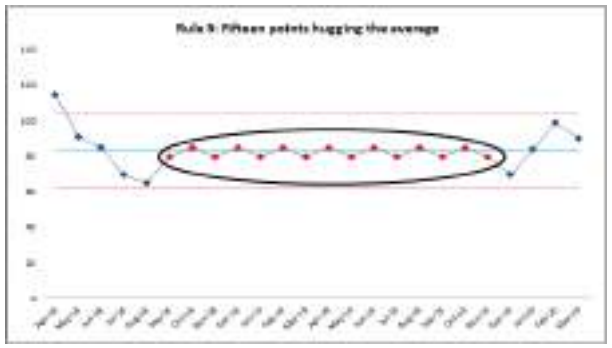
SPC Charts Rules

The Walton Centre NHS Foundation Trust









All SPC charts will follow the below Key unless indicated

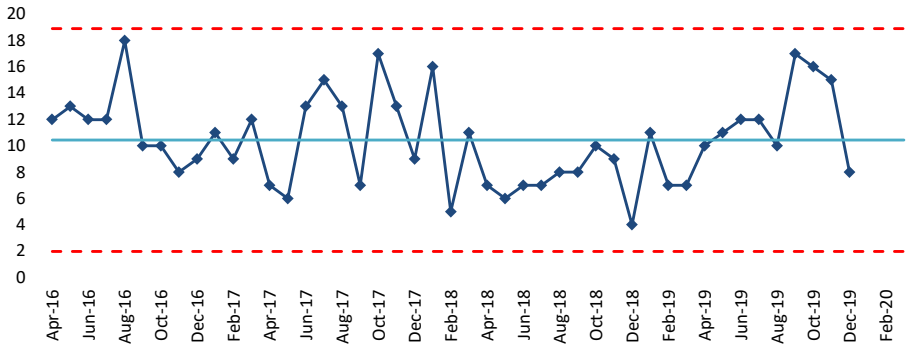
Actual — UCL — Average — LCL — National Average — Target

Quality of Care

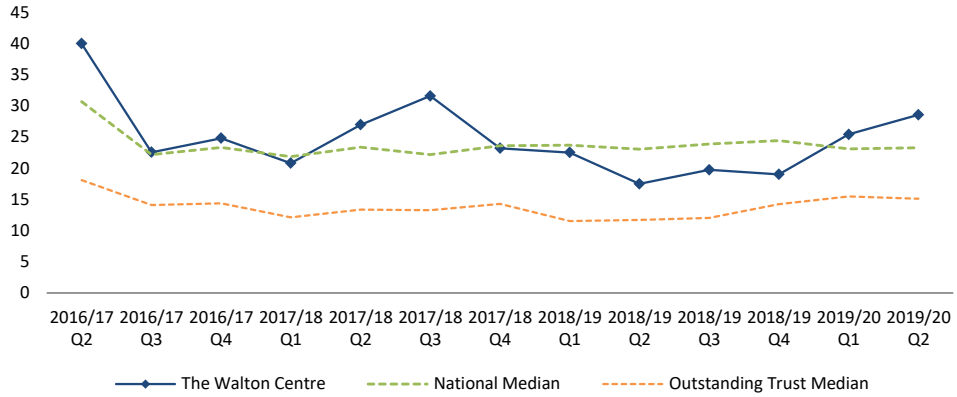
Caring - Complaints

The Walton Centre NHS Foundation Trust

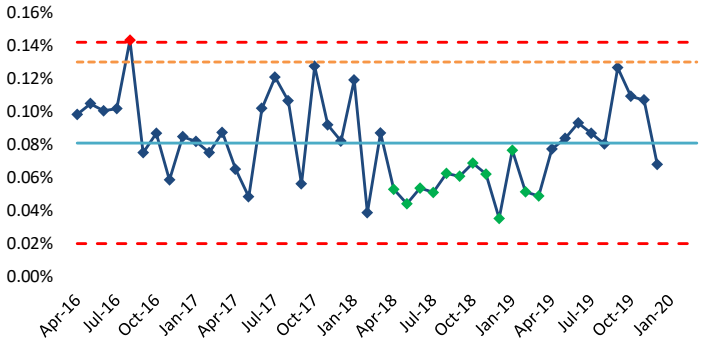
Total Complaints Received in month



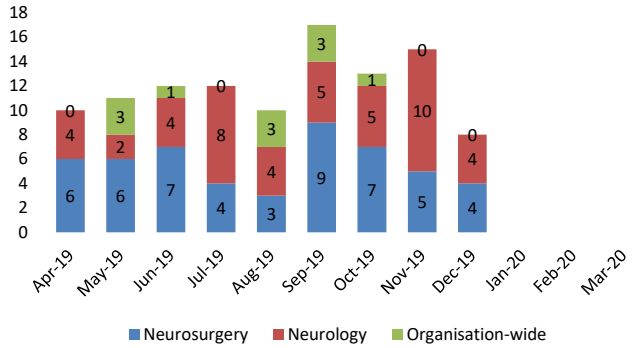
Quarterly Complaints per 100 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In December 2019 the Trust received 8 complaints.

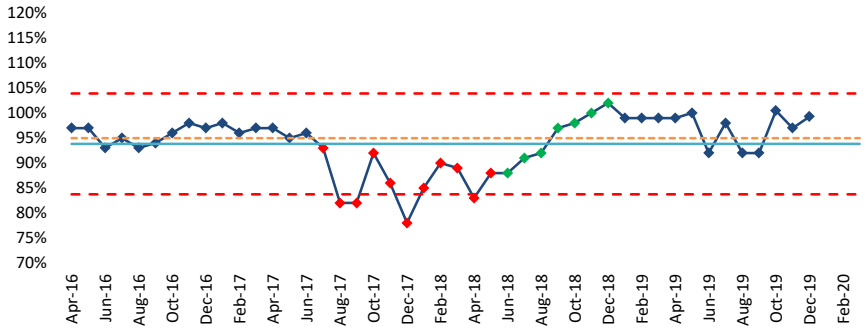
The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received per 100 WTE is above the national average. Further analysis is to be undertaken to understand the themes of complaints and a comparable peer group to be agreed for benchmarking.

Quality of Care

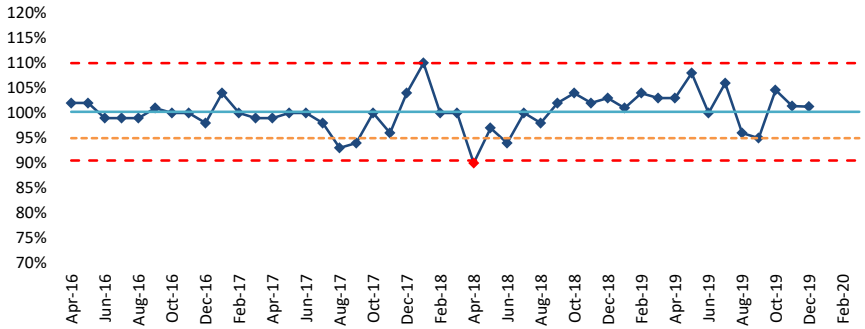
Well Led - Safe Staffing Fill Rate

The Walton Centre NHS Foundation Trust

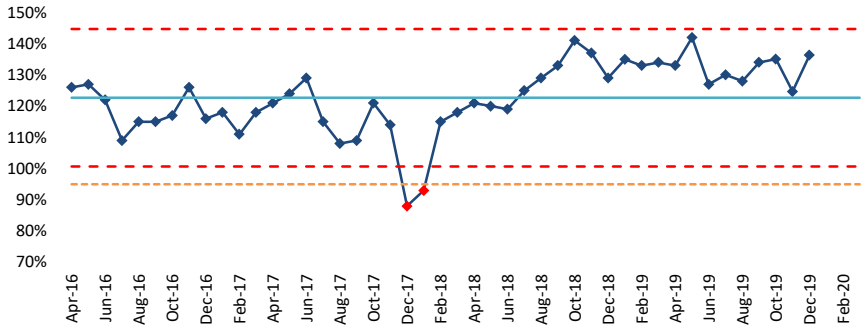
Registered Nurse - Day



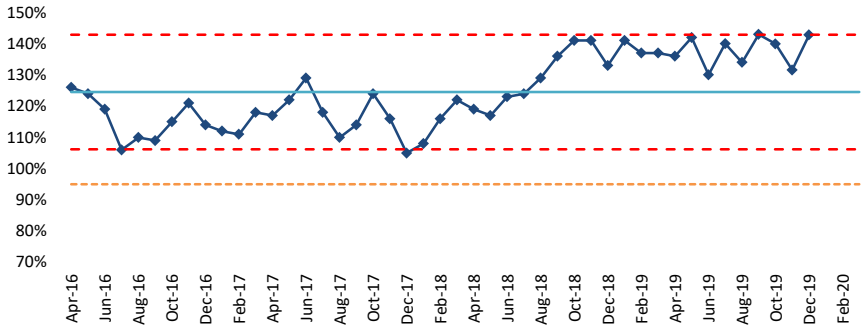
Registered Nurse - Night



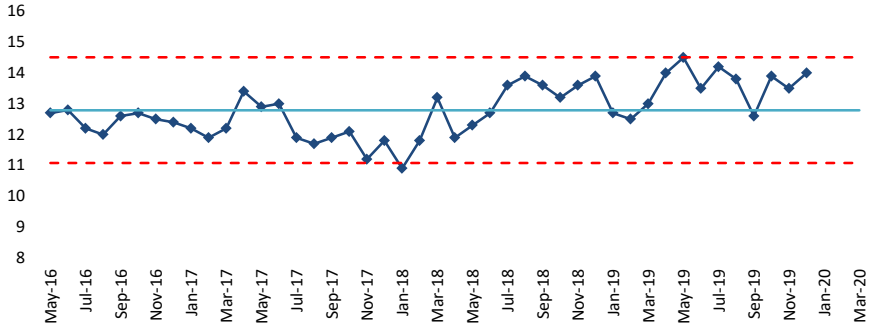
Care Staff - Day



Care Staff - Night



Care Hours Per Patient Day



Narrative

The safe staffing levels have been met across both staff groups and shifts in December 2019. The rate of care staff has been significantly above the average with the target below the lower control limit. Nursing staff rate is within normal variation, however the target is inside the control limits which could result in the target not being consistently met.

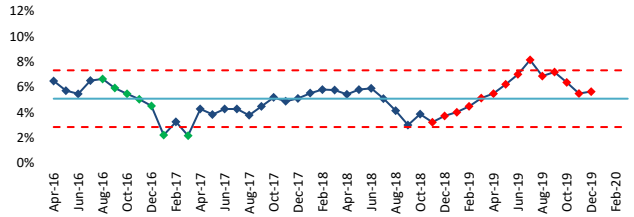
Due to the complexity of our patients and the increase in trauma patients we have seen an increase for both RN and HCA staffing levels, particularly on CRU both nights and days, this establishment is currently under review.

Quality of Care

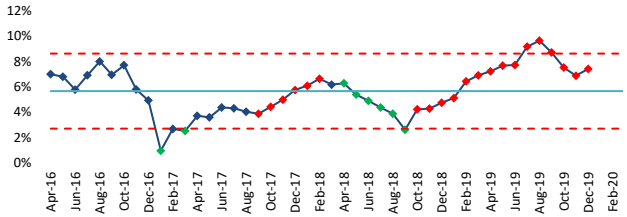
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

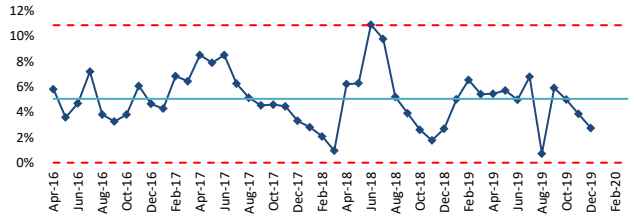
Overall Vacancy Level %



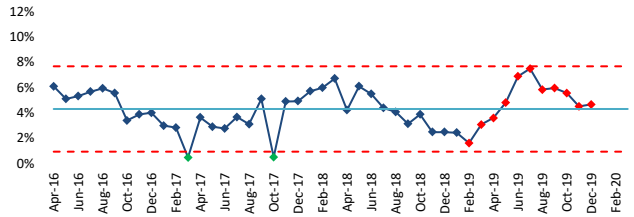
Nursing Vacancy Level %



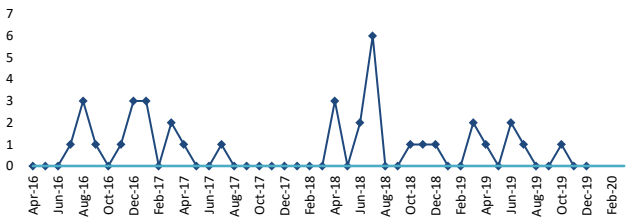
Medical Vacancy Level %



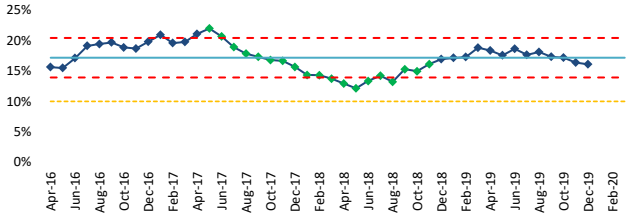
Other Staff Vacancy Level %



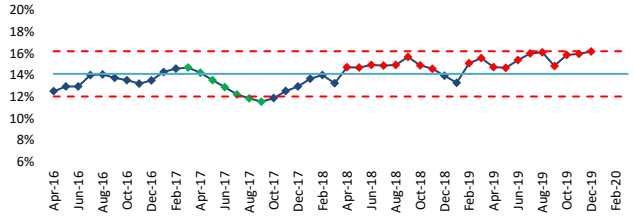
Medical Leavers



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Narrative

Vacancy Levels

Overall vacancy levels are experiencing special cause variation and have increased significantly. This is also the case when broken down to staff group for nursing and other staff. Medical vacancies are within normal variation.

Nursing Turnover

Nursing turnover is within expected limits however the target is below the lower control limit meaning this target is unlikely to be met without a change of process. At division level, the target is also outside of the control limit for neurology and neurosurgery.

Sickness/Absence

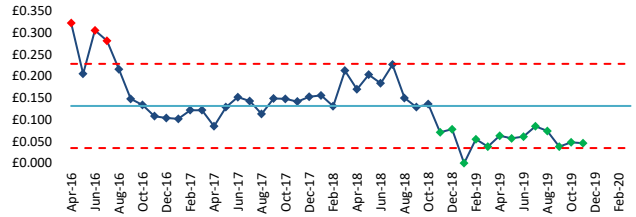
There has been a significant increase in sickness/absence levels over the past 12 months. With a series of data points close to the upper control limit. At division level, Neurology is within normal variation; however Corporate Services and Neurosurgery have both performed outside of expected levels. Corporate Services have been outside

Quality of Care

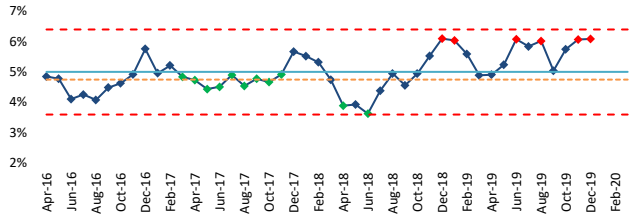
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

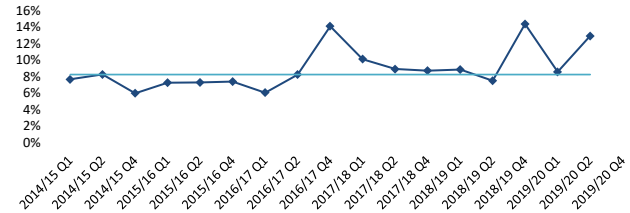
Agency Spend (£m)



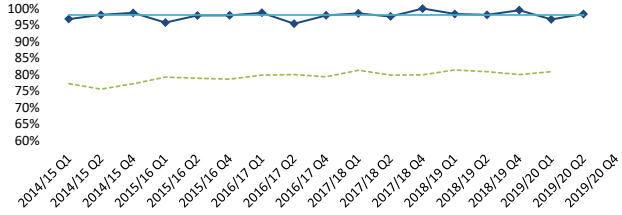
Sickness/Absence (Monthly)



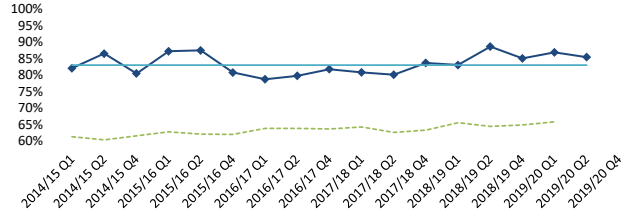
Staff FFT - % of Organisation Staff Responded



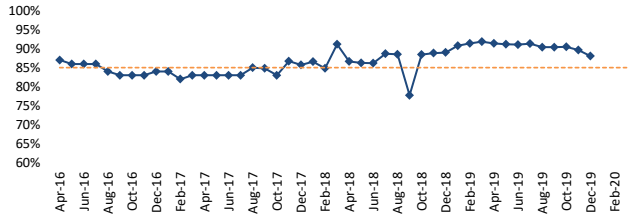
Staff FFT - % Recommend as Place of Care



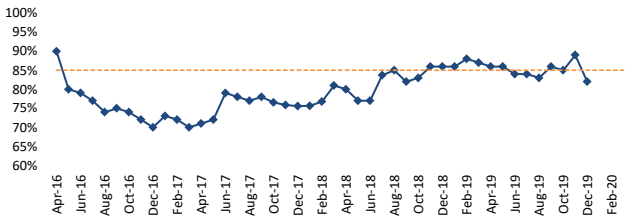
Staff FFT - % Recommend as Place of Work



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)

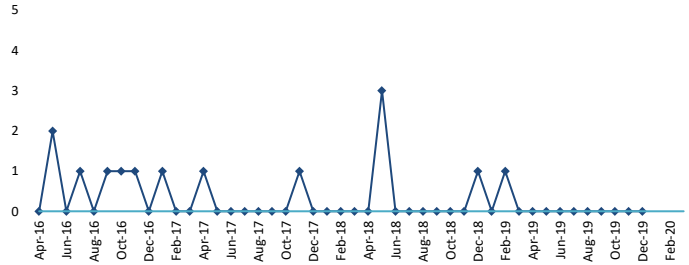


Quality of Care

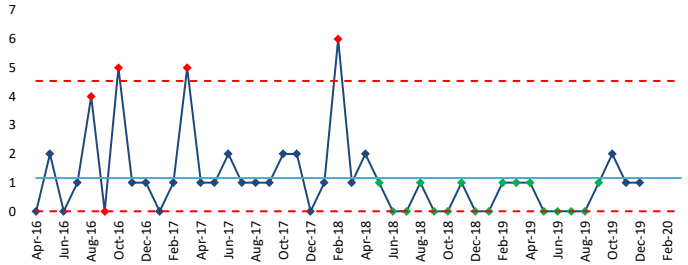
Safe - Harm Free Care

The Walton Centre NHS Foundation Trust

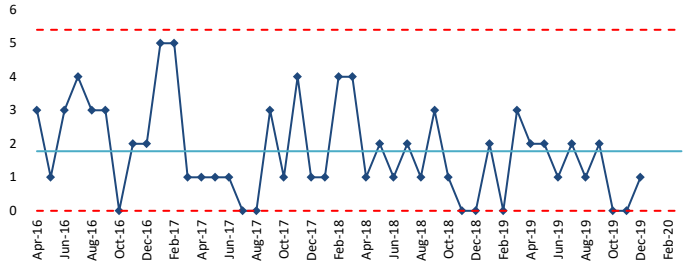
Total Moderate or Above Harm Patient Falls



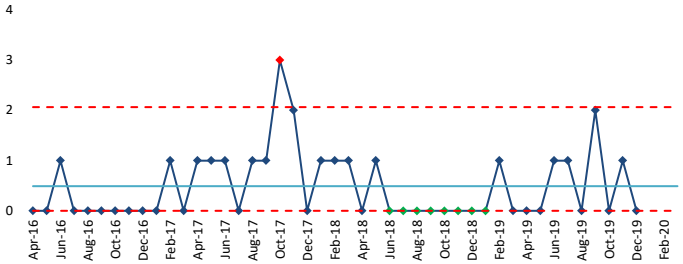
Total Hospital Acquired Pressure Ulcers (Category 2, 3 & 4)



CAUTI Incidences



VTE Incidences



Narrative

There were zero falls which resulted in moderate or above harm in December 19. The last reported incidence was February 2019.

There was one Category 2 Pressure Ulcer in December 19. Performance has significantly improved has been generally below average for 18 months.

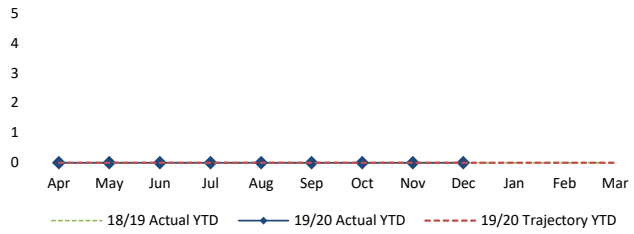
The was one CAUTI recorded in December 2019, this is within normal variation, and there were zero VTE incidences in month.

Quality of Care

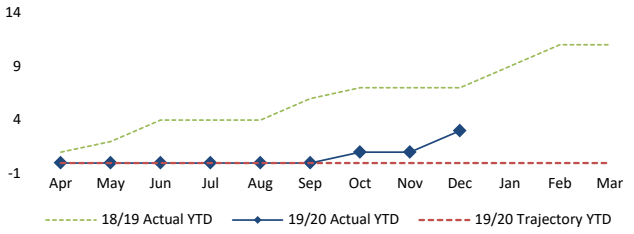
Safe - Infection Control

The Walton Centre NHS Foundation Trust

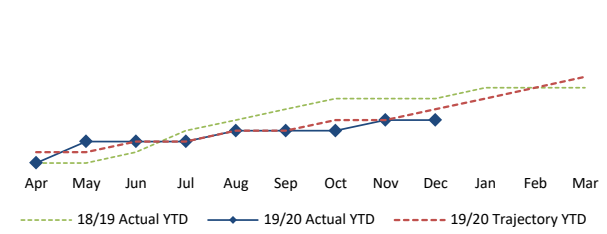
MRSA Bacteraemia



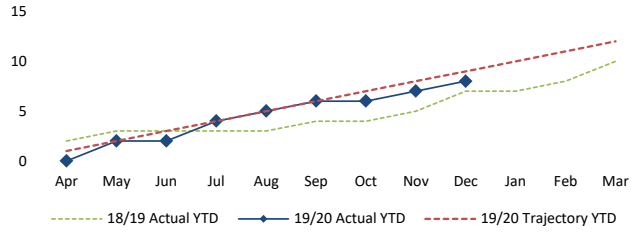
CPE



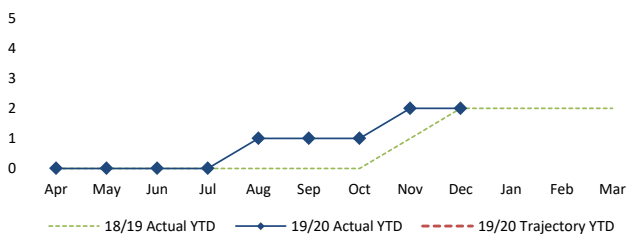
C.Diff



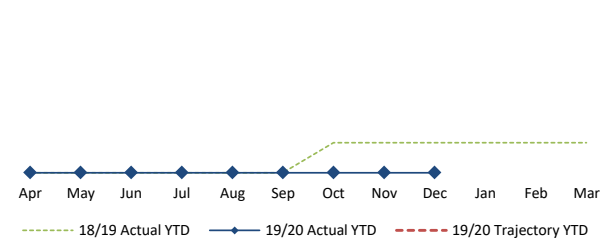
E.Coli



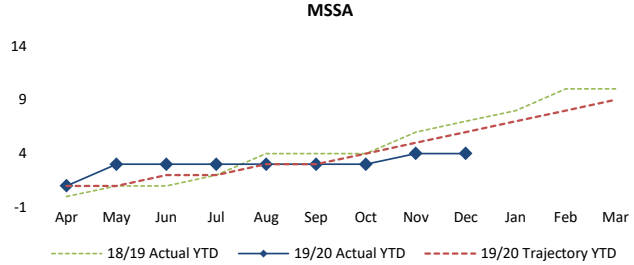
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 19/20

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

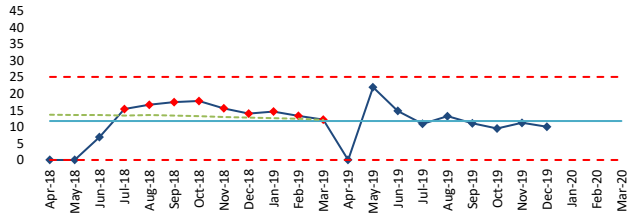
Excellence in Neuroscience

Quality of Care

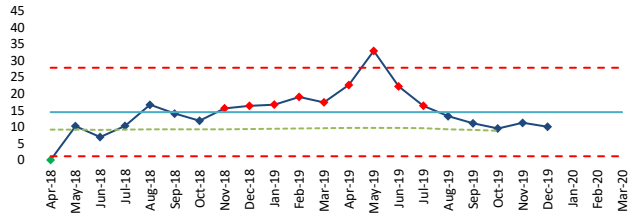
Safe - Infection Control

The Walton Centre NHS Foundation Trust

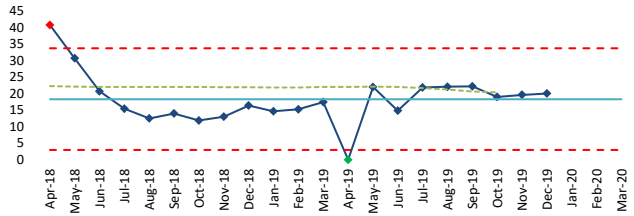
C.Diff Rate per 100,000 Bed Days YTD



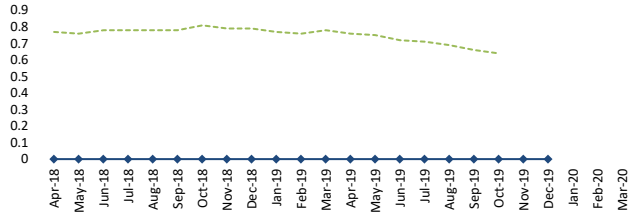
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

MSSA rates per 100,000 bed days have been above the national average since July 18.

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

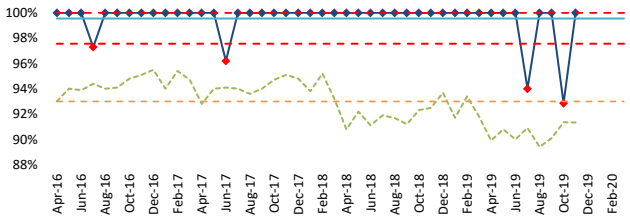
As of March 19 the C.Diff rate is no longer published.

Operational

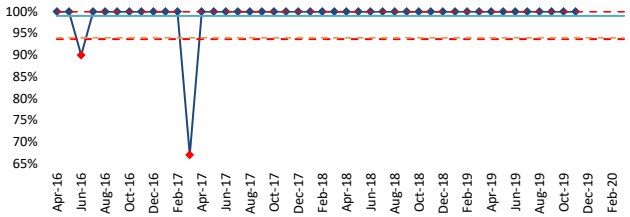
Responsive - Cancer

The Walton Centre NHS Foundation Trust

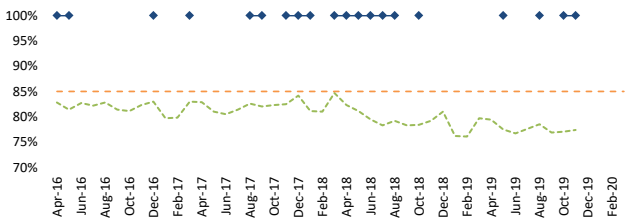
14 Day Performance



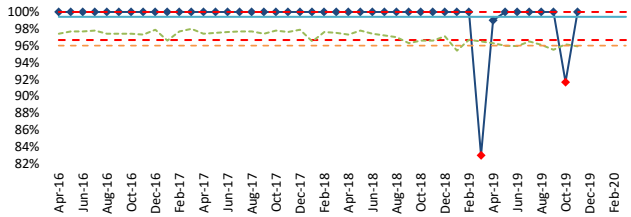
31 Day Subsequent Performance



62 Day GP Urgent Referral



31 Day FDT Performance



Narrative

All cancer performance standards were met in November 2019, with no patients waiting longer than the target times.

There were no breaches across any cancer types.

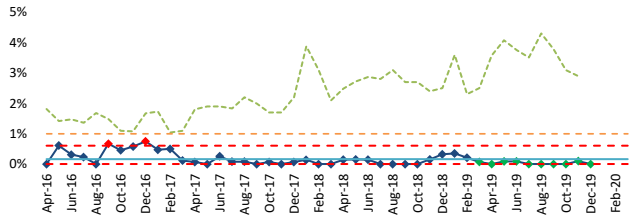
Excellence in Neuroscience

Operational

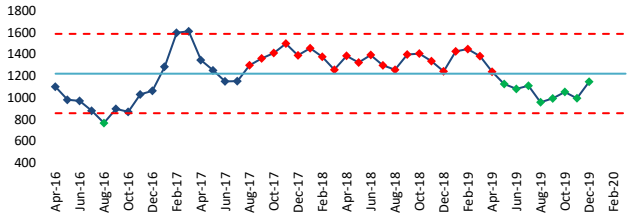
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

6 Week Diagnostic Performance



Total Diagnostic Waits at Month End

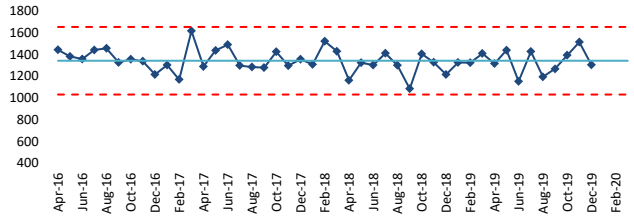


Narrative

Diagnostic performance in December 19 was 0%. Performance has been consistently below the target and better than the national average.

The number of patient waiting at month has significantly reduced while in month activity has remained consistent.

Total Diagnostic Activity in Month



There were zero six week diagnositc breaches within any modality. Performance is monitored at the weekly cross divisional assurance meeting.

WELL LED | Finance

Finance Metrics used for finance risk rating

		Plan NHSI rating (1-4)	Actual NHSI rating (1-4)	RAG Rating
Financial sustainability	Capital service capacity	1	1	
Financial sustainability	Liquidity (days)	1	1	
Financial efficiency	I&E margin	1	1	
Financial controls	Distance from financial plan	1	1	
Financial controls	Agency spend	1	1	

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,201	8,042	(159)	78,919	76,349	(2,570)	105,787	103,054	(2,733)
Exclusions	1,540	1,510	(30)	13,854	14,951	1,097	18,471	19,933	1,462
Private Patient	17	2	(15)	149	107	(42)	198	143	(55)
Provider Sustainability Funding	136	405	269	918	1,024	106	1,382	1,488	106
Other Operating	548	588	40	4,931	5,144	213	6,578	6,808	230
Total Operating Income	**10,442**	**10,547**	**105**	**98,771**	**97,575**	**(1,196)**	**132,416**	**131,426**	**(990)**
Pay	(6,104)	(5,881)	223	(55,544)	(53,479)	2,065	(73,938)	(71,382)	2,556
Non-Pay	(2,510)	(2,403)	107	(22,453)	(22,267)	186	(29,916)	(29,848)	68
Exclusions	(1,531)	(1,493)	38	(13,771)	(14,860)	(1,089)	(18,360)	(19,815)	(1,455)
Reserves	103	84	(19)	1,059	1,102	43	1,313	1,140	(173)
Total Operating Expenditure	**(10,042)**	**(9,693)**	**349**	**(90,709)**	**(89,504)**	**1,205**	**(120,901)**	**(119,905)**	**996**
EBITDA	**400**	**854**	**454**	**8,062**	**8,071**	**9**	**11,515**	**11,521**	**6**
Depreciation	(401)	(403)	(2)	(3,608)	(3,552)	56	(4,810)	(4,771)	39
Profit / Loss On Disp Of Asset	0	0	0	0	2	2	0	2	2
Interest Receivable	13	14	1	113	114	1	150	157	7
Financing Costs	(58)	(54)	4	(525)	(488)	37	(700)	(651)	49
Dividends on PDC	(131)	(131)	0	(1,183)	(1,181)	2	(1,577)	(1,574)	3
I & E Surplus / (Deficit)	**(177)**	**280**	**457**	**2,859**	**2,966**	**107**	**4,578**	**4,684**	**106**
Provider Sustainability Funding 2018/19	0	0	0	0	(106)	(106)	0	(106)	(106)
I & E Surplus / (Deficit) (CONTROL TOTAL)	**(177)**	**280**	**457**	**2,859**	**2,860**	**1**	**4,578**	**4,578**	**0**

STATEMENT OF FINANCIAL POSITION - 2019/20	Mar-19 £'000	Dec-19 £'000	Movement £'000
Intangible Assets	34	21	(13)
Tangible Assets	82,083	80,278	(1,805)
TOTAL NON CURRENT ASSETS	**82,117**	**80,299**	**(1,818)**
Inventories	985	1,118	133
Receivables	8,611	6,548	(2,063)
Cash at bank and in hand	21,713	25,232	3,519
TOTAL CURRENT ASSETS	**31,309**	**32,898**	**1,589**
Payables	(15,584)	(14,088)	1,496
Provisions	(312)	(311)	1
Finance Lease	(49)	(49)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(17,341)**	**(15,844)**	**1,497**
NET CURRENT ASSETS/(LIABILITIES)	**13,968**	**17,054**	**3,086**
Provisions	(270)	0	270
Finance Lease	(168)	(136)	32
Loans	(26,427)	(25,031)	1,396
TOTAL ASSETS EMPLOYED	**69,220**	**72,186**	**2,966**
Public Dividend Capital	26,674	26,674	0
Revaluation Reserve	3,116	3,116	0
Income and Expenditure Reserve	39,430	42,396	2,966
TOTAL TAXPAYERS EQUITY AND RESERVES	**69,220**	**72,186**	**2,966**

STATEMENT OF CASH FLOW - 2019/20	Dec-19 Plan £'000	Dec-19 Actual £'000	Variance £'000
SURPLUS/(DEFICIT) AFTER TAX	**2,859**	**2,966**	**107**
Non-Cash Flows In Operating Surplus/(Deficit)	5,634	5,108	(526)
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**8,493**	**8,074**	**(419)**
Increase/(Decrease) In Working Capital	0	538	538
Increase/(Decrease) In Non-Current Provisions	(21)	(271)	(250)
Net Cash Inflow/(Outflow) From Investing Activities	(2,762)	(2,213)	549
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**5,710**	**6,128**	**418**
Net Cash Inflow/(Outflow) From Financing Activities	(2,748)	(2,609)	139
NET INCREASE/(DECREASE) IN CASH	**2,962**	**3,519**	**557**
OPENING CASH	**20,439**	**21,713**	**1,274**
CLOSING CASH	**23,401**	**25,232**	**1,831**

Trust Income and Expenditure (after adjustment for 2018/19 PSF allocation):

In month plan: £177k deficit

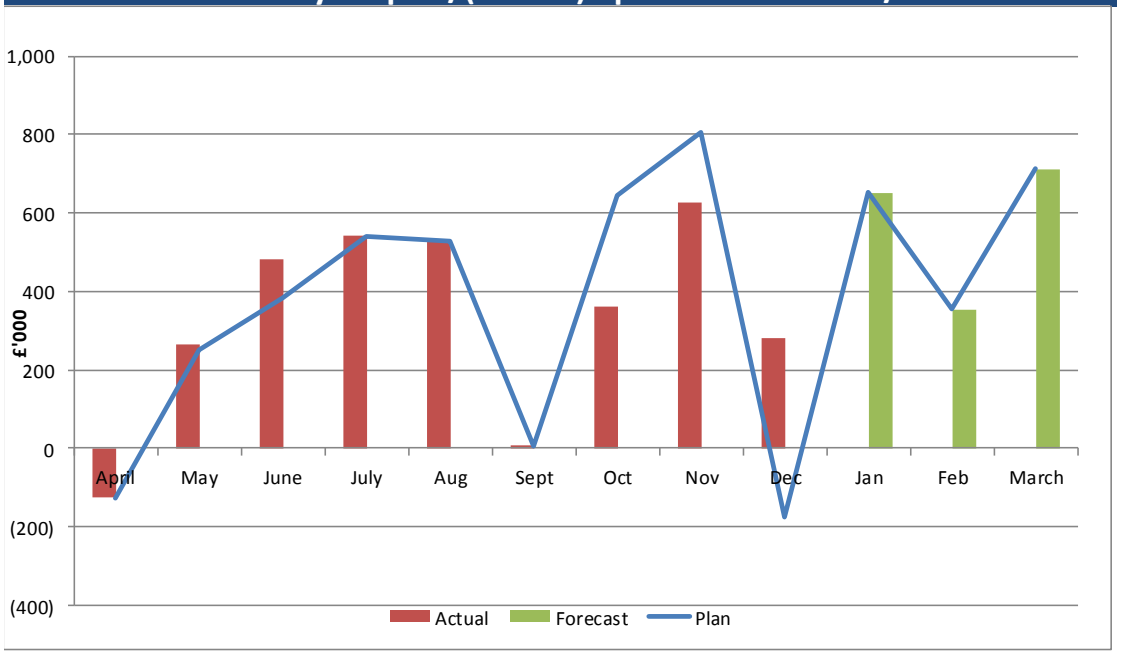
In month actual: £280k surplus

In month variance: £457k ahead of plan

Year to date variance: £1k ahead of plan

Currently forecasting to deliver control total of £4.6m (although this has become a significant challenge). A financial recovery plan has been developed to mitigate the risk and the financial position is being discussed weekly with NHSI/E.

Trust - Monthly Surplus/(Deficit) - planned vs. actual/forecast



There is a risk around delivery of the activity and income plan, especially given the issues with regards to tax on pensions for consultants who perform additional work. As such delivery of the year end control total is reliant on delivery of QIP and finance recovery plan.

At month 9, 57% of the QIP target has been delivered. The trust delivered £112k below target in month.
To note, the service improvement team have identified further QIP through outpatient and theatre productivity schemes which will be reflected in future reports and are assumed within forecast calculations

In month patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	263	229	(34)	1,633	1,477	(156)
Non-elective	170	162	(8)	1,562	1,726	164
Day case	956	809	(147)	660	669	9
OP First	3,413	3,422	9	858	889	31
OP Follow up	5,662	5,652	(10)	1,174	1,185	11
OP Procedure	569	539	(30)	129	126	(3)
Critical Care	588	513	(75)	864	772	(92)
Rehab	875	767	(108)	486	440	(46)
Other	0	0	0	2,392	2,270	(122)
TOTAL				**9,758**	**9,554**	**(204)**

Year to date patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	2,573	2,464	(109)	15,981	15,702	(279)
Non-elective	1,601	1,484	(117)	14,737	14,587	(150)
Day case	9,336	8,927	(409)	6,439	6,506	67
OP First	34,644	32,360	(2,284)	8,720	8,174	(546)
OP Follow up	57,668	58,895	1,227	11,951	12,013	62
OP Procedure	6,115	5,509	(606)	1,379	1,208	(171)
Critical Care	5,441	4,980	(461)	8,000	7,293	(707)
Rehab	7,357	6,709	(648)	4,090	3,793	(297)
Other	0	0	0	21,625	22,131	506
TOTAL				**92,922**	**91,407**	**(1,515)**

Forecast patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	3,467	3,319	(148)	21,579	21,196	(383)
Non-elective	2,111	1,986	(125)	19,398	19,654	255
Day case	12,580	12,033	(547)	8,680	8,772	92
OP First	46,703	43,621	(3,082)	11,758	11,171	(587)
OP Follow up	78,153	79,778	1,625	16,198	16,586	388
OP Procedure	8,328	7,496	(832)	1,878	1,643	(234)
Critical Care	7,225	6,589	(636)	10,624	9,804	(820)
Rehab	9,898	8,953	(945)	5,502	5,144	(359)
Other	0	0	0	28,839	29,160	322
TOTAL				**124,456**	**123,130**	**(1,326)**

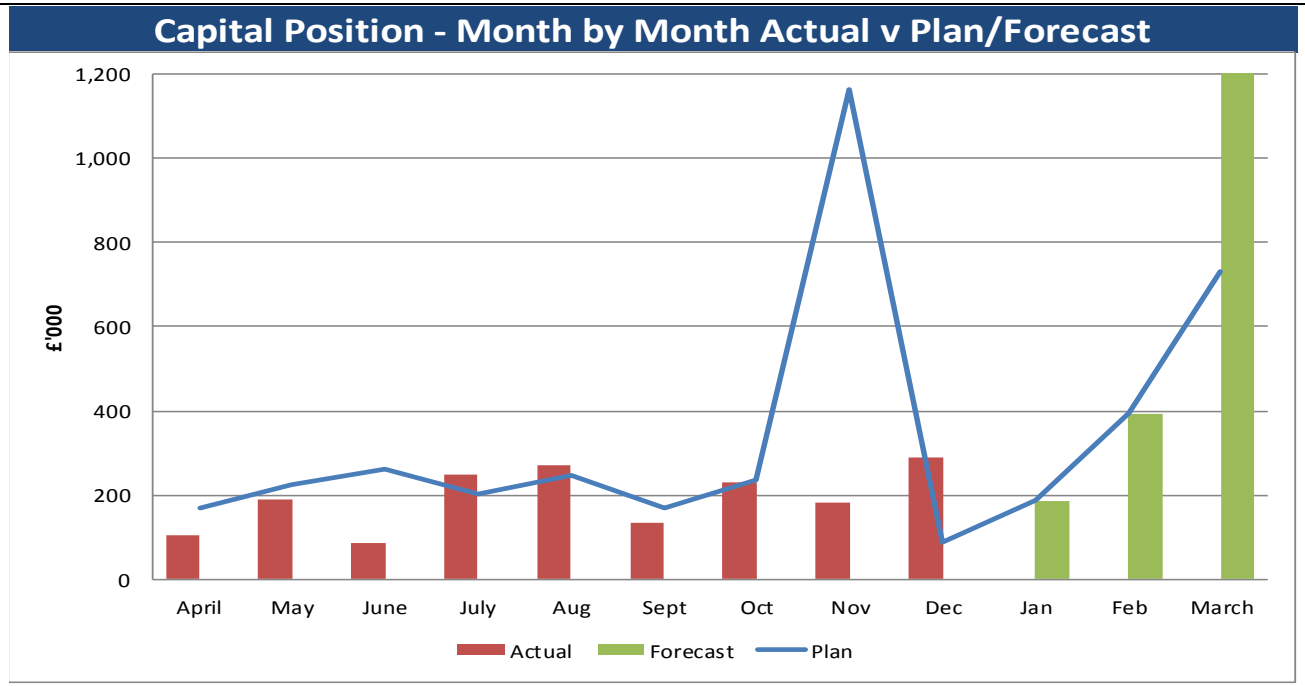
Capital

In month plan - £87k

In month actual - £290k

In month variance - £203k above plan.

Forecast - £5,975k. This includes £1.9m for replacement MRI scanner (NHSI/E have agreed to increase the Trusts capital limit to reflect spend required for the MRI replacement).



Capital is overspent against plan in month 9 by £203k. Estates are overspent in month by £245k due to the phase 2 heating replacement scheme. This is a profiling issue due to the scheme being delayed against the initial planning assumptions and is expected to come back into line with plan by the end of the year.

CAPITAL

	Annual	In month			Year to Date		
	Plan £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division							
Estates	1,069	0	245	(245)	808	1,046	(238)
IM&T	649	45	42	3	506	533	(27)
Neurology	1,427	5	0	5	1,100	23	1,077
Neurosurgery	539	17	3	14	287	131	156
Corporate	391	20	0	20	60	0	60
TOTAL	**4,075**	**87**	**290**	**(203)**	**2,761**	**1,733**	**1,028**

As of the end of December:

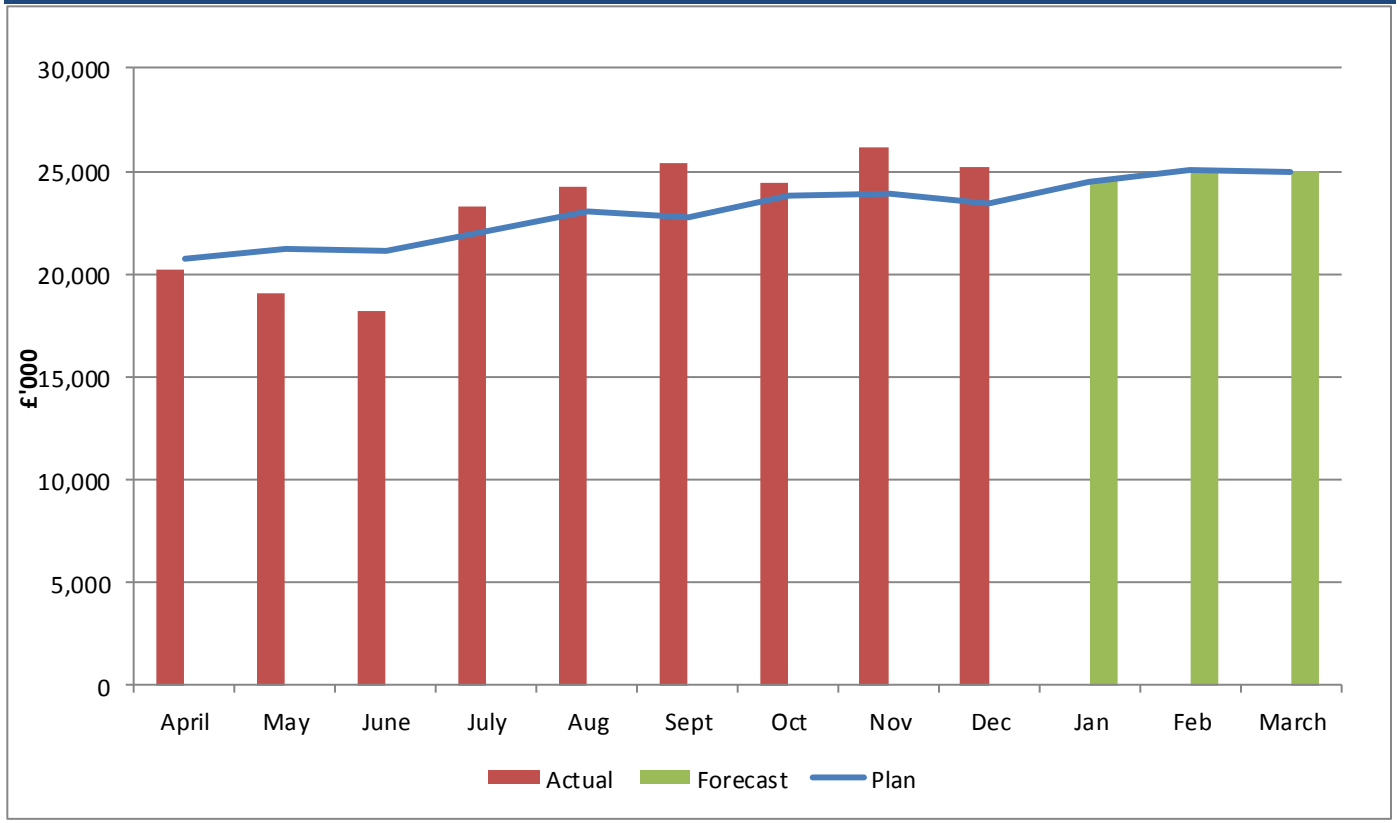
Planned Cash Balance: £23.4m

Actual Cash Balance: £25.2m

Variance: £1.8m above plan

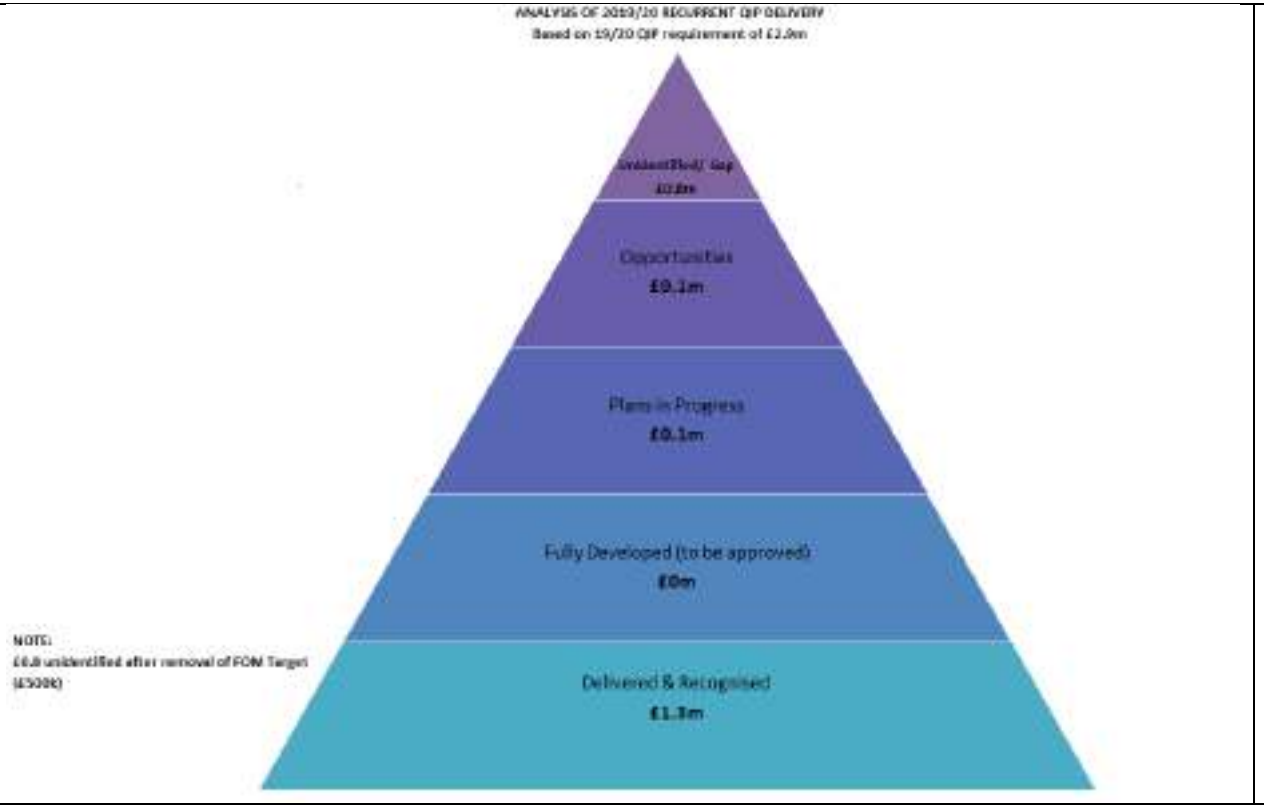
Number of days operating expenses = 76 days

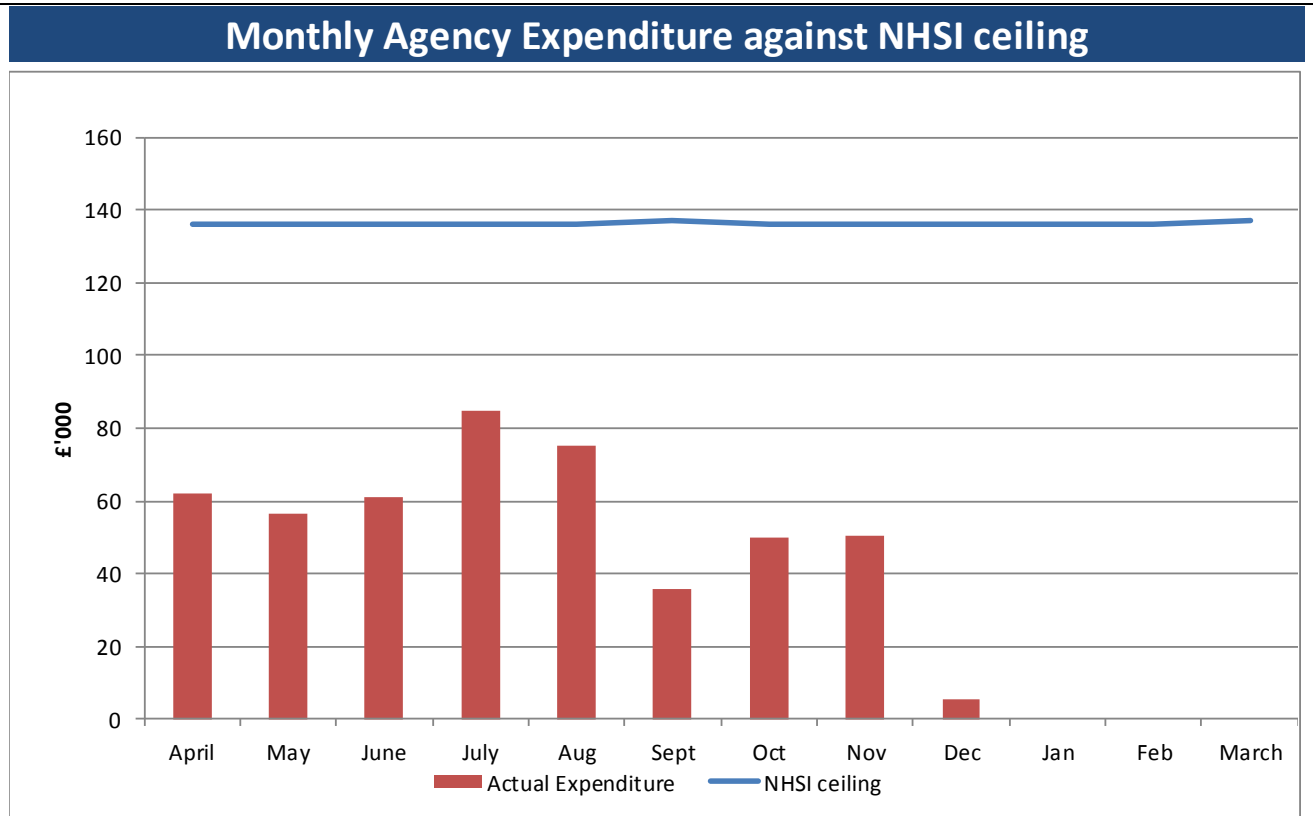
Cashflow against plan



The Trust cash balance at the end of December was £25.2m which is £1.8m ahead of plan. This is due to additional cash received for incentive, general distribution and bonus funding in relation to 18/19.

By the end of the year it is anticipated that the cash position will be back in line with plan due to the cash required to fund the replacement MRI scanner.

QIP In month Plan: £261k In month Actual: £149k In month variance: £112k below plan Year to date variance: £1,119k below plan Currently forecasting to deliver annual savings of £1.9m, a shortfall of £1.0m (Incl. FOM).		Trust delivered £149k of savings against planned savings of £261k in December, therefore £112k below the month plan. Of the £149k, £119k was delivered on a recurrent basis. The service development team have identified further savings around theatre and outpatient productivity that will be delivered later in the financial year.

Agency against NHSI ceiling: In month Plan: £136k In month Actual: £6k In month variance: £130k below plan. Year to date variance: £744k below plan (£482k expenditure against £1,634k ceiling)		Agency spend incurred in December was £6k, which is £130k below the NHSI monthly agency cap of £136k.

Key Risks and Actions for 2019/20

RISK	COMMENT/ ACTIONS
Risks to delivery of activity (and associated income) plan as a result of pension changes	The recent guidance from BMA to its members concerning potential tax liabilities on pensions linked to additional work is leading to less additional sessions being undertaken by consultants. The trust has proposed a Time off in Lieu (TOIL) scheme to clinicians as a local solution to the issue and will review the take up of this option to see if it provides a viable solution in the short term. It has also approved a pension recycling scheme in line with BMA recommendations if and when this is required, given the national letter that has recently been distributed which outlined that the NHS would pay tax bills relating to additional work that resulted in increased tax charges in 2019/20. Delivery of activity still remains a risk in achieving the 19/20 control total until an agreeable national solution is implemented.
Identification and delivery of recurrent efficiency savings	This remains a significant challenge and risk to the Trust. The Trust is progressing with 2 major transformation schemes in 2019/20 that will be resourced by a dedicated team. It is anticipated that these schemes will deliver savings and improved patient experience across the Trust. The Trust will also be using Model Hospital information to generate potential savings ideas for 2019/20.
Delivery of year end Control Total	Due to the activity under performance as a result of the potential tax liabilities on pensions there is a risk to the delivery of the year end control total. A financial recovery plan has been prepared to try and mitigate this risk and NHSI/E has been informed of the risk to delivery of control total. The financial recovery plan is being monitored regularly to understand performance against it and weekly discussions are being held with NHSI/E to understand the anticipated year end position. Given this risk, the Trust Board approved that they would seek a change to their control total at Q3. However, NHSI/E have requested that we review this again in Q4 and any changes to the control total will not be managed against the formal requirements of the protocol letter (which states that any changes requested in Q4 would be seen as poor financial management).
Future Operating Model (FOM)	Delivery of recurrent savings through the central Future Operating Model

	(FOM). Tariffs were centrally top sliced to establish the FOM infrastructure with Supply Chain identifying the level of savings associated with the move to FOM which were assumed within Trust plans. To date the level of savings delivered through FOM are £17k compared to anticipated full year savings of £500k at the beginning of the year.
Welsh Health Specialist Services Committee (WHSSC) income relating to HRG4+ tariff changes	It appears from recent discussions between NHSI/E, Welsh Government and DHSC that there is now an agreement that the Welsh Commissioners will pay at HRG4+ tariff less a 1.25% CQUIN element. The HRG4+ tariff will also form the basis of future tariff payments. The CQUIN element is to be funded by DHSC in 2019/20. The Trust is awaiting a final agreed contract from WHSSC and confirmation that DHSC will pay the 1.25% CQUIN element to completely mitigate the risk to the Trust. The DoF has contacted NHSI to ask them to confirm the DHSC position.
Levels of nurse bank expenditure	Since the introduction of the internal nurse bank, levels of spend in this area have increased significantly. There has been a reduction in agency and overtime spend. However the levels of increase in bank spend (particularly registered nursing) is much higher than anticipated partly due to the levels of sickness and increase in fill rates. The bank expenditure is being continually monitored. It should be noted that overall expenditure on bank, agency and substantive nursing is underspent against planned budget, largely due to the current level of nursing vacancies.

Neurosurgery financial position

Divisional contribution:

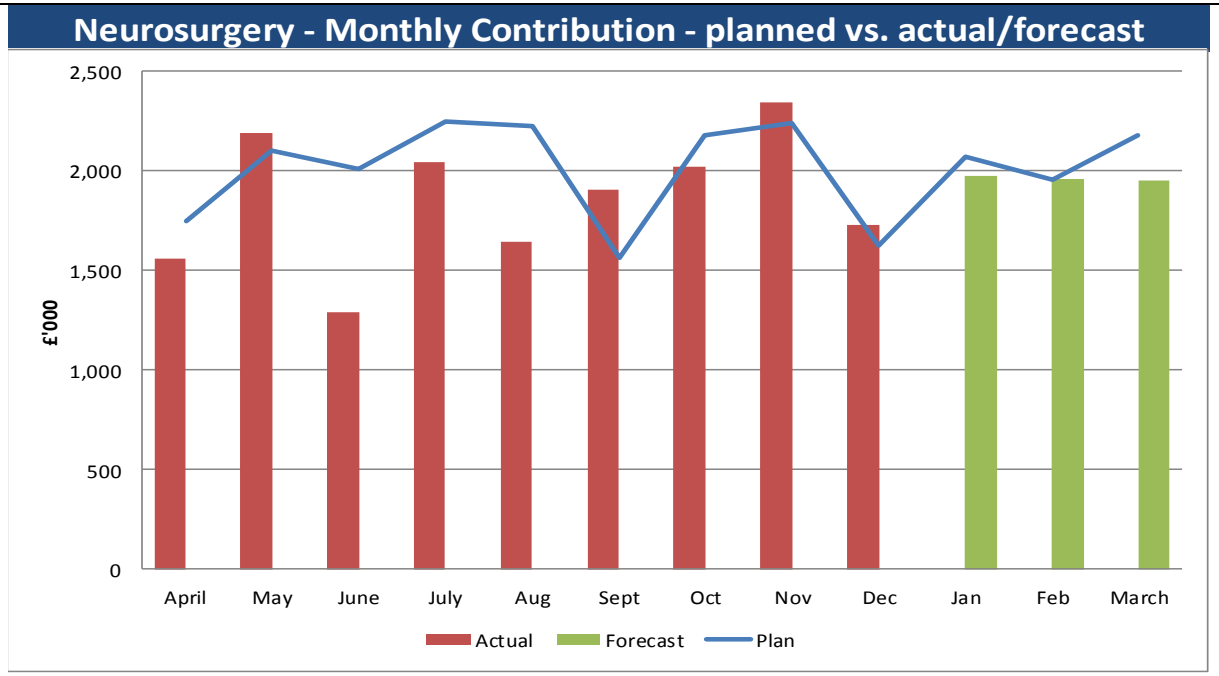
In month Plan: £1,623k surplus contribution

In month Actual: £1,731k surplus contribution

In month variance: £108k above plan.

Year to date variance: £1,196k below plan.

NOTE -The contribution excludes the QIP position which is reported centrally.



Key points:
- Patient related income in month was below plan driven by elective and day-case activity.

- Pay expenditure is underspent against plan in month primarily due to vacancies.

To note that contribution measures the direct income less the direct costs of the service before overheads

Surgery in month patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	240	209	(31)	1,586	1,427	(159)
Non-elective	147	145	(2)	1,417	1,597	180
Day case	632	464	(168)	470	459	(11)
OP First	1,103	1,251	148	318	361	43
OP Follow up	2,101	2,119	18	504	500	(4)
Critical Care	588	513	(75)	864	772	(92)
Other	0	0	0	295	269	(26)
TOTAL				**5,454**	**5,385**	**(69)**

Surgery YTD patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	2,351	2,258	(93)	15,519	15,185	(334)
Non-elective	1,389	1,267	(122)	13,390	13,126	(264)
Day case	6,161	5,594	(567)	4,578	4,478	(100)
OP First	11,498	11,092	(406)	3,316	3,209	(107)
OP Follow up	21,447	21,110	(337)	5,133	4,896	(237)
Critical Care	5,441	4,980	(461)	8,000	7,293	(707)
Other	0	0	0	2,659	2,488	(171)
TOTAL				**52,595**	**50,675**	**(1,920)**

Surgery forecast patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	3,179	3,052	(127)	20,979	20,526	(453)
Non-elective	1,821	1,691	(130)	17,557	17,669	112
Day case	8,323	7,565	(758)	6,185	6,052	(133)
OP First	15,559	14,999	(560)	4,486	4,340	(146)
OP Follow up	29,061	28,584	(477)	6,981	6,671	(310)
Critical Care	7,225	6,589	(636)	10,624	9,654	(970)
Other	0	0	0	3,519	3,218	(301)
TOTAL				**70,331**	**68,130**	**(2,201)**

Neurology financial position

Divisional contribution:

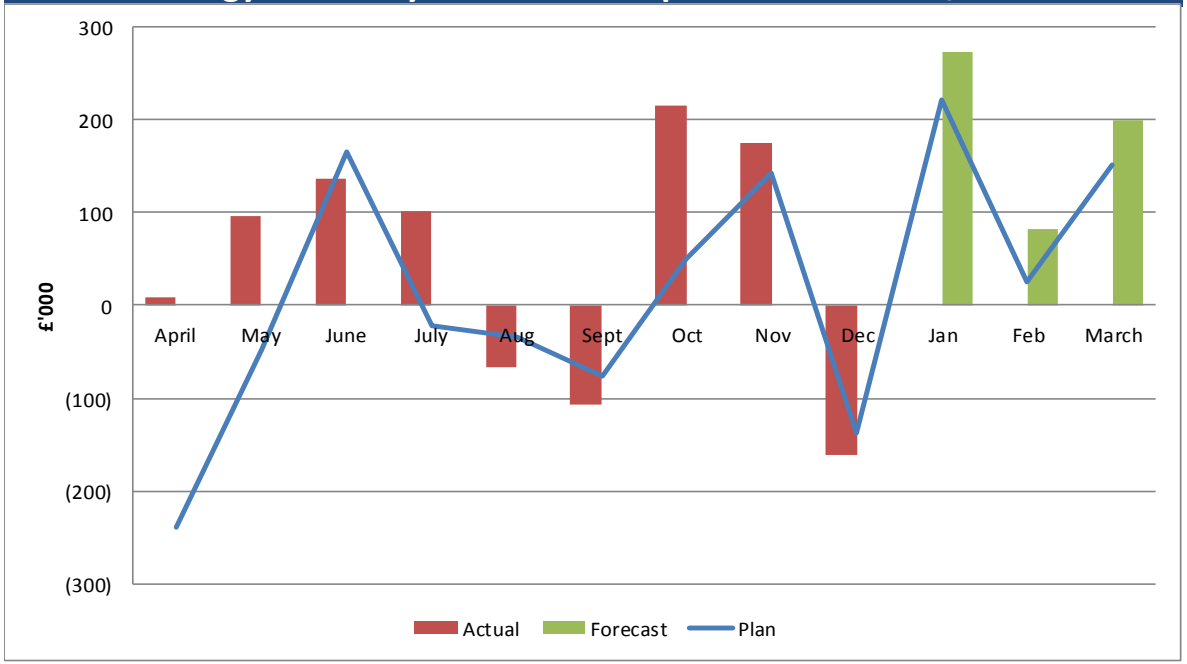
In month Plan: £138k deficit

In month Actual: £162k deficit

In month variance: £24k below plan.

Year to date variance: £598k above plan.

Neurology - Monthly Contribution - planned vs. actual/forecast



Key Points:

- Patient related income in month was below plan. This was driven by lower than planned income in OP first's, non- elective and Rehab bed-day activity.

- Pay expenditure is underspent against plan in month primarily due to vacancies across the division.

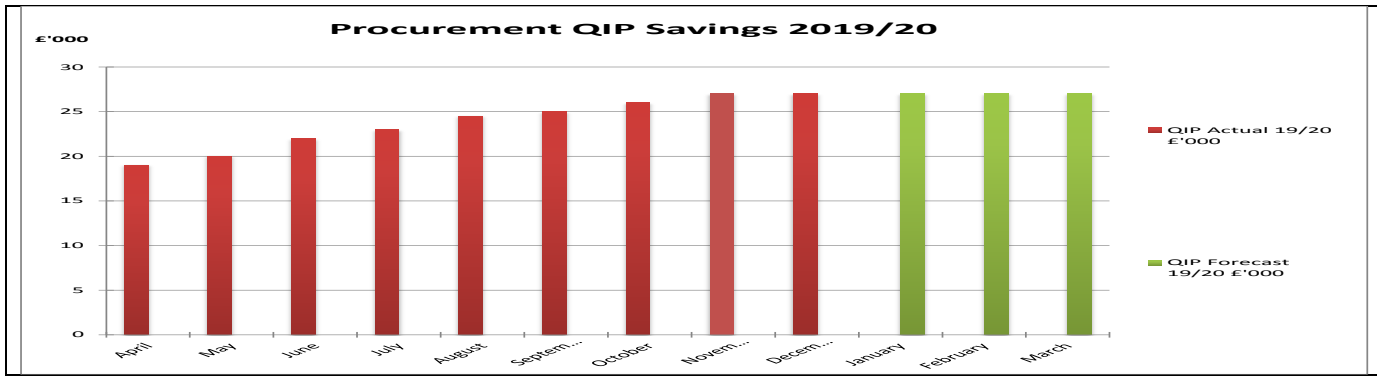
To note that contribution measures the direct income less the direct costs of the service before overheads

Neurology in month patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	23	20	(3)	47	50	3
Non-elective	23	17	(6)	146	129	(17)
Day case	324	345	21	190	210	20
OP First	2,310	2,171	(139)	539	528	(11)
OP Follow up	3,561	3,533	(28)	670	685	15
OP Procedure	569	539	(30)	129	126	(3)
Rehab	875	767	(108)	486	440	(46)
Other	0	0	0	2,020	1,936	(84)
TOTAL				**4,227**	**4,104**	**(123)**

Neurology YTD patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	222	206	(16)	462	517	55
Non-elective	212	217	5	1,347	1,461	114
Day case	3,175	3,333	158	1,860	2,028	168
OP First	23,146	21,268	(1,878)	5,405	4,965	(440)
OP Follow up	36,221	37,785	1,564	6,818	7,118	300
OP Procedure	6,115	5,509	(606)	1,379	1,208	(171)
Rehab	7,357	6,709	(648)	4,090	3,793	(297)
Other	0	0	0	18,197	18,916	719
TOTAL				**39,558**	**40,006**	**448**

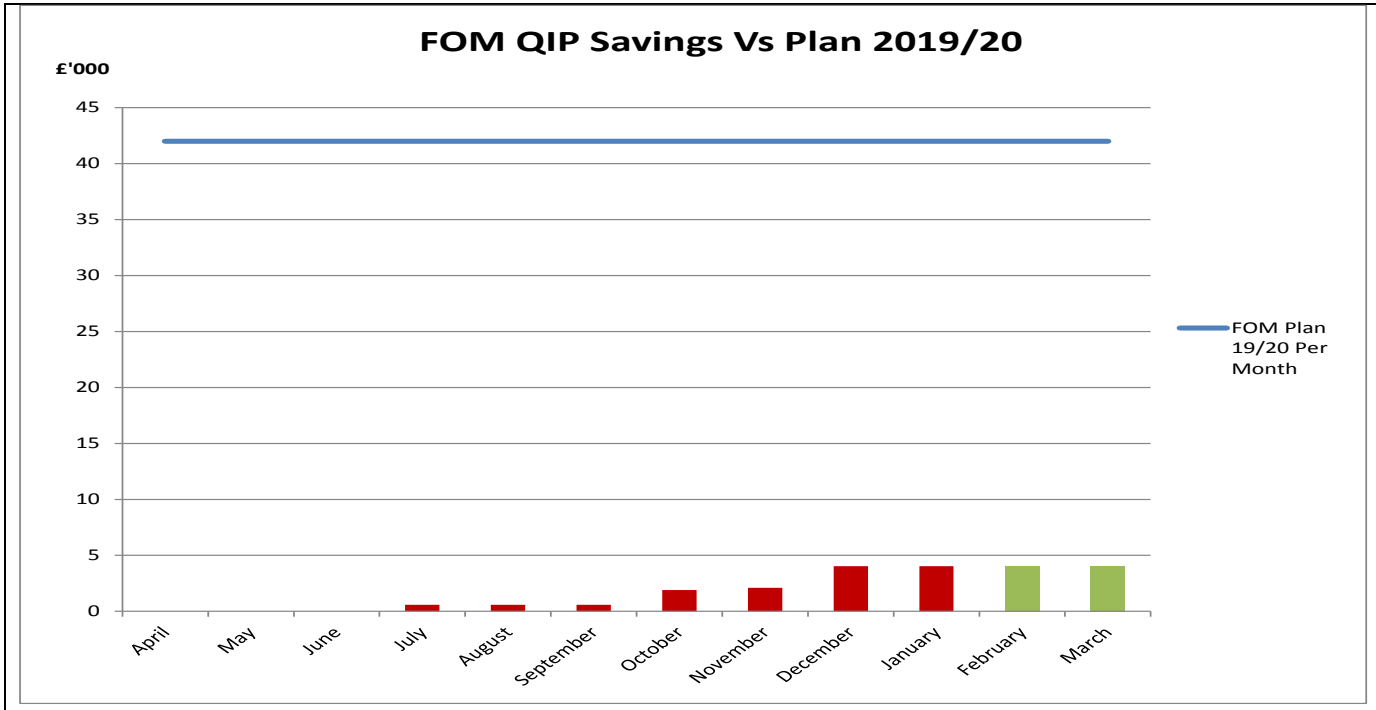
Neurology forecast patient related activity & income	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	288	267	(21)	600	670	70
Non-elective	290	295	5	1,841	1,984	143
Day case	4,257	4,468	211	2,494	2,719	225
OP First	31,144	28,622	(2,522)	7,272	6,681	(591)
OP Follow up	49,092	51,194	2,102	9,244	9,646	402
OP Procedure	8,328	7,496	(832)	1,878	1,644	(234)
Rehab	9,898	8,953	(945)	5,503	5,056	(447)
Other	0	0	0	24,266	25,251	985
TOTAL				**53,098**	**53,651**	**553**

Procurement Performance (19/20) – Month 9



The graph to the left shows the total amount of Trust wide QIP savings the Procurement team has supported.

In month QIP delivered - £0k;
FYE of delivered scheme - £307k.



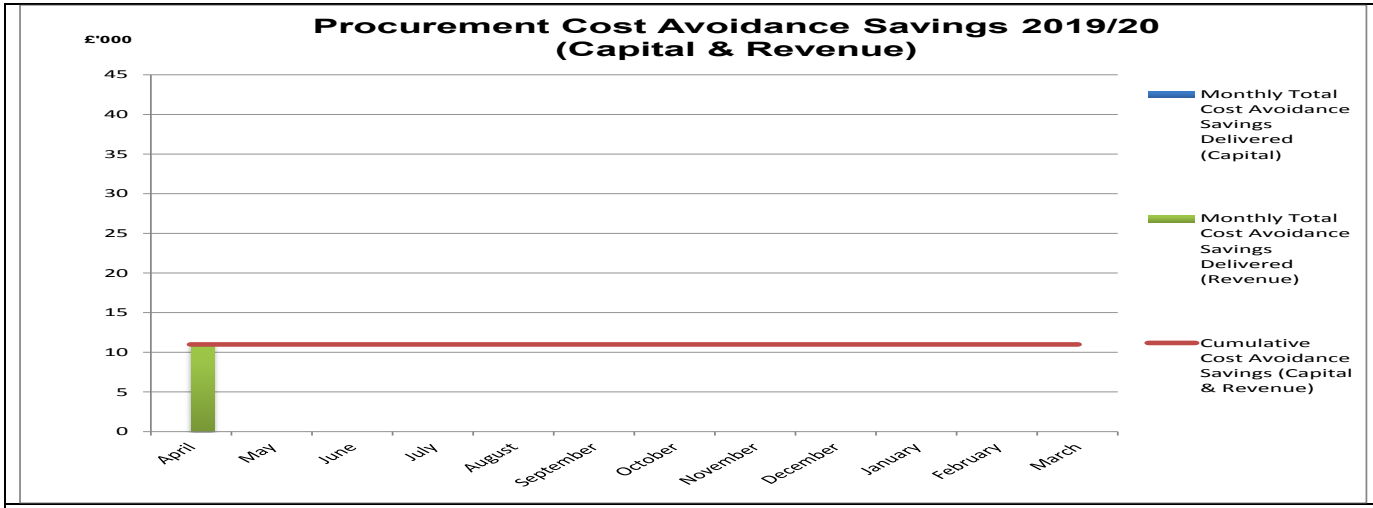
The graph to the left shows the total amount of QIP savings delivered against the Future Operating Model (FOM) projection.

In month QIP delivered - £4k;
FYE of delivered Schemes - £49k.

The DoF and Head of Procurement will meet with the regional FOM representatives in the near future to understand the current performance issues.

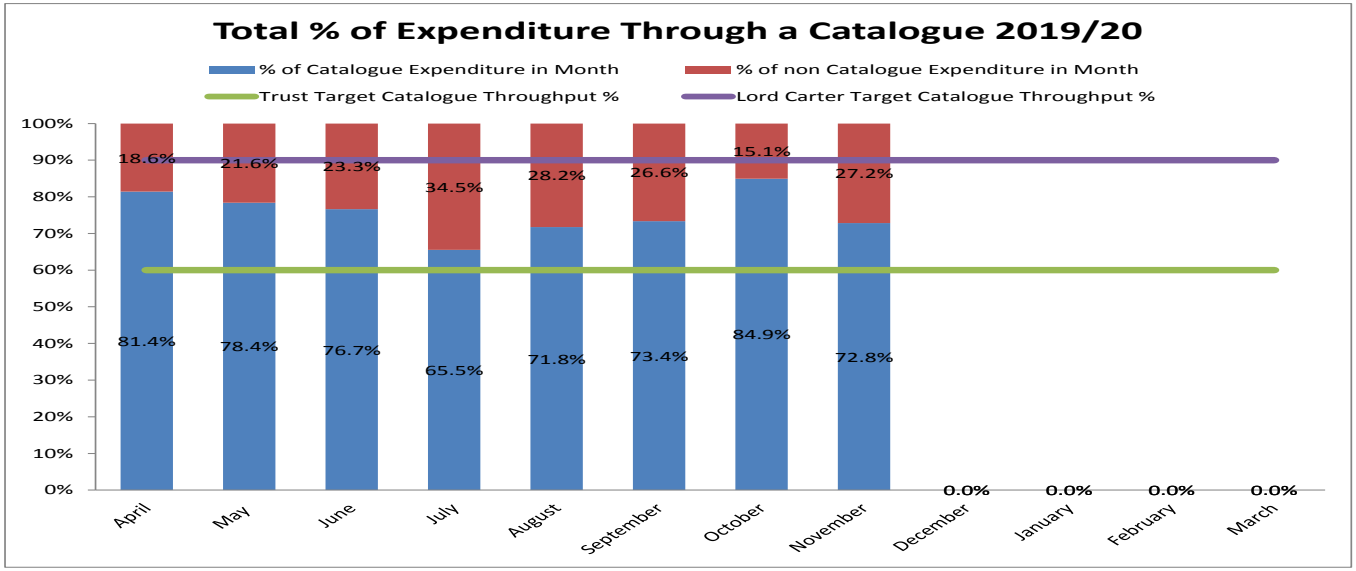
In Month Savings Detail (FY):

- MRI Maintenance Agreement - NHS SC Framework - £21k;
- Adhesive Tape NHS SC product switch - £1k;
- Chlorine Tablet - NHS SC product switch - £1.5k.



The graph to the left shows the savings delivered by the procurement team on cost avoidance (Capital and Revenue). Cost avoidance is recorded where the procurement team enable the trusts funds to be stretched further i.e. capital purchase costs vs budgeted, re-negotiating a price back from an inflationary increase, one off purchases where procurement obtain a better price.

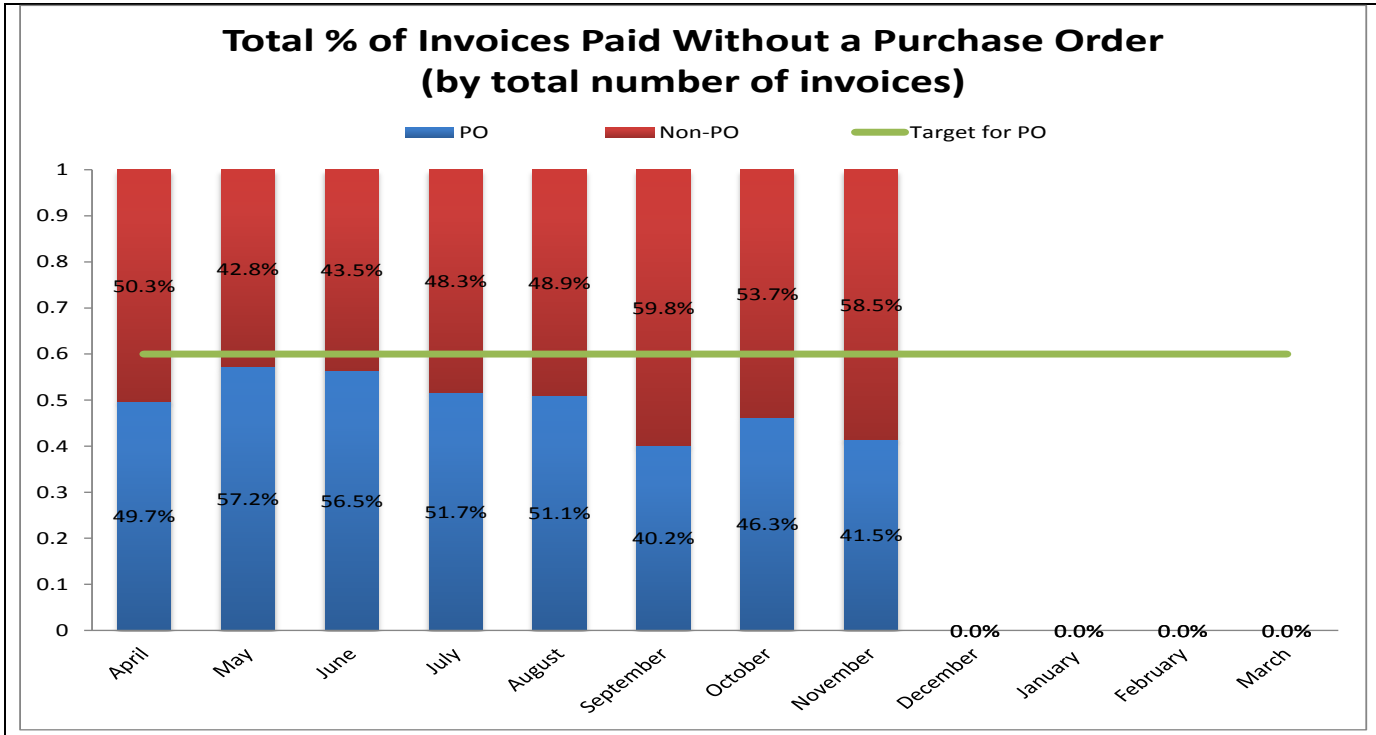
In month cost avoidance delivered - £0k
FYE of delivered Schemes - £11k



The Trust target for purchase orders placed via a catalogue as detailed in the procurement strategy for 2018/19 (Y3) was 60%. However, since then the Lord Carter metric has been introduced at a target of 90%.

In month total orders placed via a catalogue - 71%
Average catalogue throughput YTD - 75%

The above information only includes purchase order information that will lend itself to a catalogue. All spend areas in month that do not lend themselves to a catalogue have been removed from the data e.g. areas removed include service contracts, maintenance contracts, capital purchase, building works, one off purchases.



The target identified within the 18/19 Procurement strategy for invoices paid with a valid purchase order is 60%; this is for all areas of non-pay expenditure. The Lord Carter target is 90%, based on number of line transactions and value, but only addresses the Clinical & General Supplies Categories. When benchmarked against the Carter target the trust is at 92% for expenditure and 98% for transactions. Reporting will be changed to reflect the Carter target in the coming months.

In month the total number of invoices paid was **1,670** of which **54%** was paid without a valid purchase order number.

Data includes all invoices paid in month including NHSLA, Rates, Utilities and SLA's etc. which may never be able to be paid via a PO.

The Walton Centre NHS Foundation Trust

REPORT TO THE Trust Board
Date 30th January 2020

Title	**Quarter 3 Governance report**	
Sponsoring Director	**Name:** Lisa Salter **Title:** Director of Nursing and Governance	
Author (s)	**Name:** Kate Bailey **Title:** Clinical Governance Lead **Name:** Lisa Gurrell **Title:** Head of Patient Experience	**Name:** Tom Fitzpatrick **Title:** Head of Risk
Previously considered by:	Quality Committee – January 2020	

Executive Summary
The purpose of the report is to:

- Provide a quarterly summary of Governance activity across the Trust in Quarter 3 (19/20), comparing results of data over the past 3 months. Variance shown relates to a comparison with the previous Quarter.
- Provide assurance to the Trust Board that issues are being managed effectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

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

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

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

NHS
The Walton Centre
NHS Foundation Trust

Governance Quarter 3 Report (2019/20)

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

1. Introduction

This report represents the Quarterly Governance report for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health and safety.

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

These themes and trends, in turn, inform the Governance Assurance Framework process.

1.1. The purpose of this report is to provide:

- a quarterly summary of Governance activity across the Trust in Quarter 3 (2019/20), comparing results of data over the past 3 months (variance shown relates to a comparison with the previous quarter)
- assurance to the Trust Board that issues are being managed effectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from incidents, complaints, concerns, claims and deaths.

1.2. This data is accurate from the date the reports were generated for each financial year. There are occasions when incidents are retrospectively reported or complaints or claims withdrawn and those amended figures may appear in subsequent reports. Unless otherwise specified text, tables and charts refer to Q3 (2019/20 - October to December 2019).

1.3. See Appendix 1 for a glossary of terms used in this report.

2. Executive Summary

2.1. Governance Assurance Framework (GAF)

There have been 2 new themes included on the GAF; these are in relation to Legionella management and Communication. (Governance Assurance Framework **REF 304 &305**)

2.2. Incident reporting

There has been a slight increase in Trust wide incident reporting levels from 814 in Q2 to 830 in Q3 (Incidents, page15).

2.3. Serious Incident (SI)

There were 3 incidents reported to the Commissioners via StEIS in Q3, these were:

- November - Retained foreign object post operation. Chest X Ray undertaken, it was noticed that a guide wire was still in place **(Never Event)**
- December - Operation or procedure wrongly sited - patient was consented for a L5/S1 revision microdiscectomy. After performing the procedure the surgeon requested a further level check and once this was performed the surgeon found that they had performed the procedure at the wrong level
- December - Category 3 Pressure Ulcer - patient developed a category 3 pressure ulcer to bony prominence underneath his halo jacket

2.4. Moderate & above incidents (including Duty of Candour)

- There was an increase in Moderate incidents from 12 in Q2 to 20 in Q3.
- 18 of the 20 incidents in Q3 were patient safety related, requiring both verbal and written notification to the patient/relative/next of kin, under the statutory requirements of Duty of Candour. (Duty of Candour, page 17).

2.5. Quarterly incident themes

Communication incidents decreased from 122 in Q2 to 113 in Q3. Communication failure within the team had the greatest decrease, from 25 in Q2 to 16 in Q3.

- **NB** Although a decrease in incidents relating to communication issues can be seen, communication has been added to the Governance Assurance Framework Log Ref 304, following a steady increase in complaints and concerns over the previous 4 Quarters.
- The initial results from the Trust staff survey have also identified concerns with "communications issues. "

2.6. Safeguarding incidents and concerns

- Safeguarding incidents increased from 72 in Q2 to 87 in Q3.
- Safeguarding has now been split on the Governance Balance Score Card into safeguarding concerns and safeguarding incidents.

2.7. Learning from Deaths

There was an increase in deaths from 13 in Q2 to 37 in Q3 (Learning from Deaths, page 20).

2.8. Information Governance incidents

Information Governance incidents have decreased from 53 in Q2 to 49 in Q3 (Information Governance, page 20).

- there were 2 externally reportable incidents to the Information Commissoners Office (ICO), both have since been closed as no further action was required by the ICO
- to date the Trust has reported 11 externally reportable incidents this financial year to the ICO compared to 5 the full year in 2018/2019
- the ICO has responded to all incidents reported so far to advise that there is no further action required by the Trust

2.9. RIDDOR

There were 3 RIDDOR incidents reported to the HSE in Q3. (Safety, page 37)

2.10. Risks

There were 12 new risks recorded in Q3 and 10 risks closed in Q3. (Risks, page 35).

2.11. Complaints and concerns

In Q3, there was a slight increase from 35 (Q2) to 36 in the number of formal complaints received. (Concerns and complaints, page 22).

There is a noted increase of 53% in the number of complaints received in Q3 2018/19 (68) compared to at the end of Q3 2019/20 (104).

- Neurology Division complaints increase of 25% from 15 in Q2 to 19 in Q3
- Neurosurgery Division complaints remains static
- the increase in numbers are reflected in the themes as they relate to appointment arrangements

There was a noted increase of 28% in concerns from 119 in Q2 to 183 in Q3. The increase in numbers are reflected in appointment arrangements as with formal complaints.

2.12. Compliments

There was an increase in the number of compliments received from 58 in Q2 to 82 in Q3. (Compliments, page 28).

2.13. Claims

Nine claims were received in Q3 compared with 4 in Q2. There were 7 claims closed in Q3. (Claims / Legal, page 30).

2.13.1 Lessons Learned from closed claims and coronial reviews:

- Claim - Falls, a lot of education around special observation and levels of observation has been completed as a result of this case.
- Claim - Communication, referring consultants to state “URGENT REFERRAL” on covering letter
- Coroner - consent forms to be reviewed to include section to confirm that ‘risk to life’ has been discussed

2.14. Patient Experience

Friends and Family Test (Friends and family test, page).

- the Trust results for FFT remained very positive for Q3, both in terms of recommended rate and response rate
- the inpatient rate was consisent between 96-98% each month
- the recommended rate remains signficantly above the nation average around 20%, which demonstrates the positive experince recceived by both patinets and their families
- the FFT recommendated rate was consistently high across the wards although this has dipped slightly compared to Q3

We also continue to receive positive feedback as part of our local inpatient survey.

2.15. Conclusion

The Governance Q3 Report demonstrates that The Walton Centre promotes a culture that encourages patients and staff to raise safety concerns to improve the service. Staff are open and fully committed to reporting incidents and near misses.

3. Governance Assurance Framework (GAF) Log

Theme	Context	Analysis	Action	Recommendation
REF287 Violence & Aggression 09.10.2017	Feedback from incidents continually highlights the issues of violence & aggression (V&A) against staff. This has also been highlighted in the staff survey. Issues of V&A are also identified and discussed at the daily Safety Huddle meeting. This risk is on the Board Assurance Framework. **Lead:** LSMS (Health Safety & Security Group).	During Q3 a reduction of V&A incidents is evident. Physical assault incidents have decreased. Q3 data shows that 38 out of the 40 physical assaults against staff involved a patient that lacked capacity.	Continue to provide post incident support to wards in the development of risk assessments, solutions and to ensure most appropriate techniques are being used to manage the patient. Ensure V&A issues are Daily escalated to the Safety Huddle. V&A MDT working group continues to meet and identify new initiatives and work streams to help with the management of challenging patients. LAST LAP (Looking After Staff That Look After People) has now been trialled and will be rolled out early 2020. Review of V&A Risk assessments and alerting. CCTV Policy approved in November 2019 – Now includes the use of Body worn cameras (BWC) – ISS Security Guards to commence use of BWC in Q4.	It is recommended that this remain on the Governance Assurance Framework to monitor. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 286 Appointments Cancellations/Delays 16.01.2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to PAC to book/cancel appointments. It is anticipated that there will be a significant increase in DNAs, complaints and this will affect staff/patient experience going forward **Lead:** Neurology Ops services Manager (Governance and Risk)	There has been a significant increase in concerns received in Q3 regarding appointment issues. Increase in issues in Q3, relating to patients unable to get through or cancel appointments with PAC due to insufficient IT/Telephony infrastructure.	Service improvement work has been ongoing regarding outpatients/appointments. Data regarding concerns and complaints about appointments is feeding into service improvement work.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient and staff experience are sustained. 16.01.20 – Mitel business case has been approved and has now gone to Capital for funds. Once this system is in place we will have a more robust system in place for monitoring call volumes, the facility to record calls will also give greater assurance to staff and patients alike and can also be used for training and development sessions with staff i.e. reflection and developing de-escalation skills. System will also inform patient where they are in the call waiting queue which will temper expectations and also allow patients to leave a message requesting a call back. With regards to cancelled appointments we have now pulled back from 16 weeks to 6 weeks polling range which will significantly reduce the number of clinic cancellations affecting patients. Work is continuing on the FUOWL with regards to consultant validation and opt in letters have been sent to appropriate patients. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 294 Patient Case Notes 04.01.2018	An increase in the number of incidents involving the misfiling of patients notes, which could have the potential to cause major harm to a patient. **Lead:** Digital Health Records & IG Manager (IGSF)	A slight decrease can be noted on review of the Quarterly statistics from 15 Q2 to 14 Q3.	Health records incidents continue to be reviewed at IGSF monthly. All incidents being reviewed and fed back to departments at the time. All user email, Walton Weekly, Team Brief, Clinical Safety Huddle and clerk team meetings have communicated this issue to all staff. Code of conduct for employees in respect of confidentiality has also been amended to ensure staff know to check three demographics when performing a task involving personal identifiable information.	Slight improvement again has been noted in figures in Q3 of patient case notes being incorrectly filed, however, due to 11 externally reportable incidents so far this year, suggestion is to continue to monitor. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 293 Patient Falls 04.01.2018	An increase in the number of falls is evident when reviewing quarterly and annual statistics. **Lead:** Practice Educator (Falls Steering group).	Although total falls has increased slightly so far; here has been a decrease in falls in quarter 3 compared to previous quarter. This may be due to lower bed occupancy.	Incidents are reviewed at the Safety Huddle and monitored through the Monthly assurance reports. Falls incidents are discussed at Falls Prevention Steering group (FPSG). Monthly analysis sent to ward managers for sharing with staff. We are looking at different falls equipment and falls sensors in bathrooms; our high risk area for falls. Real time questionnaire are continued post fall. Share ownership of falls with patients who have capacity and who choose to ignore advice. Falls leaflets for inpatients has been reviewed and updated. To be sent for printing. New falls leaflet for outpatients with long term conditions being developed. To complete gap analysis of falls versus Datix in January 2020. Annual health and safety is an opportunity to discuss with staff, falls incidents, RCA findings and falls prevention work plan. The Trust have been collecting data for the National Falls CQUIN. Monitoring compliance against mobility assessments, drugs known to cause issues with balance and lying and standing blood pressure.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient experience are sustained. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 296 Delayed clinic letters 08.01.2018	Increase in concerns and complaints relating to delayed clinic letters. Concerns raised that this has led to delayed scan results and medication changes. **Lead:** Neurology Ops services Manager (Governance and Risk)	There was an increase in complaints regarding issues with clinic letters.	Improvement work has been taking place, which may be linked to the decrease in concerns and complaints. However, we may wish to monitor this further to see sustained improvement. Full action plan in place since August 2019 to address the ongoing issues within the Neurology secretariat such as: communication, processes and system wide concerns. This action plan is monitored monthly with HR and the division. Neurology secretariat agreed to ad-hoc outsource typing when department is experiencing unforeseen workforce pressures e.g. sickness/absence, spikes in activity and peak holiday periods. Significant improvements identified staff morale improving and genuine engagement with action plan.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient experience are sustained. 16.01.2020 - The overdue delayed clinic letters have reduced significantly over the last 3-6 months due to changes in working practices and methods and the utilisation of outsourced typing. The current backlog is minimal and we predict the KPI will continue to improve monthly and that we will meet KPI typing targets. Clinicians are being reminded weekly to verify documents in a timely manner however there are still some significant delays which will are continuing to address. I would request that the group continue to monitor. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 300 Rejection Of Pathology samples by LCL 02.10.2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. **Lead:** Labs Quality & Governance Manager (Neurosurgery Div Gov Meeting).	Rejection data now received monthly from LCL. In total, approx. 60 samples a month rejected across the trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. NOPD and HITU highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following a SUI.	Monthly rejection data now sent to Matrons and NOPD and HITU ward managers. NOPD now preparing samples from late clinics and retaining at WCFT until the following day. NOPD staff have received training on laboratory processes and specimen requirements. Addressograph labels to be used on microbiology samples. When applicable, comms to be given about rejections associated with lack of time on request. IT have prepared a prioritisation document for an order comms systems within pathology. This would ensure requests would be completed correctly and reduce number of rejections. Discussed regularly by Division.	Incidents to be monitored through Datix. **Recommendation - Continue to monitor**
REF 301 Fire Safety Compliance 17.01.2018	Following the OPD/NRC fire, following Merseyside Fire Service investigation and inspection of the Walton Centre, the following legislative breaches were identified: - maintenance of fire compartmentation lines - access to records of maintenance information provided by Aintree Estates Department **Lead:** Estates Manager (BPC).	The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. These gaps were as a result of the original building works not being inspected and signed off in as compliant as part of the schemes governance arrangements. These gaps were not fully identified in a subsequent survey by a competent contractor in 2015 post a DH Estates Alert.	A registered fire compartmentation contractor is currently on site undertaking reinstatement works. An action plan is monitored by the Head of Risk. The works are ongoing throughout the main site.	Continue to monitor until remedial compartmentation works are complete. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 302 Safeguarding 09.07.2019	Increase in safeguarding incidents reported to the commissioner in Quarter 1, as a result of the Implementation of new safeguarding section in DATIX it is anticipated that there will be a significant increase in incidents going forward.	Following the implementation of enhanced training for staff, there has been a significant increase in the identification of incidents of abuse/neglect. This increase in Datix reporting in Q3 is a positive indicator around staff knowledge and appropriate action in response to safeguarding concerns. There is also an increase in the reporting of Datix breaches due to untimely Local Authority assessment of the applications. This is in line with the revised Trust policy and processes for Deprivation of Liberty Safeguards (DoLS) applications. **16.01.20** The increase in safeguarding themed DATIX has continued to increase in Q3.	The Datix reports will continue to be monitored with oversight from the Safeguarding Matron and Executive Safeguarding Lead to ensure that appropriate escalation/actions/referrals are addressed.	16.01.20 To continue to monitor to ensure appropriate reporting of safeguarding incidents. Reporting is now split into 2 groups: safeguarding concerns and safeguarding incidents. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 304 – Communication 19.12.2019 (NEW)	Communication issues have been identified via number of sources, including the staff survey (2019/20), incidents, concerns and complaints.	There has been a slight decrease in incidents from 122 in Q2 to 113 in Q3. However there has been an increase in Patient Experience issues. Concerns increased in Q2 from 119 to 183 in Q3. Complaints have increased 53% comparing Q2 and Q3. The 2019/20 staff survey results have also identified issues with Communication	• Introduction of Divisional KPIs to monitor, measure and reduce complaints and concerns • Divisions to review current processes for escalation of concerns and complaints • Divisions to identify how learning can be embedded to prevent concerns occurring	Monitor via Incidents, complaints and concerns. **Continue to monitor in Q4 19/20 and Q1 20/21 once actions underway.**

Theme	Context	Analysis	Action	Recommendation
REF 305 – Legionella 19.12.2019 (NEW)	Legionella positive samples found in water outlets in Walton Centre. **Lead:** Estates Manager (BPC).	Following am identified problem on Lipton Ward, raising a risk, which led to testing for legionella bacteria. The samples returned identified a number of positive outlets for Legionella pneumophila serogroup 1. Further extended sampling across clinical areas has shown the existence of the same in various areas.	An exercise was undertaken to pasteurise the system by raising the hot water temperature to circa 80^{o}c followed by further re-sampling. Additional measures undertaken include the implementation of a thorough flushing regime to all areas and the installation of an additional hot water return shunt pump to try and get the water circulating better. Re-sampling results have shown that, although not eradicated, the readings obtained are showing a downward trend which suggests the measures being taken is having a positive impact. In order to protect the patients further, Point of Use filters (POU) have been fitted to all outlets where it is possible for them to be fitted. Recent samples of cold water brought one area back as positive. Upon investigation, there appears to be possible reasons why this may have occurred and these have been rectified. Additional sampling is underway to establish if this has improved the water quality. Works associated to eliminating legionella from the water systems are widespread and lengthy; therefore, there will be no “quick-fix” to the problems being experienced.	Continue with remedial, re-sampling regime and flushing. Continue to work through Water Safety Action Plan (from Hydrop). **Recommendation – Continue to monitor.**

Governance Log - Issues closed

Ref No	Theme	Date entered onto Log	Date Archived	Decision at Quality Committee	Escalated to Board Y/N
REF 291	Major Incident Management	9th October 2018	21st June 2018	21st June 2018	N
REF 292	Incomplete Patient records	9th October 2018	21st June 2018	21st June 2018	N
REF 299	National Inpatient Survey	9th July 2018	18th October 2018	18th October 2018	N
REF 295	Fire Safety provisions	4th January 2019	23rd May 2019	23rd May 2019	N
REF 297	Lack of Neuropsychological	4th July 2019	23rd May 2019	23rd May 2019	N
REF 298	Failure of Carbon Steel	9th July 2019	23rd May 2019	23rd May 2019	N

Section 1 - Incident Management

This section provides a detailed report of the number and type of incidents reported during the Quarter 3 (2019/20), and how well we perform in relation to reporting those incidents against the relevant policy. The Walton Centre NHS Foundation Trust (WCFT) is committed to the Health, Safety and Welfare of patients, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

TRUST WIDE	Quarterly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 19/20 and Q3 19/20)
Incident							
Total number of Incidents		807	875	734	814	830	
Neurosurgery		506	521	463	495	494	
Neurology		256	307	230	281	293	
Corporate		45	48	41	38	43	
StEIS reported SUI's		5	7	6	1	3	
Patient Safety Incidents reported to the NRLS		246	298	272	279	242	
Accident		105	131	112	109	97	
Communication		142	157	105	122	113	
Death		22	13	14	13	37	
Digital Systems		19	16	15	12	24	
Environmental		37	37	31	38	31	
Infection Control		34	33	22	21	30	
Information Governance		53	68	55	53	49	
Investigations, Images & Diagnosis		30	32	31	29	32	
Medical Devices, Systems & Equipment		31	46	35	44	42	
Medication		102	96	76	68	73	
Nutritional and Hydration		12	9	10	9	8	
Patient Care		96	127	108	92	83	
Safeguarding Incidents			1	13	37	30	
Safegurding Concerns					35	57	
Security		15	16	13	18	13	
Treatment and procedure		27	28	31	33	43	
Violence and aggression		82	65	62	81	68	
RIDDOR		2	2	3	3	3	
Percentage reported within 12 hours (as per Policy)		90%	91%	88%	88%	88%	
% of level 2&3 incidents acknowledged in 24 hours (as per Policy)		90%	89%	85%	75%	86%	
% of level 1 incidents acknowledged in 48 hours (as per Policy)		90%	91%	94%	89%	87%	
% of level 0 incidents acknowledged in 48 hours (as per Policy)		91%	90%	100%	87%	89%	
Rate of incidents per 100 admissions (excl Jef & OPD)		13.67%	15.87%	13.87%	16.35%	16.06%	
Number where DOC (Duty of Candour) where patient/relative have been notified?		19	17	13	15	18	

High level incident overview – Quarterly data:

1. 3 incidents were reported to the Commissioner in Q3, compared with 1 incident in Q2 (see below). Causes to be determined following investigation.

Reported	Incident Type	Incident Summary
5th December 2019	Operation or procedure wrongly sited	Patient was consented for a L5/S1 revision microdiscectomy. After performing the procedure the surgeon requested a further level check and once this was performed the surgeon found that they had performed the procedure at the wrong level.
12th December 2019	Category 3 Pressure ulcer	Patient has developed a category 3 pressure ulcer to bony prominence underneath his halo jacket.
11th November 2019	**Never Event** – Retained foreign object post operation	On a chest x-ray performed 3.11.19, it was noticed that a guide wire is still in place.

2. There was an increase in overall incident reporting from 814 in Q2 to 830 in Q3. The main increase relates to 'safeguarding', increasing from 72 in Q2 to 87 in Q3. Please note this category has now been split on the Governance Balance Score card, to identify 'safeguarding incidents' and 'safeguarding concerns.' Safeguarding will continue to be monitored for the Governance Assurance Framework Log **(Ref 302).**
3. Neurology - incidents increased from 281 in Q2 to 293 in Q3. The increase relates to 'treatment and procedure,' increasing from 14 in Q2 to 21 in Q3. On further scrutiny, 'delay in treatment and procedure,' accounted for the main increase.
4. Neurosurgery - had a slight increase in 'infection control' incidents, from 14 in Q2 to 25 in Q3, 'CPE' seen the main increase, increasing from 0 in Q2 to 3 in Q3.
5. Corporate - had a small increase in incidents from 38 in Q2 to 43 in Q3. 'Accident' increased from 3 in Q2 to 8 in Q3. On review 'fall – collision with an object or person' increased from 1 in Q2 to 4 in Q3.

Incidents by Severity:

The table below provides an oveview of incidents reported by the severity of harm in Q3.

Incidents by Severity	Q2 19/20	Q3 19/20
No obvious harm	678	697
Minor harm may require aid/support	122	105
Moderate harm requiring aid/support	12	20
Major permanent harm	1	0
Catastrophic	0	0
To be determined following investigation	1	8
Total	**814**	**830**

Duty of Candour (DoC):

The table below provides an overview of moderate patient safety incidents that have required both verbal and written notification to the patient/relative/next of kin, under the statory requirements of Duty of Candour, broken down by subcategory and Quarter.

Incident type	19/20 Q2	19/20 Q3
Burn or Scald	1	0
CDIF - WCFT acquired	1	1
CPE - WCFT Acquired	0	3
Device related pressure damage	1	0
DVT	1	0
E-Coli - WCFT acquired	3	3
Failure to refer	0	1
Klebsiella pneumoniae - WCFT acquired	1	1
MSSA - WCFT acquired	0	1
NEVER EVENT - Retained foreign object post operation	0	1
Operation or procedure wrongly sited	0	1
Pulmonary Embolism	2	1
Pressure Ulcer - WCFT acquired	2	4
Respiratory problem	0	1
Totals:	**12**	**18**

Key points to note:

1. Evident increase in CPE from 0 in Q2 to 3 in Q3.

2. Increase in Pressure Ulcers from 2 in Q2 to 4 in Q3.
3. Decrease in Pulmonary Embolisms from 2 in Q2 to 1 in Q3.

NB all incidents were verbally and formally communicated to the patient/n.o.k within the timescales noted in the duty of candour policy.

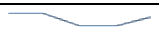
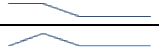
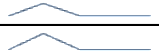
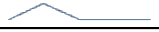
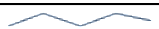
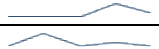
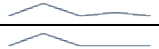
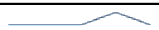
Quarterly themes:

1. Increase in deaths within the Trust, increasing from 13 in Q2 to 37 in Q3.
2. Communication incidents decreased from 122 in Q2 to 113 in Q3. Communication failure within the team saw the greatest decrease, from 25 in Q2 to 16 in Q3.
    a. **NB** Although a decrease in incidents relating to communication issues can be seen, communication has been added to the Governance Assurance Framework Log Ref 304, following a steady increase in complaints and concerns over the previous 4 Quarters.
3. The initial results from the Trust staff survey have also identified concerns with communications issues.
4. Violence and Aggression incidents decreased from 81 in Q2 to 68 in Q3.
5. Safeguarding incidents increased from 72 in Q2 to 87 in Q3.
6. Safeguarding has now been split on the Governance Balance Score Card into safeguarding concerns and safeguarding incidents.
7. Patient falls incidents decreased from 60 in Q2 to 43 in Q3.
8. FALL (slipped, tripped or fell on the same level) decreased from 17 in Q2 to 6 in Q3.

Key actions to note from Quarter 3:

1. Clinical Governance Lead conducted a review of the current safeguarding section on DATIX, splitting notifications relating to incidents and those reported as concerns. Safeguarding concern notifications sent from DATIX, now has a limited audience. This was discussed at the Safeguarding Meeting.
2. Clinical Governance Lead is currently carrying out a review of DATIX, including, incidents, risks and patient experience issues.
3. DATIX refresher training provided as an ongoing programme throughout Q3 & Q4.

Section 2 - Violence and Aggression

TRUST WIDE	Quatertly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 and Q3)
Incident							
Inappropriate Behaviour		8	8	5	5	7	↑
Physical abuse/violence - other on patient		1	1	0	0	0	→
Physical abuse/violence - other on staff		0	1	0	0	0	→
Physical abuse/violence - patient on patient		0	1	0	0	0	→
Physical abuse/violence - patient on staff		50	18	27	45	40	↓
Physical abuse/violence - Visitor		0	2	0	2	1	↓
Racial abuse/violence - patient on staff		0	0	0	3	1	↓
Sexual abuse/violence - patient on staff		0	3	0	1	0	↓
Verbal abuse/Violence - other on staff		0	6	0	0	0	→
Verbal abuse/Violence - patient on staff		16	22	24	21	18	↓
Verbal abuse/Violence - patient on patient		0	0	0	2	0	↓
Verbal abuse/Violence - staff on staff		0	3	1	0	1	↑
Verbal abuse/violence - Visitor		7	0	4	2	0	↓
Total		82	65	61	81	68	↓

Key points to note: (See Governance Assurance Framework Log - REF 287)

1. Violence and aggression incidents have reduced from 81 in Q2 to 68 in Q3. The highest category of incidents continues to be physical assaults - patient on staff. There was a reduction from 45 incidents in Q2 to 40 in Q3. This has also decreased from the comparative Quarter of the previous year, Q3 of 18/19 in which there were 50 incidents.
2. 39 of the 40 physical assaults by patients on staff within Q3 involved patients who lacked capacity.
3. The location with the highest number of violent or aggressive incidents reported was Horsley ITU with 20, followed by CRU with 12.
4. Verbal abuse incidents – patient on staff, have reduced from 21 in Q2 to 18 in Q3.
5. **NB** 'Inappropriate behaviour incidents' do not meet the criteria of verbal or physical abuse, but still require reporting. Incidents include circumstances where a patient, relative or indeed a staff member have acted inappropriately or used inappropriate language but did fit within the verbal or physical abuse categories.

Key Actions:

1. Continue to monitor implementation and roll out of electronic violence & aggression risk assessments, LAST LAP and Body worn cameras for security staff.
2. Review of current CCTV and access control systems.

Section 3 - Information Governance

Key points to note:

Information Governance incidents have decreased from 53 in Q2 to 49 in Q3. This includes all Health Records, Information Governance and Data Quality incidents. All these incidents are reviewed and monitored via the Information Governance and Security Forum on a monthly basis. Of the 49, one was a non-Walton Centre incident.

During this timeframe, there were 2 externally reportable incidents to the Information Commissoners office (ICO). Both have since been closed as no further action by the ICO. To date the trust has reported 11 externally reportable incidents this financial year to the ICO compared to 5 the full year in 2018/2019. The ICO has responded to all incidents reported so far to advise that all appropriate remedial action had been taken and the Information Commissioner was happy with the responses submitted by the Trust so no further action was required.

During Q3, the Trust has received the following:

- 115 Freedom of Information Requests compared to 143 (Q2)
- 100 Subject access requests from patients compared to 76 (Q2)
- 185 Subject access requests from solicitors compared to 214 (Q2)
- 94 Subject access requests from other hospitals and agencies compared to 57 (Q2)

The trust has had no breaches of subject access requests this financial year and to date has never had a Freedom of information breach. During Q3, eight DPIA's were submitted to the Information Governance and Security Forum and approved by the forum and the DPO. The Information Asset Register continues to be populated by all areas of the trust with assets and data flows increasing. This ensures that a robust reporting mechanism is in place which allows the Information Asset Owners to report any identified risks to the Trusts SIRO. Currently the Asset Register has 193 assets and 621 dataflows.

Key Actions:

The department have implemented a number of actions following the recent incidents which consist of:

- Code of Conduct for employees in respect of confidentiality has been revised to include specific wording around staff checking three demographics when performing any task containing personal identifiable information.
- Raised at clinical safety huddle, IGSF, GDPR compliance group to inform managers to speak to staff in their team meetings.
- Divisional managers have confirmed they have spoken to the clerks and secretaries in their divisions at team meetings.
- Top Tips newsletter devised and implemented in every area of the trust which is based on the themes of recent incidents.
- Communications sent through Walton weekly and Team Brief including verbal presentation at team brief from the Digital Health Records and IG Manager.
- Second check implemented in the Subject access department whereby a different staff member to who has processed the request does a final check of demographics on every page prior to the information being sent out.
- Standard operating procedure and change in printing process implemented in radiology department where a breach occurred.
- Extra checks implemented in HR when sending out confidential letters to staff
- Newsletter detailing recent ICO fines of other NHS trusts implemented around the trust.
- Process introduced to ensure HR send over list of locums so they are also monitored on Data security awareness e- learning regardless of length of placement.

Section 4 - Learning from Deaths

Key points to note:

1. All deaths are subject to an initial mortality review, (ideally within 7 days). Following this review if the death is considered unavoidable, the patient will be discussed at the relevant mortality group. If there are issues identified that may require further investigation / detail a Structured Judgment Review (SJR) will be requested. A serious incident related to a patient death will be reported via the SI group and an RCA commissioned.
2. In Quarter 3 October - December 2019, there has been an increase in deaths across the Trust. There were 13 deaths in Quarter 2; all deaths were considered unavoidable. There have been 37 deaths across the trust in Quarter 3.
3. The deaths in Q3 were mostly expected deaths with a high number (20) occurring in critical care. There was a mixture of diagnosis, cerebral and spinal trauma, sub-arachnoid haemorrhage and stroke.
4. In Q3 There has been one family who have raised concerns via the patient experience team and this has been escalated to the surgical division. There have been two local resolution meetings facilitated by the Neurosurgical Governance Lead.
5. There have been 27 deaths in Q3 reviewed using the initial mortality review process, of these deaths there has been 5 further reviews (SJR's) requested. There has been 1 patient death which has been reported to the serious incident group and an investigation has been commissioned.
6. There are 10 patient deaths awaiting initial mortality review.

Quarter	Total No. of deaths	Deaths in neurosurgical Patients	Deaths in Neurology patients	Deaths in ITU
Quarter 1	17	16	1	9
Quarter 2	13	10	1	11
Quarter 3	37	30	7	20

Please refer to Mortality Report for further information.

Section 5 - Complaints & compliments

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

TRUST WIDE	Quarterly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 19/20 and Q3 19/20)
Complaints							
Coroner statement requests		2	5	6	3	1	↓
Police statement requests		12	12	5	9	6	↓
Total Number of Concerns		85	72	56	119	152	↑
Appointment arrangments		36	15	36	66	75	↑
Approach and manner		7	20	10	9	14	↑
Patient Care		9	4	9	10	10	→
Communication		10	12	19	29	34	↑
Discharge Arrangements		5	3	5	5	8	↑
Total Complaints received		24	27	31	36	37	↑
Approach and Manner		10	14	19	12	11	↓
Treatment		4	9	8	10	10	→
Appointment Arrangements		8	9	13	12	14	↑
Patient Care		11	11	9	9	4	↓
Communication		2	6	12	10	17	↑
% Acknowledged within 3 working days		100%	100%	100%	100%	100%	→
% responded to within agreed timescale		100%	100%	100%	100%	100%	→
Neurosurgery complaints		14	14	19	15	15	→
Neurology complaints		11	13	8	15	19	↑
Neurosurgery/Neurology complaints		0	0	3	6	2	↓
Corporate		0	0	1	0	1	↑
% signed responses scanned on system		100%	100%	100%	100%	100%	→
Complaints to Ombudsman		0	0	1	0	2	↑

Complaints – Quarterly data

It has been recognised that the data reported in Q1 and Q2 was not accurate. In Q1 it was reported that there had been 36 complaints, on further review it has been identified that 5 of these complaints had been re-opened, so the correct number was 31. This also applies for Q2, when it was reported that 42 complaints had been received, 6 of these complaints had been re-opened, so the accurate figure for Q2 was 36. This has been amended in the BSC above.

Concerns & complaints:

Complaints:

There is a slight increase in the number of complaints received from 36 in Q2 to 37 in Q3. There is a noted signficant increase of 53% in the total numbers of complaints received year-to-date at 104 compared to 68 in 2018/19.

In Q3, there was an increase of 26% in the number of complaints (19) received by the Neurology Division compared to Q2 (15). The number received by Neurosurgery Division remains static. The increase in numbers are reflected in the themes as they relate to appointment arrangements.

Key themes for complaints in Q3 include:

- **Communication (17)** – (5) related to communication breakdowns with consultants, (5) communication failures with patient/family, (2) lack of information, (3) felt discriminated against, (1) failure within team,(1) incorrect information given.
- **Appointment arrangements (14)** – (5) patients unhappy with outcome of appointment, (4) disputing the urgency of referral, (3) waiting times, (1) cancelled appointment (1) internall error.
- **Approach and manner of staff (11)** – (7) consultant attitude, (2) nursing staff – (2)no trend in other areas
- **Treatment (10)** – (3) delays in treatment, (3) post-op complications, (3) inappropriate/wrong treatment, (1) delay in failure to monitor
- **Care (4)** – 2 related to medication issues, (1) pain management (1) consent
- **Diagnosis (3)** – (1) delay, (2) incorrect/misdiagnosis
- **Admission arrangements** – (1) cancelled surgical procedure

Concerns:

There was a significant increase of 28% in the numbers of concerns received in Q3 (152) compared to Q2 (119) and the predominant theme remaining as appointment arrangements.

The comparison between Q3 2018/19 to Q3 2019/20 shows an increase of 79%.

Appointment Arrangements – (75) relating to referrals not received/actioned, unhappy with outcome, not able to get through to PAC, internal appointment errors and cancelled appointments.

Other themes include:

Car parking issues (18), Approach & Manner (14) Communication (34), Internal appointment errors (10), Lack of information (10), Not able to get through to PAC (10), Appointment outcomes (16), Referrals not actioned/received (13)

In Summary:

Key areas for concern, combined complaints/concerns numbers in brackets:

- Appointment arrangements (89)

- Communication (51)
- Approach and Manner of staff (25)

Governance Log Theme Analysis:

Appointments – as this remains a theme for both concerns and complaints and is a key concern from patient feedback and has an impact on experience. Improvement work has commenced to improve outpatient efficiency but it is recommenced that this remains on the Governance Assurance Framework to monitor this.

Key points to note – Duty of Candour:

Two patients who had initially been contacted following a Duty of Candour had been managed via the compaints process due to questions raised – to improve the timeliness of this in the future a new process has been implemented from Q4 so that these will not form part of the complaint tracker and receive a more timely response.

Initiatives to prevent complaints:

In Q3, the Head of Patient Experience piloted weekly meeting with the Divisional Director of Surgery and Divisional Manager for Neurology to discuss the outstanding complaints and prioritise for the week ahead. This will continued in Q4 with the aim to improve complaint response times and priorities.

At the end of Q3 the Head of Patient Experience introduced walkabouts in partnership with the Divisional Nurse Director for Neurosurgery on the wards to capture patient experience in real time and address any concerns. Patients are asked to provde feedback in line with the Patient Family Journey and asked if they were expected on arrival, how care and treatment was and if they and their famlies have been kept informed of the next steps. Realtime feeback has been provided to ward managers and staff and received well. Actions to take forward are logged. This will continue in Q4 with the aim to roll out to the Neurology Division.

Support for Patients, Families & Staff:

- Home from Home Accommodation – Patient Experience Team (PET) continue to receive excellent positive feedback from families who continually report that they are supported throughout their most difficult times
- PET continued to support for patients and families as part of Duty of Candour and learning from deaths. PET continues to act as point of contact for support and facilitate meeting with clinical staff and families to ensure that all concerns about care are fully addressed and families have provided positive feedback regarding this personalised support

<u>Volunteers</u>:

Excellent progress with our volunteer service in Q3 which includes:

- At the end of Q3 we have 79 active volunteers across the Trust. We have 8 new starters and 18 awaiting interviews.
- In Q3 volunteers have dedicated an impressive 2,263 hours.
- Inductions planned from October 19 – July 2020 diaried for all speakers.
- Recent promotion of neuro buddy role with Matrons with a drive to recruit into these roles in Q4 due to the success and value this provides to patients.

New intiatives include:

- ‘Get Together’ session held in October 2019 attended by 18 volunteers –shared success stories, experiences and provided support to each other.

- Introduction of quarterly coffee mornings for volunteers to meet and share best practice and Afternoon tea planned for Q4
- Registry with Room to Reward – charitiable organisation to recognise hidden heros whereby volunteers can be nominated 1-2 night breaks and this was promoted on social media.
- Volunteer will feature in Neuromatters in Jan 2020 to share his journey and amazing story.
- Volunteers co-ordinator attended an two day autism awareness training in October 2019 – learning has been shared with volunteers.
- Partnership working planned with Aintree January 2020 to learn/share ideas
- Pilot volunteer capturing patient feedback/experience

Recognition:

- Four Hidden Heros awards – Room to Reward in December 2019
- Two winners for Volunteer of the month
- Christmas party & Awards - attended by 30+ volunteers, buffet, team quiz, raffle and prizes, event shared on social media.

Patient Stories:

- Patient stories continue to be used at Trust Board and Council of Governors Meetings and feedback provided at the Professional Nursing Form. Patients and families will continue to be encouraged to present their story in person and volunteers have been asked to promote this in their areas.

Examples of lessons learnt from concerns and complaints

Complaint Issue: Patient sustained a CSF leak and admitted to another Trust. Visiting neurologist advised patient had migraine and instructed patient should remain mobile. Patient reviewed by another neurologist who diagnosed CSF leak. The initial misdiagnosis resulted in patient experienceing uncessary pain and prescribed unnecessary medication.

Action: *Apology and full account of events and explaination provided. Complaint to be included in consultant's appraisal process, asked to reflect . Division have taken steps to improve management of emergecy referrals including systmatic estalation involveing daily contact to post operative patients.*

Complaint Issue: Patient used nurse call buzzer several times during night as needed to use the toilet. Patient had tracheotomy insitu and was non-vebal. Patient's request not answered and left in soiled linen for a length of time.

Action: Hourly checks put into place since event. Staff have reflected on impact on patient and experienced shared in ward meetings to ensure patients dignity is met at all times. Staff reminded of importance of maintaining accurate records

Issue: Patient referred from pain management to Neurology with no clear diagnosis or treatment plan following referral to other Trust.

Action: *Meeting held with Clinical Director and patient provided with appointment for review for second opinion and management plan.*

Section 6 - Patient Experience

Friends and Family Test (FFT)

The Trust results for FFT remained very positive for Q3, both in terms of recommended rate and response rate. The inpatient rate was consisent between 96-98% each month. The recommended rate remains signficantly above the nation average around 20%, which demonstrates the positive experience received by both patients and their families.

The FFT recommendated rate was consistently high across the wards although this has dipped slightly compared to Q3. It should be noted that the inpatient FFT is reported nationally, however, there is no requirement for this to be done with outpatient FFT. The outpatient FFT repsonse is significantly lower than the inpatient FFT; however this remains consistent with practice across Trusts nationally.

Overall Inpatient FFT

	October	November	December
Recommend rate	96%	97%	98%
Response rate	40%	51.90%	n/a

Overall Outpatient FFT

Recommend rate	96%	98%	93%
Response rate	5.40%	5.50%	n/a

Recommend rate by Ward (total responses in brackets)

	October	November	December
Cairns	41.1%	98.5%	41.9%
Caton	36.5%	65.6%	62.3%
Chavasse	29.0%	35.4%	45.7%
CRU	88.9%	100%	66.7%
Dott	39.4%	82.1%	48.6%
Jefferson	50.5%	84.5%	51.4%
Lipton	100%	100%	0%
Sherrington	27.5%	69.4%	34.6%

Local Questionnaires - Excellent feedback and responses for Q3.

	Did not need help	Yes	No
Were you given enough help from staff with your meals?	16%	82%	2%

	Had no worries/fears	Yes	No
Did you find someone to talk about any worries or fears?	35%	63%	2%

	Yes	No
Were you involved as much as you wanted in decisions abouy your care?	94%	6%

	Yes	No
Were you given enough privacy when discussing your condition and treatment?	98%	2%

	Yes	No
Did you feel you were treated with respect and dignity during your stay in hospital	100%	

	Excellent	Very good	Good	Fair	Poor
How would you rate the overall standard of care during your stay?	84%	16%			

Section 7 - Compliments

This table represents the numbers of compliments received centrally by the Patient Experience Team. However, it should be noted that this represents a very small reflection of the positive feedback received directly in wards or departments, and via social media. Below are examples of the compliments received by Wards and Departments during Quarter 3.

TRUST WIDE	Quarterly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 19/20 and Q3 19/20)
Compliments							
Total number of compliments		75	337	77	58	82	

Key points to note:

Examples of compliments received by Patient Experience Team – from comments and Patient Experience Round which commenced in Q3.

- Since arrival mother has received 'Excellent care' staff are 'compassionate and supportive' and nothing is too much of a problem. Recognition should be given to a porter 'Taff' who went above and beyond to make daughter feel supported just for asking if she was ok and gave her directions etc. Excellent communication with updates of care to mother and family from all disciplines – doctors, nurses, physiotherapists and dieticians. 'Care is outstanding'
- Excellent care and treatment from all nursing and medical staff. Efficient super service, fantastic, constant care and attention. Open visiting from midday – great. Nursing staff always inform family member of updated care plan each day following ward round. Food is good, staff very supportive and welcoming. It is great that you want our feedback and comments
- Home from Home – relative offered a room as soon as he arrived and was amazed at the fantastic accommodation – both he and wife have questions 'is the is the NHS' as the quality of care and family accommodation is first class
- Excellent care and treatment. All staff kind and compassionate and they really care. Under the care of Walton for last 3 years and always received excellent care. Staff wonderful in fact they are 'amazing'.
- Everyone smashing, food good. No noise at night – so able to get rest
- Excellent care and treatment from all nursing and medical staff. Efficient super service, fantastic, constant care and attention. Open visiting from midday – great. Nursing staff always inform family member of updated care plan each day following ward round. Food is good, staff very supportive and welcoming. It is great that you want our feedback and comments.
- I wanted to let you know of the decent, professional people who really care. No doubt you receive emails of complaints more so than compliments so I thought I would send this information onto yourself. Keep up the good work with your team You have a lot of work on your hands and I understand working with organisation development and culture myself that it takes time to change 'turning the ship slowly' is the metaphor I'm familiar with.
- It costs nothing to be kind and caring and I can understand in these stressful times, employees can be stressed themselves, however the Patient Experience Team put my sister as a priority, Joanne was seen as a human being, not a number, which unfortunately was how some others saw her. I am worried about people who do not have family and friends to look out for them, if I hadn't of taken this further my sister would have still been in pain as her operation was for booked in for January as she wasn't classed as an emergency.
- I wanted to express my gratitude for the surgical skill, professionalism, the explanations given for all the procedures, plus the friendly, caring

treatment I received from Miss McMahon, her team and all the many staff on Chavasse ward. I am grateful to all the staff I encountered, keeping me informed, from having an MRI at another hospital and advise to attend A&E following this I was transferred as an emergency with the operation carried out on Monday afternoon and discharged on Tuesday. Also since then my thanks to the spinal nurses, who have been so helpful in answering my queries and Lizzie for arranging to see me with the doctors, who were reassuring regarding my wound? Wonderful treatment.

Twitter and Facebook

- Thanks to the Walton Centre for looking after my husband over the last few years
- Thank you for my spinal surgery
- All the best to the Walton Centre, if it was not for you I would not be here
- Congratulations to you have looked after my wife these last weeks and the doctors explanation of the scans, results test, to us one day was wonderfully clear, helpful and personable. Part of an amazing Team!
- I wouldn't be alive if it wasn't for this man's knowledge and experience in the field of encephalitis – such a treat man
- Fantastic people – Fantastic volunteers!

Section 8 - Claims / Legal

The Trust has an agreed process in place for reporting, managing, analysing and learning from claims, in accordance with NHS guidance and Civil Procedure Rules. The Trust is a member of National Health Service Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) and Existing Liabilities Scheme (ELS) for clinical claims. The Trust is committed to ensuring that claims are resolved in a professional, efficient and timely manner. The Trust aims to achieve an equitable outcome for all parties concerned, to take appropriate corrective action and to reduce the risk of future litigation.

This section describes the number of claims received and closed during the quarter. It should be noted that owing to the timeframe to settle a claim there can be a significant period of time to open and close a claim.

TRUST WIDE	Quarterly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 19/20 and Q3 19/20)
Claims							
Total new claims received		12	4	8	4	9	
Neurosurgery claims		8	3	3	3	4	
Neurology claims		1	1	3	1	4	
Corporate claims		3	0	2	0	1	
Total number of pre-action protocols in quarter		13	15	11	14	10	
Number of closed claims in quarter		7	8	4	5	7	
Value of closed claims - Public liability		£1,286	£0	£5,427	£0	£0	
Value of closed claims - Employer liability		£0	£0	£0	£15,736	£0	
Value of closed claims - Clinical Negligence		£1,414,763	£1,134,580	£12,265	£447,102	£155,194	

Key Points to note:

9 claims were received in Q3 of 19/20 compared to 4 received in Q2. See breakdown below:

1. LS (210) Neurosurgery Letter of Claim received

Claimant experienced an episode of awareness during positioning of the claimant on the operating table due to the sedation not being turned on. The claimant now suffers with PTSD following surgery.

2. SD (211) Neurology Letter of Claim received

Claimant alleges that there was a delay in diagnosis of nerve damage by the Walton Centre following surgery at Warrington and Halton Hospital.

3. PEC (212) Neurology Letter of Claim received

Claimant was being seen by his GP from 2011 for platelet count and blood pressure investigations. In January 2014 he was seen at the stroke clinic and in A&E Whiston. He was referred to WCFT in March 2014 and was seen by Neurology in June 2014 who explained to the claimant that the episodes could be sporadic hemiplegic migraine. The consultant also referred him for a scan. He had the MRI scan in July 2014 where the results showed multiple strokes some of which explained left sided weakness of sudden onset. He was referred to his local stroke team. The allegations are that the WCFT should not have diagnosed sporadic hemiplegic migraine and that TIA's and stroke should have been a considered diagnosis and urgent investigations carried out.

4. SW (213) Neurosurgery Letter of Claim received

Claimant had a fall from a ladder in October 2018 and was seen by her GP. She attended A&E on 08/11/18 where a T12 fracture was diagnosed and requested advice from WCFT. Advice was to fit TLSO brace. She was referred to ECFT and was seen on 26/11/18 – no TLSO brace fitted as advised on 08/11/18. WCFT referred to orthotics for TLSO brace. 14/01/19 follow up clinic WCFT but still no brace fitted until 25/01/19. Allegations are that TLSO should have been fitted when claimant attended WCFT clinic on 26/11/18. As a result of the delay the claimant has suffered 8 weeks of pain and suffering and further collapse of fracture.

5. AMcG (214) Neurology Letter of Notification received

Claimant had coiling of aneurysm on 09/03/18. On 10/03/19 Radiologist removed the sheath in the right groin but was unable to insert the closure device to seal the femoral artery due to patient's BMI. CT scan showed haematoma. Claimant was transferred to the Royal Liverpool Hospital for surgical repair of femoral artery. Allegations are that the removal of the sheath was carried out in a negligent manner. Failure to perform the removal in the correct setting with the necessary equipment. Failed to obtain informed consent. Subjected the claimant to unnecessary risk. The claimant now suffers with pain, sensitivity at this site and has a 4 inch scar.

6. KO (215) Neurosurgery Letter of Notification received

It is alleged that the treating consultant dismissed recent MRI scan results and advised the claimant that he had CRPS following bypass surgery in December 2016. It is alleged that the diagnosis and treatment provided was incorrect.

7. DD (216) Neurosurgery Letter of Claim received

Patient inappropriately assessed on admission as not being at risk of falls. Following surgery on 02/12/15 mild weakness was noted but falls risk not re-evaluated. Pt had a fall on 03/12/15. It is alleged that the fall caused the haematoma at C7/T2 region. Further surgery was required. Further MRI on 09/12/15 showed either infection or inflammation to the same area of the spinal cord. On 13/12/15 haematoma was surgically removed. The claimant now

suffers with permanent ASIA B paraplegic level T2.

8. RK (217) Neurology Particulars of Claim received (co-Defendant Aintree)

Allegations are that the consultant failed to adequately consider the MRI scan report that was taken in January 2015 at Aintree Hospital in his consultation on 29/04/2015, failed to give due regard to the symptoms reported by the claimant's physiotherapist, failed to consider that the claimant was suffering with spondylitic cervical radiculopathy, failed to carry out an adequate neurological examination and failed to refer to a Neurosurgeon.

9. SC (25) Public Liability Claim

Ward hostess slipped on wet floor. Broken left wrist, bruising to both knees, pain to knees and arms.

Closed Claims

7 claims were closed in Q3 of 19/20. The total value of closed claims decreased to £155,193.58 in Q3 of 19/20 compared to £462,837.92 in Q2 of 19/20. All closed claims were CNST.

- There were 8 new CNST claims in Q3 compared to 4 in Q2.
- There was 1 new corporate claims in Q3 compared to 0 in Q2.
- There were no re-opened claims in Q3.
- There were 10 pre-action requests for medical records in Q3 compared to 14 received in Q2. 7 claims were closed in Q3 compared to 5 being closed in Q2. We had to pay damages, claimant and defence costs for 3 of the closed claims. For the remaining 4 closed claims we paid defence costs only for 3 of them and no costs at all for the remaining 1. These claims may re-open if we receive any further correspondence from the claimants' solicitors at some point in the future. It should be noted that it may take over 5 years to settle an individual claim so any increase is not an indicator of any change in service between years.
- The Trust has served 10 Letters of Response of which 6 denied liability, 3 made a partial admission and 1 made full admission.
- The Trust has settled 1 claim in Q3.

Following the introduction of Getting it Right First Time (GIRFT). All Letters of Claim/Notification are now discussed in the Serious Incident Group bi-weekly meetings. For Q3 none of the LOC/N discussed, which have not initially gone through the RCA process, have required an RCA to be carried out.

Coroners Inquests

We had 3 cases which have now closed where the Coroner had requested that staff provide statements and attend Inquest.

DS.

The deceased's wife raised concerns with the Coroner regarding the tracheostomy and platelet care/treatment provided to her husband during his inpatient stay. She is of the opinion that the care/treatment provided contributed to his death. Directions were received from the Coroner for statements from staff involved in the patient's care which were provided. We have received inquest funding from NHSR and Hill Dickinson (HD) have been instructed to deal with this matter. The deceased's wife has also instructed solicitors. We attended several Pre Inquest Review meetings to assist the Coroner with her investigations and an Inquest was held from 16/12/19 to17/12/19 inclusive. During the Inquest evidence was given from WCFT and RLBUH (Heamatology) staff.

After hearing all of the evidence the Coroners main concerns were:

- Treating team did not chase up results in the days leading up to the scheduled surgical procedure. This is ultimately the responsibility of the treating

consultant. Had the platelet results been chased and received in the days leading up to the surgery there would have been more time to discuss the platelet disorder with the family so they would have had the opportunity to absorb the informed diagnosis.

- Treating consultant should have documented the conversation that they had on the morning of surgery with DS (this could have been documented after surgery if not done before).
- Coroner was satisfied that the Trust RCA writer will take concerns raised by DS wife forward.

The Coroner concluded that the care and treatment afforded to DS was appropriate and it is more likely that DS died of natural causes.

VH.

The deceased's husband raised concerns with the Coroner regarding a delay in diagnosing and treating his wife's brain tumour from December 2018 to May 2019. His opinion was that had she received an earlier diagnosis the treatment received would have been provided earlier giving a better outcome and therefore giving her more quality time to spend with her family before her death. The Trust attended two Pre Inquest Review meetings. The first meeting focused on delay of diagnosis and treatment. The consultant who attended explained the reason behind the delay in diagnosis and further the reason for the delay in treatment – this explanation was accepted by the Coroner and the family. The second and final Inquest meeting focused on the consent form and whether the patient and family had been informed on the "risk to life" before undergoing the surgery to de bulk the tumour. Following the Registrar's evidence the Coroner was satisfied that the "risk to life" had been discussed. The Coroner recorded a verdict of misadventure. The Coroner further suggested that the consent forms should contain a section to confirm that "risk to life" had been discussed. Further discussions suggested that patients/families who find themselves in the situation where they receive a life changing/limiting diagnosis should be given the opportunity and enough time to be able to take on board the seriousness of the diagnosis and therefore enable them to consider all treatment options and make a decision regarding treatment which is right for them. Following the Inquest the deceased's husband attended a meeting at the Trust with the Head of Patient Experience, Lead Cancer Nurse and Claims Manager to discuss how the Trust can improve the service provided to support patients and families. Following this meeting the Lead Cancer Nurse highlighted this case with the consultant in charge of care of the patient, ward staff, quality committee, patient centred care group, chair of the neuro oncology MDT and organ donation team. We met with the deceased husband again and fed back the concerns that had been raised and how these will be taken forward to improve the service provided for future patients.

WH.

The deceased's family raised concerns with the Coroner as they felt that the treatment and care that WH had received was not adequate and contributed to his death. They had several questions that they wanted to put to the consultant through the Coroner. Their main concern was that WH had lost 5 stone in weight due to his swallowing difficulties following his surgery.

WH had ACDF surgery on 06/05/2016. Following surgery the deceased had some swallowing issues due to the position of the cage which can be expected following this type of surgery. Further WH developed an infection at the wound site and was re-admitted for wound exploration and wash out in May 2016. He was discharged in June 2016 and attended follow up clinic on 30/06/19 and had an x ray which showed slight prominence of the upper part of the metal plate within intact cage positioning. It was deemed that further surgical intervention was not necessary. Subsequent x rays did not show any further movement. The deceased was also discussed at MDT meetings. By November 2016 the deceased was wheelchair bound. He had been seen in Neurology clinic and was diagnosed with a form of neuropathy. His swallowing difficulties had not increased. The deceased had a further surgery C3-C5 central laminectomy in January 2017. The deceased decided that he did not want to be seen by the treating consultant anymore and therefore was last seen in March 2017 and referred to the pain team.

At Inquest on 02/12/19 the pathologist and consultant in charge of care gave evidence and answered questions from the Coroner and the family.

The consultant explained that although the metal plate had initially moved by 7mm following surgery WH could still swallow. Further x-rays and scans

showed no further movement of the metal plate.

It was also confirmed that while WH was an inpatient at the WCFT (3 admissions in total from May 2016 to January 2017) his weight fluctuated between 94.3kgs to 90kgs. WH did not lose 5 stone in weight while under the care of WCFT.

During all consultations WH raised concerns about pain and mobility problems and not swallowing problems.

The consultant confirmed that he had not received any correspondence regarding any deterioration in WH's health following his last appointment in March 2017.

After hearing all of the evidence and answers to questions asked the Coroner was satisfied enough to conclude the Inquest and asked the family if there were any further question. The family said that there was a big difference in two photographs taken within three week of WH death and in their view they said that WH showed signs of malnutrition although the pathologist had said that WH was of medium size for his age. They added that when WH was at AUH a health professional had said that they had discussed WH condition and nothing further could be done for him. However, the family did not know who WH's condition had been discussed with. They asked the Coroner if AUH could be approached to provide information. The Coroner has adjourned the case and requested information from AUH.

Staff Support

All staff involved in claims are fully supported regarding the process of clinical negligence claim.

Lessons Learned from closed claims and coronial reviews:

- Claim - Falls, a lot of education around special observation and levels of observation has been completed as a result of this case
- Claim - Communication, referring consultants to state URGENT REFERRAL on covering letter
- Coroner - Consent forms to be reviewed to include section to confirm that 'risk to life' has been discussed

Section 9 - Risks

TRUST WIDE	Quarterly trend	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Quarterly variance (Q2 19/20 and Q3 19/20)
Risks							
Current Number of High Risks 15 and above		24	25	22	22		⇩
Current Number of Medium Risks 6-12		145	154	147	150	157	⇧
Current Number of Low Risks 1-5		46	53	53	43	57	⇧
Number of new Risks opened in the Quarter		23	24	19	23	12	⇩
Number of closed Risks in the Quarter		16	10	16	17	10	⇩
Number of Risks increased in the Quarter		0	2	1	0	0	⇨
Number of Risks decreased in the Quarter		2	7	4	6	7	⇧

Key Points to note:

1. An increase in medium risks rating 6-12, increasing from 150 in Q2 to 157 in Q3.
2. Increase in low risks rating 1-5, increasing from 43 in Q2 to 57 in Q3.
3. Q3 - 12 risks were opened, 10 risks were closed, No risks were increased and 7 risks were decreased.

Top 3 Board Assurance Framework Risks:

Please refer to the Board Assurance Framework.

Top 3 Operational/Divisional Risks:

1. Risk of not meeting the Activity Plan due to Consultants not undertaking WLI's – Risk Rating of 20 – Division: Neurosurgery.
2. Achievement of balanced budget – Risk Rating of 20 – Division: Neurosurgery.
3. There is a risk that RTT targets will not be met at specialty level for NHSE and overall for NHSI due to demand versus capacity gap.– Risk Rating of 16 – Division: Neurosurgery.

Key Actions:

1. Continue to ensure the Risk Register process is embedded in the Trust by providing continuous training and scrutiny of the risk registers at various groups and committees. Risk Register Training continues to be provided throughout the year.
2. Risks have now been split by subcommittee of Board following a recent MIAA Audit.

Section 10 - Safety Section

Fire Safety

1. Q3 has seen a reduction in unwanted fire alarms. (See table below) however the theme continues with 2 out of 4 alarms being caused by avoidable actions, (fogging and aerosol). The actuation caused by a toaster, has been identified as an incorrect detector head fitted to the pantry on Jefferson Ward.

Fire alarms unwanted fire signals (UwFS):

	Actual Fire	Manual Call Point	Steam	Toaster	Microwave	Fogging	Nebuliser/ aerosol	Smell of smoke	System fault	FRS Attendance
October	0	0	0	1	0	0	1	0	0	1
November	0	0	0	0	0	0	0	0	0	0
December	0	0	1	0	0	1	0	0	0	1
Total:	0	0	0	1	0	1	1	0	0	2

3. Q3 has seen a drop in training figures, however this is inevitable as people reach and exceed due dates heading toward the end of the calendar year. Staff training is ongoing with on-site department/ward training still popular, particularly with night staff.

Key actions:

1. Fire Risk Assessment review is ongoing with actions being addressed both in area and by the Estates dept.
2. Plans for Fire evacuation drills are currently being discussed with department managers and a programme will be developed for the coming year.
3. Local Fire and Rescue Service crews will be attending the trust to carry out site familiarisation visit, early in Q4. These visits are important for both the trust and the FRS to allow for integrated operations, in the event of a Fire Incident occurring.
4. Continue to monitor progress of post fire action plan, compartmentation upgrade and repair programme nearing completion.

Moving and Handling

Key actions:

1. Equipment: Medical Devices
   - Outline Operating procedure is being devised for equipment which accompanies patients on leave from the Trust
   - Awaiting third and final phase of replacement mobile hoists, familiarisation training to commence on receipt
2. Education and Training
   - Risk 311 remains at 12 due to resource constraints; ratio of facilitator to number of attendees, space constraints and time allocation. Investigation is underway to suitably realign the Induction programme (blended learning approaches support the programme in that the Moving and Handling Advisor continues to provide advice and training inputs in the work place)

3. Human Factors Ergonomics (HFE)
   - HFE advice and guidance is being provided for the setting up of a Complex Clinic within the Outpatient department
   - Risk rating for Risk 712 (Inadequate HFE system in relation to the use of fabric washable patient slings) has been reduced to 10. Staff are reminded at every training input to check these slings on each use and remove for safekeeping if any concerns are identified. Moving and Handling Advisor inspects, removes from service and decommissions if not fit for purpose.
3. Bed Management
   - The bed manufacturer has been approached and is compiling an age profile of our current bed compliment
   - Scoping of our current compliment will provide the specification detail for future replacement requirements
   - Horsley ITU currently trialling high dependency model
   - Potential for 'in-house' planned preventative maintenance has been explored and is progressing through the Head of Risk
4. DATIX
   - There have been 9 reported adverse events received during this reporting period with a Moving and handling component, of these 2 required reporting to the HSE under RIDDOR. Investigated where necessary and followed up with staff support via advice, guidance, training and consolidation of safe approaches to facilitating movement with patients and use of assistive equipment.
5. Staff Risk Assessment
   - A total of 8 staff assessments have been requested and provided for staff diagnosed with a musculoskeletal disorder or health condition, working with individuals in clinical practice where required.
6. Safeguarding
   - Support provided to the Safeguarding Lead in relation to CQC Reg 13 report

Health and Safety

Key actions:

1. The Trust has reported 3 RIDDOR incidents to the HSE in Q3. Two incidents affected Trust staff as well as an off duty member of ISS staff.
   - Off duty member of ISS staff stated she was walking from the public car park towards the main entrance of the Walton centre and tripped over a raised paving flag.
   - Two Members of staff was called to assist a patient with poor mobility to stand. On standing the patient would use a Zimmer frame for support and mobilising. During the assisted lift the patient leaned forward placing all her weight onto the two staff members resulting in back injuries to one staff member of staff. The Trust manual handling coordinator will review staff handling techniques to ensure correct procedure is being.
   - While assisting a patient who had fallen and laying on the floor, the member of staff tending the patient twisted from a kneeling position to reach a pillow for the patient and in twisting injured her back.

Key actions:

1. During Q3 the Deputy Head of Risk has, with the cooperation of departmental managers, identified 10 non-clinical members of staff who would like to complete a one day Emergency First Aid at Work training course.
2. The online Health & Safety Environmental risk assessment tool has been tested by key members of staff, some minor alterations have been identified

and completed with expected roll out and training to begin during February 2020.

3. Review of Control of Substances Hazardous to Health (CoSHH) will also be reviewed during Q4 with a short CoSHH awareness presentation for responsible staff to raise awareness and ensure compliance with current legislation.

Emergency Planning

Key actions:

1. The 2019-20 Emergency Preparedness Resilience & Response (EPRR) Core Standards outcome of self-assessment for the Trust was compliant with the applicable standards. A report was sent to BPC and Trust Board, were it was duly approved.
2. New Senior Manager joining the on-call rota have received training and awareness, including major incident response, contents and locations of contingency cupboards within designated incident rooms.
3. The Deputy Head of Risk is now attending the Merseyside Local Health Resilience Partnership Practitioners Meetings.

Appendix 1 - Glossary of Terms

1. Clinical Risk Management - focuses on the risks directly associated with patient care.
2. Emergency Preparedness, Resilience and Response (EPRR) - is the means by which the NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport or terrorist incident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.
3. Fire Safety - is the means by which all NHS organisations ensure the safety of patients, staff and visitors. For all premises under their control NHS organisations will need to select and effectively implement a series of measures to achieve an acceptable level of fire safety.
4. Formal complaint – is defined as a complaint managed in line with NHS Complaints Procedure 2015 in line with the Department of Health guidance which is known as local resolution.
5. Health and Safety Management - is “the means by which an organisation controls risk through the management process”. The management of occupational health, safety and wellbeing is now central to the effective running of the NHS. There is strong evidence linking patient safety, patient experiences and the quality of care with the safety, health and wellbeing of the workforce.
6. High Risk - is a risk will be deemed high if, the likely impact of the risk would lead to major disability or death of an individual or loss of service or reputation of the organisation or prosecution.
7. Incident reporting - is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents and near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may have a negative impact on the patient experience and result in a loss of public confidence in the organisation and a loss of assets.
8. Management of medical devices - is the systematic approach to the acquisition, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices and medical device training, to ensure that medical devices are used safely, competently and effectively for the best care of patients and to comply with all relevant legislation and guidance.
9. Moving & Handling - The Manual Handling Operations Regulations 1992/2016 (MHOR) define manual handling as “any transporting or supporting of a load including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force.”
10. Non Clinical Risk Management - is associated with all other Trust activities.
11. Risk Management - is a process of identifying, assessing, controlling and reducing risk across the whole organisation.
12. Risk - is defined as a hazard / exposure to danger which may lead to harm. The consequence of risk can be damaging and consequently steps must be taken to eliminate or minimise risks and / or limit the impact / frequency of occurrence.

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

Pharmacy and Medicines Management Annual Report 2018-19

Pharmacy's mission statement is: 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:

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Executive Summary

Purpose

The purpose of this report is to submit, for the Board's information, the annual report for Pharmacy and medicines management within the Trust for the period April 2018-March 2019.

Context

Medicines management in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution medicines make to producing informed and desired outcomes of patient care.

Medicines optimisation is an approach that seeks to maximise the beneficial clinical outcomes for patients from medicines. Medicines optimisation is part of the wider medicines management agenda. It focuses on the prescribing of medicines, the impact on the prescribing and medicines budget, the access to high risk and high cost medicines and elements of safe and secure handling of medicines.

Pharmacy services at The Walton Centre are provided by Liverpool University Hospitals NHS 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.

This report updates the Board on progress made within the Pharmacy and medicines management agenda.

Highlights in 2018-19

- Pharmacy services were delivered in accordance with the service level agreement.
- The roles and profile of pharmacists within the Trust continued to grow, with increased formal involvement of senior pharmacists in various Trust committees/groups and projects as well as more contact and informal working with a wide range of clinical and non-clinical staff.
- Prescribing pharmacists have continued to utilise their extended skills by contributing to daily surgical ward rounds, optimising inpatient prescriptions and writing discharge prescriptions, and reviewing all same day admission patients, prescribing their usual medicines and ensuring appropriate management of medicines peri-operatively. These roles have become well established and accepted as part of the surgical multidisciplinary team.
- Evaluation of pharmacist prescribing showed a high volume of prescribing, with 16,456 inpatient and 5998 discharge items being prescribed by Pharmacist Independent Prescribers in 2018-19. Audits showed reduced time until discharge prescriptions are written and a much lower incidence of prescribing errors than medical staff.
- Further improvements to the EPMA web portal, including the function for pharmacy staff to order named-patient fluids electronically including IV immunoglobulins for patients on Jefferson ward, improving safety and efficiency of dispensing.
- Medicines Optimisation CQUIN requirements achieved.
- Improved compliance with the national requirements regarding immunoglobulin prescribing, patient review and data collection and database entry.
- Improvements made to governance of homecare medicines, including monitoring of key performance indicators from companies and regular meetings.

- Planning and implementation of new processes in response to the Falsified Medicines Directive which came into force in February 2019.
- Achievement of the Quality Account target for omitted doses of critical medicines; a 36% reduction was achieved.
- Involvement in CQC inspection process.
- Focus on improving practice with controlled drugs, particularly in terms of documentation on wards, patients' own controlled drugs and management of discrepancies in stock levels.

Areas for further development

- Ongoing discussions and planning regarding the potential switch of Electronic Prescribing system at Aintree, and the impact of this on Walton. Revised roll out date of electronic patient record (EPR) at Aintree which has delayed confirmation of plans.
- Outsourcing of outpatient dispensing to allow savings on VAT. Implementation expected November 2019.
- Submission of a business case for extra pharmacist time to improve clinical homecare governance and provision, in order to manage the increasing workload and to fully implement the requirements of the Hackett report and Royal Pharmaceutical Society (RPS) standards for homecare.
- Submission of a business case for increased pharmacy cover on critical care following CQC review and recommendations and to comply with national Guidelines for the Provision of Intensive Care Services.
- Implementation of increased antimicrobial stewardship, including antimicrobial pharmacist involvement in a new multidisciplinary outpatient antimicrobial therapy clinic.

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. All statistics include only work relevant to Walton unless specified. The developments described benefit both Trusts.

1.1 General information

Aintree Pharmacy employs 150 staff, comprising pharmacists, technicians, pharmacy assistants and administrative staff. In March 2019 compliance with mandatory training was 92%, sickness absence 6% and completion of annual appraisals 91%. (These figures relate to the whole department.)

It is a Registered Pharmacy with the General Pharmaceutical Council (GPhC), and has a wholesale dealer's license in order to supply medicines to the Walton Centre. It was inspected by the Home Office for renewal of its license to supply controlled drugs to the Walton Centre in December 2017. The license is valid until January 2020.

1.2 Dispensary services - medication supply

During 2018-19, a total of 63,869 items were dispensed for individual Walton inpatients, discharge prescriptions and outpatients, and 19,300 stock items. 3717 items were returned to stock and credited to Walton.

The average turnaround time for Walton discharge prescriptions was reported monthly and was consistently under the target of 2 hours. The average number of Walton discharge prescriptions clinically checked on the ward in 2018-19 was 82% against a target of 70%.

The pharmacy 'robot' (automated dispensing machine). 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 container (the computer where the label was produced or in the correct ward box in stores.) Most medicines are processed into the robot automatically via the 'hopper' chute (left hand side) which conveys them into the robot for bar code scanning and then storage.

The EPMA pharmacy web 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 web 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 indicates recent medication supplies made by Pharmacy for each patient and the ward the medicines were sent to. This reduces duplicate ordering, reducing medication wastage and 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 and robot abolish the potential for dispensing errors due to incorrect manual entry of medicine details, manual selection of correct medicine from the shelf or incorrect entry of 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. However all dispensed items routinely undergo a final check, so very few dispensing errors leave Pharmacy.
- Discharge medicines are also labelled via the web portal as for inpatient medicines.
- Electronic ordering of controlled drugs (CDs) is mandatory. This allows a safety check of the prescription by pharmacists before supply is authorised for CDs not routinely used on the ward. It also removes the need for porters to bring CD order books across to Pharmacy from Walton each morning. The electronic ordering of CDs is also linked to the automatic labelling systems in pharmacy and follows the same process as the ordering and supply of non-CDs, except rather than being stored in the robot, there is an Omnicell electronic CD cabinet linked in to the EPMA system to improve safety and security of CDs.

These systems all improve patient safety by reducing the risk of various types of errors, and also save staff time (nurse, porters and pharmacy). The web portal is subject to ongoing development and introduction of new functions, and is regarded as very innovative within Hospital Pharmacy circles.

During 2018-19 the following updates were made to the pharmacy web portal:

- A function was added for pharmacy staff to order named-patient fluids electronically including IV immunoglobulins for patients on Jefferson ward, improving safety and efficiency of dispensing.
- A form was added to record when drugs were borrowed between wards
- As part of the work to improve management of controlled drugs (CDs) on the wards the nurse CD balance checks record was expanded to include the following three questions: CD stocks checked & correct? Patients' own CDs checked and correct? CD stationary secure? When entering a patient's own CDs onto the portal the requirement for a double nurse signature was added.
- Requirement for a second nurse to witness entry of patients' own controlled drugs onto the electronic register (at the request of Walton staff, to reduce errors).

The process of outsourcing outpatient dispensing was commenced and is expected to be completed in late 2019.

1.3 Pharmacy stores - procurement, stock distribution and medicine recalls

Pharmacy stores has a wholesale dealer's license and provided a stock top up service to all wards and departments, including refills and checks of used or expired resuscitation boxes of emergency medicines. Ward stock lists were reviewed regularly by ward pharmacists in

liaison with ward managers. Approximately 25 medicine recalls were received during the year, and appropriate action taken.

Shortages of specific medicines nationally has been an increasing problem in recent years. Pharmacy stores play a key role in managing stocks and sourcing alternatives 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 patient safety and optimal care. Significant shortages during 2018-19 included water for irrigation, oral nimodipine and the intravenous fluids Plasmalyte, Hartmann's solution and sodium chloride 0.9%.

The procurement team's work also included:

- sourcing of unlicensed medicines
- monitoring changes in contracts negotiated by the regional purchasing hub, and alerting pharmacists to significant price changes or safety issues eg 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.
- 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, appropriate facilities with close monitoring and control.

As a licensed unit we ensure all activity complies with the principles and guidelines of good manufacturing practice (GMP), working safely and efficiently to meet the growing demand of sterile, high quality products such as chemotherapy and parenteral nutrition in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA).

The Aseptic unit is situated in the main Pharmacy. The 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 re-circulation 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 which also includes pressure and temperature checks. A particle counter is present to detect contamination. Manipulations and checking of volumes are completed using camera systems.

Preparation of all 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 reduce costs by allowing multiple doses to be prepared from one vial, reducing wastage.

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

In 2018/2019 the licensed Pharmacy Aseptic unit prepared for Walton approximately:

- 2600 batches of ready to use injectable medicines for Walton for stock on wards e.g. intrathecal Vancomycin and prefilled syringes of Ketamine
- 700 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
- 98 ready to use medicines for clinical trials

1.5 Medicines Information service

The Medicines Information team answered 137 queries regarding medicines during the year, mostly clinical, using a wide variety of specialist reference sources and/or comprehensive literature searches. 68% of these were complex level 2 and 3 enquiries each taking on average in excess of 2 hours to complete. This included 6 queries from the patient hotline which is advertised via an insert with all discharge prescriptions. In addition they dealt with a large number of 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 online 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.

Various Safeline bulletins were produced and disseminated to Walton to highlight areas of risk identified from national alerts or local incidents, for example “Antibiotics in Myasthenia Gravis”, “Delayed and omitted medicines”, “Gabapentin and pregabalin – risk of severe respiratory depression”, “Gentamicin – change in dosing and monitoring” and an updated bulletin regarding safe use of sodium valproate.
Medicines information staff continued to monitor external medicines updates, warnings or bulletins from a variety of sources, and disseminated them to pharmacists to cascade them on to relevant clinicians.

In 2018-19 the team started following up clinical queries received out of hours by the on call pharmacist, to ensure that where appropriate, a more detailed review was carried out and the answer recorded on the database, which was then accessible for future similar queries.

1.6 Drug expenditure information and analysis and cost improvements

Medicines expenditure for the year was £8,616,587 plus more than £6 million further 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 Walton and their cost were produced monthly for Walton finance staff by the pharmacy computer services manager.

In order to reduce waste, the pharmacy department returned and credited high cost items that are returned from ward areas, so they could be reused. To maximise the efficiency of this process, expensive medicines were coded with a star system and high cost items were marked *** on the dispensing label. £701,712 was re-credited to Walton this year.

Senior neurosciences pharmacists undertook analysis of medicines expenditure to identify any potential cost improvements (CIPs) as part of the annual pharmacy cost improvement exercise. Potential savings highlighted through this or other mechanisms were then brought to the attention of relevant Walton staff. Examples of CIP achieved through changes in formulation were a change in strength of saline nebulisers, change in strength of dexamethasone injection and a change from sodium chloride polyfusers to bags. Similarly, medicines where patents expired resulting in a lower price were submitted as a potential CIP for Walton, for example Stalevo. Medicines where an unavoidable price increase was anticipated were also highlighted.

Pharmacy staff liaised with finance staff to advise on whether medicines were included or excluded from tariff, confirm high cost medicine submissions to commissioners, and discuss 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

Between April 2018 and March 2019, pharmacy staff dispensed and checked 64 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, receiving in deliveries, monitoring temperatures and dealing with excursions. They also maintained and held a code break list for all studies to allow ease of access and support out of hours. Four 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 23 trials involving trial medicines were open at any one time during the year.

This reduction in activity compared to last year is due in no small part to a fire that occurred in November 2018 in the Outpatient Department, which resulted in all room temperature stock being quarantined and replaced, with patient visits and trial openings subsequently being delayed.

Pharmacy staff continued to be involved with the implementation of the action plan drawn up from MHRA findings at the most recent inspection. 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 except critical care since April 2014.

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

The EPMA safety group at Aintree was dissolved and incorporated into a Medication Safety Group. This group met on a monthly basis at Aintree discussing any EPMA related issues and incidents. Walton was represented by one of the neuroscience specialist pharmacists, and feedback from the meeting given as a standing agenda item at Walton's Safer Medication Group.

Aintree continued work towards a joint electronic patient record (EPR) system with other Trusts across Liverpool. It is planned that in 2019/2020 Aintree will switch from their current EPMA system (JAC) to the new EPR system with integrated EPMA functionality. This will have a significant impact on Walton as the Trust will either have to increase funding for licenses and ongoing maintenance of JAC alone rather than as a joint venture with Aintree, or switch to a new system. Senior pharmacists attended and contributed to planning meetings to discuss suitable options for EPMA for Walton. Ongoing discussions and input will be required in the coming year as the timeline for Aintree's switch becomes more apparent.

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. For the period from April 18 to March 19, the on call pharmacist service was utilised 364 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 potential treatment for each patient, taking into account all relevant factors from each individual. They ensured appropriate monitoring of bloods/observations was undertaken for specific medicines and were vigilant for side effects. They discussed medicines with patients, providing information and answering questions. They also ensured compliance with the Pan Mersey formulary and local policies/guidelines where appropriate. With the support of pharmacy technicians, medicines reconciliation was undertaken for all patients except a minority who were only admitted for a short period e.g. day case patients or over weekends. Medicines reconciliation involves confirming the patient's usual medication regimen from a combination of sources to ensure accuracy, and 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 24 hours (as recommended nationally) for an average of 74.5% of patients each month, thereby meeting the agreed target of 70%.

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 Pharmacy 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 new patients, those still requiring 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 functionality is innovative and highly useful, and unique to Walton and Aintree. Most Trusts do not have any kind of Pharmacy dashboard to refer to.

The web portal has functionality for nurses in addition to the ordering of medicines and controlled drugs already described. The nurse dashboard for each ward includes a discharge prescription tracker, to see when these have been received and completed in Pharmacy, and highlights patients on certain medicines such as IV medicines or controlled drugs. Finally nurses can view where to find each medicine out of hours, and there are links to medicine information resources online.

1.10.2 Ward rounds and multidisciplinary team meetings (MDTs)

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

- The daily neurology 'board round'
- 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 an agreed prescribing formulary). Staffing numbers restricted our impact on these ward rounds, as we could attend at best 3 of the 6 simultaneously held ward rounds.
- One of the two simultaneous daily Horsley ward rounds (alternating each day)
- The weekly antimicrobial collaborative ward round
- The daily ITU antimicrobial ward round (as often as possible)
- Weekly Horsley MDT
- Workload allowing, a junior pharmacist attended the weekly MDT meetings on Lipton and CRU.
- From February 2019 a senior pharmacist attended the weekly Multiple Sclerosis Disease Modifying Therapy (DMT) MDT.

The requirement to see all same day admission patients pre-theatre Monday to Friday can impact on multidisciplinary commitments, as ward rounds may start before clerking on Jefferson ward is completed. Attendance can be further reduced due to other competing demands; for example, surgical ward rounds may overlap with both the antibiotic ward round and the MS MDT.

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.
- Prescribing pharmacists can prepare short-term leave / discharge prescriptions for patients highlighted to be suitable for discharge. This ensures prompt action, saves junior doctor time, and audit data shows much lower risk of prescribing errors than medical colleagues.
- 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 2018-19 pharmacists participated in 996 ward/board rounds or MDTs, an average of 83 per month (excluding the ITU daily antimicrobial ward round 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 five of the permanent specialist neurosciences pharmacists are registered and active as prescribers, though due to other commitments, not all perform all roles below.

All prescribing by pharmacists is formally 'verified' (clinically checked and signed off as safe and appropriate) by a different pharmacist, usually the ward pharmacist, as for prescriptions written by any other prescriber.

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 discharge medicines and completing the brief summary of the admission on the discharge prescription document.

Since same day admission started in May 2017, the pharmacists have reviewed and prescribed all appropriate medicines for every weekday same day admission patient on Jefferson. In 2018-19 this was an average of 141 patients per month. All five pharmacist prescribers contributed to this service, with two required on most mornings to ensure all patients can be reviewed and appropriate medicines prescribed in a timely manner before they go to theatre. With this small pool of staff there is limited resilience for sickness, annual leave and vacancies. 2018-19 was a challenging year in this respect, with a period where 2 of the 5 posts were vacant, and sickness having an impact at other times in the year. However the service was maintained with help from other pharmacist prescribers based at Aintree on an overtime basis, and goodwill and overtime on the part of the remaining team.

During 2018-19 pharmacists prescribed 28% of discharge prescriptions, an average of 71 discharge prescriptions per month (where 1 prescription indicates all discharge medicines for 1 patient). These figures are lower than last year and reflect the vacancies and higher sick leave within the team during the year.
The benefits of the pharmacist prescribing roles have been evaluated, and were reported in detail in last year's annual report. In addition to the reduction in junior doctor workload demonstrated by the figures showing quantity of prescribing, audits also showed that pharmacists had an extremely low rate of prescribing errors compared to medical staff, and wrote discharge prescriptions in a more timely manner than medical staff.

The team plan to submit a report of the benefits of the pharmacist prescribing service for external publication in 2019-20.

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 as detailed in this report).

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

In 2018-19 funding for extra pharmacist time was agreed for antimicrobial stewardship and requested for homecare medicines management, to reflect the increasing workload and new tasks required in these areas. It is hoped that in 2019-20 a new pharmacist post can be created from these funds, in combination with agreed reorganisation of skill mix and roles within the current SLA funding. If agreed, the sixth senior pharmacist post will also contribute to the prescribing roles, particularly same day admission, which will increase the resilience of this service, and may also allow more surgical ward rounds to benefit from pharmacist contributions.

1.10.4 Pharmacy Technician service to pre-operative assessment outpatient clinics

Evidence shows that pharmacists and appropriately trained pharmacy technicians will in general obtain a more complete and accurate medication history than other health professionals. Making use of multiple sources improves accuracy.

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 any medications which may need attention before surgery, and is able to advise the patient of any changes needed before or on the day of 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 they still obtain details from the GP records where possible, and pass on this list from the GP to the nurse so the nurse can check this with the patient. If time does not allow the technician to obtain the GP list at the time of clinic, then for same day admission patients, the technician will obtain the GP list a day or two before admission to ensure the information is readily available the morning of admission to enable safe prescribing.

From January 2019- April 2019, the technicians' records indicate that 1022 patients were due to attend pre-operative assessment clinics. They discussed medicines with the patient and/or carer and thus documented a full medication history for 79% (n = 809) of 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 (and there is only ever one technician available for clinics at any one time).

The service is much appreciated by the specialist nurses in clinic, and also by the prescribing pharmacists who see same day admission patients when they arrive. It saves much time for the pharmacists to reconfirm the previous list with the patient and ask about any recent changes or additions, rather than having to start from scratch. 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. As mentioned above, there was a period where two of the senior neurosciences pharmacist team posts were vacant. During this time tasks had to be prioritised, and a reduction was seen in some of the key performance indicator figures. Walton senior managers were kept up to date, priorities discussed and agreed, and mitigations put in place where appropriate, to ensure there were no deviations of concern to essential services.

The agreed pharmacy key performance indicators 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.

Following queries at Quality Committee about the target for medicines reconciliation within 24 hours, prospective manual audits were carried out to further review practice. The methodology of the manual prospective audit reflected performance more accurately than the automated monthly report and gave some assurance that compliance with prompt medicines reconciliation was higher than the monthly report suggested. Results were reported at Quality Committee and also showed that in most cases where medicines reconciliation was not achieved within 24 hours, this was not possible with current resources. This was either due to the timing of the admission in relation to pharmacist working hours, or because the patient was in theatre when the pharmacist was first available. Subsequently, a further report was produced for Quality Committee to discuss the level of risk arising due to the lack of a 7 day clinical pharmacy service.

A full review of the service level agreement was commenced in late 2018-19 and will be completed in 2019-20.

1.12 Developments in Pharmacy core services

Developments made during the year within pharmacy include:

- Planning and implementation of procedures to allow Pharmacy to comply with the new Falsified Medicines Directive which came into force in February 2019. Advice given to Walton senior managers on issues involved to allow compliance by Walton.
- Work towards outsourcing of outpatient dispensing; the new service is anticipated to commence in late 2019.
- Various updates to the pharmacy web portal to improve safety and efficiency in labelling and dispensing of medicines.
- Launch of the Pharmacy Safety Group, a bimonthly meeting which looks at safety issues within pharmacy raised by members of the pharmacy team. The purpose of the group is to look for processes which could be implemented to address any patient safety concerns/issues within the department. Meetings were attended by a Walton pharmacist and disseminated back to other pharmacists within the team.

1.13 Homecare medicines: administration and governance

Homecare medicine services deliver on-going 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 purpose of a homecare medicines service is to improve 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
- a new prescription was due
- prescriptions met all the legal requirements for dispensing
- 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 correlate 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. 877 patients were receiving medicines prescribed by Walton via homecare in March 2019. In addition to the day to day prescription processing, there were various significant homecare-related projects undertaken during the year including:

- Introduction of subcutaneous immunoglobulins in December 2018 to the portfolio of therapies currently offered via homecare by the Trust. This treatment was delivered by a new homecare provider (Quest). Restricted stock quantities nationally has however limited the number of patients we have been able to establish on this therapy.
- Scoping of another new peer-recommended homecare provider for further expansion of our homecare therapy profile. The regionally agreed SLA was reviewed and approved by the Trust's Drugs and Therapeutics Committee. Staff shortages within the procurement team have prevented this SLA reaching the board committee for sign off.
- A new pharmacy homecare database was rolled out in May 2018. Benefits include faster processing, clear data display and improved reporting functionality.
- Negotiation with NHSE regarding switching patients on glatiramer via homecare from the original brand to the newly launched bioequivalent.
- Discussion with the headache team and neurology division regarding capacity to take on an anticipated additional 100-125 patients to receive a new free-of-charge migraine preventative therapy via homecare

Homecare team funding is currently significantly below National Homecare Medicines Committee recommendations for the current number of patients treated per annum. In order to continue to deliver the current level of service and improve upon compliance with national standards (as measured in the 2018 Royal Pharmaceutical Society self-assessment audit) we plan to submit a business case for increased senior pharmacist staffing for homecare management.

2 Medicines Management and Clinical Governance at Walton

Medicines management in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution medicines make to producing informed and desired outcomes of patient care.

These services were mostly provided by the designated Walton senior pharmacist team and/or the Assistant Clinical Director of Pharmacy, in collaboration with many different Walton Centre staff. The Walton senior pharmacist team consists of five permanent senior pharmacists (the lead pharmacist for neurosciences, three neurosciences specialist pharmacists and one neuro ITU specialist), plus one annual rotational senior pharmacist. Together with three junior pharmacists at a time assigned to Walton on four monthly rotations, they also contribute to some of the core pharmacy services, particularly the clinical services detailed in section 1.10.

2.1 Medicines safety and learning from medication incidents at Walton

301 medication incidents were reported in 2018-19, making them one of the most common incident types within Walton. It is well established both nationally and at Walton that medication errors/incidents are common and such incidents are under-reported. These 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 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 Appendix 1 for a list of improvements made by the Safer Medication Group and other parties.

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 national patient safety alert 'Valproate medicines (Epilim▼, Depakote▼): contraindicated in women and girls of childbearing potential unless conditions of Pregnancy Prevention Programme are met.' was issued in April 2018 further to other alerts on this topic. An action plan was drawn up by senior pharmacists and a consultant neurologist, and monitored through to completion at the Safer Medication Group. This required much work to reach compliance, involving liaison between Pharmacy, medical staff at Walton and Aintree, the Pan Mersey medicines safety subgroup and wider CCGs. The joint Aintree/Walton guideline was updated and agreed at both Trusts, and a prescription template was designed to ensure compliance with the alert. Subsequently a senior pharmacist was asked to present on the national MSO WebEx regarding our actions in response to the sodium valproate alert.

Pharmacists contributed to the Trust response to other national safety alerts including insulin pen devices and hyperkalaemia. 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.

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

The Safer Medication Group reviewed compliance within the Trust against old national safety alerts relevant to medication-related never events.

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.

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.

There is much further work, particularly more proactive work, that 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:

- availability of unlicensed medicines or different formulations
- advice on formulary status and whether GPs could prescribe medicines
- prices of medicines
- queries over apparent shortages of specific medicines in primary care
- advice on commissioning issues or individual funding requests
- medicine interactions, cautions and contra-indications
- payment by results exclusions
- suitability of medicines formulations for intrathecal administration
- 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 certain medicines, significant price changes, and availability of generic versions of branded products or new safety warnings.

2.3 Education and training of other staff

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.

- Nurse NPSA study days
- 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 talks:
    - Antimicrobial stewardship
    - Medicines management
    - Intravenous administration of medications

Senior pharmacists also delivered several ad-hoc teaching sessions:

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

Within the Pharmacy team, senior neuroscience pharmacists were 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.

Externally, senior neuroscience pharmacists delivered teaching on neurology topics for regional pre-registration pharmacists, and for pharmacists undertaking the postgraduate clinical diploma at both Liverpool John Moores University and the University of Central Lancaster.

2.4 Non medical prescribing governance

Increasing numbers of nurses, pharmacists and physiotherapists are training, qualifying and subsequently practicing as Independent Prescribers within the Trust. By March 2019 there were over 60 staff who were either already registered independent prescribers or were currently undertaking the training. The Lead Neurosciences Pharmacist is one of two named Trust Non Medical Prescribing (NMP) leads, the other being the Deputy Director of Nursing. With support from another specialist neuroscience pharmacist, the NMP leads provide much informal support to NMPs, particularly during their training and initial prescribing practice.

The NMP leads considered staff currently giving medicines using patient group directions (PGDs) or patient specific directions (PSDs) and identified those situations where non medical prescribing would be more appropriate. These staff were then encouraged and supported to undertake the NMP course where appropriate. For example, staff administering botulinum toxin or capsaicin patches.

The NMP/PGD subcommittee continued to meet regularly to provide formal support and governance for NMP within Walton and was chaired by one of the two NMP leads. Prescribing formularies of specialist nurses, pharmacists and physiotherapists were reviewed and updated, and support given to encourage them to use their qualification to improve patient care. Personal formularies were presented to D&T for final ratification once problems and issues had been resolved within the NMP/PGD subcommittee meetings.

An ‘NMP forum’ was held. All NMPs within the Trust were invited, as an opportunity to come together to hear updates, discuss their experiences as NMPs, share good practice, identify barriers or problems and consider ways to improve the experience of both patients and NMPs. These meetings are planned to continue regularly every six months.

All existing NMPs were encouraged to review and update their formularies, and asked to submit annual review forms and reflective accounts were presented to the subcommittee for NMPs who submitted them in line with the NMP policy.

The Lead Pharmacist started attending meetings for regional NMP leads.

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 NMP/PGD subcommittee and/or Drugs and Therapeutics Committee reviewed and updated existing documents, and also commented on/approved new PGDs. For example, a PGD to allow flu vaccines to be administered to staff by specific registered nurses as part of the annual staff vaccination campaign.

Encouraging nurses to use PGDs is expected to improve patient care and relieve pressure on junior doctors. Audit of the use of PGDs is planned for the future.

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 2018-19, the team updated 9 clinical guidelines, 3 prescription forms, a drug monograph and the antimicrobial formulary. 11 new documents were also created to reflect new practices and address gaps in the Trust's guidance including an ocrelizumab treatment pathway, insulin substitution policy and revised GKI prescription chart and support guideline.

Senior pharmacists routinely attend meetings of the Drugs and Therapeutics Committee, Clinical Effectiveness and Services Group and Patient Safety Group, and as part of this membership, reviewed and commented where appropriate on documents presented for approval.

Pharmacy also keep the Medicines Policies and Pharmacy pages on the intranet up to date with any newly approved documents, practical information about the pharmacy service, and links to relevant external sites for information about medicines.

In November 2018 a new document management system was launched by the Risk Lead due to safety concerns with the previous site. The transfer of documents between systems was time consuming, but provided the opportunity to standardise the formatting of medication related documents and create an improved system to track document expiry. This will enable pharmacists to inform document authors of imminent document expiry going forward and maintain a more robust reference system.

2.7 Freedom of information requests and complaints

Senior pharmacists, with support from the Pharmacy Computer Services Manager and the Assistant Director of Pharmacy, responded wholly or partly to 34 freedom of information (FOI) requests during the year. Requests were very varied, but the most common type was for information about quantities used 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 at the Pan Mersey Area Prescribing Committee subgroups for new medicines, formulary and guidelines, shared care and safety subgroup, and occasionally attended the Area Prescribing Committee (APC) meetings to present specific items. Pharmacists attended these meetings as and when agenda items were relevant to Walton, as agreed with commissioners. The Assistant Clinical Director of Pharmacy represented both Aintree and Walton routinely at the APC.

NHS
Pan Mersey
Area Prescribing Committee

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

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

- Erenumab new medicines assessment
- Liaising with NHSE and neurology team regarding prior authorisation (Blueteq) for Duodopa®
- Update to riluzole shared care framework
- Review and negotiation of amber sub classification for methadone tablets for pain
- Sodium valproate updated safety requirements as per national alert

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

In 2018-19 the Trust was required to comply with a Medicines Optimisation CQUIN. This included targets relating to:

- switching from use of brands to generic/biosimiliar products for specified medicines, including for existing patients
- specified data types and format for information sent to commissioners to claim reimbursement for high cost excluded medicines
- increased use of cost effective dispensing routes for outpatient medicines (such as using homecare to save VAT)

Senior pharmacists worked closely with Walton Finance and Neurology Division staff to plan and implement actions to ensure that all requirements were met. This included liaison with NHS England about glatiramer acetate to ensure that requirements for use of the biosimilar were suspended while a national tender exercise took place. Following the tender exercise, Pharmacy initiated discussions with NHS England to agree further details for a potential switch to biosimilar glatiramer. The availability of differing homecare options for the biosimilar added complexities to the decision as to the best course of action. These discussions are ongoing.

The CQUIN was achieved to the satisfaction of 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.

Reduction in omitted doses of critical medicines was agreed as one of Quality Account targets for 2018-19. The Lead Pharmacist worked with senior nursing staff to plan and implement actions to reduce omissions. The target was achieved, with audits showing a 36% reduction in omitted doses of critical medicines in 2018-19 compared to the last 6 months of 2017-18.

Pharmacy supplied information to finance regarding breakdown of Pharmacy costs to different areas to support patient level costing estimates for NHS Improvement.

2.10 Drugs and Therapeutics Committee

At least two senior neuroscience pharmacists attended each of the year's Drugs and Therapeutics committee meetings, and presented many of the documents to the committee. Due to the volume of work required for review by the committee, 9 meetings were held in the 2018-19 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
- Non-Medical Prescriber formularies
- Reports from the Safer Medication group, Antimicrobial Stewardship group and Pan Mersey Area Prescribing Committee subgroups

- New national guidance on medicines including safety alerts
- Medicines expenditure and potential cost improvements or cost pressures
- Medicines – related audits including controlled drug quarterly audits.
- A cluster of applications to participate in early access to medicines schemes or company-sponsored free of charge access to medication schemes, for particular patient cohorts while medicines were awaiting licensing or commissioning or for individual patients who had benefited from medicines during clinical trials. For example, erenumab, eculizumab, fremanezumab, nusinersin and cannabidiol.
- Significant miscellaneous issues arising relating to medicines, for example shortages of medicines

2.11 Contribution to Walton committees and groups

Senior pharmacists attended/contributed to the following groups on a regular basis:

- Patient Safety Group
- 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
- NMP/PGD subcommittee
- Team Brief
- Quality (CQC) Assurance Group
- Drugs and Therapeutics Committee
- 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*
- Same day discharge planning meetings*
- OPAT planning meetings*

*Attendance at these groups was a new development requested during 2018-19.

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

Senior Walton pharmacists attended various external meetings where they represented Walton specifically. For example, the various Pan Mersey subgroups and regional networks regarding homecare, medication safety and non medical prescribing.

In addition other senior pharmacists based at Aintree attended various external meetings where they represented both Trusts, such as the Head and Chief Pharmacists regional meetings.

2.12 Audit & Service Evaluation

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

- Controlled drug quarterly audits
- Antimicrobial prescribing quarterly point prevalence audit
- Medicines reconciliation service evaluation
- Sedation data collection on ITU for regional network audit
- Data collection on the management of secretions on ITU for a national audit
- Medicines storage audit
- An evaluation on the compliance of the prescribing of medicines post operatively in neuro surgical patient
- Service evaluation of prescribing of valproate to women of childbearing potential
- Review of the initiation of anti-epileptic therapy post head injury
- Review of pharmacist contributions on ward rounds

Results were (or will be) 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.

Baseline assessment audits were completed for NICE NG 109 UTI (lower) antimicrobial prescribing, NICE NG 112 UTI (recurrent) antimicrobial prescribing and NICE NG 113 UTI (catheter associated) antimicrobial prescribing.

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 such as 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 good antimicrobial stewardship at the Walton Centre a particular challenge.

During 2018-19, 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:

- Attendance at the weekly collaborative antimicrobial ward rounds; reviewing every patient prescribed antibiotics alongside a consultant medical microbiologist, medical teams and IPC (infection prevention and control) nurse specialists. Any identified themes were raised by a senior pharmacist at the Infection Control Committee and with the IPC lead neurosurgeon.
- Attendance at the daily collaborative antimicrobial ward round on ITU (when possible) by the specialist neurosciences ITU pharmacist, reviewing all patients who were prescribed antibiotics on ITU.
- 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.
- The data collection tool for the Quarterly Point Prevalence Audits was reviewed and amended by the senior pharmacist with the assistance of the consultant microbiologist.

The audits were presented to the Infection Control Committee and 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 Infection Control 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.

New developments in 2018-19

- Funding for an 8A senior antimicrobial pharmacist was approved in late 2018 for 0.4WTE pharmacist. The pharmacy department felt this would be difficult to recruit and submitted a further business case for further funding (homecare), which along with some redeployment of existing funds within the SLA, would enable the recruitment of a WTE. This will be reviewed in 2019-20 as part of the SLA review.
- The Trust antimicrobial formulary was reviewed and updated by the consultant microbiologists for Walton and a senior pharmacist. This included the reintroduction of piperacillin/tazobactam following the previous shortage.
- Clinical governance of patients receiving outpatient antimicrobial therapy (OPAT; intravenous antibiotic therapy at home administered by local nursing teams) was a challenge. Planning was undertaken for an OPAT clinic consisting of a consultant neurosurgeon, consultant microbiologist, specialist nurse and specialist antimicrobial pharmacist. A senior pharmacist was involved in the development of the clinic including paperwork, in the absence of an antimicrobial pharmacist. The clinic is expected to commence in May 2019 and will start seeing all spinal patients discharged on long term antimicrobial therapy.
- In response to the recent (March 19) MHRA safety alert regarding fluoroquinolones, the antimicrobial stewardship group plans to review prescribing at Walton and produce a Trust statement, with the involvement of a senior pharmacist.

2.14 CQC compliance

Pharmacists supplied various documents and narrative to CQC as part of the preparation for the anticipated CQC inspection in early 2019. During the unannounced visit in March 2019 inspectors took a close interest in medicines management and safety, and pharmacy staff were informally interviewed on wards. 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.

CQC highlighted the need for increased ITU pharmacy staffing to reach compliance with national standards, and a business case will be submitted to address this in 2019-20. Concerns were raised over some aspects of medicines management on the wards, namely temperature monitoring and checking of expiry dates, and actions have been taken since then to improve practice in these areas, in collaboration with senior nurses.

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 a 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 high cost and high usage medicine. Work included:

- Attending the national update meeting on the immunoglobulin database and national requirements
- Identifying outstanding reviews or documentation and ensuring completion
- Monthly immunoglobulin advisory panel meetings (multidisciplinary) 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.
- Monitoring of compliance against CQUIN.
- Pharmacist clinical check of immunoglobulin prescriptions before supplying.
- Managing shortages of specific immunoglobulin products, which was 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.
- Switching some longterm immunoglobulin patients to subcutaneous immunoglobulin which the patients could self-administer at home rather than having to attend Jefferson regularly for IV infusions. This required liaison with the neurologist and specialist neuromuscular nurse to ensure all the necessary clinical and practical considerations were addressed before the first patient could switch.

2.16 Other projects and developments

Other specific projects and developments in 2018-19 involving medicines management or pharmacy included:

- Work to improve practice with controlled drugs. In quarter one there was a Mersey internal audit agency review of the management of controlled drugs within Walton. Senior pharmacists helped agree the audit parameters, facilitate access to data and explain practice to the auditor. Following receipt of the report which showed limited assurance, senior pharmacists worked with senior nurses to advise on appropriate responses and implement actions. This work was ongoing throughout the year with improvements in practice seen, but some aspects still needing further improvement, particularly management of patient's own controlled drugs on the wards. Examples of improvements made following the external inspection include:
    - Introduction of CD competencies for trained staff nurses
    - Additional guidance to staff regarding what discrepancies required reporting and what to do if a discrepancy was identified
    - Supply of measuring cylinders to each ward/area using liquid controlled drugs to perform weekly balance checks
    - Introduction of liquid controlled drug bottle bungs to enable more accurate measurement and reduced wastage
    - Formal routine review of controlled drug quarterly audits at the Professional Nurse Forum and Drugs and Therapeutics Committee.
- Newly licensed mexiletine launched. Pharmacy identified patients currently on the unlicensed therapy and created a database to plan and monitor the transition of eligible patients to the licensed medication.

- Legal status of cannabis changed in November 2018, resulting in many queries regarding access, and much work to clarify the situation.
- The Lead Neurosciences Pharmacist was a member of the UK Clinical Pharmacist Association Neurosciences Committee, and attended meetings with neuroscience specialist pharmacists from around the country to share ideas and good practice, and work together on problematic issues. In addition she participated in an informal email network sharing information, advice and good practice.
- New / revised emergency medication kits (anaphylaxis, intubation and seizure) rolled out across the trust.
- Review of emergency drugs storage on ITU and in Theatres and roll out of emergency trolleys.
- Discussion and update of the Medicines policy to specify medicines-related roles of the new Nurse Associates
- Pharmacy were involved in meetings and correspondence to plan for a 'no deal' Brexit.
- Pharmacists received daily alerts for all patients triggering alerts for potential acute kindey injury, based on their blood results. They reviewed the blood results and considered where any medication changes were indicated, and liaised with other clinical staff as appropriate to ensure all necessary actions taken. The team were nominated for a monthly 'Good catch' award at Walton for their work on these alerts.
- Review of risks and hazards for the current EPMA system, and update of documentation.
- 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.

3. Future plans and areas for development

Some of the work described above is on-going. Specific areas of focus for 2019-20 include:

- Updates awaited regarding the timing of a switch to a new Electronic Prescribing and Medicines Administration system at Aintree, as part of their planned new Electronic Patient Record system. Once timing known, discussions and planning at Walton will restart to consider options for EPMA at Walton.
- Outsourcing of outpatient dispensing to allow savings on VAT.
- Collating audits and other data gathered to evaluate the pharmacist prescribing service, and presentation of a formal evaluation summary to the Trust. This may then lead to consideration of a business case for further staff resource for prescribing and other general roles. The skills and contributions of the senior pharmacist team have been valued by Trust staff both in clinical settings and medicines management / clinical governance roles, and in practice these can present conflicting demands on the pharmacists' time. In addition surgical teams are keen to have a pharmacist present on more ward rounds routinely.
- External publication of work evaluating the pharmacist prescribing service.
- Completion of the review of the pharmacy service level agreement. Extra pharmacy resources for homecare and for critical care have been requested to allow for increased homecare workload and compliance with national standards for critical care.
- Further improvements in governance of homecare medicines, commencement of a new homecare service for a new medicine for migraine (depending on outcome of SLA review) and a switch of provider for some medicines to improve quality.
- Recruitment of the antimicrobial pharmacist and subsequent work to improve antimicrobial stewardship within the Trust.
- 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 at Aintree or elsewhere would reduce risk of microbial contamination, preparation errors and save time for specialist nurses.
- Involvement in the new subregional immunoglobulin advisory panel
- Aintree University Hospital NHS Foundation Trust is set to merge with the Royal Liverpool and Broadgreen University Hospitals NHS Trust in October 2019. This is not expected to have any significant impact on services to Walton.

Appendix 1: Other miscellaneous improvements to practice during the year 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. All these changes involved Pharmacy, although some were led by other staff.

- Managing discontinuation of abciximab and switch over to tirofiban including new clinical guideline
- Changes to patient controlled analgesia (PCA) strengths & launch of new PCA policy in March 2019
- FP10 (external) prescriptions ordered for Walton for use by the pain team. For patients on controlled drugs which have to be repeat prescribed by the pain team, this allowed the pain team to post prescription forms for patients to get dispensed at their local community pharmacy, rather than having to come to Liverpool to collect the medicines.
- In November 2018 a new system was devised for intrathecal vancomycin ordering/supply and recording of patient names, to ensure compliance with data recording requirements.
- New method of prescribing IV fluids on ITU introduced in order to address administration of IV fluids without valid administration order
- Standardised practice for prescribing of continuous infusion of water via feeding tube on critical care prescription chart.
- Improved access to summary care records (GP medication records) for patients following clarification of consent requirements, saving time and improving safety for inpatients and patients at pre-operative assessment clinics.
- Laminated cards produced to be placed in patient medication lockers when they have controlled drugs in the ward controlled drugs cabinet. This is to serve as a reminder to return them to the patient (where appropriate) on discharge.
- New record book for patients' own controlled drugs designed and printed for those areas where electronic recording is difficult.

The Walton Centre NHS Foundation Trust

REPORT TO Quality Committee
Date 30th January 2020

Title	**Accountable Officer for Controlled Drugs – Annual Report August 2018-July 2019**
Sponsoring Director	Name: Dr Andrew Nicholson Title: Medical Director
Author (s)	Dave Thornton Assistant Clinical Director of Pharmacy Alison Ewing Clinical Director, Pharmacy
Previously considered by:	• Quality Committee

Executive Summary

This report provides the Quality Committee with an overview of Controlled Drug (CD) activity during 2018/19. 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.
- Assurance audits have been undertaken and the Trust is mostly compliant. The increased frequency of balance discrepancies represents a drive to report all discrepancies through datix.
- A review of the management of controlled drugs at the Walton Centre by MIAA was published and an action plan was implemented to address the shortfalls. A subsequent re-audit in January 2019 demonstrated good progress had been made since the initial review. However, the handling of patient's own CDs remains an area of concern.

Related Trust Ambitions	• Best practice care
Risks associated with this paper	The report is a statutory requirement
Related Assurance Framework entries	NA
Equality Impact Assessment completed	NA
Any associated legal implications / regulatory requirements?	• Yes – (please specify) The report is a statutory requirement
Action required by the Board	• To consider and note

Accountable Officer for Controlled Drugs – Annual Report
August 2018 to July 2019

1. Executive Summary

This report provides the Trust Board with an overview of Controlled Drug (CD) activity during 2018/19. The following are the key issues of note from the report:

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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. The last update took place in September 2018.

- *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. A review of the management of controlled drugs at the Walton Centre by MIAA was published in August 2018 and an action plan was implemented to address the shortfalls. A subsequent re-audit in January 2019 demonstrated good progress had been made since the initial review. However, the handling of patient's own CDs remains an area of concern.

- *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 100 incidents that involved CDs reported at The Walton Centre between August 2018 and July 2019 compared with 35 in the same period last year. This large increase was primarily driven by an initiative to ensure all incidents relating to stock discrepancies and record keeping were recorded.

All of the 2018/19 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	8
Governance	10
Patients/public of concern	3
Prescribing	3
Record keeping	22
Accounted for losses	4
Unaccounted for losses*	50

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

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 number of CD balances were incorrect with balances of liquids and patient's own drugs accounting for all of the discrepancies. It is worth noting that the last audit in this period demonstrated a large improvement. All balance discrepancies are investigated by the ward pharmacist and ward manager. Inappropriate amendment of records has also been highlighted as an area for improvement.

All ward managers undertook regular controlled drug checks; daily stock checks were carried out on the majority of wards. When this was not the case, it was only the odd day in the quarter that was not reported.

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. All occurrence reports were submitted this year, no concerns were reported to the LIN.

4.7 CQC Self-Assessment

The CQC reviewed the self-assessment process in 2014 and have issued the new scheme which gives a red, amber, green assessment rather than a percentage score. The new assessment covers CD standard operating procedures, pharmacy, ward and transport, audits, reporting arrangements and information sharing. The CDAO undertook the self-assessment for the Trust in September 2018 and all categories scored green.

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
September 2019

Prepared by: Dave Thornton, Assistant Clinical Director, Pharmacy

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 30th January 2020

Title	**Q2 Morbidity & Mortality Report 2019-2020**
Sponsoring Director	Name: Dr Andy Nicolson Title: Medical Director
Author (s)	Mr D Carter, Chair of Neurosurgery M&M Committee Mr M Wilson, Chair of Neurology M&M Committee Patricia Crofton, Clinical Quality Lead, Learning from Deaths
Previously considered by:	Quality Committee January 2020

Executive Summary

This report is a quarterly review of Morbidity & Mortality within the Walton Centre. It draws together information from case reviews, medium and longer term trends, hospital standardised mortality rates (HSMR), readmission rates and trends, and surgical site infections.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Mortality outliers are monitored by NHS regulators
Related Assurance Framework entries	None
Equality Impact Assessment completed	No –
Any associated legal implications / regulatory requirements?	Mortality outliers are monitored by NHS regulators
Action required by the Board	**The Board is requested to:** • **Note the report**

Q2 Morbidity & Mortality Report 2019-2020

Overview

This report is a quarterly review of Morbidity & Mortality within the Walton Centre. It draws together information from case reviews, medium and longer term trends, hospital standardised mortality rates (HSMR), readmission rates and trends, and surgical site infections. Unless stated, figures relate to both Neurosurgery & Neurology combined.

1. Admission data 1st April – 30TH September 2019

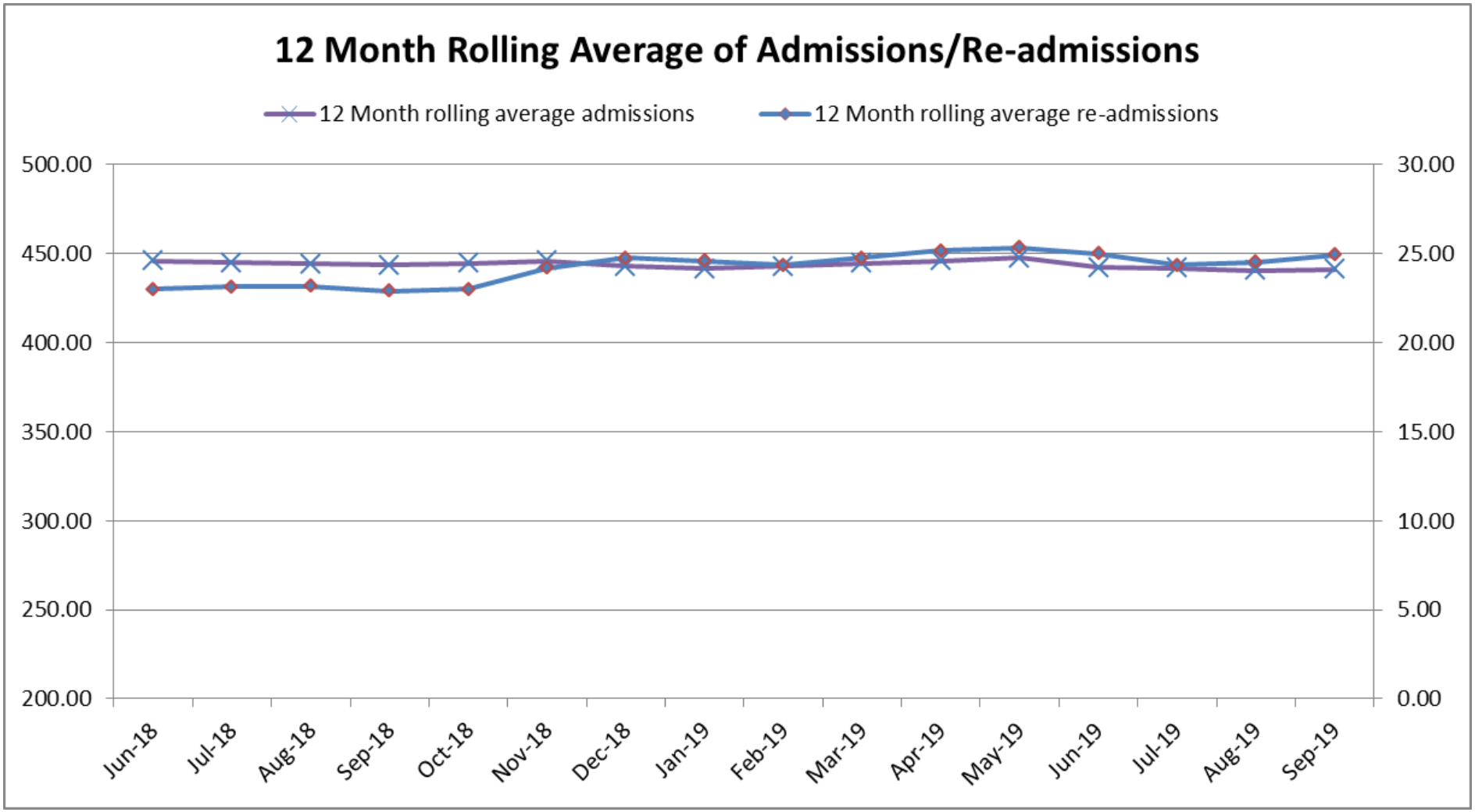
The Neurosurgical & Neurological admissions and re-admissions are detailed below. The re-admission rate (within 28 days of discharge) remains low. There is no significant variation on a monthly or quarterly basis.

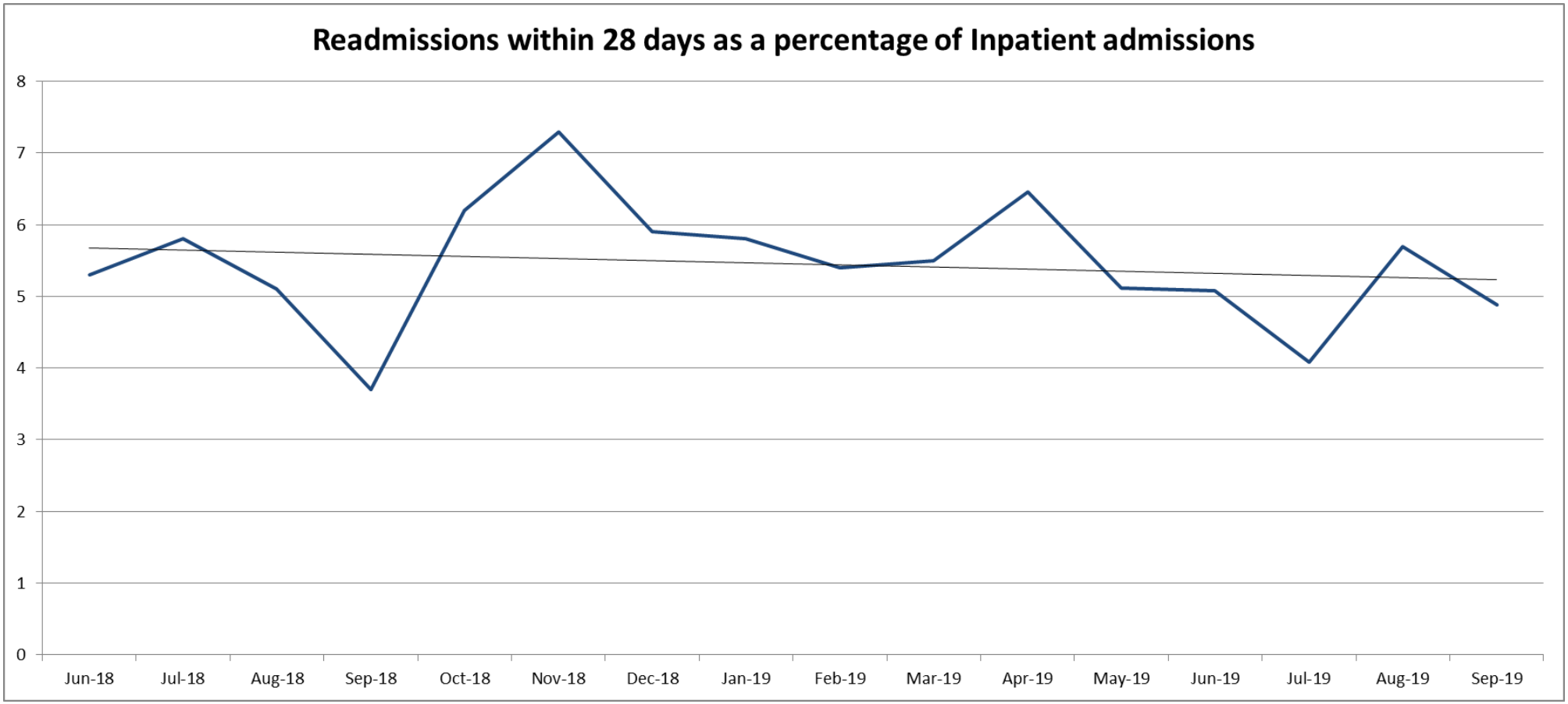
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Admissions	449	469	413	441	439	410
Re-Admissions	29	24	21	18	25	20
%	6.5	5.1	5.1	4.1	5.7	4.9

1.1 Overall Re-admissions by Quarter

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Admissions	1294	1325	1364	1290	1360	1301	1363	1311	1331	1290
Re-Admissions	82	71	55	73	71	64	89	73	74	63
%	6.3	5.4	4.0	5.7	5.2	4.9	6.5	5.6	5.6	4.9

The rolling average number of readmissions remains within the expected range and the monthly trend of the percentage of patients who are re-admitted continue to show a slow decline.




Readmissions within 28 days as a percentage of Inpatient admissions
8
7
6
5
4
3
2
1
0
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19

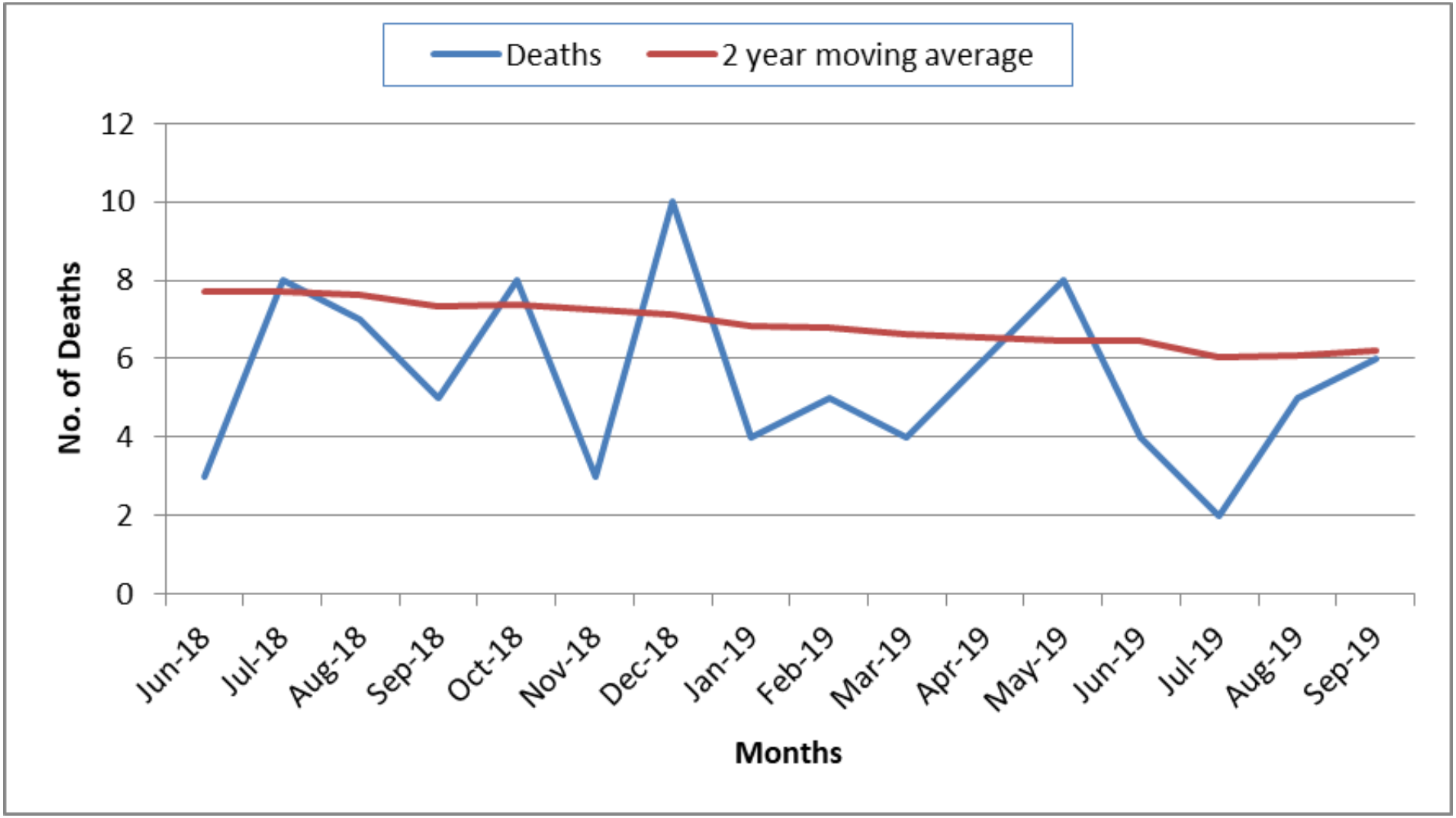
1. Surgical Site Infection (SSI) data

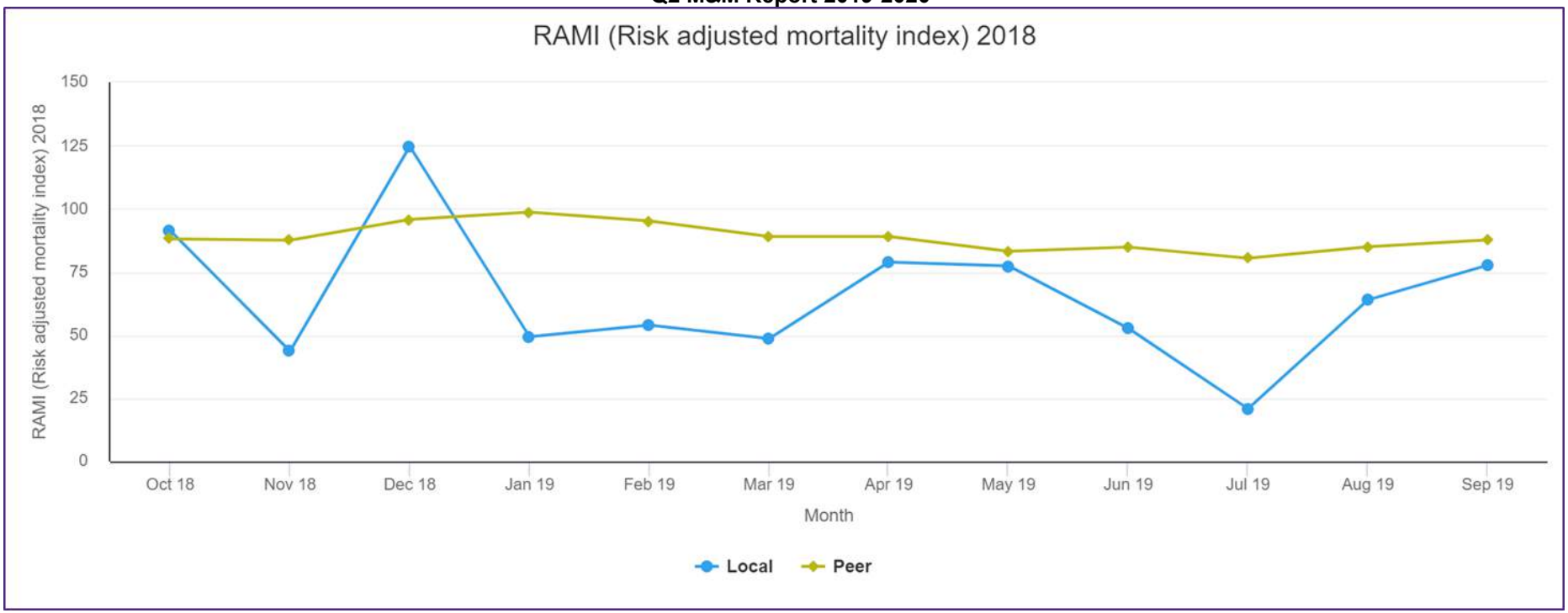
Since July 2010 a new SSI form has been introduced, which provides more detail into the type of operation and degree of clinical urgency. Because the number of patients undergoing surgery in the 'immediate' category is low (i.e. the denominator), a single infection in this group may constitute a large percentage, therefore the number of cases is more pertinent in looking for trends. Staphylococcal species account for the majority of infection.

Quarterly summary

	Elective ops	Infections	%	Urgent ops	Infections	%	Immediate ops	Infections	%	Expedited ops	Infections	%	Not record ops	Infections	%	Total ops	Total Infections	% Infection Rate
Q1 18/19	622	13	2.1	173	2	1.2	31	1	3.2	130	3	2.3	0	0	0.0	**956**	**19**	**1.99**
Q2 18/19	603	15	2.5	160	5	3.1	35	4	11.4	131	6	4.6	0	0	0.0	**929**	**30**	**3.23**
Q3 18/19	597	17	2.8	172	4	2.3	36	0	0.0	126	4	3.2	0	0	0.0	**931**	**25**	**2.69**
Q4 18/19	592	12	2.0	161	2	1.2	32	0	0.0	122	3	2.5	0	0	0.0	**907**	**17**	**1.87**
Q1 19/20	612	11	1.8	147	4	2.7	35	1	2.9	116	6	5.2	0	0	0.0	**910**	**22**	**2.42**

The crude number of deaths is shown in the chart below, along with the rolling 2 year average. The average has remained within expected limits.





Risk Adjusted Mortality Index (RAMI17) is now used as a replacement for Hospital Standardised Mortality Ratio (HSMR). The methodology behind RAMI17 is limited to just six factors, each of which is known to have a significant and demonstrable impact on risk of death. They are:

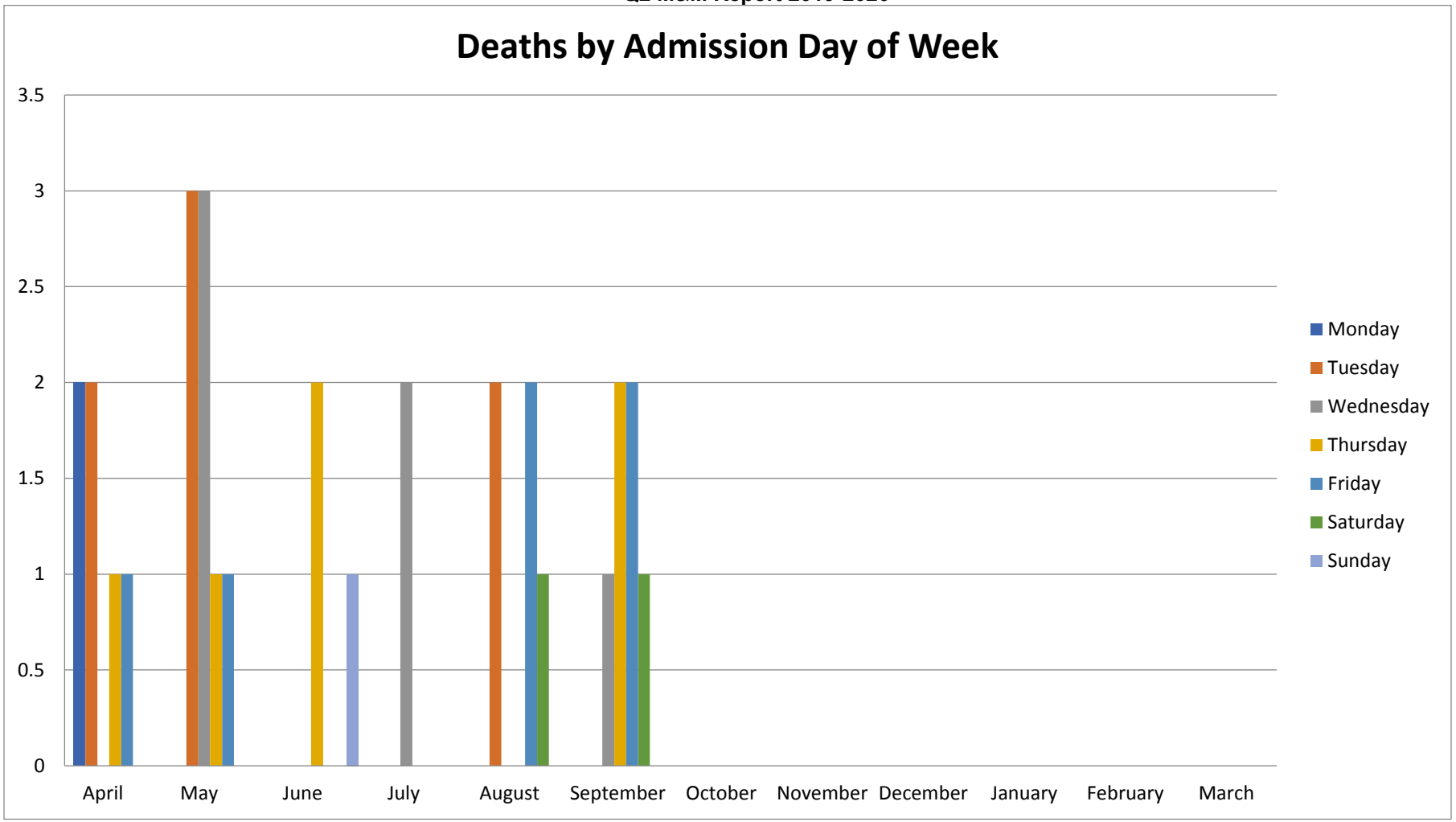
1. Age - six groups
2. Admission type - elective or non-elective
3. Primary clinical classification - 260 CCS (Clinical Classifications Software) groups
4. Sex - defaults to female if not known
5. Length of stay - specific groups only
6. Most significant secondary diagnosis - list covers 90% of all diagnoses mentioned in patients who died

The first five of these as primary factors. Each is known with greater certainty and recorded with greater consistency than secondary diagnoses. The methodology uses these factors first, and then looks to see which secondary diagnoses most significantly and consistently increase risk of death.

4.3 Quarterly Analysis – Neurosurgery and Neurology

Deaths by Admission Day of Week

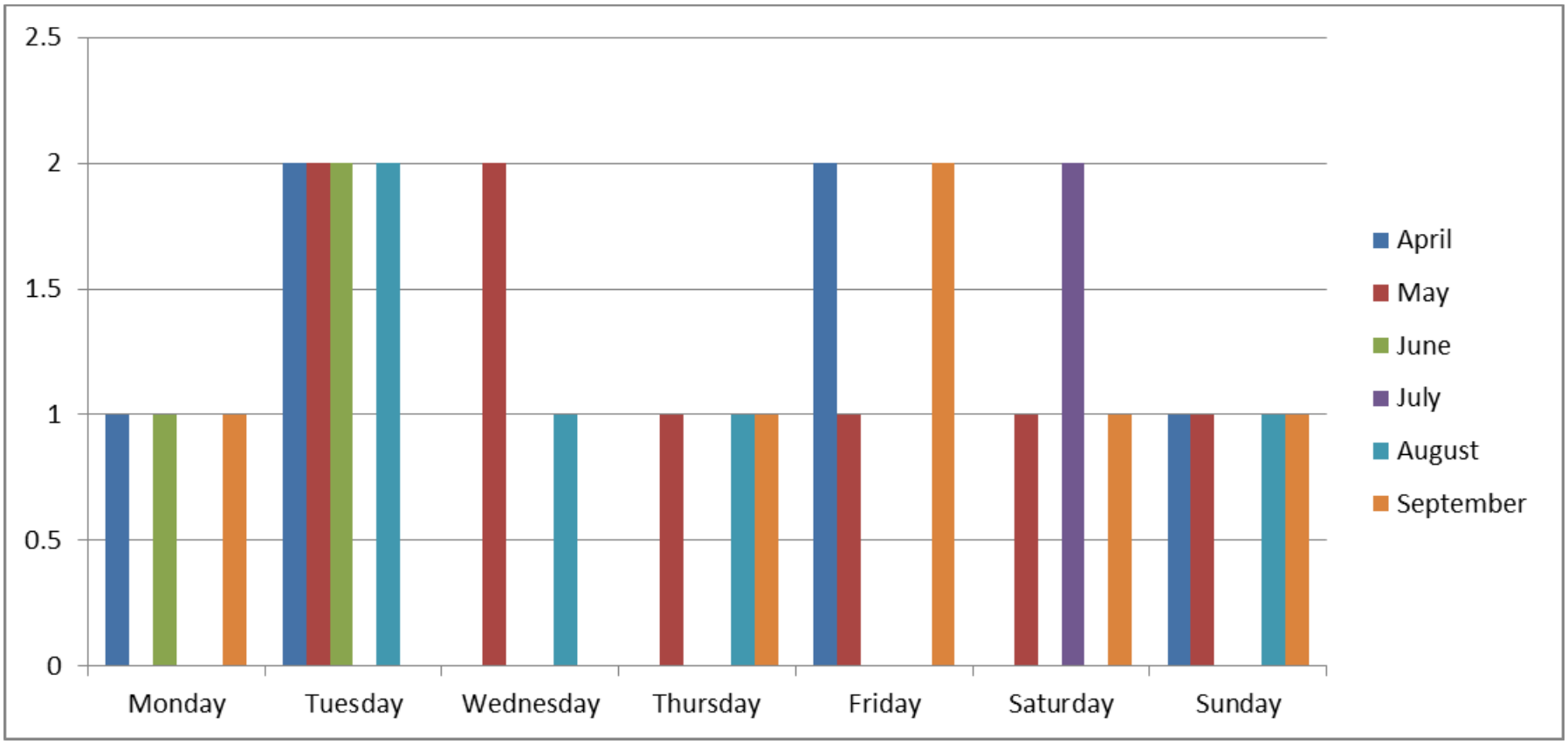
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 18/19	5	4	4	3	2	3	3	24	
Q2 18/19	4	5	2	2	1	1	4	19	
Q3 18/19	7	3	2	3	3	2	1	21	
Q4 18/19	3	0	1	3	2	3	1	13	**77**
Q1 19/20	2	5	3	4	2	0	1	17	
Q2 19/20	0	2	3	2	4	2	0	13	
Q3 19/20									
Q4 19/20									**30**


Deaths by Admission Day of Week
3.5
3
2.5
2
1.5
1
0.5
0
April
May
June
July
August
September
October
November
December
January
February
March
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday

Deaths by Day of Week

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 18/19	4	3	2	4	6	3	2	24	
Q2 18/19	4	1	1	4	3	2	4	19	
Q3 18/19	4	3	1	2	2	7	2	21	
Q4 18/19	2	2	2	0	3	1	3	13	**77**
Q1 19/20	2	6	2	1	3	1	2	17	
Q2 19/20	1	2	1	2	2	3	2	13	
Q3 19/20								0	
Q4 19/20								0	**30**

Deaths by Day of Week



4. Summary of Mortality Cases. 4. Summary of Mortality Cases.

4.1. Q2 Neurosurgery Mortality Cases (1st July 2019 – 30th September2019).

In Q2 there were 12 Neurosurgical inpatient Deaths:

Vascular 2
Cranial Trauma 6

Spinal Trauma1

Hydrocephalus 1
Neuro Oncology 2
Functional 0

There were no deaths related to thromboembolic complications.

Of the 12 surgical deaths, 11 patients were emergency admissions and 1 elective admission. 10 patients died in critical care with 2 in the acute ward areas following a period of critical care.

3 deaths were elderly patients who had suffered spinal and / or cranial trauma.
Of these patients 1 had an advanced directive and refused ventilation, 1 patient who had been ventilated and refused a tracheostomy for weaning from ventilation, the Specialist Palliative Care Team (SPCT) were involved supporting patients, their families and staff.

Within critical care, all patients and families were supported by the Critical care team assisted by the Specialist nurses for Organ donation (SNOD) and the SPCT ,3 patients went on to donate organs.

The Walton Centre works closely with the Blood and Transplant service and continues to build on previous good practice. In the first 6 months of 2019/20 from 9 consented donors the WCFT facilitated 6 solid organ donors. This resulted in 10 patients receiving a transplant during the time period. This was an increase from the previous year.

The SNOD team are an integral part of the critical care team and provide care for the patients and family during this difficult time. The quality of care at this time has been audited and when compared to national data, the WCFT was considered excellent for the potential organ donors and exceptional for Specialist Nurse Presence when approaching families to discuss organ donation.
Again the Specialist palliative care team have been involved with the patients who died during Q2. The referrals have been timely and symptom control optimum. There have been no incidents, complaints or concerns raised for escalation.

The mortality reviews highlight several of the emergency admissions had complex previous medical histories with multiple co-morbidities, including chronic conditions. These conditions often require treatment with anticoagulant and antiplatelet medications which may have contributed to the neurological event and required complex management.
There were several patients with previous malignancy,
All deaths were reviewed according to the Walton Centre Mortality Review Policy and all deaths were considered unavoidable. There were no actions for escalation

The Walton Centre NHS Foundation Trust: Learning from Deaths Dashboard - September 2019-20

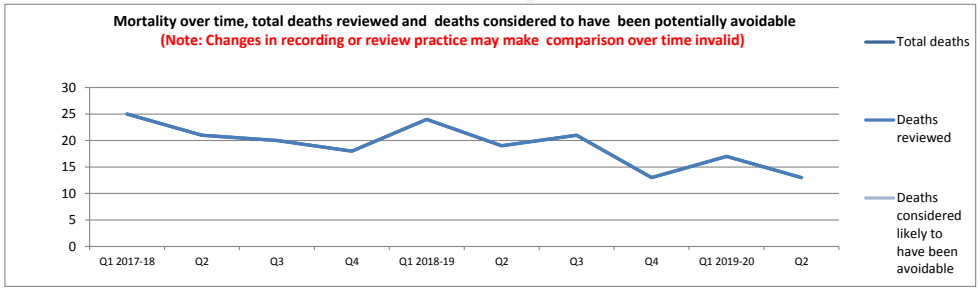
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed (under the Structured Judgement Review Methodology from Q4 2017-18). Dashboard only enables data from 2017/18 onwards to be entered.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
5	2	6	5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
13	17	13	17	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
30	77	30	77	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q2



Total Deaths Reviewed by RCP Methodology Score

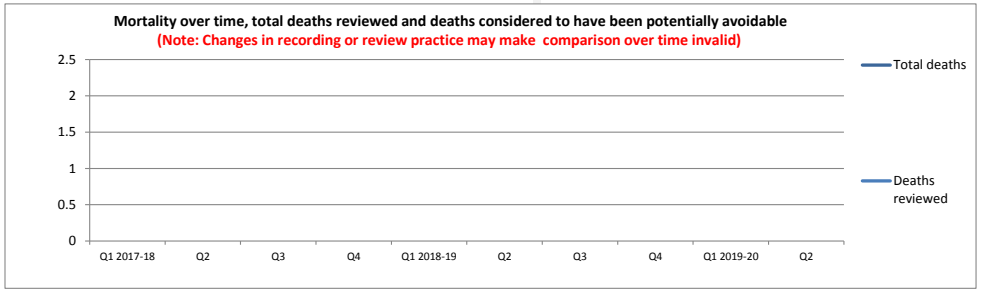
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	6	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	13	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	30	100.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. There is not enough data to populate the graph.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q2



The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date

30th January 2020

Title	**Guardian of Safe Working Quarterly Report**
Sponsoring Director	Name: Dr Andrew Nicolson, Medical Director
Author (s)	Name: Dr Christine Burness, Guardian of Safe Working
Previously considered by:	None
Executive Summary This paper summarises progress in providing assurance that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.	
Related Trust Ambitions	• Be recognised as excellent in all we do
Risks associated with this paper	Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks patient safety and the safety of the doctor. Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks overtime payments and fines being levied
Related Assurance Framework entries	Risk ID42 – Quality
Equality Impact Assessment completed	
Any associated legal implications / regulatory requirements?	
Action required by the Board	The Board is asked to • note the Guardian's quarterly report

GUARDIAN OF SAFE WORKING QUARTERLY REPORT: AUGUST 2019 – OCTOBER 2019

BOARD OF DIRECTORS MEETING

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 32 junior doctors' placed in the Trust who 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 (see appendix 1)*

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 5 exception reports at the Walton Centre.
(see below)

The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum every three months in addition 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 Quarterly Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

High Level Data (requested by NHS Employers)

Number of doctors in training (total)	52
Number of doctors on 2016 T&C (total)	32
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 (for education and training)	0.25

Locum and agency hours and spend to cover junior doctors rota gaps

	August 2019	September 2019	October 2019	**Total**
Neurology	£13,533	£8,952	£14,189	**£36.674**
Neurosurgery	£28,470	£9,130	£22,389	**£59,989**
Total	**£42,004**	**£18,082**	**£36,577**	**£96,663**

a) Exception reports

There have been 5 exception reports during this period.

b) Work schedule reviews

We have not had to undertake any work schedule reviews.

c) Vacancies

The Trust has 52 established training posts, currently there are 3 Neurosurgery and 1 Neurology trainee Out of Programme completing PhD projects. HEE have not recruited any new trainees in Neurosurgery for the 2nd year 2018 & 2019 as a high number of Post CCT trainees have been unable to secure consultant posts. Rota templates are amended if fewer trainees are rotating into the Trust in specialities that have an out of hours commitment.

d) Fines

No directorate within the Trust has received a fine.

Qualitative Information

The exception reports during this period were all from Specialist trainees in Neurology regarding additional hours worked during an on call shift. All have been resolved by offering time off in lieu.

Director of Medical Education Report

Educational feedback via the forum has generally been very positive with no major concerns raised. The Core trainees commended their experiences in the out-patient setting & support from the trust SMART team out of hours. They value the opportunity to take part in the end of placement case competition. 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.

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. 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 being reviewed in anticipation. There have been no reported training issues.

The Guardian of Safe Working will provide a refresher on the new contract and particularly the process of exception reporting and work place assessments.

Summary

There are currently 32 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 12 exception reports. All have been resolved with TOIL.

Junior doctor contract comparison

BMA

January 2020

Topic/title	2016 TCS, pre-2018 review	2016 TCS, post-2018 review
Pay progression	4 point nodal pay scale with pay 'frontloaded' earlier in the career, with parity in earnings from ST3 onwards for those on OOP or training LTFT. Funding for new 'senior decision maker's allowance' in future to increase pay further at end of training.	**October 2020** A fifth nodal point will be introduced from October 2020 trainees at ST6 and above, in order to recognise the significant high service contribution these trainees make. This will be introduced through a staggered approach from October 2020 as follows: – In October 2020 the value will be £3,000 – In October 2021 the value will increase to £6,000 – In April 2022 the value will increase to £7,200
Pay protection	Pay protected if you re-train in a shortage specialty (GP, emergency medicine, psychiatry), or in any other specialty for reasons relating to disability or caring responsibilities. Qualifying period of 6 months continuous service at the current level of basic pay, 0 months for disability reasons. GMC-led review to support appropriate recognition of experience when transferring training paths.	**September 2019** Pay protection on changing specialities expanded to additional specialities which the JNCJ defines as hard-to-fill. When switching to a hard-to-fill specialty pay protection is based on earnings had the trainee not switched, provided that they have achieved at Outcome 1 or 2 at their most recent ARCP. Transitional pay protection extended until 2025.
Basic pay	Basic pay (40 hour week) plus range of other pay elements which could all apply, including up to 8 additional rostered hours, weekend allowance, night work enhancement, on-call availability allowance, flexible pay premia, pay for all hours of additional work done via exception reporting.	No substantial changes.

Non-resident on-call	On-call availability allowance of 8% of basic pay for on-call duty. Prospective average estimate of hours worked on-call paid, plus pay for any additional hours worked over the average estimate. On call work includes travel time, answering phone calls and non-clinical work off site.	**September 2019** When necessary to be resident for NROC because of emergency response requirements, employers must provide accommodation without charge. **November 2019** Principles of the Good Rostering Guidance on NROC to be contractualised. This includes calculating prospective hours, predictable and unpredictable work, NROC design process, exception reporting for NROC and effective management of rotas.
Night working	Enhancement of 37% of basic pay paid on hours worked between 9pm-7am any day of the week. Additionally shifts of 8 hours or more that start no earlier than 8pm and no later than midnight will receive the enhancement for the whole shift up to 10am the next day.	**September 2019** Too tired to drive home provisions, employer must provide alternative transport (including return journey) or accommodation. **December 2019** Shifts finishing after midnight and before 4am will be paid at the enhanced rate (+37%) for the entirety of the shift.
Weekend working	When work is rostered at the weekend (one or more shifts/duties starting on a Saturday or Sunday) at a minimum frequency of 1 in 8 up to a maximum frequency of 1 in 2 across the rota cycle, a weekend allowance of between 3% and 10% of basic pay will apply.	**September 2019** Removal of maximum 1 in 2 weekend frequency exemption for nodal point 2 trainees. **October 2019** Clinical reason and JDF approval required to roster more than 1 in 3 weekends. **December 2019** The following revisions to weekend frequency allowance: – Doctors working a weekend frequency of 1 in 2 will receive an allowance of 15% of basic pay – Doctors working a weekend frequency of less than 1 in 2but greater than 1 in 3 will receive an allowance of 10% – Doctors working a weekend frequency of less than 1 in 5 but greater than 1 in 6 will receive an allowance of 5%
Flexible pay premia	FPP of £8,282 p/a for GP trainees (when in a practice placement), £20,200 for emergency medicine, psychiatry and OMFS split across the eligible years of the training programme, £4,040 p/a for academics. Rate fixed at time of application and payable until trainee finishes.	**November 2019** No substantial changes to FPPs, although there were some minor changes regarding eligibility requirements for Academic FPPs.
Restrictions on hours	Comprehensive list of hours restrictions and rest requirements going beyond the WTR, including new maximum limit of 72 hours in 7 consecutive calendar days, no more than 1 in 2 weekends, max limit of 8 consecutive shifts, limit of 4 consecutive night shifts.	**October 2019** No more than 72 hours work in a consecutive 168 hour period. 46 hours of rest required after any run of night shifts (even one), maximum of four consecutive night shifts retained. **August 2020** Maximum seven shifts of any length worked on seven consecutive days. Maximum four long shifts on consecutive days. Although the previous limits of eight consecutive days and five consecutive long shifts can be retained by local agreement.

Breaks	One 30 min break after 5 hours, a second 30 min break after 9 hours. Breaks should be taken separately but if combined must be taken in middle of shift. If breaks are missed on at least 25% of occasions the guardian will fine the trust at twice the hourly rate.	**September 2019** Night shifts of 12 hours or more receive third 30 min paid break.
Locum work	Junior doctors must first offer any spare hours they have for locum work to the service of the NHS via a staff bank.	**September 2019** Clarity that staff banks have authority to set rates of locum work. National locum rates outlined in pay circular and referenced in TCS have been removed. Locum clause amended to clarify trainees can offer spare time to any staff bank of their choosing and commitment to work with NHSI to improve staff banks.
Safeguards	Guardian levies a fine if juniors breach safe working limits, money split between paying junior at enhanced rate and the guardian who will spend fine, money on additional benefits for juniors at the trust and not facilities that should be provided as standard. Elected junior doctor forum to scrutinise use of fine money and spending reported in transparent accounts.	**August 2019** Total value of guardian fine based on 4x multiplier of 2019 NHSI locum rate, not standard hourly rate. **November 2019** Scope of guardian fines extended to include four more types of safety breach.
Pay for all work done	Exception reporting system to report breaches of the work schedule and/ or safe working limits, and missed training opportunities. Pay at a penalty rate for breaches of safe limits, TOIL or pay offered for additional hours worked – TOIL for rest requirement breaches must be taken within 24 hours or the doctor is paid. Ability to claim for pay for all hours worked on-call above the prospective hours estimate. Pay for all hours of work done.	**September 2019** Scope of exception reporting expanded. Pre-authorisation for additional hours of work. **October 2019** Review process for exception reports revised to streamline the process and accelerate the actioning of reports. **November 2019** Any untaken TOIL will automatically convert to pay at end of placement. Payment for ER must be within a month of payment outcome being agreed, with no further admin (e.g. forms) to complete.
Work scheduling	Personalised work schedule must be agreed between junior doctor and their supervisor, including both service commitments and training. Work schedule reviews can be requested at any time, with the guardian of safe working overseeing any disagreements. Step by step escalation process, with final stage panel that must include trade union representation.	**October / November 2019** Principles of the Good Rostering Guidance, relating to NROC, LTFT, cover arrangements and leave are contractualised.

Guardian of Safe Working Hours	Guardian of safe working is an independent senior appointment in each trust to oversee new safe working system. The appointment panel must include 2 juniors and the whole panel must reach consensus on appointment. They are advised by the elected junior doctors' forum. Guardian must report quarterly, reports must include detail on rota gaps in trust and plans to resolve these. Separate instructions to ensure guardian role works for GP trainees in smaller practices and employ.	**November 2019** Trade union involvement in reviewing and agreeing the time commitment required for the guardian role and what level of administrative support is required for the role.
Fee paying work	Junior doctors can either remit the fee to their employer, or keep the fee and make the time up later, or have the relevant amount deducted from their salary (if the fee is greater than the salary they earned for that time, for example).	No changes.
Leave	Fixed leave should not be contained in rotas. Only in exceptional circumstances, with the explicit agreement of the trainee, could allocated leave be considered – for example in cases where it would otherwise be very unlikely that the trainee could take their full leave entitlement. Special recognition given to the importance of annual leave for significant life events (eg weddings).	**April 2019** Enhanced shared parental leave. Child bereavement leave of two weeks with full pay. **September 2019** Leave for life changing events clarified. **October 2019** Study leave must not be used by employers for statutory or mandatory training. **November 2019** Re-introduction of prospective cover for study leave.

British Medical Association
BMA House, Tavistock Square, London WC1H 9JP
bma.org.uk

BMA 20200019

Framework agreement: amendments to the 2016 junior doctors' contract

Outline Implementation Timetable

This implementation timeline should be read in conjunction with the published framework agreement. The framework agreement sets out both the pay investment that will be made and the amendments to the 2016 junior doctors' contract following negotiations between NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC).

We are working with software providers to ensure the appropriate software updates are made to give effect to the relevant provisions.

Updated terms and conditions for the 2016 contract and implementation support materials will be published in due course.

For queries:

Employers can contact doctorsanddentists@nhsemployers.org, and may find NHSE's FAQs useful.

Junior doctors who are BMA members can contact: support@bma.org.uk or on 0300 123 1233, and may find the BMA's FAQs useful.

Date	Proposed implementation
1 April 2019 (backdated)	**Annual pay uplifts** • Annual 2% uplift applied during the period 2019/20 to 2022/23. Backdated to 1 April in 2019/20 • ESR response: system updates in place by September 2019
7 August 2019 (first Wednesday in August)	***Amended 2016 contract is introduced (version 5)*** **Pay and transitional arrangements** • Trainees who are currently in receipt of 'Section 2' transitional pay protection under Schedule 14 will have their pay protection extended until 2025 • Pay protection for changing specialty clause is updated to reflect the agreed method of calculating pay protection for those moving into hard-to-fill specialties **Leave** • Leave for life changing events

Safety and rest limits

- Breaks for night shifts
- Weekend frequency exemption for nodal point 2
    - FY2 rotas using the weekend frequency exemption will be risk assessed at the point of commencement in August. Where no significant risks are identified that would render the service unworkable, rotas will be amended to a maximum frequency of 1 in 2 weekends, using local rota change processes, in line with the Good Rostering Guide.
    - Where significant risks are identified that would render the service unworkable, the existing rotas will remain in place until no later than December 2019.

Employers notified of 12-month timeframe to commence the process to alter existing rotas and will need to start consultation with trainees to reduce:

- The maximum number of consecutive shifts rostered or worked over 8 consecutive days reduced from 8 to 7
- The maximum number of consecutive long day shifts rostered or worked reduced from 5 to 4

Arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020.

Locum work

- Locum clause clarification

Facilities

- Too tired to drive home provisions
- Payment for accommodation when non-resident on-call

GP Trainees

- Supernumerary status of GP trainees
- Additional mileage/expenses for GP trainee home visits

The parties have committed to clarify what additional mileage expenses can be accessed by GP trainees who may be required to undertake home visits in their own vehicle to enable employers to process claims. The parties will work to resolve this as soon as possible, within a future iteration of the updated terms and conditions. Any claims unresolved at the point of resolution will be processed immediately and payment will be backdated. As such, trainees should continue to submit claims, as their payment will be backdated.

	Guardian fines • Rates of guardian fines **Exception reporting** • What can be exception reported • Pre-authorisation for additional hours of work **Work scheduling** • Personalised work scheduling meetings and off-site educational supervisors • Exception reporting for missed personalised work scheduling meetings ***Due to the short notice with the implementation of this provision. For trainees commencing on 7 August, it may not be possible to arrange a meeting with their educational supervisor within the 4-week time frame. In this situation the trainee must arrange a meeting with the clinical lead as soon as its practicable to do so.***
Oct 2019	***Amended 2016 contract is introduced (version 6)*** **Safety Limits** • Maximum of 72 hours work in any consecutive 168-hour period ***To enable employers to implement this provision it has been necessary to wait for software system updates to be made (DRS and Allocate systems). This existed as an optional functionality in the Allocate system for some time, so we are aware that many employers may have already implemented this provision. All other employers are encouraged to implement this provision as soon as is practicable and, in any event, concluded by December 2019.*** • Rest after night shifts • Maximum 1 in 3 weekend frequency ***Recommended to be reflected in rotas from October 2019 and to be included in all rotas no later than February 2020. In some cases, the introduction of this provision will require recruitment to fill the gaps left on the rotas, which may not be possible by February 2020. Please see FAQs for detail on what to do in situations where an employer identifies that it is not feasible for a rota to function at a frequency of 1:3 weekends or less.*** **Work scheduling** • Mandatory training requirements to be sent with generic work schedule • Generic work schedules to be sent to include the local trust induction required to be undertaken prior or at the start of the placement ***Recommended to issue for October 2019, or at the trainee's next scheduled rotation.***

	Exception reporting • Review process for exception reports locally **Agreed sections of the Good Rostering guidance** • LTFT principles • Cover arrangements and leave
Dec 2019	***Amended 2016 contract introduced in November (version 7)*** ***Amended 2016 contract introduced in December (version 8)*** **Pay and transitional arrangements** • Pay protection clause for those on 2002 terms and conditions is updated to reflect pay protection arrangements for those moving onto the updated 2016 TCS **(in version 8)** ***Trainees still employed on 2002 TCS will be expected to transition at the earliest opportunity and no later than 5 February 2020. Full details were published in version 8 of the 2016 TCS, and are applicable from October 2019.*** • Weekend frequency allowance **(in version 7)** • An enhanced rate of pay for shifts that finish after midnight and by 4am **(in version 7)** **Guardian of safe working hours (in version 7)** • Administrative time and support **Guardian fines (in version 7)** • Breaches that attract a financial penalty **Flexible Pay Premia (in version 7)** • Academic FPP **Less Than Full Time (in version 7)** • LTFT Allowance **Exception reporting (in version 7)**

	• Response time for educational supervisors ***Software systems to be updated for Dec 2019 and payment for validated reports made in the next available payroll. The submissions of reports in Dec 2019 after go-live may not be resolved in time for Jan 2020 payroll and may be carried into Feb. It is recommended that these are processed earlier, where possible.*** • Payment for exception reports • Conversion of untaken time off in lieu (TOIL) into pay • Automatic acceptance of exception reporting outcomes **Agreed sections of the Good Rostering guidance (in version 7)** • NROC Leave **(in version 7)** • Prospective cover for study leave **Work scheduling** • Host and lead employer responsibilities (guidance) **Flexible training (in version 8)** • Champion of flexible training ***Supplementary guidance published January 2020 to give clarity on appointment and implementation in non-hospital settings and scenarios where the role could span multiple sites.***
5 August 2020	**Code of practice** • 8/6-week notification provisions, with supporting caveats ***Changes to be in place by June 2020, for doctors rotating from 5 August 2020, requiring notifications at 8 and 6 weeks prior to this date, and all future rotation dates applicable.***
October 2020	**Introduction of the fifth nodal point** • 1 October 2020 the value will be £3,000 [£52,036] • 1 October 2021 the value will increase to £6,000 [£56,077] • 1 April 2022 the value will increase to £7,200 [£58,398]

Additional provisions

- Enhanced shared parental leave and child bereavement leave introduced from 1 April 2019.

REPORT TO THE TRUST BOARD
Date30th January 2020

Title	**DBS (Disclosure & Barring Service) Update Service**
Sponsoring Director	Name: Mike Gibney Title: Director of Workforce and Innovation
Author (s)	Name: Vicki Brough Title: HR Manager
Previously considered by:	Trust Board – 26th June 2019

Executive Summary

There is an ongoing issue in reaching an agreement with trade union partners on a process for annual DBS (Disclosure and Barring Service) checks. It is proposed that a new enhanced process would be introduced for new staff joining Trusts. There is no dispute with trade union partners that the new process offers an improved service and is something that would ultimately improve patient safety. However the sticking point is who pays the £13 annual subscription fee. This brief update is an overview of this issue, current level of implementation and suggested next steps.

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	There is a risk that we have employees who have not declared a relevant conviction.
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	• No – will complete for final agreed process if introduced
Any associated legal implications / regulatory requirements?	• Yes – enhances the DBS process
Action required by the Board	The Board is requested to: • consider and note

DBS Update Service

1. Background

There is an ongoing issue in reaching an agreement with trade union partners on a process for annual DBS (Disclosure and Barring Service) checks. This has been on the regional agenda for over 3 years as part of the streamlining initiative and remains unresolved across the wider NHS system.

Currently staff in roles requiring a DBS check undertake this as part of the recruitment process; this check is never repeated throughout their employment. All employees are required to complete a self-declaration annually. This is a handwritten form that is labour intensive with inconsistent compliance levels and is ultimately dependent on the individual employee being honest.

2. The New Process

It is only proposed that this process would be introduced for new staff joining the Trust; current staff would continue with the annual self-declaration process. In the last 12 months there have been 178 new starters requiring DBS checks.

New starters would pay the same amount for their initial DBS check as they do now (£44.43 for Enhanced, £27.43 for standard) and would then have 30 days to sign up for the DBS update service. This service costs the employee £13 per year. There is no dispute with trade union partners that this offers an improved service and is something that would ultimately improve patient safety. However the sticking point is who pays the £13 annual subscription fee.

3. Benefits of new process

The Trust is notified via ESR as soon as someone receives a caution/conviction and therefore we would no longer be reliant on self-declaration and therefore this is a significant improvement to the process and therefore patient safety. The benefit to staff is that if they leave us they will not have to pay to have a DBS check elsewhere; their new employer can just check the update service website.

4. Drawbacks of new process

Introducing this new process would require the implementation of a governance process and several decisions would need to be made in terms of:

- The process for checking that they have signed up to the update service initially
- The process for checking that they have updated their membership each year
- What will happen if they don't update? (disciplinary, suspension etc)

The update service costs £13 a year so this would be an additional cost for employees or for the Trust. If the Trust had paid for the update service for everyone who would have been applicable in 2019 it would have cost £2,314.

5. Next Steps

Clearly the ideal resolution is that there is an agreement with staff side across the Cheshire and Merseyside healthcare system in the first instance. A survey of current practice is being led by Chris Samosa Strategic Workforce Lead, Health & Care Partnership for Cheshire & Merseyside.

We informally contacted 9 local Trusts and only 1 (Merseycare) has mandated the update service and have a process in place for monitoring compliance. The individual employee pays the subscription fee.

Once we have the full picture across the region we will then look to agree a consistent process at the Cheshire & Merseyside level. However, if this is not possible The Walton Centre will then need to make a clear decision on the introduction and payment for the new process.

REPORT TO THE TRUST BOARD
Date 23rd January 2020

Report Title	**Chairs Assurance Report for Quality Committee**
Sponsoring Director	Seth Crofts (Non Executive Director)
Author (s)	Lindsey Vlasman – Acting Director of Nursing and Governance
Purpose of Paper:	
The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update the Board of the meeting of the Quality Committee held on 23rd January 2020	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Potential future changes for EPMA
- Introduction of the new IPR
- Increase of Mortality in October 2019 noted on the IPR
- 2 Serious Incidents in December 2019 (1wrong level surgery and 1 category 2 pressure ulcer)
- 2 CPE on Sherrington Ward for December 2019 both being investigated

2.0 Items for the Board's information and assurance

A) Patient Story

A patient story was presented with key actions and key learning shared.

B) Digital Strategy

An overview of the digital strategy was presented including,

- Future developments with EP2
- Cyber attack updates
- End of life of IT products
- New NHS email system
- Windows 10
- Transformation programmes
- Call centre patient access centre
- Upgrade of software

C) Medical Directors Update

- Update regarding the latest report from blood and organ donation
- ICNARC report positive

D) Integrated Performance Report

The new format of the IPR was discussed and how this would be presented at future meetings. A discussion regarding complaints and the Walton centre being an outlier for the amount of complaints that we receive compared to other outstanding trusts.

RAMI data was discussed and an agreement was made that AN was to have a further meeting regarding mortality reports and reviews and widening the remit of mortality meetings to the MDT.

HO to have a further meeting with MF to discuss pressure ulcers and how they are recorded on the IPR.
Divisions also to meet with MF to discuss the divisional charts

The committee happy with the new format of the IPR but would like a heat map for each division which would be easier to present.

E) Board Assurance Framework

An overview of the BAF was provided and the risk for violence and aggression risk was discussed and has been reduced. A new risk has been put onto the BAF regarding the Quality Strategy and the risks associated with achievement of this.

F) Mortality and Morbidity Quarter 2 Report

DC gave an overview of neurosurgery mortality and MW gave an overview of neurology. All cases within the report were discussed.

G) Safety Huddle Quarter 3 Report

An overview of the safety huddle for Q3 was provided with the key themes

H) Infection Prevention Quarterly Quarter 3 Report

An overview was provided for Q3 regarding infection prevention.
Legionella update provided with the current position, hydrops has now been purchased and will be rolled out across the trust and will support staff with their flushing schedules.
Tissue Viability Nurse post remains vacant and will be advertised this week.
Flu Campaign CQUIN currently not met further work needs to be undertaken for final figures.

I) Medicines Management Annual Report

An overview was provided regarding Medicines Management at The Walton Centre.

- Medicines reconciliation was also discussed
- A description of the portal was provided
- Controlled Drugs Update was provided
- Non Medical prescribing overview
- Anti Microbial stewardship
- EPMA
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Review work plan for this report to come to committee in June rather than January

J) Governance and Risk Management Q3 Report

Overview of the report was provided, looking at incidents, complaints, and the increase of incidents for safeguarding.

There has been a further increase in complaints, concerns and claims for quarter 3 and the key themes have been identified. The divisions will be working to address these.

K) Quarterly Trust Risk Register

The trust risk register was presented and a discussion was had for the high risks and the new risks.

L) Quality Accounts

The quality accounts were presented with an overview of accounts that had been chosen from the council of governors meeting. Further engagement will be provided to Health watch ad the other external provide

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REPORT TO THE TRUST BOARD
Date 30th January 2020

Report Title	**Chairs Assurance Report**
Sponsoring Director	Seth Crofts – Non-Executive Chair, Research, Development and Innovation Committee
Author (s)	Gill Williams (Hamblin) Head of Research
Purpose of Paper:	
The paper provides an update to the Board of the meeting of the Research, Development & Innovation Committee held on 8th January 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

There were no matters requiring the Board's attention.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Liverpool Neuroscience Biobank at Walton (LNBW)

Dr Carrie Chadwick and Dr Khadja Syed gave a presentation on the development of the Biobank. There are currently two separate biobanks operational at The Walton Centre; the tissue bank and the blood/CSF biobank. Work is progressing on combining the two aspects into one biobank, which will be known going forward as the Liverpool Neuroscience Biobank at Walton. The new single biobank will hold data, blood and tissue samples as well as MRI images for research. This provides clinicians within the trust with further research opportunities and is aligned with the Research and Development Strategy. The pathology team has applied to become a national ISO pilot site for new biobanks and a decision is expected February 2020.

b) *Strategic Partners update*

a. ARC: The newly formed Applied Research Collaboration (ARC)held its launch November 2019 The event was well attended by professionals and patient representatives and will focus on themes selected by patients that will impact on the local healthcare priorities. Professor Tony Marson is one of the newly appointed theme leads.
b. Innovation Agency: No update
c. NWCCRN: Dr Chris Smith informed the committee that the network has slippage monies available for bidding against. The next round of business meetings will be held in the coming weeks with each trust. The Walton Centre meeting will be represented by Gill Williams and Laura Evans. Budget planning for 2020/21 will be included in the discussions.
d. LHP:
    i. Professor Tony Marson gave an update. Dr Connor Mallucci has been appointed as Director of Neuroscience , a Programme Manager is to be appointed to support this programme and the formal launch of the new Institute of Neuroscience at the University of Liverpool is expected to be October 2020.
    ii. Professor Andrew Pettit recently met with Hayley Citrine to discuss the LHP Cancer Programme. A sllideset was shared with the committee for information
    iii. Gill Williams updated the committee on the SPARK initiative. All staff are now appointed, SOP's are being ratified and the NRC are working closely with the teams to align processes in the set up and delivery of clinical trials.
    iv.

c) **Research & Development Strategy**

a. **Gill** Williams and Dr Rhys Davies shared key points from the draft R & D strategy 2019-2024. Key points discussed were engagement and awareness, access to clinical studies for all patients, the NRC infrastructure, funding, SPARK and LHP collaborations, and the development of new researchers within the organisation: It was acknowledged that research nurse capacity is currently an issue, work is progressing on identifying solutions including different ways of working. A work plan will be drawn up and monitored via the RDI committee. The Committee ratified the draft strategy prior to formal sign off by the Board at the end of January 2020.

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d) RDI Finance & Performance

a. *Laura Evans updated the committee. There is approximately a deficit of £130k which is unlikely to be resolved before year end. This is linked to the reduction in the number of commercial trials but will be addressed by the appointment of additional staff and a change in working practices over the coming year. Performance is down compared to this time last year. Additional nurse support will be requested from the CRN as a short term solution.*

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REPORT TO THE TRUST BOARD
Date 30th January 2020

Report Title	**Chairs Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Jane Hindle, Corporate Secretary
Purpose of Paper:	
The Audit Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board following the meeting of the Audit Committee held on 21st January 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

There were no matters requiring the Board's attention.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Internal Audit Update Report and Follow Up Report

The Committee received updates on the following Equality Diversity and Inclusion, Clinical Coding and Critical Applications. The Trust's systems and processes for **Equality Diversity and Inclusion (EDI)** received **substantial assurance** with the improved position in relation to the Workforce Race Equality Standard being recognised. A number of minor recommendations were made primarily around the governance arrangements for ED&I.

A review of the Trust's **Clinical Coding** processes found that the accuracy of clinical coding is of a high standard. However issues were found with the source documentation in some cases the documentation was insufficient to support accurate coding. The recommended actions would address this by the end of April.

The Committee received a report in relation **Critical Systems** – specifically the Electronic Patient Record system (EP2) and noted a number of areas of good practice. The work associated with the system is reliant on one member of the IT Team which presents a risk. The review identified 22 recommendations which the Trust is developing a plan to address.

b) *Limited Assurance Reports*

The Committee received a report in relation to the accuracy and validity of data within the ePatient system utilised within Neurophysiology. The overall assessment was of limited assurance and a number of high risk recommendations had been identified. The Trust had taken action to address a number of the recommendations and work will continue with the remaining actions due for completion in April 2020.

c) Anti-Fraud Progress Report

The Committee received a progress report outlining the activities undertaken from July to December 2019. Risk assessments have been completed in relation to all areas of fraud and these will be monitored via the corporate risk register. No referrals had been made to the Anti- Fraud Specialist in the reporting period and there were no outstanding referrals.

d) External Audit Progress Report and Audit Plan 2019/20

The External Auditor updated the Committee in relation to the audit plan for 2019/20. The interim visit will take place in March with final work taking place in April and May. Meetings have taken place with the Director of Finance and the Corporate Secretary as part of the audit planning processes for 2019/20 audit.

e) Preparation of Financial Statements 2019/20

The Committee received a report outlining the basis on which the financial statements will be prepared for 2019/20 and the timeline for submission. The draft accounts must be submitted to NHSI/E by noon on 24th April and the final audited accounts, approved by the Board must be submitted by 29th May. The Committee approved the Going Concern Assumption on the basis that there are no material uncertainties or conditions that may cast significant doubt about the liability of the trust to continue as a going concern.

f) National Cost Collection Index / Reference Costs

The Committee received a report in relation to 2018/19 National Cost Collection Index (NICCI) which assesses the base cost of an NHS organisation against the national average for the range of services provided by that organisation. For 2018-19 the Trust had a NICCI of 102 after adjustment which in comparison with 109 in 2017/18 shows that the Trust is improving its efficiencies. The Trust is however 2% more expensive than the average in 2018/19.

g) Aged Debtors Report

The Committee received a report of debtors over 90 days. The majority represent NHS to NHS debt both via provider and CCG's. The Trust was in discussion with the highest debtor to resolve the issue and the Committee noted that there were legacy issues relating to this.

h) Tender Waivers

In line with the Standing Orders the Committee received the quarterly report in relation to those cases in excess of £50,000 where a formal tendering process has not been followed. During quarter 3 there were 2 occasions where the process had not been followed, these were reviewed and found to be applicable to the waiver process.. It was confirmed that the £50,000 limit was in line with other specialist trusts.

i) External Visits Report

The Committee received a report in relation External Visits. This detailed all actions outstanding from visits and inspections conducted by regulators and external agencies since 2016. A number of actions remain outstanding and the Committee requested a further report in order to understand the detail.

j) Risk Owners Presentations to Committee

The Committee considered a proposal for each of the Divisions to deliver presentations to the Committee in relation to their governance arrangements. The presentations will cover the business planning process and how the strategic objectives are disseminated into operational objectives and plans. Risk Owners will also describe the Governance structure that enables exception reporting and supports delivery of objectives, and the top risks and themes within the division. The Committee agreed to commence this reporting in July 2020.

3.0 Progress against the Committee's annual work plan

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

- Draft Annual Governance Statement
- Draft Annual Report
- Board Assurance Framework
- Compliance with the Provider License
- Quality Account
- 3rd Party assurances
- Annual Report of the Committee

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REPORT TO THE TRUST BOARD
Date 30 January 2020

Report Title	**Chairs Assurance Report**
Sponsoring Director	Mike Burns – Director of Finance and IM&T
Author (s)	Mike Burns – Director of Finance and IM&T
Purpose of Paper:	
The paper provides an update to the Board of the main points discussed at the meeting held on 9th January 2020	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

There were no matters requiring the Board's attention.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) *Presentation: Neurology Service Response to GIRFT*

Dr Wilson delivered a presentation demonstrating the Hub and Spoke Network Model for Neurology, clinic data, ward consultation sessions and included the GIRFT audit results. The strengths and issues with the service were noted and in summary data demonstrated that:

- WCFT sees a lot of outpatients and RTT targets are met;
- Acute neurology is less well served which is reflected in DGH Length of Stay (LoS) data,
- This is entirely consistent with clinical experience

The Programme Board's views were sought on the data and clinical pathway. LoS was identified as an issue and there is an appetite to better understand the reasons behind this. It was agreed that different models for some chronic diseases could be explored; different methods of undertaking this would be considered.

b) *Presentation* – RightCare – Neurological Problems

Ms Russell (RightCare) delivered a presentation entitled: Neurological Problems. Key points included

- A huge variance in primary care prescribing for neurological conditions;
- Significant variations on spend for neurological conditions and pain admissions within Cheshire and Merseyside;
- Spend is higher than peers on unspecified diagnostic spinal punctures;
- Work is still needed on the spinal pathway;
- Chronic pain is still the most common reason for admission amongst high intensity users.

A new programme adopted for Respiratory was demonstrated to the Programme Board as an example of a different model and pathway for Cheshire & Merseyside which would also support primary care. The Programme Board agreed that an Operational Group would be formed to look at how to take this forward; Mr Burns will progress this.

c) **Update on the MS Pathway**

The MS Pathway is to be launched in February 2020 through the Neurological Alliance. Work is ongoing to look at GIRFT data and information around existing resources to align this with the new pathway.

d) Update on The PD Pathway

The PD pathway is to be launched; this includes an internal pathway for giving advice and guidance and also a national programme which the Trust is actively involved in and which will be updated through the National Neurological Advisory Group.