NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 30th July 2020

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA

The Walton Centre NHS Foundation Trust

Virtual Meeting
WCFT Thursday 30th July 2020
09:30 – 13.00pm

V = verbal, d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.30	Minutes and actions of meeting held on 22nd June 2020 - to follow	J Rosser	Decision (d)
4	09.35	Patient Story	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update - verbal	J Rosser/ H Citrine	Information (v)
6	10.10	COVID-19 Update	H Citrine/ Execs	Information (d)
7	10.20	Trust 5 Year Strategy – Annual Update	H Citrine	Assurance (d)
PERFORMANCE				
8	10.40	Integrated Performance Report	CEO/NED Chairs	Assurance (d)
QUALITY				
9	11.00	Equality Diversity and Inclusion Annual Report and 5 Year Vision Update	L Salter	Assurance (d)
10	11.10	Equality, Diversity & Inclusion – Tackling Racism	H Citrine	Information
11	11.20	Freedom to Speak Up Guardian Report	L Salter	Assurance (d)
12	11.30	Quality Account	L Salter	Assurance (d)
13	11.40	National Inpatient Survey Results	L Salter	Assurance (d)
GOVERANCE				
14	11.50	Governance Report	J Hindle	Decision (d)
15	11.55	Quality Committee Chair's Report	S Crofts	Assurance (d)
16	12.00	Business Performance Committee Chair's Report	S Samuels	Assurance (v)
17	12.05	Research Development and Innovation Committee Chair's Report	S Crofts	Assurance (d)
18	12.10	Charity Committee Chair's Report	S Rai	Assurance (d)
CONCLUDING BUSINESS				
19	12.15	AOB Feedback from NED discussions with operational staff	J Rosser	Information

Date and Time of Next Meeting: 24th September 2020, WCFT

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

Monday 22 June 2020

Present:	
Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Ms S Samuels	Non-Executive Director
Ms B Spicer	Non-Executive Director
Professor N Thakkar	Non-Executive Director (part)
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Salter	Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation
In attendance:	
Ms J Hindle	Corporate Secretary
Observing	
Ms B Strong	Governor

Trust Board Attendance 2020-21

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

TB27/20-21	**Welcome and apologies**
	Ms Rosser welcomed those present to the meeting via Microsoft Teams. There were no apologies to note.
TB28/20-21	**Declarations of interest**
	There were no declarations of interest in relation to the agenda.
	Minutes and matters arising from the meetings of 22nd May 2020.

	Mr Burns and Ms Citrine had identified amendments to the minutes, and these would be forwarded to Ms Hindle for action. **Matters arising action log** The following updates was provided: **Pay back for annual leave** – Mr Gibney advised that it was unlikely that a decision would be given until the end of the financial year when the full reality of the position across the NHS would be known. Mr Burns advised that whilst the Trust had made a contingency for this in month 1, NHSI had advised all trusts to remove any such contingencies. There would be a cash impact however NHSI would need to revisit the position towards the end of the financial year.
TB29/20-21	**COVID - 19 Update Report**
	Ms Citrine introduced the report which summarised the current position in relation to the national and local response to COVID-19 **Black Lives Matter** It was noted that both nationally and regionally the issue and relevance to the NHS had been highlighted particularly in light of the impact of Covid-19 for BAME staff. Bill McCarthy, Regional Director, had set up a BAME Advisory Group and nominations had been sought from trusts. Ms Citrine reported that Professor Thakkar and Ms Rai had been nominated on behalf of the Trust. The inaugural meeting was due to take place on 29th of June. At a local level Ms Citrine was keen to progress the work that the Trust had offered commenced to support BAME staff and risk assessments were currently being undertaken. Ms Citrine was due to meet with the Trust's ED&I Lead and the Deputy Director of HR to discuss the issue and an update would be provided at the next meeting. **System Capacity** Across Cheshire and Merseyside it had been identified that 300 Seacole beds would be required to introduce additional capacity for patients requiring rehabilitation following Covid-19. The Trust had expressed an interest and if successful planned to host them in the Sid Watkins Building. The Trust was awaiting a response to its submission as part of the capital bids round. Mr Burns was part of the team of Finance Directors charged with considering the capital bids from across Cheshire & Merseyside **Hospital Cell** As part of the in hospital cell work Ms Citrine had was leading the Directors of Nursing to obtain regional consensus around visiting, testing and how hospital transmitted infections would be monitored. **Infection Prevention & Control** Temperature testing of staff and visitors had now been introduced throughout the Trust and the wearing of masks was now a requirement in public areas. Referring to the attached Covid-19 dashboard Ms Citrine stated that in the earlier stages it would appear

	that people contracted Covid-19 from being in the hospital however the lack of testing at that point had been a real problem and additionally the test was not always accurate in the first instance. **Operational Activity** In answer to a question submitted in advance Ms Ross outlined the challenge of planning to increase activity whilst maintaining infection, prevention control principles and ensuring that the trust clinically validates anyone receiving treatment. Phase 3 of recovery was focussed on ramping up activity whilst still applying social distancing measures and therefore maintaining safety for patients and staff. Ms Rosser noted that the infection prevention control measures were obviously time consuming and would therefore have significant impact on operational performance. Ms Rosser stated that it had been reported at a national meeting that NHSI would look to introduce some mechanism within the contract to incentivise trusts to increase activity. Mr Burns reported that he was not aware of any such incentives however he was aware of discussion regarding introducing greater financial controls at a regional level. Ms Citrine added that whilst the planning assumptions had been changed nationally there hadn't been any information to explain the changes. Whilst the expected level of activity was around 80% there was no rationale behind it as to how this should be achieved. The tension between increase activity and infection control was apparent however managing this had been left to local discretion. Ms Citrine noted that in relation to increased activity the Trust's current occupancy level was around 60%. **PPE** Ms Rosser referred to a national call that she had participated in where the issue of the supply of PPE had been raised and queried if the Trust anticipated this to be an issue locally. Ms Ross responded that the Trust had managed this well and unlike other trusts in the area had introduced both FFP2 and FFP3 masks and continued to fit test. Ms Salter added that this was discussed during the daily huddle and if there were issues staff were free to raise these. Dr Nicolson confirmed that Medics were entirely comfortable with the approach the Trust had taken and had no concerns. **COVID Working Survey** Ms Rosser queried what action the Trust planned to take in light of the results of the COVID-19 survey. Mr Gibney advised that the results, together with the results of the national Staff Survey would inform several focus group discussions, involving staff from all disciplines. An action plan would be developed as a result and would be reported to the Business Performance Committee. In terms of the response rate 502 out of 1473 staff had taken the time to respond which was noted as a positive. It was recognised that there was a tension between those services that can easily adapt to flexible working and those services that are essential to deliver increased activity and therefore cannot be provided with the same degree of flexibility. A piece of work was underway to develop an agile working approach and this was being overseen by Mr Gibney and Ms Ross. **The Board** • **noted the updated position**
TB	**Integrated Performance Report**
	Ms Citrine referred to the report that had been circulated with the agenda and highlighted the impact of COVID-19 on the waiting times in all areas. The Trust was continuing to

treat stroke patients, however was receiving less trauma patients, and seeing different rehab needs post Covid-19. It was also noted that there had been a positive impact in the rates of C-Difficile, a reduction in falls and workforce metrics reflected the impact of COVID-19 on staff across the Trust.

Ms Ross advised members that in relation to activity the Trust was only treating urgent patients and whilst seeing some improvement it would not have a significant impact on the performance metrics. Whilst the Trust had met the cancer target however diagnostic performance was poor and would be discussed in more detail in the next agenda.

Ms Salter referred to the quality metrics within the report and advised members that there had been a clear improvement in the management of complaints evidenced by the reduction in number, with 28 being closed since the beginning of lockdown

Mr Crofts reported that the Quality Committee had reviewed the position in relation to complaints having recognised that there had been a reduction in complaints however there had been a back log and the current environment may could this. Ms Salter reported that now there was no more than 3 open complaints and they were in within date, 85 concerns had been closed plus 46 enquires had also been closed. The divisions had worked closely with the Patient Experience team to

It was recognised that due to COVID-19 there was a clear theme relating to Waiting Lists and the Trust was managing this by contacting patients to ensure that they were managing their condition. The Trust had issued a standard letter which detailed those conditions which could be prioritised and the rationale why. Ms Ross stated that the Trust continued to maintain contact with patients via letters as whilst the outcome wouldn't change it was important that patients believed that the Trust did care.

Ms Samuels commented that another Trust had provided an answer phone message that clearly stated what their current position was in relation to outpatient appointments to support them in avoiding complaints. Ms Salter confirmed that the Trust had now adopted a similar approach.

Mr Burns provided an update in relation to financial performance.
As previously reported the Trust was now required to break even in the first four months of the financial year. In month 2, income was higher than costs but was be reduced by £424,000 to break even.

The underperformance in income of £1 million was primarily due to Wales and the Isle of Man not paying at the levels of income assumed by NHSI/E in their plans for the Trust. This had been raised with NHSI. Expenditure underspend was also £1million. There had been additional Covid related costs of £129k and Mr Burns reported to members that Deloitte had begun to audit Covid-19 costs in other organisations.

The Trust incurred £129k of capital of which £74k related to Covid spend and therefore the Trust would look for reimbursement from the centre. Capital Limits were now being set at HCP level and the Trust's limit was expected to be £4million however Mr Burns was still in discussion with the STP regarding the flexibility on this.

The current cash position of £38.8m was extremely healthy and the equivalent of 119 days operating costs which included one month in advance.

In response to a question submitted in advance of the meeting Mr Gibney provided an

	update in relation to sickness absence clarifying the position as follows: **Sickness absence** Clarity had been sought in relation to the current position which was known to be; 135 – Unavailable staff 57 - Staff shielding 78 - Staff currently sick 18 - Staff with Covid related sickness 60 - Staff with other sickness National guidance stipulated that those individuals required to shield must continue to do so until the end of July. **Mandatory Training** The current situation had provided an opportunity for staff to focus on the completion of mandatory training and this was reflected in the improved figure. **The Board** • **noted the report.**
TB30-20/21	**Quality Committee Chair's Report** Mr Crofts provided a verbal update from the meeting held on 18th of June. It was appropriate to escalate to the Board the current position around Mortality and Morbidity as there had been an increase in deaths with following 19 deaths in October and therefore this had an impact on the cumulative position for the year. The Committee was satisfied that all cases had received a robust review and that there were no underlying issues in terms of care and treatment. The Committee had received an update from the Trust's ED&I Lead in relation to the delivery of the Equality Diversity and Inclusion visions and objectives. The matter of progression within the organisation had been discussed and Professor Thakkar and Ms Samuels had agreed to work with the ED&I Lead to support this and to ensure that progress is made against all of the ED&I outcomes. In relation to the risk assessments of staff and patients shown within the IPR there was an improved position although there was still work to be done. The Committee had also received and queried the Corporate Risk Register and had queried risk 748 which related to patients not receiving follow-ups due to gaps in their discharge summaries on time. The team had been asked to review the risk and mitigations to ensure that the level of risk would be reduced. Ms Salter observed that the Chair's report should focus on the matters for escalation to the Board and the business covered in the meeting and therefore did not require the same level of detail as minutes. **Action: Ms Hindle to share an example of an alternative Chairs report with Ms Rosser: July 2020** **The Board** • **noted the update from the Committee**
TB32-20/21	**Business Performance Committee Chair Report** Ms Samuels provided an update from the meeting that had taken place 26th May and escalated the following matters:

	The Board Assurance Framework (BAF) and current position in relation to risks given the shift in the external environment. It was recognised that the appetite for risk had shifted and therefore the target risk scores were possibly too ambitious. The Board should consider this in the next review of the BAF and this also should prompt a review of the Board's risk appetite statement as Ms Hindle stated that the Trust had received guidance from internal audit in relation to risk appetite and this suggested that the Board would want to re-visit this before the end of quarter 2. Ms Rosser stated that this was an important item however feedback suggested that Non-Executive members would prefer any board development sessions to be conducted face to face and until social distancing rules were changed this may be difficult to factor to the Board's business. The Committee had received and approved the National Data Opt-Out Policy which described the process for patients wanting to opt-out of having their data used if it was for non-clinical purposes. The Committee had also received an update in relation to the Trust's Capital Programme noting that there were concerns however this had been covered by Mr Burns in his earlier update. **The Board:** • **Noted the report from the Committee**
TB33-20/21	**NHS Foundation Trust Self-Certification** Ms Hindle presented the report which was a requirement of the annual reporting process and advised members that ordinarily NHSI would conduct an audit to establish if trusts had published the statement. Due to the pandemic and shift in regulatory oversight this would not be taking place in 2020 however the Trust was still required to publish the certificate it on the website. The report provided the evidence against each of the required licence conditions to enable the Board to be satisfied that these had been met during the year. Ms Hindle reported that the changing governance environment due to Covid-19 had been included as a risk to compliance and to mitigate this the governance arrangement were subject to on-going testing. **The Board:** • **approved the self-certification for publication**
TB34-20/21	**AOB** Ms Rosser thanked Ms Strong, Lead Governor for her attendance and queried if she had any questions for the Board. Ms Strong stated that it had been very informative, and it had been helpful to understand the Trust's current response to Covid-19 and operational

	performance noting this was re-assuring from a patient's perspective. **There being no further business the meeting closed.**

TRUST BOARD
Matters arising Action Log
July 2020

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **May 2020** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ June 2020	
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. **March 2020** Comments following Charity Committee to be included in the next version. RDI need to factor in the changes to the sub-groups. **May 2020** Ongoing **June 2020**	~~Nov 2019~~ ~~March 2020~~ ~~April 2020~~ June 2020	

				Draft T2020ORs for RD&I to be discussed at the July meeting and now include Medical Education On the agenda.		
22.06.2020	**TB30-20/21**	**Quality Committee Chairs Report** To circulate an example of a Chairs report to Ms Rosser for consideration.	J Hindle	Item has been shared with J Rosser and L Salter.	July 2020	

Actions not yet due

22.05.20	**TB16/20-21**	**COVID 19 Update** Director of Workforce to provide update on the national and local position in relation to annual leave of staff.	M Gibney	**June 2020** There had been no national update on the matter and it was not expected until the end of the financial year.	~~June 2020~~ February 2021	

The Walton Centre
NHS Foundation Trust

REPORT TO TRUST BOARD
Date 30th July 2020

Title	**COVID-19 Update Report**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Jan Ross, Director of Strategy and Operations, Mike Gibney, Director of Workforce and Innovation, Lisa Salter, Director of Nursing and Governance, Mike Burns Director of Finance.
Previously considered by:	None

Executive Summary

The purpose of the report is to summarise the approach to COVID-19 to date; to inform the Board of new ways of working, emergency resilience and operational preparedness, recognising regional and national responses and directives.

Action required by the Board	The Board is requested to: • note the updated position
Related Trust Ambitions	1. Deliver best practice care and treatments on our specialist field. 2. Provide more services closer to patient's homes, driven by the needs of our communities, extending partnership working. 3. Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff. 4. Lead research, education and innovation, pioneering new treatments nationally and internationally. 5. Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family centred care. 6. Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing
Risks associated with this paper	BAF Risk ID001 COVID-19
Related Assurance Framework entries	BAF Risk ID001 COVID-19
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	Follows national and regional guidance related to Coronavirus

1.0 INTRODUCTION

1.1 The purpose of this report is to update the Trust Board on key national, regional and local developments in relation to COVID-19.

2.0 NATIONAL CONTEXT

2.1 Covid Recovery Service

Tens of thousands of people who are suffering long-term effects of coronavirus will benefit from a revolutionary on-demand recovery service.

Nurses and physiotherapists will be on hand to reply to patients' needs either online or over the phone as part of the service.

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

2.2 The impact of COVID-19 on LGBT Communities

Whilst the impact of Covid-19 is well known to have had a disproportionate impact on our BAME communities, the impact of the pandemic on LGBT communities is not so well know. A recent finding revealed that LGBT communities have been affected mainly by not being able to access important mental health services and appointments during time of crisis.

Online Listening Event on Inequalities and LGBTQ+ NHS Employers hosted an online listening event on Tuesday 21st July, 11am – 12.30pm, to look at the inequalities experienced by LGBTQ+ people, and what can be done to tackle them.

2.3 NHS Staff Survey 2020

It has been agreed that the 2020 NHS Staff Survey will run in the same way as again this year and that the majority of the survey questionnaire will remain the same to ensure it is possible to compare the results to fully understand the impact of this year on staff experience.

A small number of new questions will be added around staff deployment and experience around Covid-19 which will allow greater analysis and learning from the results and also additional free text questions which will allow staff to tell us about their experiences in their own words. The focus for the survey will be about learning from staff experiences rather than performance management of organisations. The questionnaire is currently being tested and the final questionnaire and guidance documents are planned to be published by the end of July. The survey will be in field in October / November and the results published in February, as normal.

2.4 NHS People Pulse Survey

The Trust are participating in the NHS People Pulse - a national online survey, developed for all NHS provider and commissioner organisations, to support local listening and engagement activities. Results will provide a national, regional and local view of employee experience and wellbeing. The survey takes only 5 minutes to complete and asks employees how they are responding to the pressures during COVID-19 and recovery, at work and at home, including how supported, motivated or anxious they may feel, and what other support would make the biggest difference to their experience at work at this time. The feedback will inform local and national changes that improve the experiences of our people and patients. NHS People Pulse will run from 1 July 2020 until 31 January 2021, with a new survey cycle taking place every two weeks to allow us to explore various aspects of response to COVID-19 and the recovery phase.

3.0 REGIONAL POSITION

3.1 Adopt and Adapt programme

The Adopt and Adapt programme is intended to mirror the "nightingale thinking" approach that was taken in Phase 1 of the Covid response. The purpose is to rapidly address a specific issue – in this case the urgent restoration of endoscopy activity and is additional to medium to longer term transformation programmes (which will align and continue in parallel).

Each region is required to have plans in place by Friday 31st July.

3.2 Capacity and Demand

The Cheshire & Merseyside system is currently progressing a 'live' capacity model to support system wide planning. The aim is for it to take into account PPE availability, staff absence, bed availability both in and out of hospital.

3.3 Procurement and supply of PPE

The Trust continues to follow national and regional processes for updating stock levels and escalating shortages of PPE on a daily basis. Other critical consumables are now reported on a bi-weekly basis and reviewed by a national clinical team to ensure adequate levels of stock will be distributed across the nation. Mutual aid is on-going with Trusts supporting each other to ensure organisations can continue to offer care to patients.

The MOD organise daily deliveries of PPE via Clipper logistics and bulk orders have been received through collaboration with the Cheshire and Mersey region. Locally the Trust continues to identify gaps and procure solutions which cannot be fulfilled nationally or regionally. A national shortage of FFP3 masks has been communicated, therefore the Trust has now procured additional reusable masks and the details

shared with other Trusts to enable an increase in activity across the region.

The processes implemented over the past month will continue for the foreseeable future with updates to systems to improve the visibility of stock nationally.

3.4

Rollout of national NHS 111 first programme in Cheshire and Merseyside

Warrington and Halton Hospitals NHS Trust is one of two 'first mover' sites in the region to implement the new national NHS 111 First programme.
The approach aims to ensure that patients can access the clinical service they need, first time via the NHS 111 service, with the convenience of a booked appointment or time slot if they need to attend an emergency department.

NHS 111 First is part of a national integrated programme to improve outcomes and experience of urgent and emergency care. Warrington and Halton Hospitals and a second site, Blackpool Teaching Hospitals, will implement the new approach first, by late August, and it will then be introduced across the region through the autumn, in line with the national rollout.

3.5 Industrial Relations during the Pandemic

The national Social Partnership Forum (SPF) Statement on Industrial Relations during the Pandemic came into effect from the 1 July 2020. The document is inconclusive as to whether trusts can resume business as usual case work, therefore it has been agreed to develop good practice guidance at the North West SPF chaired by the Director of Workforce.

3.6 Summer Childcare Provision

This is currently a major area of concern for working parents and NHS organisations across the region. The NHS England Staff Experience national team have been working with DfE, national childcare providers, NHS Employers and NHS Charities Together to put information and offer of support together.

4.0 LOCAL POSITION

4.1 Walton consultants lead research into neurological effects of COVID-19

Clinicians from The Walton Centre have led an early stage national study of hospitalised patients who developed brain complications in patients with COVID-19.
Lead researcher Dr Benedict Michael, a consultant neurologist with the Trust, worked with the *Coro*Nerve Studies Group, a collaboration between the universities of Liverpool, Southampton, Newcastle and UCL, to study 153 patients treated in UK hospitals during the acute phase of the COVID-19 pandemic.

The findings, published this week in *The Lancet Psychiatry*, describe a range of neurological and psychiatric complications that may be linked to the disease, including

stroke and an altered mental state such as brain inflammation, psychosis and dementia-like symptoms. The study provides valuable information for clinicians and researchers taking the next steps in neuroscience COVID-19 research and planning.

4.2 Infection prevention and control

The Trust continues to maintain robust infection prevention and control measures for staff and patients in line with national guidance.

4.3 Patient Experience

The Senior Nursing Team and Director of Nursing & Governance are regularly attending the wards to seek feedback from patients regarding quality care and their experiences. Both patient and family feedback is collated from social media and from staff contacting families to update them regarding their loved one. This information is shared with the Patient Experience Team. In addition letters from loved ones and regular telephone calls / zoom calls to families is supported via the Trust staff.

In order that the Non-Executive Directors have the opportunity to talk to staff about their experiences and patient care, a plan was shared with managers and NEDs alike to enable a buddy system to be in place. Some calls have already happened however this will be referenced further in Trust Board.

4.4 Outpatient appointments

Most of our outpatient appointments are now being undertaken in a different way. When it is necessary to attend the hospital, the patient should attend alone, where this is not possible, either due to potential psychological distress or physical support, one person may accompany the patient attending outpatients, both should wear face coverings.

4.5 Agile Working

Due to the current COVID situation a number of staff have been required to work from home where possible as directed by the government. This has allowed the teams to us to look into how we can implement agile working at The Walton centre. Staff were asked to complete a survey to inform us how this new way of working impacted them and have a number of focus groups have been held with staff to see what they would need to help them work in an agile way.

Feedback to date has been very positive with staff saying that the change has been welcomed and afforded them better work life balance. To compliment this we are implementing agile work spaces for staff to utilise when they need to come into the Trust and work. We will have our ‘Show Home’ in place mid-August where staff can come to see how this way of working will look and feel, giving them the opportunity to speak to staff currently working in this way.

4.6 Walton Centre Charity

The emergency appeal set up in March in response to the public's desire to support the NHS during the covid crisis, closed on 5th July in conjunction with the national NHS72 celebrations. This decision was made in order to give a definite closure to the appeal, thank supporters and move on to planning and fundraising for hospital projects/patients/services again. £16,500 was raised through the dedicated webpage on the Charity's website, with gift-aid still to be added to the total.

The level of gifts-in-kind received has also reduced significantly in line with the ease of lockdown as would be expected. The Charity is still supporting patients as long as visiting restrictions are in place through the provision of toiletries and a snack trolley managed by the dieticians, so any gifts-in-kind which are received are redirected for these purposes if appropriate.

In addition to the emergency appeal, the Charity also received two grants from the NHS Charities Together national campaign - £35,000 and £10,500 in April – and following an application by the Head of Fundraising a further grant of £50,000 to support the refurbishment of the junior doctors' mess, was awarded on 21 July.

This brings the total received specifically to support the physical and emotional wellbeing of staff during the covid crisis to £112,000. This money is of course designated for this purpose, and to date approximately £27,000 has been spent on initiatives such as breakfasts/snack bags for staff; Project Wingman Lounge; Volunteer wellbeing packs; snack trolley for patients during visiting restrictions; and extra seating in courtyard.

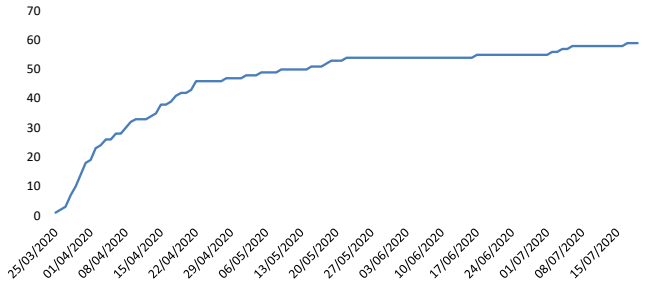
Of the remaining £85,000, £50,000 is designated for the refurbishment of the junior doctors' mess and the rest is allocated to improve staff areas – a number of ideas and proposals are currently being explored including improving the staff courtyard, Chavasse courtyard, and the possibility of creating an internal staff area/lounge if a suitable space can be identified.

Quality of Care

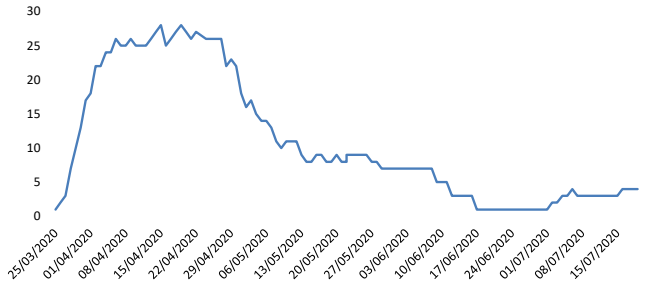
Safe - COVID

The Walton Centre NHS Foundation Trust

Daily Cumulative COVID Positve Patients



Daily COVID Patients Occupying Beds



Patient Outcomes by Week of Positive Result

Week of Positive Result	Died	Discharged	Stepped Down	Positive	Total
23/03/2020 - 29/03/2020	1	8	1		10
30/03/2020 - 05/04/2020	3	13			16
06/04/2020 - 12/04/2020	1	5	1		7
13/04/2020 - 19/04/2020	3	5	1		9
20/04/2020 - 26/04/2020	1	3			4
27/04/2020 - 03/05/2020	1	1			2
04/05/2020 - 10/05/2020		2			2
11/05/2020 - 17/05/2020		1			1
18/05/2020 - 24/05/2020		2	1		3
25/05/2020 - 31/05/2020					0
01/06/2020 - 07/06/2020					0
08/06/2020 - 14/06/2020					0
15/06/2020 - 21/06/2020				1	1
22/06/2020 - 28/06/2020					0
29/06/2020 - 05/07/2020		1	1		2
06/07/2020 - 12/07/2020			1		1
13/07/2020 - 19/07/2020			1		1
Total	**10**	**41**	**7**	**1**	**59**

Days from Admission to Positive Result

Week	0-3 Days	4-7 Days	8-14 Days	15+ Days	Total	% 15+
23/03/2020 - 29/03/2020			3	7	**10**	**70.0%**
30/03/2020 - 05/04/2020	4		1	11	**16**	**68.8%**
06/04/2020 - 12/04/2020	4			3	**7**	**42.9%**
13/04/2020 - 19/04/2020	7	1		1	**9**	**11.1%**
20/04/2020 - 26/04/2020	2		1	1	**4**	**25.0%**
27/04/2020 - 03/05/2020	1		1	0	**2**	**0.0%**
04/05/2020 - 10/05/2020	2			0	**2**	**0.0%**
11/05/2020 - 17/05/2020				1	**1**	**100%**
18/05/2020 - 24/05/2020				3	**3**	**100%**
25/05/2020 - 31/05/2020				0	**0**	
01/06/2020 - 07/06/2020				0	**0**	
08/06/2020 - 14/06/2020				0	**0**	
15/06/2020 - 21/06/2020	1			0	**1**	**0%**
22/06/2020 - 28/06/2020				0	**0**	
29/06/2020 - 05/07/2020				2	**2**	**100%**
06/07/2020 - 12/07/2020				1	**1**	**100%**
13/07/2020 - 19/07/2020			1	0	**1**	**0%**
Total	**21**	**1**	**7**	**30**	**59**	**51%**
%	**35.6%**	**1.7%**	**11.9%**	**50.8%**		

Staff Antibody Test Results

Week	Positive	Negative	Rejected	Total	% Positive
01/06/2020 - 07/06/2020	254	555	10	**819**	**31.0%**
08/06/2020 - 14/06/2020	71	261		**332**	**21.4%**
15/06/2020 - 21/06/2020	23	99		**122**	**18.9%**
22/06/2020 - 28/06/2020	8	32		**40**	**20.0%**
29/06/2020 - 05/07/2020	6	25		**31**	**19.4%**
06/07/2020 - 12/07/2020	6	12		**18**	**33.3%**
13/07/2020 - 19/07/2020	1	5		**6**	**16.7%**
Total	**369**	**989**	**10**	**1368**	**27.0%**
%	**27.0%**	**72.3%**	**0.7%**		

Staff Sickness

Week Ending	Total Staff	Total Abesence	Total COVID	% Overall Absence	% COVID Absence
26/04/2020	1459	100	37	6.85%	2.54%
03/05/2020	1477	84	25	5.69%	1.69%
10/05/2020	1479	93	32	6.29%	2.16%
17/05/2020	1480	76	19	5.14%	1.28%
24/05/2020	1480	86	20	5.81%	1.35%
31/05/2020	1479	70	12	4.73%	0.81%
07/06/2020	1479	75	13	5.07%	0.88%
14/06/2020	1476	135	78	9.15%	5.28%
21/06/2020	1473	135	69	9.16%	4.68%
28/06/2020	1473	131	68	8.89%	4.62%
05/07/2020	1465	121	66	8.26%	4.51%
12/07/2020	1468	106	55	7.22%	3.75%
19/07/2020	1465	109	54	7.44%	3.69%

***staff self isolation figures included from w/e 14th June**

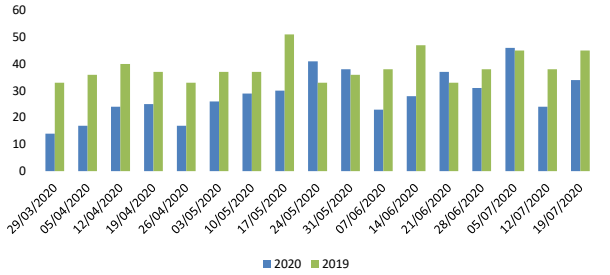
Staff PCR Test Results

Week	Positive	Negative	Total
30/03/2020 - 05/04/2020		3	3
06/04/2020 - 12/04/2020	20	23	43
13/04/2020 - 19/04/2020	8	21	29
20/04/2020 - 26/04/2020	7	14	21
27/04/2020 - 03/05/2020	31	358	389
04/05/2020 - 10/05/2020	5	14	19
11/05/2020 - 17/05/2020	2	2	4
18/05/2020 - 24/05/2020	7	6	13
25/05/2020 - 31/05/2020	2	7	9
01/06/2020 - 07/06/2020		8	8
08/06/2020 - 14/06/2020		11	11
15/06/2020 - 21/06/2020		5	5
22/06/2020 - 28/06/2020	1	7	8
29/06/2020 - 05/07/2020	3	39	42
06/07/2020 - 12/07/2020		72	72
13/07/2020 - 19/07/2020		51	51
Total	**86**	**641**	**727**
%	**11.8%**	**88.2%**	

Correlation Between Staff AB and PCR Test Results

		PCR Result		
		Negative	Positive	Not Tested
Antibody Result	Negative	349	11	647
	Positive	104	57	213
	Not Tested	147	16	1

Total Non Elective Admissions Excluding Stroke Transfers (by week ending)



Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
30th July 2020

Title	**Trust 5 Year Strategy Update**
Sponsoring Director	Name: Hayley Citrine
Author (s)	Name: Hayley Citrine Title: CEO
Previously considered by:	Executive Team Meeting

Executive Summary

The update reviews the successes against last years (year 2 of strategy) priorities and additional achievements in year that further our strategic ambitions. Furthermore commitments for year 3 outlined for discussion, as anticipate this years are heavily influenced by COVID-19 pandemic.

Once approved by the Trust Board a publication will be shared with staff and via communication channels to patients and stakeholders over the summer.

Related Trust Ambitions	• All
Risks associated with this paper	• Risk of not having updated strategy would mean lack of clarity for staff and patients on next steps
Related Assurance Framework entries	• Several BAF risks are associated with the strategic ambitions and in particular new ways of working during pandemic – the strategy update provides direction in this year's approach to help mitigate some of those risks further.
Equality Impact Assessment completed	• N/A
Any associated legal implications / regulatory requirements?	• Well led CQC criteria expects live Trust strategy that is regularly updated and communicated to staff
Action required by the Board	The Board is requested to: • To discuss Strategic update • Note progress on year 2 and • Agree priorities for year 3 and ratify before publication of update.

Trust Strategy 2018 - 2023

PROGRESS UPDATE

View our achievements in year 2 (2019/20) and our commitments for year 3 (2020/21)

NHS
The Walton Centre
NHS Foundation Trust

DELIVER
Deliver best practice care and treatments in our specialist field.

RECOGNISE
Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing.

PROVIDE
Provide more services closer to patients' homes, driven by the needs of our communities, extending partnership working.

Excellence in Neuroscience

Dedicated specialist staff, leading future treatment and excellent clinical outcomes for brain, spinal, and neurological care, nationally and internationally.

ADOPT
Adopt advanced technology and treatments, enabling our teams to deliver excellent patient and family centred care.

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.

Trust Strategy 2018 – 2023 (Progress Report 2020)

The Walton Centre NHS Foundation Trust

In 2018/19 we took an inclusive approach to refreshing our 5 year strategy 2018 – 2023 involving:

- Patients, their families and carers
- Our staff
- The Council of Governors
- The Board
- Partner organisations
- Commissioners and regulators

Our Vision

Excellence in Neuroscience

Our vision is ***Excellence in Neuroscience***. We are always striving for outstanding patient outcomes and the best patient, family and carer experience. We will continue to cherish the standards we have achieved, whilst exploring how we can enhance these further, shaping neuroscience treatments and care for the future.

Our Purpose

Dedicated specialist staff leading future treatment and excellent clinical outcomes for brain, spinal and neurological care nationally and internationally.

Our vision is what we strive for and our purpose is what we do. Our purpose has been chosen by our staff to reflect our culture, what we believe in and what we strive to deliver for our patients and their families. To deliver our vision and to meet our purpose, we have through consultation agreed a set of ambitions together.

Our Ambitions

We will:

Our Values

To meet our ambitions we need to ensure a learning culture, that empowers staff to believe they can make and lead change, be curious and seek continuous improvement.

We want all staff to feel comfortable being open and honest, treating patients and each other with dignity and respect and we do this through our Walton way values; Dignity, Respect, Caring, Pride and Openness.

COVID19 Pandemic

In 2020 we continued our annual review of our commitments and strategy, ensuring they support the approach to COVID19 pandemic requirements.

This includes longer term commitments to new ways of working based on learning from the initial stage, preparation of services and new ways of working for the next phases through the year.

As always we will continue our work and focus to ensure excellence in care for all our patients as a specialist hospital and our commitment to staff health & wellbeing.

DELIVER
best practice care

Our successful strategy will mean that we are:

- **Leading standards** and consistently delivering **excellent evidence based care** in neurosciences.
- Providing patients with an **experience** that is **beyond their expectations**.
- Improving quality and services using a **consistent quality improvement methodology** across the organisation.
- Delivering the **best patient clinical outcomes** in our field.
- Continually investing in our **patient environments**.
- Ensuring our **staff** have access to training, education and events that **increase their knowledge and empower them in their roles**.
- Working together recognising our **strength in diversity and embracing our inclusivity**.

In 2019/20 we committed to and delivered:

- A new best practice pathway for patients with Parkinson's disease.
- Set up a new group clinic providing support networks for our patients with cerebral aneurysms.
- A full review and upgrade of our patient information leaflets
- Consulted and agreed on a new 5 year Quality Strategy for the hospital
- Following a successful pilot – moving to same day discharge to enhance the experience for our patients undergoing lumbar spine surgery
- Established a new group to focus on improving patient and family centred care shaping services for the future.
- Utilised A3 methodology to share and celebrate quality improvement that furthered our patient/family experience.
- Extended our staff H&WB programme to include our building rapport course for line managers.
- Year on year improvements for our staff – in national CQC staff survey results.
- Year on year improvements for patients – in national CQC patient survey results
- Achieved level 2 status in our disability work place assessment becoming a disability confident employer level 2.
- Became a more diverse Trust Board in line with our ED&I vision.
- Transformed workforce approaches through new ways of working e.g. in neurophysiology
- An extended Thrombectomy Service for patients across all 7 days of the week.

In 2019/20 we also completed

- Adapted rapidly to new ways of working in phase1 of COVID19.
- European recognition as a surgical spinal centre of excellence – the first hospital in the UK to achieve this.
- Investing in our patient environments with dayroom upgrades, 3D goggles and aromatherapy in pre operative care.
- Centre of clinical excellence status for neuromuscular services from Muscular Dystrophy UK
- Rated 'Outstanding' by Care Quality Commission (CQC).
- No patients with MRSA for the second year and no patients since November 2017 with MRSA.
- Year on year reductions of our patients with health care associated infections e.g. Clostridium difficile, MSSA and CPE
- Implemented aseptic non touch technique (ANTT) Trust-wide

This year 2020/21 our commitments are:

Deliver best practice care that supports approach to COVID19.

  - Supporting wider C&M system by caring for stroke patients and extending our skills.
  - Supporting the wider system and providing theatres and staff for Aintree's patients requiring head and neck cancer surgery.
  - Caring for patients with COVID 19 transferred from Aintree and other hospitals during COVID surges.
  - Prioritising our neuroscience patients care and services adapting and changing in line with COVID new ways of working.
  - Redesigning policies and practices in line with national guidelines

- Review our current environments, services, workforce, IT and equipment using transformational quality improvement approaches as we adapt and change to new ways of working with and after COVID pandemic keeping patients, families and staff safe and well cared for.
- Continue to support our staff's well being and embrace inclusivity using Anchor Institute and Walton Way values investing in our staff and communities health and wellbeing.
- To support and develop pathways for patients with visual impairment
- Implement FOCUS (Free of Criticism Universal Safety) in theatres and ITU department.

PROVIDE
more services closer to patients' homes

Our successful strategy will mean that we:

- Establish **new partnerships**, delivering **collaborative benefits** with commissioners, local authorities, community services, business and commercial partners.
- Build on our Neuro Vanguard work by **positively influencing patient pathways** of best practice across Cheshire and Merseyside (C&M) and beyond. **(Neuroscience Programme)**
- **Build and increase** on the range of **services** we provide and the areas in which we provide them.
- **Involve patients and the public to shape our services** and developments at every stage.
- **Invest in new roles and technology** to enhance services and partnership working.

In 2019/20 we committed to and delivered:

- A new dedicated spinal clinic for patients in North Wales.
- A new best practice pathway for patients with Parkinson's disease.
- Extended our Cheshire and Merseyside headache pathway into North Wales for all patients
- Following a successful pilot commenced an ambulatory care service for patients attending St Helens and Liverpool University Foundation Trust (LUFT) Hospitals.
- Provided a best practice secondary headache patient pathway to all acute Trusts across Cheshire and Merseyside
- Developed a head injury pathway that supports improved access, experience and outcomes for patients.
- Continued to support the Cheshire and Merseyside spinal service and agreed a move to a single site service for patients across Walton & LUFT.
- Established a neurosciences steering group to support and monitor progress of the neuroscience programme
- Utilised telemedicine solutions to improve patient access in our clinics and services.
- Provided new telephone clinics for patients with post trauma head injury.
- Developed new opportunities and partnerships through our Head of Commercial Engagement & Marketing role

In 2019/20 we also completed:

- Worked at pace to improve patient access using IM&T solutions during COVID pandemic to keep patients at home supported.
- Developed our virtual clinic model.
- Extended new partnership working through our spinal improvement partnership approach.
- Invested in a variety of new and extended clinical roles to support patients.
- Built a compelling case and then invested in a new multitom rax radiology equipment to enhance patient experience and quality of their diagnostics
- Invested in a new MR scanner for patients.
- Agreed to provide community rehab services to patients at St Helens and Knowsley.

This year 2020/21 our commitments are:

- Review our range of services and approaches in relation to COVID 19 exploring new ways of working.
- Utilise IT solutions to enable more out-patient services to take place closer to home, or reach areas currently with poor accessibility (e.g. Ashworth).
- Work with C&M in-hospital and out of hospital cell for collaborative benefits of NHS services.
- Continue our increased services in COVIDs initial response, for example, caring for patients who have had a stroke.
- Commence our community rehabilitation services for patients in St Helens & Knowsley
- Invest in new IT and infrastructure to enable a more agile working for staff and to support more remote patient access and care closer to home.
- §Implement the Trust's new Spinal Improvement Partnerships and explore application in new service areas.
- Operationalise the agreed single spinal partnerships approach across C&M for patients.
- Introduce Road to Recovery Rehabilitation Programme for Welsh patients in a community setting in Wales.

INVEST

be financially strong

Our successful strategy will mean that we:

- **Consistently meet** our financial targets by working closely with commissioners & patients to ensure **excellent outcomes, service delivery & good value for money.**
- Deliver a NHS Improvement **risk rating of one** (lowest risk) which enables the Trust to have maximum autonomy in terms of financial decision making.
- Explore **new opportunities** and markets to **diversify** our portfolio of **income**.
- **Consistently deliver** our cost improvement programme through our **Quality Improvement Programme** (QIP) methodology.
- **Increase our productivity and efficiency** through **streamlining** patient pathways and **utilizing technology**.
- Concentrate on **two main Trust wide service improvements** utilising our QIP approach each year.
- **Build partnerships** to deliver mutual benefits.
- **Invest in our services, staff, facilities and innovations** for patients.

In 2019/20 we committed to and delivered

- Delivered Control Total and Use of Resources (UOR) rating of 1.
- Redesigned business case model documentation to be used across the Trust for capital and revenue investments.
- Worked in alliance with other Specialist Trusts as a group on specific areas of mutual benefit e.g. procurement
- Developed a new patient level costing system to provide richer information for decision making around services.
- Furthered the proposal to support the posture and movement analysis programme.
- Embedded the QIP programme to deliver efficiencies within the organisation.
- Invested in the new Head of Commercial Engagement & Marketing post working with new partners to diversify income streams and commence financial joint projects
- Engaged with innovation leads to develop financial proposals.
- Launched the finance and procurement strategies and are now developing underpinning key performance indicators.
- Developed mature option appraisal processes for large contracts through procurement.
- Continued to work with C&M Group on the 'Collaboration at Scale Programme' to maximise opportunities.

In 2019/20 we also completed

- Negotiated settlements with main commissioners which mitigated risk in delivering control total.
- Finance Team moved to remote working at short notice in response to COVID-19 and managed to meet deadlines for the final accounts.
- Responded at short notice to the financial regime introduced as part of the COVID-19 response.
- Prepared case for new services in 2020/21in rehabilitation for patients in the community region of St Helens
- Created model and skills for new joint partnership working with businesses initially trialled in the spinal improvement partnership approach.
- Invested in equipment and IT to support patients and staff such as multi-tom rax, ipads at ward level and laptops/IT provision to enable staff to work at home during COVID to continue patient clinics.
- Secured investment for new equipment and services for C&M spinal services.
- Obtained substantial assurance on our national costing audit.

This year 2020/21 our commitments are:

- Deliver value for money and build on local partnerships developed during COVID as part of our Anchor Institute ambition.
- Procure locally wherever possible and utilise weighting in contract specification to recognise firms investments in the local populations health and well being (Corporate responsibility).
- Adapt to new challenges as NHS and regional finance approaches change e.g. block contracts.
- Meet financial targets and remain risk rating 1 or equivalent.
- Utilise transformational quality improvement approaches in learning from COVID and new ways or working;
    - Align to Walton Way values
    - Align to Anchor Institute values
    - Informed by our new green ambitions
    - Improve our patient and staff well being
- Diversify our income streams through spinal improvement partnership so we can invest in innovation.
- Review the Finance 'offer' to the Trust as a result of the changes following COVID-19 and new ways of working including understanding and implementing the new Financial Framework.
- Continue to ensure that finance are accredited by FSDIFFF showing staff are developed and to attracted the best talent to the organisation.
- Develop and establish costing strategy to further embed SLR within the Trust.
- Implement the Trust's new Spinal Partnership to generate a new stream of income.

Our successful strategy will mean that we:

- Develop a **culture of learning and innovation** through a pipeline of Trust wide projects.
- **Collaborate with** universities, businesses & commercial **partnerships** to lead innovation, education, research & new ways of thinking.
- **Increase research**, publications and the number of patients in clinical and commercial trials in neurosciences.
- Demonstrate how our research, education and innovation **lead, shape and improve practice in our field**.
- Create & **embed a focus upon neuroscience** across the whole curriculum for both under and post graduate medical students.
- Increase the effectiveness of clinical and academic delivery for the whole workforce through a **more integrated and seamless education provision**.

In 2019/20 we committed to and delivered:

- In partnership with University of Liverpool developing the City's first Neuroscience Department for research.
- Met increased charitable income target of £847k to support innovation aspirations & prepare for movement analysis campaign
- Created a new training post for the higher scientist specialist training (HSST Programme) for neurophysiology, supporting new ways of working
- Developed a masters module for spinal management
- Launched research and innovation strategies detailing the Trust's approach to research & innovation.
- Invested in new roles in readiness to extend NIHR (National Institute for Health Research) trial portfolio increasing opportunity for patients involvement in commercial trials
- Developed a new governance process for approving research requests
- Developed a formal process for innovation projects pipeline and created a database to track progress
- Finalising business case for Posture and Movement Analysis (CAREN) to lead to our charity campaign.
- Established a database for all innovation projects (not just charitable)
- Supported and embedded Liverpool Health Partners' concept and Joint Research Service
- Developed business case for Multi-tom Rax – now successfully purchased.
- Invested in Head of Commercial Engagement & Marketing role to support development of innovative and commercial development areas in research/education environments
- Presented initial case series on falls reduction with Quantitative Timed Up and Go (QTUG) for patients with Deep Brain Stimulation at the World MDS Conference in Nice in September 19.

In 2019/20 we also completed

- Reviewed research and development department structure to support ambition in R,D&I
- Made joint appointment with Liverpool Health Partners of a clinical SRO lead for the neuroscience theme of research.
- The development of the Virtual Engagement Rehabilitation Assistance (VERA), Elementary Routine Nutritional Screening Tool (EARNST) and other initiatives progressed.
- Development, legal review and Board approval of the spinal improvement partnership.
- In support of Anchor Institution objectives, the Trust hosted a 'workplace safari' in February 2020 with Liverpool City Region Careers Hub. Over 200 school children attended to talk to staff abut NHS careers.
- Researcher of the Year category: Professor Carolyn Young for TONiC Finalists:
- The Ruth Young Award for Research Implementation category: The Life Link Clinic, The Cheshire and Merseyside Rehabilitation Network (which is hosted by the Trust)
- Award for Reducing Health Inequalities category: Suzanne Simpson: Tackling health inequalities for people with motor neurone disease.

This year 2020/21 our commitments are:

- Collaborate with University of Liverpool john Moores University, Edge Hill University and Liverpool Health Partners to increase and progress our neuroscience research ambitions.
- Use new ways of working to create opportunities to invest staff's time in research, education and innovation to inform our practice, benefit our patients and lead in our field.
- Design research, education and training trajectories/career escalators for staff wishing to pursue these areas to help lead and shape our future.
- Review our education, learning and development approaches in line with new agile ways of working and flexibility for staff.
- Agree priority initiatives for research and ensure appropriate level of resource.
- Increase research opportunities for our patients and our staff.
- Finalise our movement analysis business case and launch fundraising appeal
- Deliver MSc module for spinal in conjunction with Liverpool John Moores University (LJMU).
- Ensure the successful introduction of the new and expanded model of medical education.
- Support the development of Liverpool health ventures to facilitate regional innovation.
- Further phases of the TONIC study to be initiated with international companies and academic partners.
- Support the further development of VERA, ERNST and other initiatives.
- Secure spinal improvement partnership contracts to support further innovation.
- Use links with local, national and international partners (in the public, business and third sectors) to innovated

Our successful strategy will mean that we:

- **Maximise technology** at patients' bedsides and beyond to improve care and enhance patient experience.
- Utilise **data and analytics** to **reduce duplication** and **enhance decision making** for staff.
- Be part of a **'one digital record' ambition** across Cheshire & Merseyside to connect patient records to improve/integrate safer care.
- **Develop digital intelligence**, utilising analytics and technology to drive service and pathway improvements for patients, whilst enabling staff to continuously inform service development.
- Have a culture of **innovation, curiosity and creativity** that progresses options for digital, IT, pharmaceutical, diagnostic and treatment **technology to advance patient care**.

In 2019/20 we committed to and delivered:

- Completed and delivering the underpinning Digital Strategy in year and became a pilot site for NHS Digital on cyber agenda which included training our Trust Board members.
- Reviewed options for Multi-tom Rax – now successfully purchased.
- Prepared criteria and now procuring a new Trust website to enable patients and staff to be 'sign posted' to latest / relevant information about the Trust.
- Delivered key components of our eP2 system including digital dashboards for our operational staff as a continued drive to a paper-lite hospital.
- Worked together with our clinical staff to implement a Medics Specialist module as next step solution to our eP2 system.
- Implemented informatics action plan for service improvement, strengthening the department with the recruitment of a new Head of Informatics Business Intelligence and Performance.
- Consolidated the 3 existing data warehouses into 1 business intelligence warehouse so information reporting is consistent.
- Developed telehealth applications with external partners – exchange , Share 2 Care.
- Investment in Share 2 Care community document sharing for all clinical correspondence.
- Invested in ward level/bedside technology/IT to support clinicians delivering patient care. E.g. IPADs, COWS
- Preparing approach for the Head of Informatics to work with clinicians and Operational team to utilise some of our key patient outcome data and use as part of our Trust intelligence for continuous improvement.

In 2019/20 we also completed:

- Investing in Multi-tom Rax advanced technology to move around the patient for better imaging and patient experience,
- Investment in IPADs on the ward and COWS on wards to ensure greater accessibility
- Use of Microsoft teams to empower new and agile ways of working
- Investment in 3D goggles for patients in the pre-operative areas.
- Invested and implemented paging system in ITU to enable families to return to ITU, maximising time with their loved one.
- ISO 27001 accreditation achieved.
- Close working with Service Improvement Team to implement paper light and remote working for patients
- Initiated attend anywhere implementation.
- Worked at pace to increase technology and IT during phase 1 of COVID.

This year 2020/21 our commitments are:

- Maximise IT/technology to support agile and flexible working to enhance patient services.
- Utilise our improved data and business intelligence to guide our future thinking and services for patients.
- Digitilise our out patients offer with 'attend anywhere' and other options reducing the need for face to face consultations.
- Review patient outcomes and quality gains following investment in the innovative multi-tom rax in radiology
- Progress our digital strategy ambitions
- Expansion of agile working architecture to ensure connectivity to hospital systems.
- VOIP expansion to reduce reliance of LUFT's system and expand unified communications within the Trust
- Investment into load balancing architecture to ensure greater resilience of critical trust systems.
- Introduce the Trust's new website to benefit both staff and patients enhancing the new ways of working.

RECOGNISE
be recognised as excellent in all we do

Our successful strategy will mean that we:

- **Compete with the best in Europe** in neuroscience **patient outcomes and treatment options**.
- Have a reputation for **delivering outstanding care by outstanding specialist staff**.
- Be at the **leading edge of innovation and research** shaping neurosciences treatment and care for the future.
- Have an **engaged workforce** that is increasingly flexible, adopting new ways of working, being recognised as a representative employer and valuing and **embracing diversity** in our workforce.
- Have a **health and wellbeing programme** for staff that is an **exemplar** in the NHS and supports our staff in their roles.
- Be a **system leader** working with partners to **share best practice** & improve patient pathways & experiences in the communities we serve & beyond.

In 2019/20 we committed to and delivered:

- Established a joint strategic workforce partnership with Liverpool City Council co-chaired by the two organisations.
- Being a system leader working with partners developing;
  - Regional response to COVID19
  - a Specialist Trust Group
  - spinal improvement partnership
  - and single spinal service approach across C&M.
- Successfully accredited with CQC outstanding rating again and improvement overall on number of outstanding areas
- Achieved year on year improvement in our National in-patient survey
- Achieved year on year improvement in our National staff survey
- Expanded our leadership support to first line managers as part of our staff H&WB through our building rapport course.
- Through our Neuroscience Programme expanded patient pathways of best practice in C&M & beyond.
- Seen year on year progress in our ED&I 5 year Vision work.
- Have new partnerships in place, delivering collaborative benefits.

In 2019/20 we also completed:

- The Walton Centre hosted the Neuroscience Day/Sutcliffe Kerr event in March 2020 on behalf of the Liverpool Neurosciences Group.
- Awards included;
- NWC Research and Innovation Awards in February 2020: Winner:
- Researcher of the Year category: Professor Carolyn Young for TONiC Finalists:
- The Ruth Young Award for Research Implementation category: The Life Link Clinic, The Cheshire and Merseyside Rehabilitation Network (which is hosted by the Trust)
- Award for Reducing Health Inequalities category: Suzanne Simpson: Tackling health inequalities for people with motor neurone disease.
- Surgical spine center of excellence status from Eurospines , first in the UK.
- Centre of excellence status in Neuromuscular services from Muscular Dystrophy UK
- Association of perioperative practices named Walton theatres ' team of the year' for their work.
- The Engage Awards are the largest engagement awards in Europe and the Shiny Minds app received special commendation in the category of 'Best Use of Innovation in Employee Engagement' category. In addition, the Director of Workforce and Innovation, received a Life Time Achievement Award for staff engagement within local government and the NHS.
- The Director of Finance and IM&T was recognised as Finance Director of the year across the Liverpool City Region.

This year 2020/21 our commitments are:

- To have undertaken fundamental review of our current services and approaches to further improve patient care and staff health and well being.
- Have successful new ways of working that support our patients needs and care following COVID19 pandemic.
- Have extended and changed our services and provided excellent care to our patients and new patient groups.
- To have increased our research involvement and trials for patients, to influence our future care.
- To have utilised IT and technology to support staff agility and flexibility to support care and care for patients differently.
- To aspire to Investors in People platinum award, including the new industry standard for Health and Well-being.
- To deliver outstanding care and to be recognised as such by the Care Quality Commission.
- To be an anchor institute and system leader supporting the communities we serve.
- To achieve year on year improvements in our in-patient and staff national surveys.
- Develop and implement the next stage of Building Rapport training programme to include action learning sets.
- Embed the regional strategic Workforce Partnership with Liverpool City Council with particular emphasis on recruitment and retention.

REPORT TO TRUST BOARD

Date 30/07/2020

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

Executive Summary

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

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

Key Performance Indicators – Caring **Opportunity for Improvement Measures** Complaints – Due to covid19 all complainants were written to and advised there may be a delay in response. The divisions and patient experience team are now working closely together to respond to the backlog of complaints. **Key Performance Indicators – Well Led** **High Performing Measures** Agency Spend Staff Friends & Family Test **Opportunity for Improvement Measures** Vacancy Levels Nursing Turnover Sickness/Absence	**Key Performance Indicators – Responsive** **High Performing Measures** Cancer Standards – Two Week Wait Cancer Standards – 31 Day First Definitive Treatment Cancer Standards – 31 Day Subsequent Treatment Cancer Standards – 28 Day Faster Diagnosis **Underperforming Measures** 6 Week Diagnostic Waits – a recovery plan is in place however this performance measure remains a risk. **Key Performance Indicators – Effective** **Underperforming Measures** Referral to Treatment – Wales as described in the paper the trust has only seen and treated urgent patients **Key Performance Indicators – Safe** **Opportunity for Improvement Measures** Infection Control – local performance is on plan and the Trust is generally in line with national benchmark average with the exception of MSSA in which incidences has increased in Q1 20/21.
Related Trust Ambitions	Delete as appropriate: • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____

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

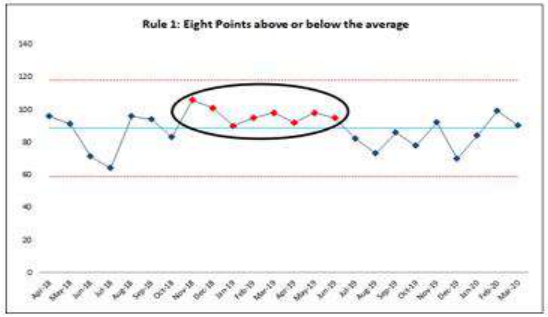
Board KPI Report
July 2020

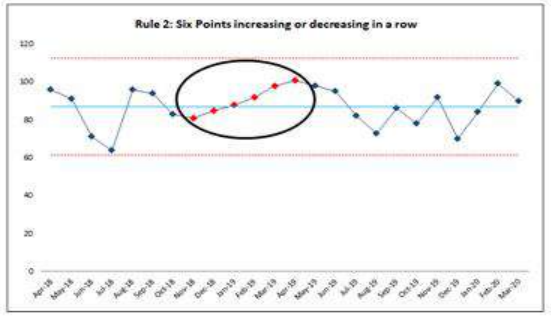
Data for June 2020 unless indicated

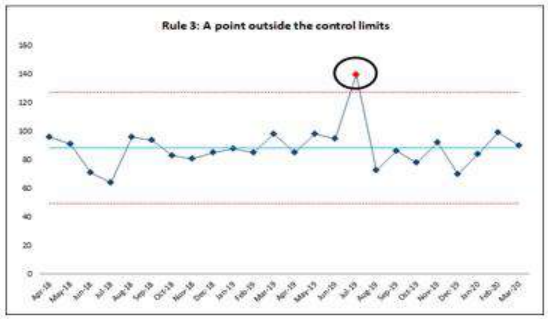
SPC Charts Rules

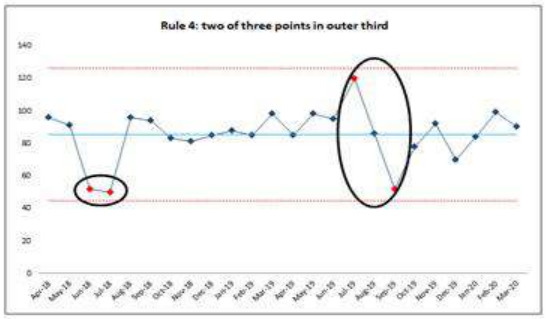
The Walton Centre
NHS Foundation Trust

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









All SPC charts will follow the below Key unless indicated

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

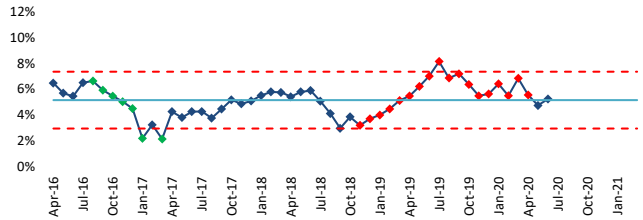
Excellence in Neuroscience

Quality of Care

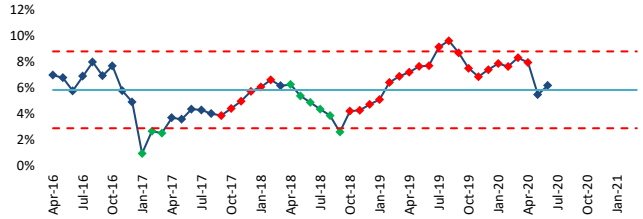
Well Led - Workforce KPIs

NHS
The Walton Centre
NHS Foundation Trust

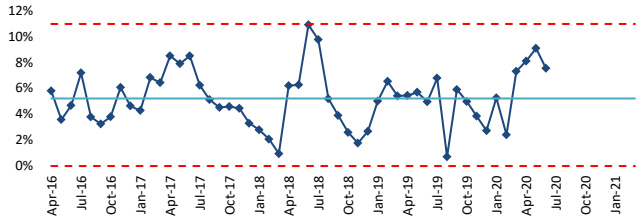
Overall Vacancy Level %



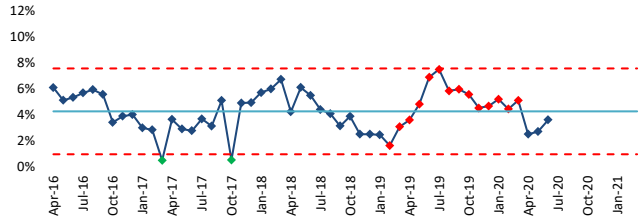
Nursing Vacancy Level %



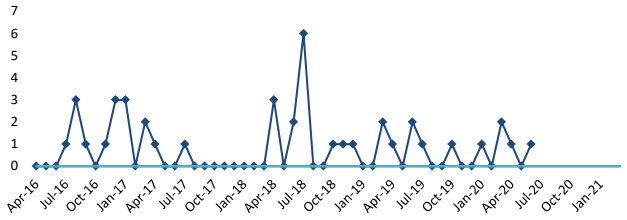
Medical Vacancy Level %



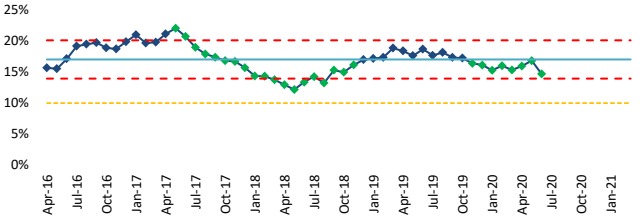
Other Staff Vacancy Level %



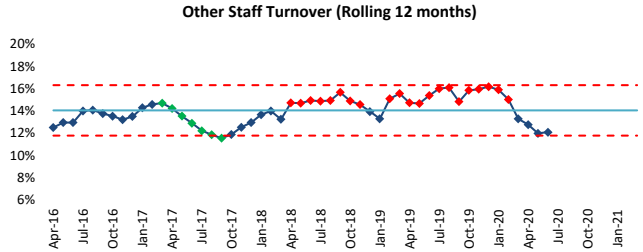
Medical Leavers



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Vacancy Levels

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

Nursing Turnover

Nursing turnover has significantly improved over the last 8 months and is within special cause variation, 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.

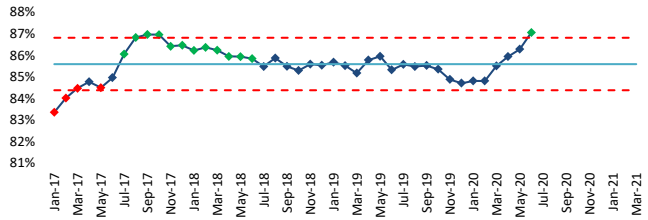
Sickness/Absence

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

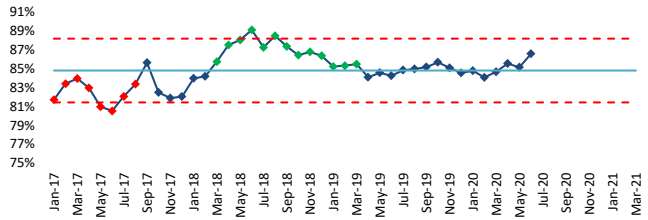
Staff Stability

Staff stability index for all staff is outside of expected limits in June 20, this looks driven by more nursing staff remaining in post for 12 months.

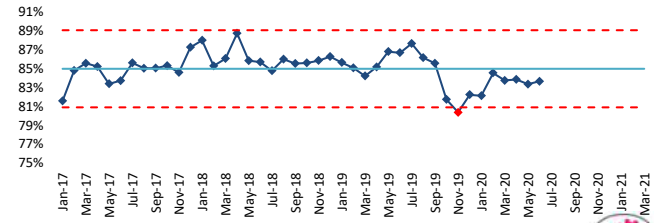
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

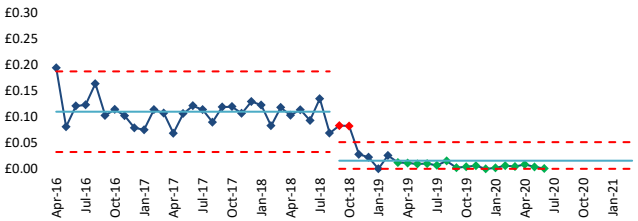


Quality of Care

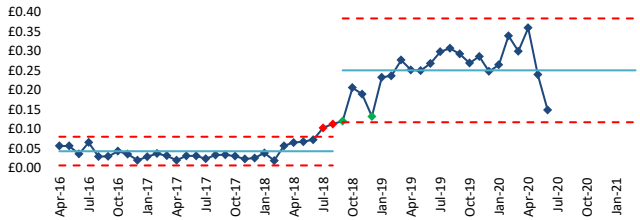
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

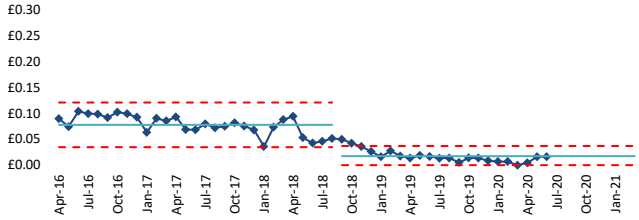
Nursing & HCA Agency Spend (£m)



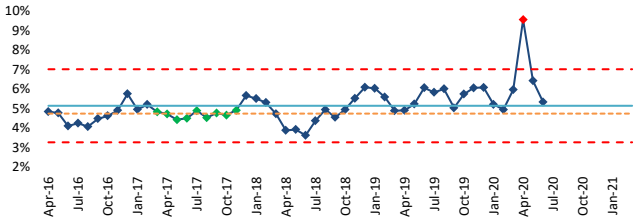
Nursing & HCA Bank Spend (£m)



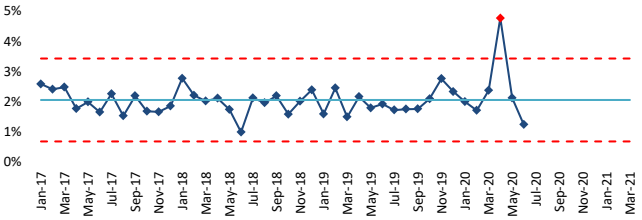
Nursing & HCA Overtime Spend (£m)



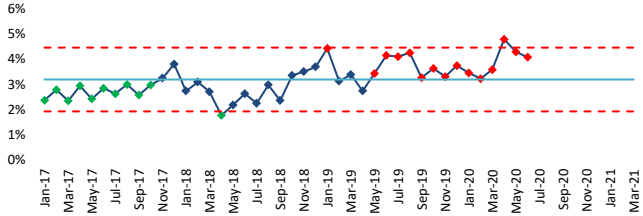
Sickness/Absence (Monthly)



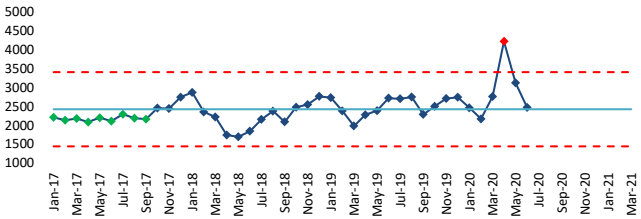
Short Term Sickness/Absence (Monthly)



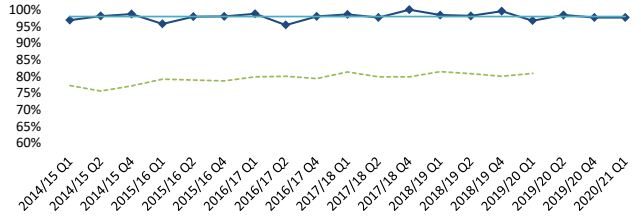
Long Term Sickness/Absence (Monthly)



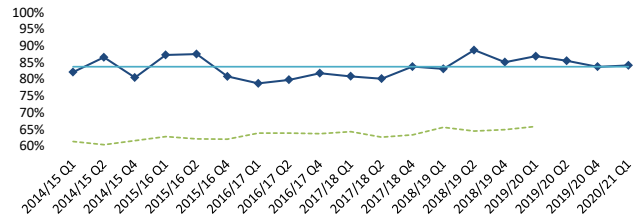
Lost Days due to Sickness/Absense (Monthly)



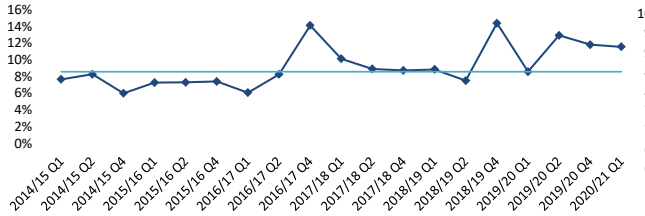
Staff FFT - % Recommend as Place of Care



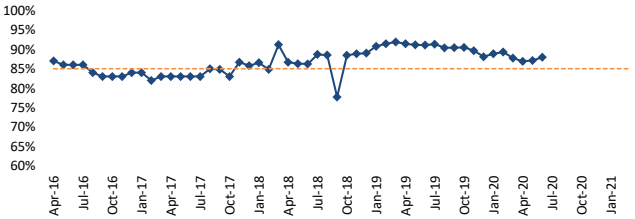
Staff FFT - % Recommend as Place of Work



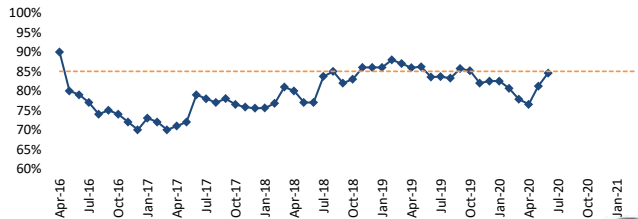
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



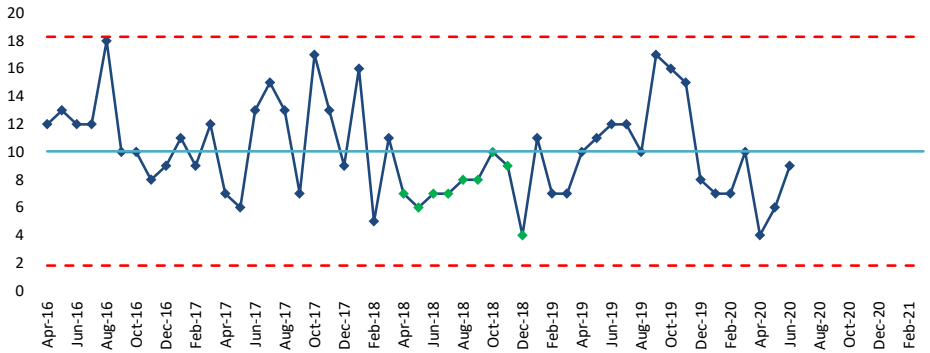
Excellence in Neuroscience

Quality of Care

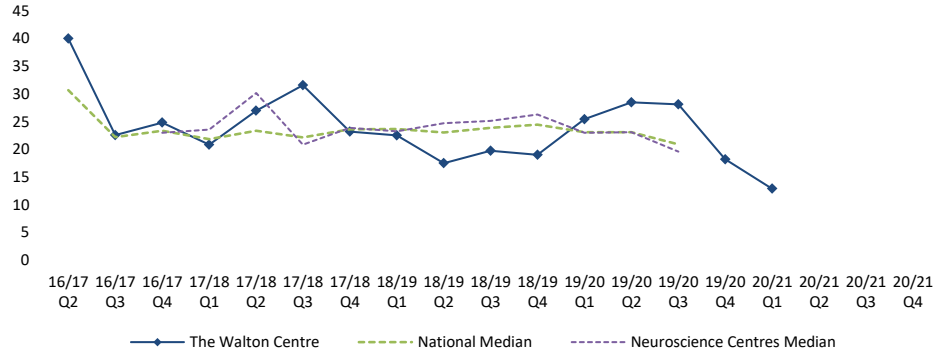
Caring - Complaints

The Walton Centre NHS Foundation Trust

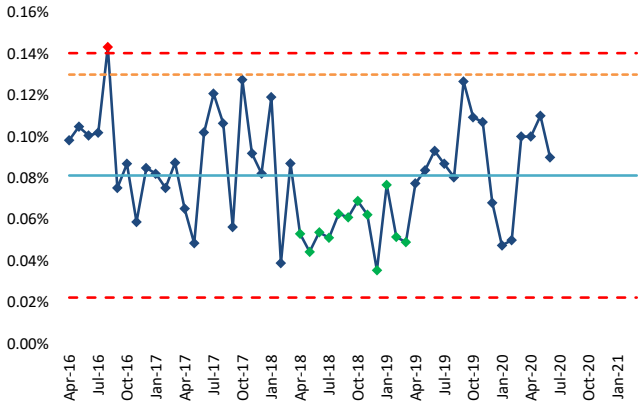
Total Complaints Received in month



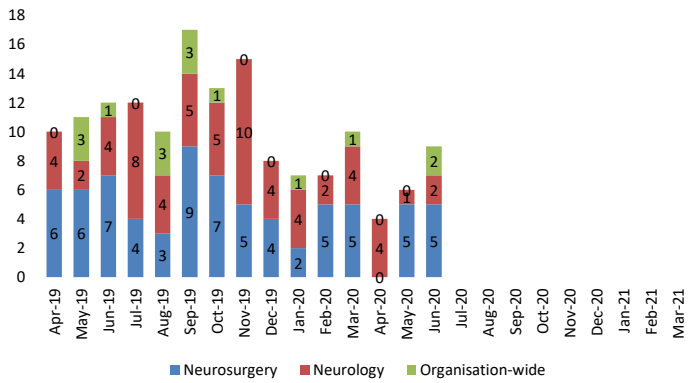
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In June 2020 the Trust received 9 complaints. 2 Neurology, 5 Surgery (3 reopened) and 2 organisation wide.

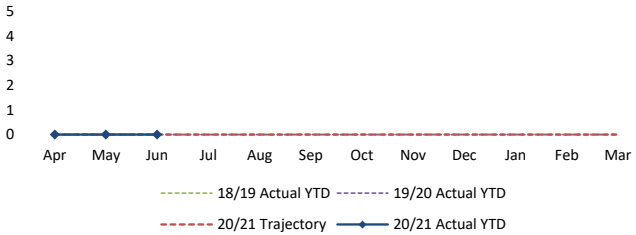
The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received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

Quality of Care

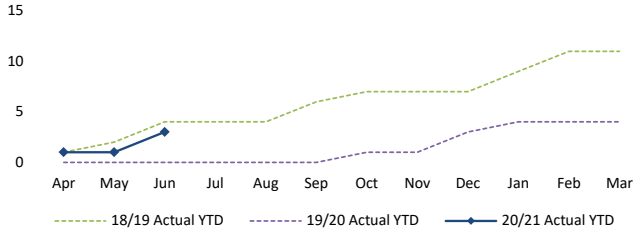
Safe - Infection Control

The Walton Centre NHS Foundation Trust

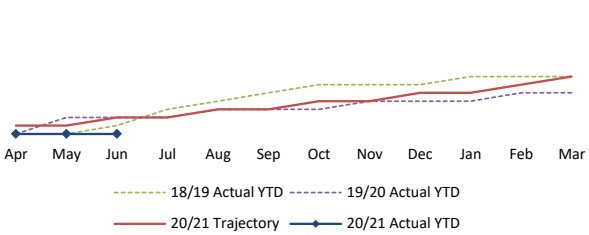
MRSA Bacteraemia



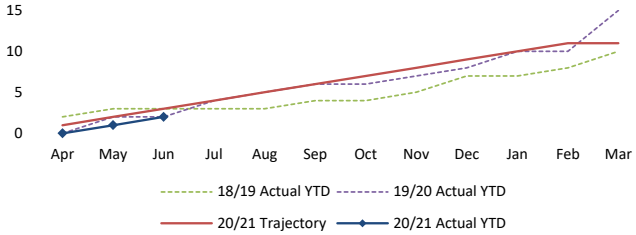
CPE



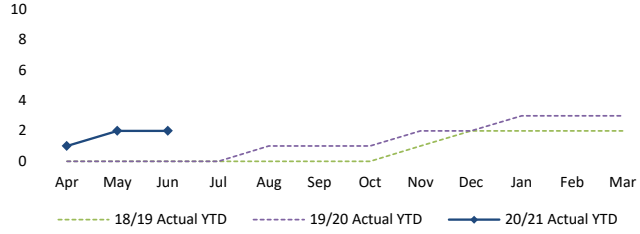
C.Diff



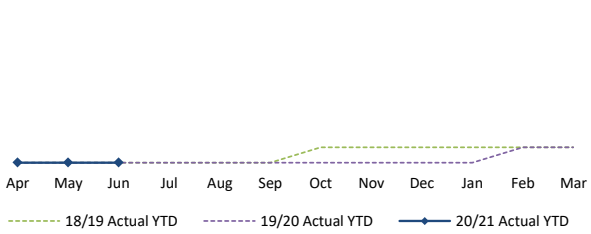
E.Coli



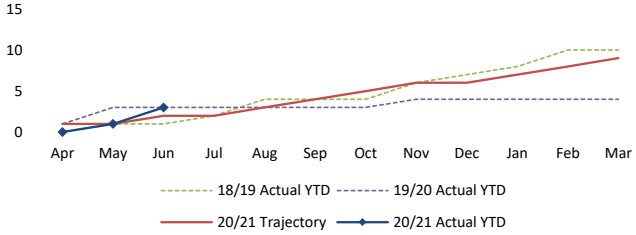
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

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

June Breakdown

1x E.Coli - Dott
2x CPE - Horsley, Dott
2x MSSA - Cairns, Caton

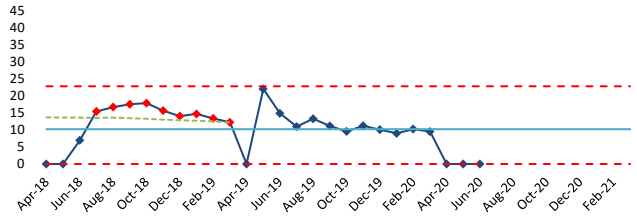
Excellence in Neuroscience

Quality of Care

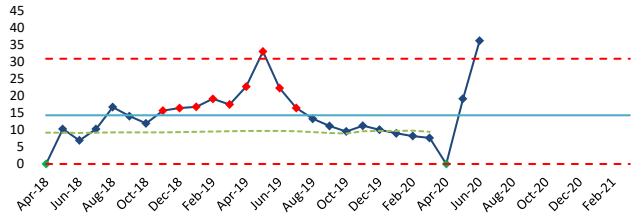
Safe - Infection Control

The Walton Centre NHS Foundation Trust

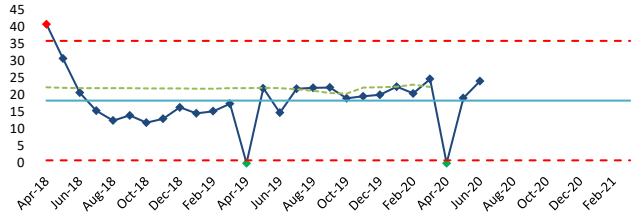
C.Diff Rate per 100,000 Bed Days YTD



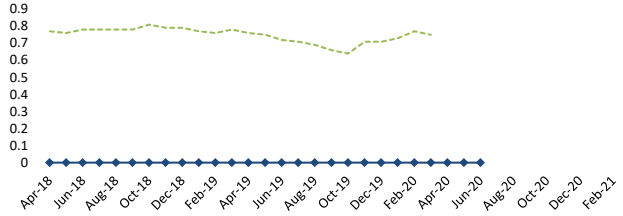
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

All infection types are within their YTD trajectory level for 20/21 during May 20.

MSSA rates per 100,000 bed days had typically been above the national average since July 18. However performance has now improved and is in line with the national average.

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

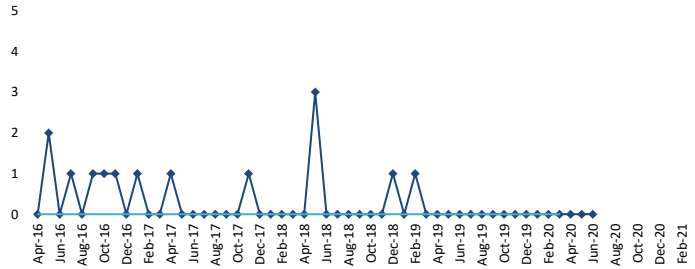
As of March 19 the C.Diff rate is no longer published.

Quality of Care

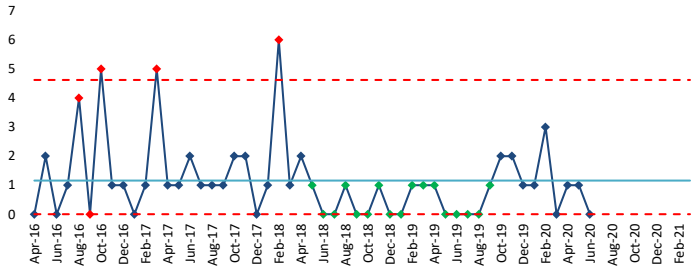
Safe - Harm Free Care

The Walton Centre
NHS Foundation Trust

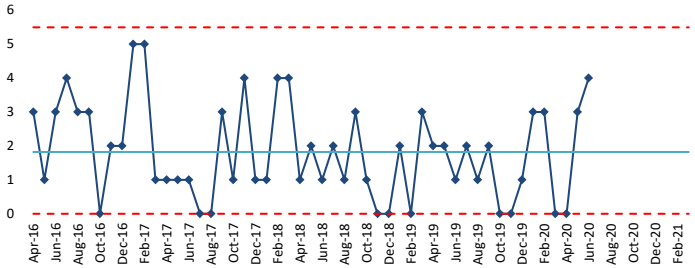
Total Moderate or Above Harm Patient Falls



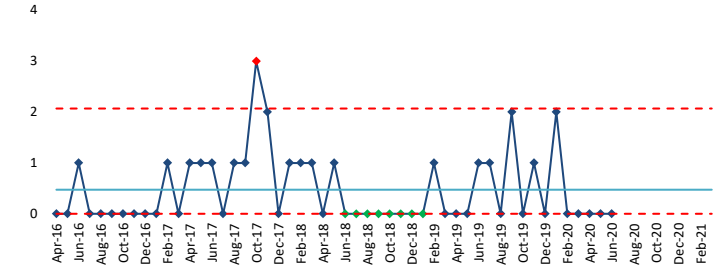
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no fall which resulted in moderate or above harm in June 20.

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

There were four CAUTI incidences in June 20

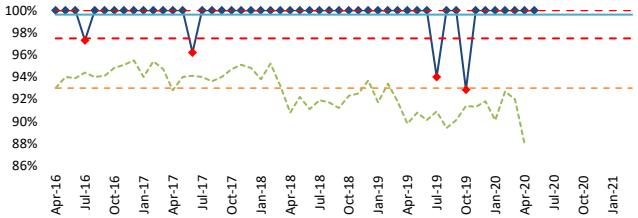
There were zero VTE incidence in June 20

All Harm indicators are within normal variation.

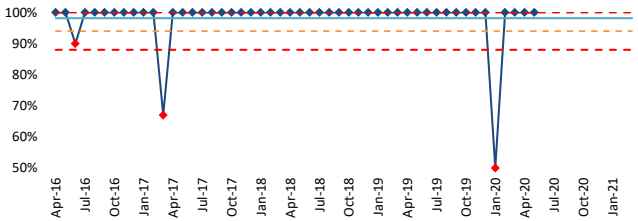
Operational
Responsive - Cancer

The Walton Centre
NHS Foundation Trust

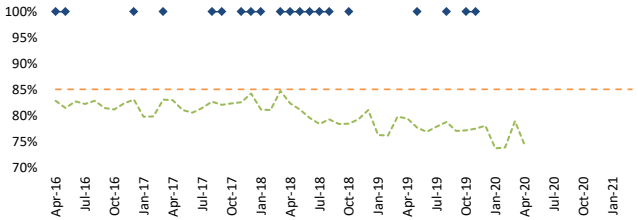
14 Day Performance



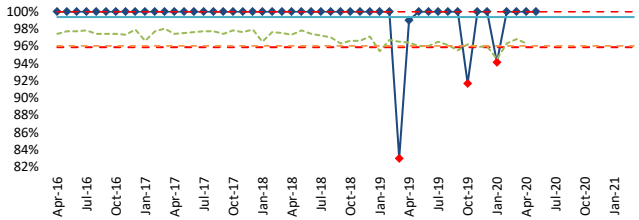
31 Day Subsequent Performance



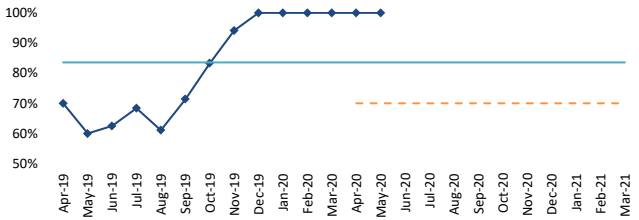
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

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

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

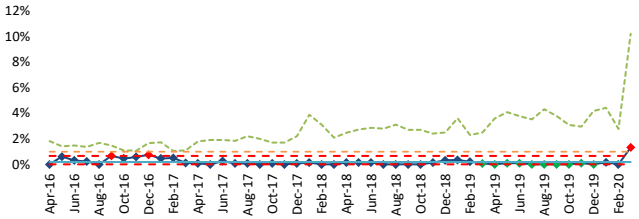
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has been above this point since September 2019 and performing at 100% for the last 6 months.

Operational

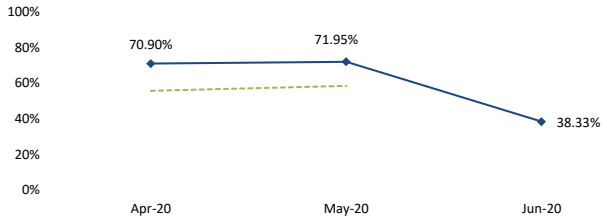
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

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



6 Week Diagnostic Performance (20/21)



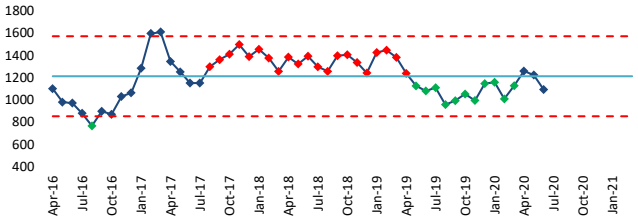
Narrative

Diagnostic performance in June 20 was 38.33%. This is a significant improvement from 71.95% in May 20.

Activity has been severely impacted by the ongoing COVID-19 situation and is running at 20% of expected levels, as only urgent cases were seen.

The Trust is working through plans to increase activity however performance against the diagnostic standard

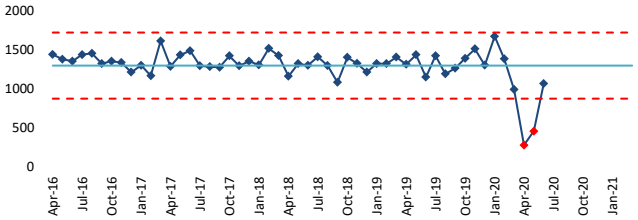
Total Diagnostic Waits at Month End



There were 419 six week diagnostic breaches in month.

MR - 309
CT - 40
EMG - 68
Sleep - 2

Total Diagnostic Activity in Month



WELL LED

Finance

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date			April - July 2020		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,681	8,577	(104)	26,043	24,679	(1,364)	34,725	33,165	(1,560)
Exclusions	1,786	1,786	0	5,357	5,357	0	7,142	7,142	0
Private Patient	20	(2)	(22)	60	0	(60)	80	0	(80)
Other Operating	613	540	(73)	1,840	1,563	(277)	2,453	2,028	(425)
Total Operating Income	**11,100**	**10,901**	**(199)**	**33,300**	**31,599**	**(1,701)**	**44,400**	**42,335**	**(2,065)**
Pay	(6,116)	(5,939)	177	(18,348)	(17,839)	509	(24,464)	(23,778)	686
Non-Pay	(2,660)	(2,419)	241	(7,980)	(6,831)	1,149	(10,640)	(9,119)	1,521
Exclusions	(1,798)	(1,219)	579	(5,394)	(3,348)	2,046	(7,192)	(4,725)	2,467
COVID / Reserves	31	(750)	(781)	93	(1,873)	(1,966)	124	(2,438)	(2,562)
Total Operating Expenditure	**(10,543)**	**(10,327)**	**216**	**(31,629)**	**(29,891)**	**1,738**	**(42,172)**	**(40,060)**	**2,112**
EBITDA	**557**	**574**	**17**	**1,671**	**1,708**	**37**	**2,228**	**2,275**	**47**
Depreciation	(387)	(400)	(13)	(1,161)	(1,212)	(51)	(1,548)	(1,617)	(69)
Profit / Loss On Disp Of Asset	0	2	2	0	2	2	0	2	2
Interest Receivable	14	0	(14)	42	5	(37)	56	7	(49)
Financing Costs	(53)	(52)	1	(159)	(155)	4	(212)	(207)	5
Dividends on PDC	(131)	(131)	0	(393)	(393)	0	(524)	(524)	0
I & E Surplus / (Deficit)	**0**	**(7)**	**(7)**	**0**	**(45)**	**(45)**	**0**	**(64)**	**(64)**
Capital donations I&E impact	**0**	**7**	**7**	**0**	**45**	**45**	**0**	**64**	**64**
I & E Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

At month 3, the Trust reported a £275k surplus position before adjusting income to report a breakeven position YTD, in line with NHSI/E guidance. To note that the plan has been set by NHSI/E based on average expenditure incurred in months 8-10 in 2019/20 (plus 2.8% inflation).

The in month position includes £0.5m spend incurred as a result of COVID-19, which has been partially offset by a reduction in clinical supplies and excluded drugs and devices spend compared to M8-10 in 19/20) due reduced elective activity with only urgent patients being seen and treated in June due to the current environment.

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

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Jun-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	42	(7)
Tangible Assets	82,591	81,758	(833)
TOTAL NON CURRENT ASSETS	**82,640**	**81,800**	**(840)**
Inventories	1,232	1,273	41
Receivables	9,287	7,121	(2,166)
Cash at bank and in hand	26,673	38,023	11,350
TOTAL CURRENT ASSETS	**37,192**	**46,417**	**9,225**
Payables	(18,088)	(27,227)	(9,139)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(28,901)**	**(9,139)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**17,516**	**86**
Provisions	(639)	(639)	0
Finance Lease	(115)	(104)	11
Loans	(25,031)	(24,333)	698
TOTAL ASSETS EMPLOYED	**74,285**	**74,240**	**(45)**
Public Dividend Capital	27,554	27,554	0
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,142	(45)
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,240**	**(45)**

STATEMENT OF CASH FLOW - 2019/20	June-20 Actual
	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(45)**
Non-Cash Flows In Operating Surplus/(Deficit)	1,756
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**1,711**
Increase/(Decrease) In Working Capital	13,318
Increase/(Decrease) In Non-Current Provisions	0
Net Cash Inflow/(Outflow) From Investing Activities	(2,664)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**12,365**
Net Cash Inflow/(Outflow) From Financing Activities	(1,015)
NET INCREASE/(DECREASE) IN CASH	**11,350**
OPENING CASH	**26,673**
CLOSING CASH *	**38,023**

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

COVID-19 expenditure:

YTD £1.2m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	544
Annual leave provision	287	(287)	52	52
PPE	62	148	259	469
Decontamination	9	8	(2)	15
Remote working	21	(19)	1	3
ITU	5	2	(3)	4
Other	37	24	18	79
TOTAL	**520**	**130**	**516**	**1,166**

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

A provision has been included in the June financial position for the anticipated cost of junior doctor annual leave, that has been unable to be taken during the COVID – 19 pandemic

Capital

In month plan - £204k

In month actual - £117k

In month variance - £87k below plan.

Year to date actual - £373k

CAPITAL

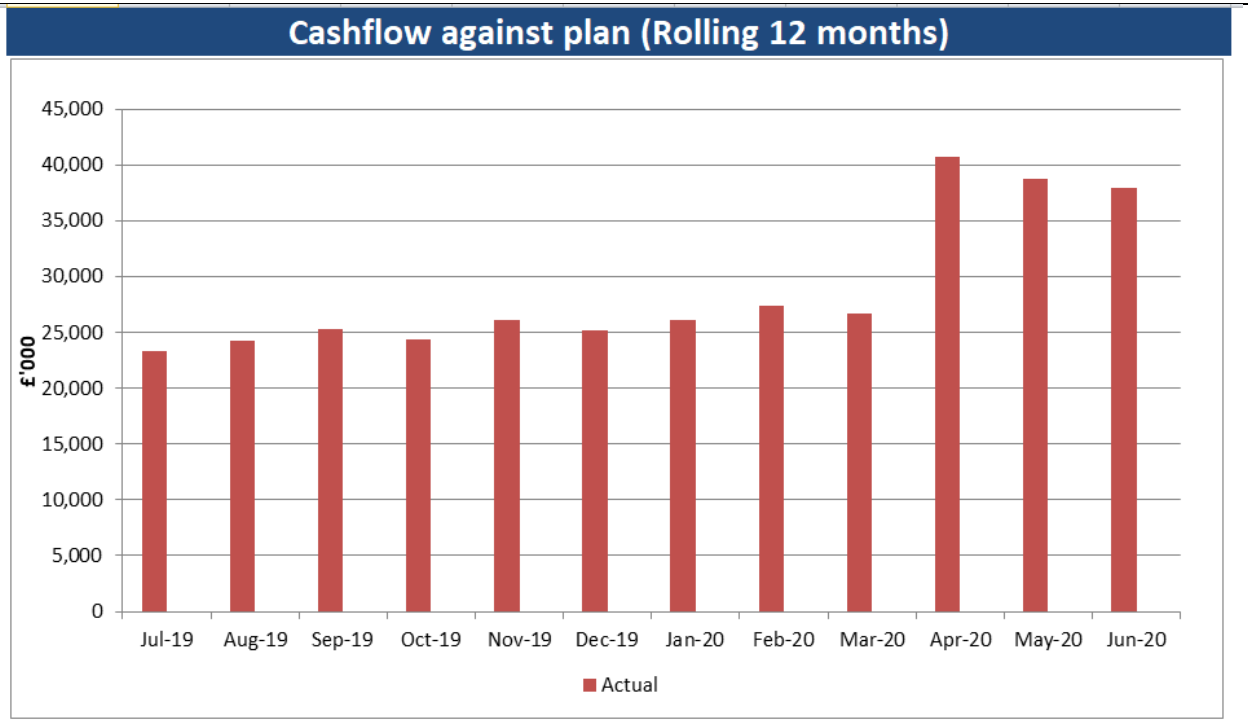
	Annual Plan £'000	In month Plan £'000	In month Actual £'000	In month Var £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Var £'000
Division							
Heating & Pipework	978	98	2	96	98	9	89
Estates	368	31	36	(5)	92	43	49
IM&T	1,283	107	29	78	321	95	226
Neurology	2,122	43	13	30	130	13	117
Neurosurgery	1,702	142	0	142	426	0	426
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,603)	(217)	0	(217)	(651)	0	(651)
TOTAL (excl. COVID-19)	**4,000**	**204**	**80**	**124**	**416**	**160**	**256**
COVID-19	0	0	37	(37)	0	213	(213)
TOTAL	**4,000**	**204**	**117**	**87**	**416**	**373**	**43**

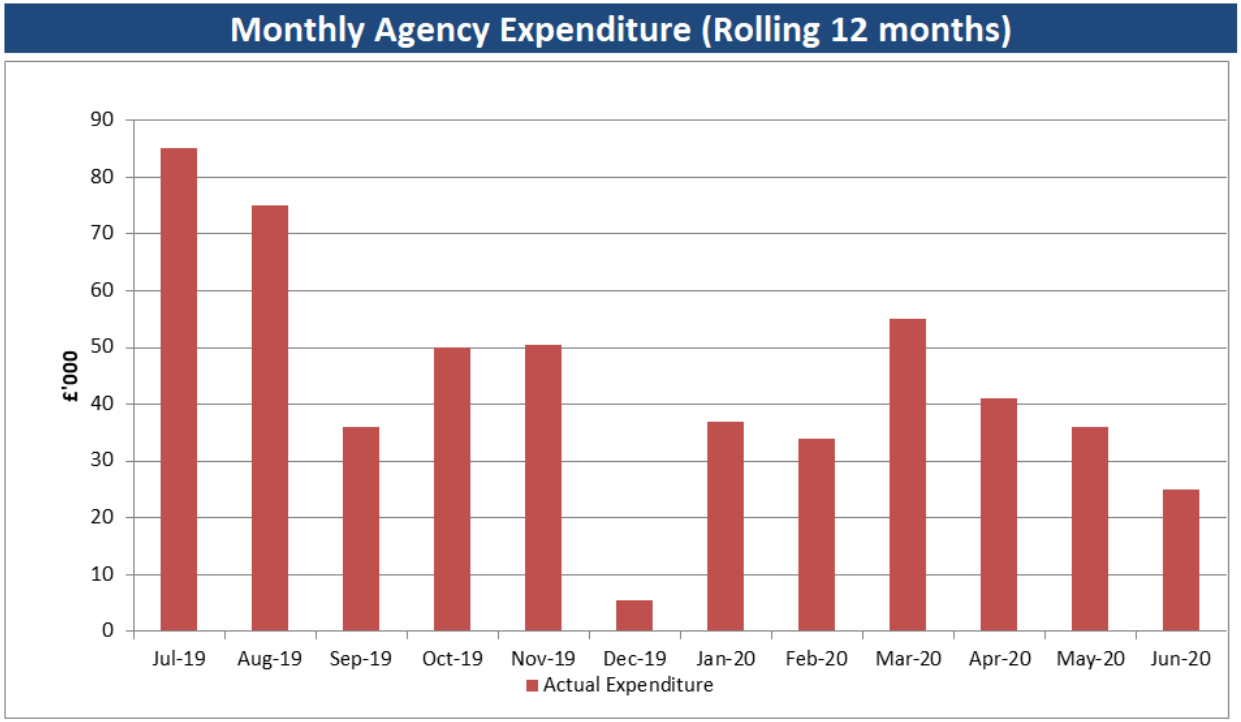
Capital spend in month is £117k, of which £37k is in relation COVID-19 expenditure. This will be refunded as per the guidance from NHSI/E so will not score against the Trusts capital plan.

The COVID-19 expenditure includes medical equipment - £36k and IM&T hardware and software licences in relation to setting up remote working - £1k.

There is £2k capital spend on phase 3 heating/pipework included within the Estates category. Capital spend on phase 3 heating and pipework are forecasted to increase between M4 and M10.

Given the pressure on capital within the C&M HCP, the Trusts proposed increased capital submission could not be funded and therefore its capital plan for 2020/21 is set at £4m. This will come under pressure given the demand on capital in year.

As of the end of June: Actual Cash Balance: £38.0m Number of days operating expenses = 114 days		The Trust cash balance at the end of June was £38.0m. This is a decrease of £0.8m from the end of May. The reduction is due to the payment of loans in June. The cash position also includes an additional month block payment received in June for the new financial arrangements to cover the COVID-19 pandemic.

Agency Expenditure: In month Actual: £25k YTD Actual: £102k		Agency spend incurred in June was £25k, a reduction of £11k compared to May. In month, there has been a reduction in the use of agency in nursing. A proportion of the in month expenditure relates to the COVID 19 response. At the end of June, £36k agency expenditure relates to COVID.

Key Risks and Actions for 2020/21

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

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the 1st 4 months of the year and income being based on block values determined nationally (based on 2019/20 expenditure between October and December 2019). The suspension of PbR is anticipated (though not confirmed) to remain in place at least for the remainder of 2020/21. To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable covid-19 and other known cost increases from 2019/20 (e.g. CNST contributions);
- The expectation that trusts will deliver breakeven during the pandemic but it is currently not clear what financial targets will be set after July 2020 (although it has been mooted that similar arrangements will exist until September 2020);
- 2020/21 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this allocation does not include any phase 2/3 Covid-19 capital requirements;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

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

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	NHSI/E block payments for planned income is based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. However, Welsh commissioners are currently paying 2019/20 contract levels with no level of inflation but have issued a revised offer which is based on the 2019/20 M9 position + 2.8% inflation which is still lower than the Trusts expectations (resulting in an underpayment on expected levels of income), which has been assumed within the financial position. IOM have also stated that they plan on only paying for actual activity that has been delivered, again resulting in an under payment compared to expected levels of income. Both issues have been raised with NHSI/E and in month 3, the shortfall in income is assumed to be covered by NHSI/E (as well as a reduction in spend on excluded drugs and devices). However this could create an additional pressure for the Trust if NHSI/E do not agree to fund this

	income shortfall once the updated block payments and recovery mechanism are in place.
Current/ Future financial architecture	Currently guidance has been issued for NHS financial architecture until July 2020; however it is not clear what the financial architecture will be beyond this time. Due to the level of uncertainty it is not possible to undertake financial planning or fully understand the future financial position of the Trust.
Efficiency requirements going forwards	Due to the current uncertainty around the financial architecture beyond July 2020, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult.
Changes to 2020/21 capital limits	The Trust had submitted an increased capital plan to the C&M HCP given the investments required in 2020/21. This was not able to be facilitated by the HCP given the forecast over-spend for the providers in the HCP against the overall allocation. This means that there is a risk that the Trust could overspend its allocation (which would impact on other providers in the HCP), unless it reviews its priorities or capital becomes available later in year via any underspend from other HCP providers.
Future delivery of clinical services whilst still managing COVID19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as less patients will be able to be seen given the additional PPE/ social distancing requirements).

REPORT TO TRUST BOARD
30th July 2020

The Walton Centre NHS Foundation Trust

Title	Equality, Diversity and Inclusion Annual Report 2020
Sponsoring Director	Mike Gibney, Director of Workforce and Innovation / Lisa Salter, Director of Nursing & Governance & E, D & I.
Author (s)	Andrew Lynch, Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary This report is summarises how the Trust meets its General and Specific Duties under the Equality Act 2010 and how the Trust has progressed work against the 5 year E, D and I vision.	
Related Trust Ambitions	Delete as appropriate: • Be recognised as excellent in all we do
Risks associated with this paper	See performance assurance framework (separate report)
Related Assurance Framework entries	**N/A**
Equality Impact Assessment completed	• No – This report makes no recommendations for changes. This report publishes information about the Trusts equality related activities and equality profile in line with the Specific Equality Duty under the Equality Act 2010, as such its positive affect on equality is axiomatic.
Any associated legal implications / regulatory requirements?	• Yes – The publication of this EDI Annual report is mandated as a Specific Equality Duty under the Equality Act 2010.
Action required by the Board	The Board is requested to : • consider and note the report

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Public Sector Equality Duty

Equality, Diversity and Inclusion Annual Report 2020

Contents

1 Introduction

I am pleased to introduce The Walton Centre NHS Foundation Trust Annual Equality Diversity and Inclusion (ED&I) Report 2020, which sets out the Trust's approach to ED&I and how the Trust meets the Public Sector Equality Duty (PSED).

Based in Liverpool, the Trust has a wide catchment population of about 3.5 million drawn from areas of ranging diversity across Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales. In addition, due to an international reputation in some areas of expertise, referrals are received from other geographical areas of the UK. The Walton Centre has achieved an outstanding CQC rating on 2 occasions and Investors in People Gold accreditation, excellent patient and staff survey ratings, recognising the Trust as a great place to work. Due to our specialist nature and outstanding reputation our workforce also come from a wider area, including Liverpool, Cheshire, Manchester, North Wales and other surrounding areas. These factors mean that direct demographic comparisons for both our patient profile and workforce demographics are more difficult.

1.1 Our Vision

Our vision is Excellence in Neuroscience. We strive for outstanding patient outcomes and the best patient, family and carer experience. We will continue to cherish the standards we have achieved, whilst exploring how we can enhance these further, shaping neuroscience treatments and care for the future.

1.2 Our Purpose

Dedicated specialist staff leading future treatment and excellent clinical outcomes for brain, spinal and neurological care nationally and internationally.

1.3 Our Ambitions

To deliver our vision and to meet our purpose, we have through consultation with staff, patients and partners agreed a set of ambitions together.

We will:

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

1.4 Our Equality Diversity and Inclusion Vision

The Walton Centre's commitments to equality, diversity, and inclusion can be encompassed in the following statements:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity.
- We are committed to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre.
- We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

Walton Way:

- **Caring** - caring enough to put the needs of others first
- **Dignity** – passionate about delivering dignity for all
- **Openness** – open and honest in all we do
- **Pride** – proud to be part of one big team
- **Respect** – courtesy and professionalism – it's all about respect

The Walton Centre is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place in 2019/20 and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity. Covid 19 has meant that the Trust has had to work differently and ensure that our staff are supported and we will continue to strive to deliver outstanding care for both our patients and our staff. We will monitor our equality diversity and inclusion progress against our action plans and report annually and openly.

Lisa Salter

Lisa Salter
Director of Nursing and Governance,
Executive Lead for ED&I

2 Equality Act 2010

The Equality Act, introduced in October 2010, replaced previous anti-discrimination laws with a single Act. Bringing together 9 pieces of primary legislation and over 100 pieces of secondary legislation the Act aimed to reduce bureaucracy, simplify the legislation and ultimately ensure that people are treated fairly when using services or whilst at work.

The Act protects people from discrimination on the basis of 'protected characteristics', which vary slightly depending upon whether a person is at work or accessing services. For example, 'marriage and civil partnership' is a protected characteristic for employees but not for people using services.

The nine protected characteristics are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Race (ethnicity)
- Religion or belief
- Sex (gender)
- Sexual orientation

'Equality recognises that historically certain groups of people with protected characteristics such as race, disability, sex and sexual orientation have experienced discrimination. ... The Equality Act 2010'

2.1 The General Duty

The General Duty, as set out in the Equality Act 2010, was introduced in April 2011, and it is the General Duty which guides the everyday work undertaken within the Trust. This includes having due regard to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between those who share and do not share a protected characteristic.

2.2 The Specific Duty

The Specific Duties under the Public Sector Equality Duty require public bodies to:

- Publish information to show their compliance with the Equality Duty, at least annually; and
- Set and publish equality objectives, at least every four years.

3 How the Walton Centre Pays due Regard to the General Equality Duty

The information below provides an update regarding some important ways the Trust works to meet the requirements of The General Equality Duty. In the interests of brevity and readability it is not possible to include all actions that we take throughout the year, so this report only highlights some of the more significant actions taken by the Trust in meeting the Equality Duty. More information can be found on the Trust's website.

3.1. Eliminating discrimination, harassment, victimisation and other prohibited conduct

3.1.1 Policies & Training

The Trust continues to work to improve the way we identify and address potential discrimination, to ensure that our staff, patients, and their families and carers, experience care or employment that is free from any prohibited behaviours, and that redress is transparent and open for all.

- The Trust has policies and procedures in place to tackle discrimination, harassment, bullying, victimisation, abuse, violence and aggression. These policies are both for staff, and for patients and their families.
- All policies have an Equality Impact Assessment (EIA) carried out on them prior to their approval and these EIAs are made available alongside the relevant police.
- Both the induction for new starters and the three yearly mandatory eLearning equality and diversity module raise awareness of discrimination and highlight that such behaviour is not permitted. The refresher training also ensures that all staff are maintaining awareness of equality and remain up to date with any changes in legislation. In response to feedback from staff the need for additional equality awareness training has been delivered to both staff and managers in 2019 and 2020, to date.

3.1.2 Support for Staff with a Disability

In June 2019 the Trust was successful in being reaccredited with DWP Disability Confident Scheme.

Through Disability Confident, the Trust is working with to ensure that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations.

This scheme will help The Trust to recruit and retain from the widest possible pool of talent and help us to keep their valuable skills and experience. The Trust has gained the following:

- A Disability Confident Committed badge, valid for 12 months until 09/06/2020
- A Disability Confident Committed certificate to demonstrate our commitment.

The Trust has now moved on to gain Disability Confident Employer (Level 2) and will be striving in the coming year to move on to Level 3.

Recruiting managers do not see any applicant's personal demographics, including their name, prior to the shortlisting stage. This helps to ensure that any potential discrimination at this stage is prevented. In 2018/19 the Trust took steps to include diverse interview panels in the recruitment process for senior managers and NEDs to ensure fairness in recruitment. Work is currently underway to enhance this further.

Access to Work is promoted within the Trust for staff with disabilities. All staff can also access Occupational Health and counselling support, as well as the support that can be provided by the HR. This includes the completion of a Tailored Reasonable Adjustment template which looks at what changes can be made to support an individual to remain in work and to have the same opportunities as employees who do not have a disability.

3.1.3 Workforce Disability Equality Standard (WDES)

The Trust held a launch for the WDES in July 2019 in order to engage staff in activities to advance equality of opportunity for Disabled staff in advance of publication of the Trust's WDES Report in July 2019. The WDES Report was discussed by the Trust Board and appropriate actions were drawn up to advance equality further in relation to workforce disability. A copy of the Trust's 2019 WDES report can be found on the Trust's website at:
http://www.thewaltoncentre.nhs.uk/uploadedfiles/PDF/WDES%20Report%202019.pdf

3.1.4 The NHS Accessible Information Standard

The Trust has developed a new SOP / best practice guideline / policy for Reasonable Adjustments which is part of a joint piece of work with Clinical Commissioning Groups on Merseyside and local NHS Trusts. This work constitutes a review of the Trust's approach to the NHS Accessible Information Standard and will be progressed through the E, D & I group.

3.1.5 ED&I Champions

The Trust has been reviewing the best approach to staff participation in equality and diversity in the light of poor attendance at EDI Champions meetings in 2019. The ED&I champions are still active, but joint work with other Merseyside NHS trusts and Clinical Commissioning Groups continues to find more effective and sustainable ways to engage with staff in regards to the equality agenda. The E, D and I group is due to meet next month and will push refocus this important work.

The Trust originally established ED&I Champions in 2018. Recruited from a diverse range of staff from across the organisation, their aim is to create a higher profile for E, D & I and to drive positive culture change to further support the Trust's equality commitments. The role of the Equality and Diversity Champions are:

- To support Walton Centre patients and colleagues to make positive improvements.

- To actively influence the way in which the hospital operates, monitors, plans and develops its services and staff to reflect the value of equality and diversity.
- To promote awareness of equality and diversity issues within our services, and across the Trust as a whole and the wider community; to act as a two-way communications channel between the Trust, colleagues, people who use our services and those who care for them.
- To develop knowledge of equality and diversity issues and educate others on the value of these
- To provide information and advice on equality and diversity issues and/or signpost people to alternative sources of information and advice within the Trust.

The role may alter somewhat following discussions with our staff to ensure that all aspects of covid 19 and Black Lives Matter work are discussed.

3.1.6 Cultural Ambassadors Programme

During 2018 The Walton Centre participated in a pilot programme with the RCN regarding Cultural Ambassadors. The Trust recruited some of our Black and Minority Ethnic (BME) staff to receive training to be able to support colleagues through various Human Resources (HR) processes to ensure fairness and improved cultural awareness e.g. Disciplinary, Grievance and Capability processes. During the period since the Cultural Ambassadors have been active, the Trust has not seen many opportunities for Cultural Ambassadors to help out in Disciplinary, Grievance or Capability processes, primarily because the Trust has been in the fortunate position of not having the relevant cases relating to BME staff for the Cultural Ambassadors to be called upon. While this is a positive reason for not calling on the Cultural Ambassadors, it does mean that the Trust has started to take steps to ensure that we develop more roles and activities for the Cultural Ambassadors to participate in, thus ensuring that their skills and commitment will be used and not eroded by underuse. The joint work around the use of Cultural Ambassadors has not yet achieved a solution to the problem of there not being enough disciplinaries to sustain the roles as currently constituted.

3.1.7 Navajo Chartermark

This Chartermark is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA people in Cheshire and Merseyside. Navajo looks at employment practices and how services are inclusive for LGBTIQA people. Since the Trust successfully obtained Navajo reaccreditation in March 2018 further steps have been taken to embed this work and spread best practice. The Trust has participated actively in the work of the Navajo Health Sub-Group. The Trust has also supported a staff member to undergo Navajo Assessor training and to participate in assessing another local NHS Organisation to spread of best practice. The Trust is also working with Navajo to increase the adoption of the Chartermark among NHS trusts across Cheshire and Merseyside.

The Trust has also participated in further initiatives to improve equality for LGBTIQA people e.g. The Trust had nearly 750 staff sign up to the NHS Rainbow Badge

initiative to increase awareness of LGBT+ equality issues, and to help improve the experiences of healthcare for LBGT+ patients and our staff.

The Trust participated in Liverpool Pride 2019 as part of a joint effort with other local NHS trusts. The Walton Centre contributed to having an NHS stand and banner and encouraged staff to participate in the event wearing the Trust logo alongside other NHS organisations. Due to covid 19, Liverpool Pride 2020 was cancelled, however a National Pride 2020 celebration was held 'virtually'.

3.1.8 Gender Pay Gap

The Trust has met its Gender Pay Gap reporting obligations for this year and the results are published on the Trust's website. The results do show a gender pay gap, however there is no indication that this is the result of any current direct discrimination by the Trust. The gap appears to be more connected with more generalised features of gender differences in different professions e.g. most of our nursing staff are female which is a feature of the current demographic of the profession rather than any bias in the recruitment practices of the Trust. The Trust Board is, however, committed to understanding the data in more detail in order to find the most appropriate actions to close the Gender Pay Gap. To this end, the Trust Board has examined figures for 2018 in June 2019 which is one year in advance of the reporting requirements which ask for the figures relating to two years previous to the current one. The Board has taken note of the results and has made use of the data to inform action planning in order to get ahead of the curve in terms of the Trusts response the Gender Pay Gap in 2020.

3.1.9 Reciprocal Mentoring

The Trust is successfully implemented the second year of its reciprocal Mentoring Programme. The Reciprocal Mentoring scheme has been established in conjunction with two other local NHS Trusts. The aim of the programme is to support employee's from Black and minority ethnic (BME) groups to further their development whilst also improving the understanding of senior leaders regarding what it means to be a BME employee within the Trust. In 2019 there were 5 BME staff on the programme, matched with 5 senior leaders.

3.1.10 Equality Impact Analysis

The Improved Equality Impact Assessment/Analysis (EIA) Guidance has now been developed and is being implemented for staff completing EIAs. Staff are also signposted to the Trusts Equality and Inclusion Lead to advise them on the process if needed. The Trusts Equality and Inclusion Lead is also included into the system for signing off Cost Improvement Plans (CIPs) before they go to the Trust Board in order to provide an enhanced level of assurance in respect of the equality compliance in relation to these important decisions.

3.2 Advancing Equality of Opportunity between People who share a Protected Characteristic and People who don't

The Trust is currently 2.5 years into its ED&I 5 Year Vision which it published at the end of 2017. Good progress continues to be made in relation to the commitments made in that vision:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard
- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity
- We are committed to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre
- We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

3.2.1 Organisational Context

This Vision is additional and complimentary to the many other key objectives, action plans and reporting that the Trust undertakes to ensure that it remains compliant with ED&I relevant statutory requirements and reporting frameworks.

The Equality Act 2010, Public Sector Equality Duties: general and Specific Duties:

General Duty:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between those who share and do not share a protected characteristic.

The Specific Duties

- Publish information to show their compliance with the Equality Duty, at least
- Annually
- Set and publish equality objectives, at least every four years.

Reporting:

- EDS 2 submissions to NHS England and published in the ED&I Annual Report online
- Workforce Race Equality Standards (WRES) published annually online
- Gender Pay Gap Reporting Published annually online
- Forthcoming Workplace Disability Equality Standards 2019 published online

These other key ED&I activities are progressed and monitored via The E,D&I Steering Group and Operational group, the Senior Management Team and Trust Board.

3.2.2 Narrative

The table below outlines the progress to June 2020. The Trust is tracking progress against 24 goals associated with the ED&I 5 Year Vision. The Goals that have been achieved are tagged Green. Goals that are achieved in part or are continuing on track towards achievement are marked in Amber. There are no goals that are in danger of not being achieved which, if present, would be marked red.

Goal 1	**Goal description: We have an ED&I 5 year strategy developed by staff and launched. Achieved in 2017.**	
Goal 2	**Goal description: We have ED&I champions roles defined and recruited to add value to our efforts to realise the Trust's ED&I 5 Year Vision. Achieved in 2017. There has been some change.** The COVID-19 outbreak and the disproportional impact on people with certain protected characteristics makes traditional face to face meetings impractical so the Trust has explored ways to engage with champions/staff digitally etc.	
Goal 3	**Goal description: We have year on year improvement of our measurements (in National Surveys relating to In-Patients and Staff) Ongoing. There has been no significant change. The Gender Pay Gap reporting for 2020 has been completed and the WRES and WDES are due for publication later in 2020.** This goal is only realistically achievable by the end of the 5 Year Vison. As yet reporting is too early to show sustained patterns of either improvement or deterioration, however, the WRES monitoring for the year to March 2019 show significant improvements on the previous years as outlined in the Workforce Race Equality Standard (WRES) Findings and Actions Report 2019 http://www.thewaltoncentre.nhs.uk/uploadedfiles/PDF/WRES%20Report%202019.pdf The Trust has also implemented the Workforce Disability Equality Standard (WDES) for the first time, which shows that the Trust is on an equal footing with the average figures across the NHS in relation to its workforce disability monitoring and performance for disabled staff as outlined in the Workforce Disability Equality Standard (WDES) Findings and Actions Report 2019: http://www.thewaltoncentre.nhs.uk/uploadedfiles/PDF/WDES%20Report%202019.pdf The Trust continues to report on the Gender Pay Gap, which continues to close incrementally year on year. The Trust has analysed and reported the figures for this year : http://www.thewaltoncentre.nhs.uk/uploadedfiles/Gender%20Pay%20Gap%20Report%202020.pdf The Trust will be keen to implement future National equality monitoring and reporting frameworks as they develop.	
Goal 4	**Goal description: We are the employer of choice for staff with protected characteristics. Ongoing. There has been no significant change, the WRES and WDES are due for publication later in 2020.** WRES monitoring demonstrates that the Trust has maintained a workforce that is more diverse than	

	the local community in terms of race/ethnicity. The distribution of BME staff, however, remains much more evident in clinical and in medical roles and there are also comparatively fewer BME non-medical managers. Gender monitoring has shown that we have more females than males at the Trust, but despite an incremental closing of the Gender Pay Gap, male earnings are disproportionately higher because their distribution in clinical and medical posts is different. WDES analysis has highlighted that Disabled staff are underrepresented in all areas of the Trust, however, due to there being a significant numerical difference between the numbers of Disabled staff recoded on ESR and Disabled staff responding to the staff survey, it is suspected that there is a large measure of under reporting of disability on ESR: The percentage of Disabled staff on ESR is (3.14%) compares with a (3%) average measured from trust's ESR records across England. The percentage of Disabled staff responding to the Walton Centre Staff Survey was (18.11%). Like most other trusts The Walton Centre seems to have ESR underreporting of disability of approximately (15%). The Trust continues to liaise with Disabled staff to better understand and tackle under reporting of disability.	
Goal 5	**Goal description: We have good engagement and working relationships with 3rd sector expert groups. Achieved/Ongoing. There have been some difficulties encountered this year due to COVID-19.** This is a goal that requires ongoing action to maintain its effectiveness into the future. 3rd Sector Engagement was a key piece of work done by the Trust to inform the local health economy across Merseyside about health inequalities as part of joint working. The Trust is continuing to work with Local Healthwatch to develop more effective community engagement across Merseyside Trusts. The main change to note in this report is that engagement across the board has been badly affected by the COVID-19 epidemic. Many 3rd sector workers who would normally be involved in engagement are furloughed or redeployed at present e.g. most Healthwatch engagement officers, so there is little scope at present for detailed engagement work, however the Trust is continuing to maintain contacts with key Healthwatch officers in readiness for the end of the current COVID-19 epidemic.	
Goal 6	**Goal description: We have an increase in Equality Impact Assessments (EIA) undertaken for planning and projects. Achieved 2018. There has been no significant change.** All Trust policies, procedures, strategies, projects, CIPs and service changes are now accompanied by an EIA prior to their approval and publication. The Equality and Inclusion Lead now has to sign off all CIPs prior to their implementation. The Chair and the CEO have made themselves aware of the Brown Principles and EIA guidance has undergone further revision and is now comprehensive. The Equality and Improvement Lead provides one on one guidance and support to managers completing EIAs on request.	
Goal 7	**Goal description: We have set up and established terms of reference for the ED&I Steering Group Achieved 2017. There will need to be some changes made due to accommodate new ways of working due to COVID-19 e.g. arranging MS Teams.**	

Goal 8	**Goal description: We complete action plans for data and track progress and impact. Ongoing. There is no significant change.** The Trust has action plans and tracks data in accordance with the Public Sector Equality Duty (See above). Data monitoring and action planning has also increased as a result of the introduction of the WRES and WDES.	
Goal 9	**Goal description: We complete action plans for WRES findings and track impact. Achieved/Ongoing There is no significant change.** The WRES is an annual reporting mechanism, so this work is never fully achieved; however the Trust is fully compliant to this point in time.	
Goal 10	**Goal description: Our Public Sector Equality Duty is met (PSED) Achieved 2018.** **There is no significant change** The Trust continues to pay due regard to the PSED during the 2020 COVID-19 epidemic. The Trust has taken steps to ensure that staff who are in COVID-19 higher risk groups due to disability, race, pregnancy etc. are risk assessed and control measures are agreed to allow them to continue to work safely. The Trust is also conducting an EIA on its response to COVID-19 to learn any lessons and make any changes required to maintain PSED compliance. The Trust has also published its Gender Pay Gap report this year.	
Goal 11	**Goal description: We are successful in our reaccreditation for Navajo or have an action plan for future accreditation. Achieved 2018. There has been some difficulty encountered in 2020 due to COVID-19.** Engagement is continuing with Navajo and The Trust remains on target to maintain the Navajo Chartermark in future years. The Trust has also successfully participated in the Navajo assessment of another local Trust for their Chartermark. Although the Trust has renewed its Navajo Chartermark engagement with Navajo, internally, work is ongoing; however, 3rd Sector engagement is one of the areas most affected by COVID-19, leading to Navajo activities being on hold during the COVID-19 epidemic. Engagement with Navajo will resume on the easing of the epidemic.	
Goal 13	**Goal description: We have met Accessible information standard. Ongoing. There has been some positive progress for this goal.** Evidence from the Trusts intranet http://intranet/intranet_new/586/accessible-information-standard.html Also, the Interpretation & Translation and Accessible Information Policy, April 2018 indicates that the Accessible Information Standard has been achieved; however, this goal requires ongoing monitoring to ensure that it is maintained, which the E, D and I group will progress.	
Goal 14	**Goal description: We have had an increase in staff with protected characteristics in our workforce over the life of the Vision. Achieved 2018** in regard to race, however this work is **ongoing. There has**	

	been no significant change. In 2019 there was a small decline in the Trusts percentage of BME staff in the workforce as reported by the WRES, however, the Trust remains in line with regional demographics. This metric will be monitored closely to ensure that the recent fluctuation is not the start of a negative trend. WRES reporting is due later in 2020. That WRES Report will show any improvements from previous year's figures. The WDES has now given the Trust a 2019 baseline figure to measure progress regarding the measurement of disability equality progress in coming years. WDES reporting is due later in 2020. The WDES will show any improvements from previous year's figures.
Goal 15	**Goal description: We have improved experience of patients with learning difficulties, brain injuries & protected characteristics. Achieved 2018. There has been no significant change.** The Trust participated in the Learning Disability National Survey for NHSI in 2018. The results from the survey will inform future plans regarding Learning Disabilities. The Trust worked with The Local CCGs and service providers to improve sign language interpretation provision across the system. The Trust is currently participating in talks with other local trusts and Liverpool CCG to jointly procure Translation and Interpretation services and the Trust is in the process of adopting Translation and Interpretation Standards developed jointly with local CCG and trust partners. There has been no further progress yet achieved regarding this joint piece of work.
Goal l16	**Goal description: We have expanded training in unconscious bias/cultural competency. Ongoing. There has been progress on this goal.** In November 2019 and January 2020 The Trust has conducted ED&I training with a particular focus on, unconscious bias and cultural competence. The Trust also provided equivalent EDI training for managers in the first quarter of 2020.
Goal 17	**Goal description: Our staff feel equipped with skills and knowledge on ED&I. Ongoing.** Please see the answer given in Goal 16 above.
Goal 18	**Goal description: We have a place on a national campaign – e.g. Building Leadership for Inclusion or alternative. Achieved 2018. There had been progress on this goal.** The Trust successfully participated in the NHS Employers Diversity and Inclusion Partners Programme in both 2018 and 2019. The Trust actively engages in the networking, sharing of best practice that this provides. The Trust has now graduated to participating in the NHS Employers Diversity and Inclusion Partners Alumni Programme .
Goal 19	**Goal description: We have increased/improved patient data monitoring Achieved/Ongoing. There has been progress on this goal.**

	The Trust has updated the PAS System to enable the better recording of patient data in line with national data standards, e.g. on Sexual Orientation Monitoring SOM). https://www.datadictionary.nhs.uk/web_site_content/navigation/main_menu.asp https://www.datadictionary.nhs.uk/web_site_content/supporting_information/contact_details.asp?shownav=1 The Trust has also completed improvements to its equality monitoring forms based on patient's feedback.	
Goal 20	**Goal description: We have increased/improved workforce monitoring (particularly disability). Achieved/ Ongoing.** Please see the answers given in Goal 3 and 4 above.	
Goal 21	**Goal description: We have greater awareness of key cultural dates and events. Achieved/Ongoing. There has some difficulty with this goal due to COVID-19 but the work continues.** The marking of key cultural events has been adversely affected by the COVID-19 epidemic, nevertheless, the Trust carried out actions to mark Holocaust memorial day in January 2020 and Ramadan in April/May 2020. The Trust participated in Virtual Pride 2020, despite covid 19.	
Goal 22	**Goal description: We have equivalent to CQC 'Outstanding' and IiP Gold in Equality and Diversity. Wellbeing Ongoing. There has some difficulty with this goal due to COVID-19 but the work continues.** Due to the disruption caused by COVID-19 e.g. it has not been possible to engage with 3rd sector partners properly for months and face to face engagement with staff and the public has been badly affected too. So it is not now realistic to expect to reach Goal 22 in 2020. 2021 Is a more realistic target for this goal given the current COVID-19 situation and communication will recommence via MS Teams.	
Goal 23	**Goal description: Our staff feel happy and confident, supported and not judged by the Trust in relation to ED&I, that inclusion is our everyday practice. Ongoing. There has been no significant change.** The WRES data is significantly better in most respects this year including BME staff perceptions as measured by the staff survey. The WRES data on this goal will be updated later in 2020 with the publication of this year's WRES report. Any improvements in the happiness and confidence levels of disabled staff will be identified later in 2020 with the publication of the second WDES monitoring report. The Trust has also introduced the NHS Rainbow Badge scheme this year to ensure that staff can provide a visible sign of their support for an inclusive environment and welcome at the Trust for LGBT+ patients and staff. It is not yet possible to measure the happiness and confidence levels of LGBT+ patients and staff as there is no specific monitoring and reporting mechanism in place to do this.	

Goal 24	**Goal description: We celebrate diversity and see our strength in inclusion as one of our core strengths. Ongoing. There has been no significant change.** This is not a goal that we would expect to achieve until the later years of the 5 Year Vision. Consideration should be given as to how this goal is to be measured effectively and if no adequate measure is identified consideration should be given to dropping this goal.	

3.2.3 Conclusions regarding progress on the ED&I 5 Year Vision.

Despite some difficulties arising from the COVID-19 pandemic the Trust continues to make steady progress towards achieving the goals in the 5 Year ED&I Vision. Discussions have taken place at Quality Committee this month and further work is now being progressed via the E, D and I group.

3.2.4 Professional Interpretation and Translation Services

The Trust contracts with professional interpreting and translation service providers can be contacted 24 hours a day e.g. we have a contract with Action on Hearing Loss who provide sign language interpretation and translation to support our staff and patients. We recognise that this provision is essential for effective and safe communication in people whose first language isn't English, and that this provision promotes equality of opportunity as well as ensuring that dignity, respect and privacy is maintained.

3.2.5 Support for Staff with a Disability.

Access to Work is promoted within the Trust to support staff with disabilities regarding reasonable adjustments. All staff can also access Occupational Health and counselling support, as well as the support that can be provided by HR. This includes the completion of a Tailored Reasonable Adjustment template which looks at what changes can be made to support an individual to remain in work and to have the same opportunities as employees who do not have a disability.

3.2.6 Workforce Race Equality Standard (WRES) 2019 Findings and Actions

The WRES requires Trusts to demonstrate progress against nine indicators focussing on workforce race equality, Board level representation and differences between the experience and treatment of White and BME staff. These findings are returned via the Unify 2 system to enable comparisons to be made between Trusts nationally, as well as being individually published on the Trust website, along with an associated action plan.

The Trust has met its WRES reporting requirements for 2019 and the results are published on the Trust's website. At the time of publication of this ED&I Annual Report, the Trust is working towards publication of the 2020 WRES report which will be presented to The Trust Board later in 2020.

The 2019 WRES Report shows that the Trust is making clear progress on 8 of the 9 WRES indicators and the one indicator where the Trust has not progressed marks the Trust returning closer to the regional average for overall BME staff numbers rather than dipping below that average.
The full 2019 WRES Report is published on the Trust's website.
http://www.thewaltoncentre.nhs.uk/uploadedfiles/PDF/WRES%20Report%202019.pdf

3.2.7 Complaints

Complaints data is monitored in respect of discrimination and other prohibited conduct via the Trusts Patient Experience Group (PEG). Any patterns identified would be addressed accordingly.

3.3 Fostering Good Relations between People who Share Protected Characteristics and People who don't

Many of the actions detailed in the Five Year ED& Vision mentioned above also support this aim, however detailed below are a few of the extra things the Trust does in support of fostering good relations:

- The Trust has a Patient Experience Group. Membership includes governors and members as well as staff, Board members and local Healthwatch. This allows active dialogue and engagement between the Trust and the people using our services.

After the enthusiastic reception from staff to the Black History Month stand that the Trust set up in October 2018, the trust also repeated this activity in October 2019. Black History Month UK aims to address the long standing unfairness and lack of recognition for the contribution made by people of African descent to life, development and history of the UK by celebrating the achievements and contributions of the black community over the years.

3.3.1 ED&I Patient and Engagement

Due to the COVID-19 epidemic, it has been difficult to maintain relationships with community organisations. Many 3rd sector workers who would normally be involved in engagement are furloughed or redeployed at present e.g. most Healthwatch engagement officers, so there is little scope at present for detailed engagement work, however the Trust is continuing to maintain contacts with key Healthwatch officers in readiness for the end of the current COVID-19 epidemic. Equality continues to be a standing item on the Patient Experience Group agenda. Involvement with other local networks and charities has included regular engagement with the Brain Charity, epilepsy patients and Navajo etc.

The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings.

4 The Specific Duty and the Walton Centre

The Trust meets its Specific Duties under the Equality Act 2010 via the publication of this Equality, Diversity and Inclusion Annual Report and the equality objectives stated within it. A further level of PSED assurance is provided by the Trust's participation in Equality Delivery System 2 (EDS 2).

4.1. EDS 2

The Trust's EDS 2 review of priorities is currently being undertaken for 2020; however progress on this has been slowed by the disruption caused by the COVID-19 epidemic. The Trust is, therefore, not seeking to increase its grades on any of the sub-goals in 2020 as the COVID-19 slowed or paused much of the cooperative working that we have been doing with other Merseyside Trusts. Despite these difficulties, much progress has been made in regard to updating our arrangements for making Reasonable Adjustments for both disabled patients and staff.

EDS2 has four key goals (with 18 specific outcomes) which are achieving better outcomes, improving patient access and experience, developing a representative and supported workforce and finally, demonstration of inclusive leadership. Each of these goals are assessed and a grading applied to illustrate progress. Involvement of the communities and organisations who represent the views of people with protected characteristics is important. The grading's applied are as follows:

1. ***Undeveloped*** if there is no evidence one way or another for any protected group of how people fare or Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well

2. ***Developing*** if evidence shows that the majority of people in three to five protected groups fare well

3. ***Achieving*** if evidence shows that the majority of people in six to eight protected groups fare well

4. ***Excelling*** if evidence shows that the majority of people in all nine protected groups fare well

The current equality objectives are:

- Objective 1 – Extend patient profiling (equality monitoring) data collection to all protected characteristics
- Objective 2 – Improve support for, and reporting of, disability within the workforce
- Objective 3 – Ensure ongoing involvement and engagement of protected groups including patients, carers, staff, Healthwatch and other interested parties
- Objective 4 – Ensure all staff members are paid equally for equal work done
- Objective 5 – Increase the number of BME staff within management positions.

Recent EDS 2 gradings for the vast majority of patient and public related services (Goals 1, 2 & 4) for The Walton Centre have been assessed as ***developing*** The currently proposed 2019 EDS2 grades for The Walton Centre can be viewed in the table immediately below and in **Appendix 1**.

4.1.1 Current 2019/20 The Walton Centre EDS2: The Goals and Outcomes			Grade Status
Goal	Sub	Description of outcome	
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing
	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
	2.3	People report positive experiences of the NHS	Achieving
	2.4	People's complaints about services are handled respectfully and efficiently	Developing
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Developing
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing

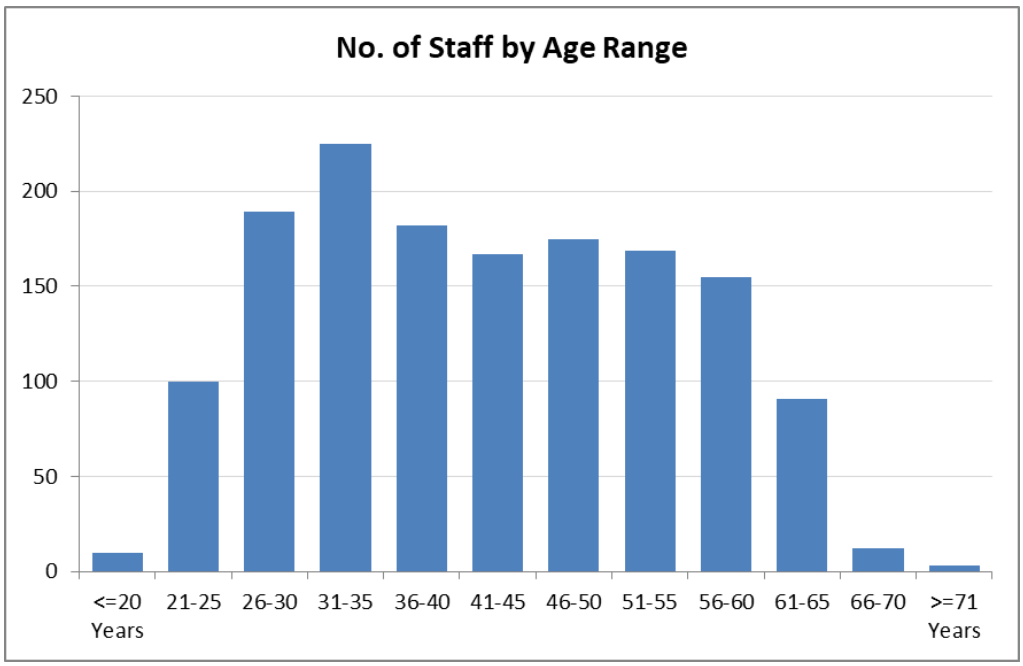
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

5 Workforce ED&I Profile

Workforce ED&I Profile 1st June 2020.

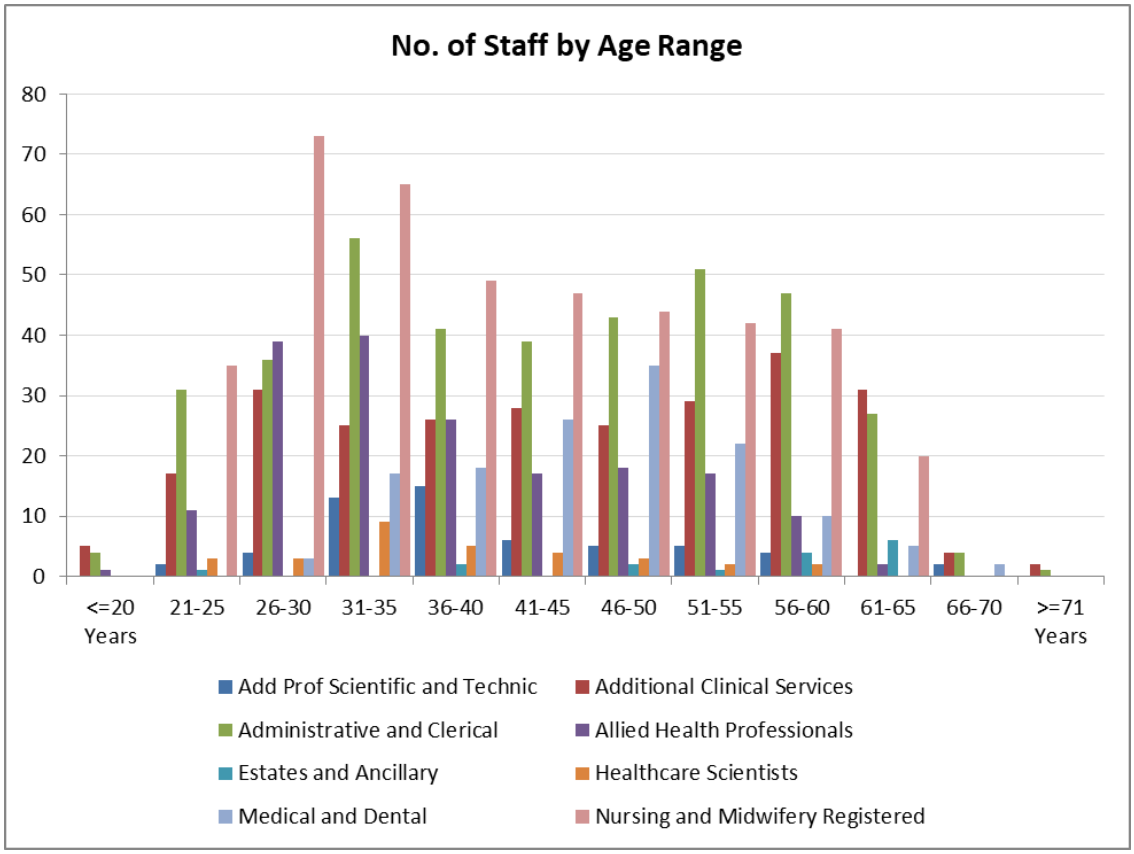
5.1 Workforce by Age

Age Range	No. Of Staff
<=20 Years	10
21-25	100
26-30	189
31-35	225
36-40	182
41-45	167
46-50	175
51-55	169
56-60	155
61-65	91
66-70	12
>=71 Years	3
Grand Total	**1478**


No. of Staff by Age Range
250
200
150
100
50
0
<=20 Years
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71 Years

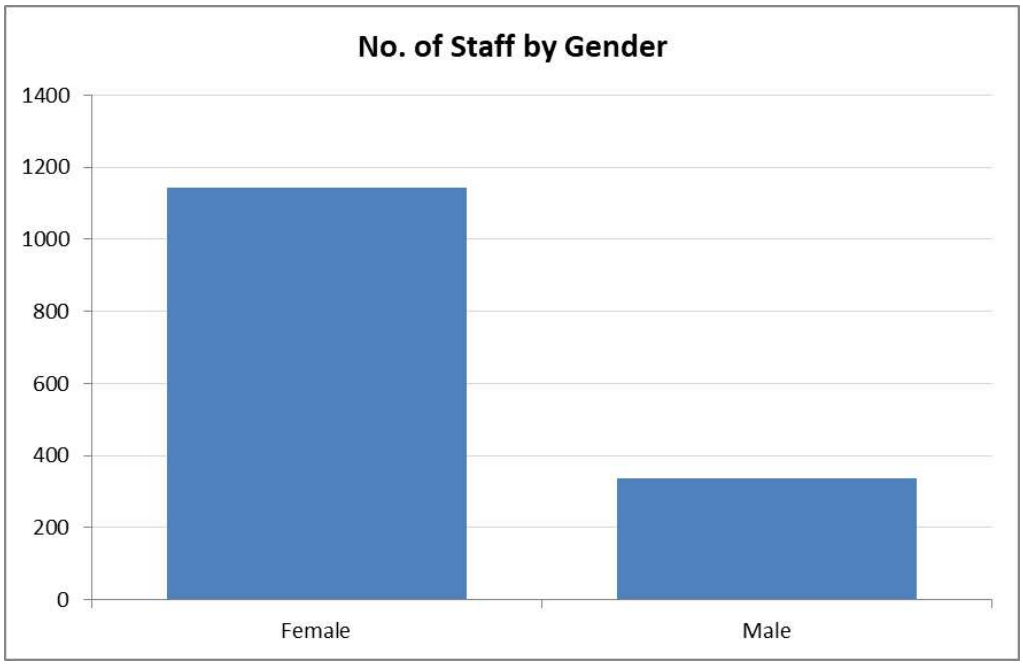
5.1.1 Staff Group by Age

Age Range	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
<=20 Years	0	5	4	1	0	0	0	0	**10**
21-25	2	17	31	11	1	3	0	35	**100**
26-30	4	31	36	39	0	3	3	73	**189**
31-35	13	25	56	40	0	9	17	65	**225**
36-40	15	26	41	26	2	5	18	49	**182**
41-45	6	28	39	17	0	4	26	47	**167**
46-50	5	25	43	18	2	3	35	44	**175**
51-55	5	29	51	17	1	2	22	42	**169**
56-60	4	37	47	10	4	2	10	41	**155**
61-65	0	31	27	2	6	0	5	20	**91**
66-70	2	4	4	0	0	0	2	0	**12**
>=71 Years	0	2	1	0	0	0	0	0	**3**
Grand Total	**56**	**260**	**380**	**181**	**16**	**31**	**138**	**416**	**1478**


No. of Staff by Age Range
80
70
60
50
40
30
20
10
0
<=20 Years
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71 Years
Add Prof Scientific and Technic
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered

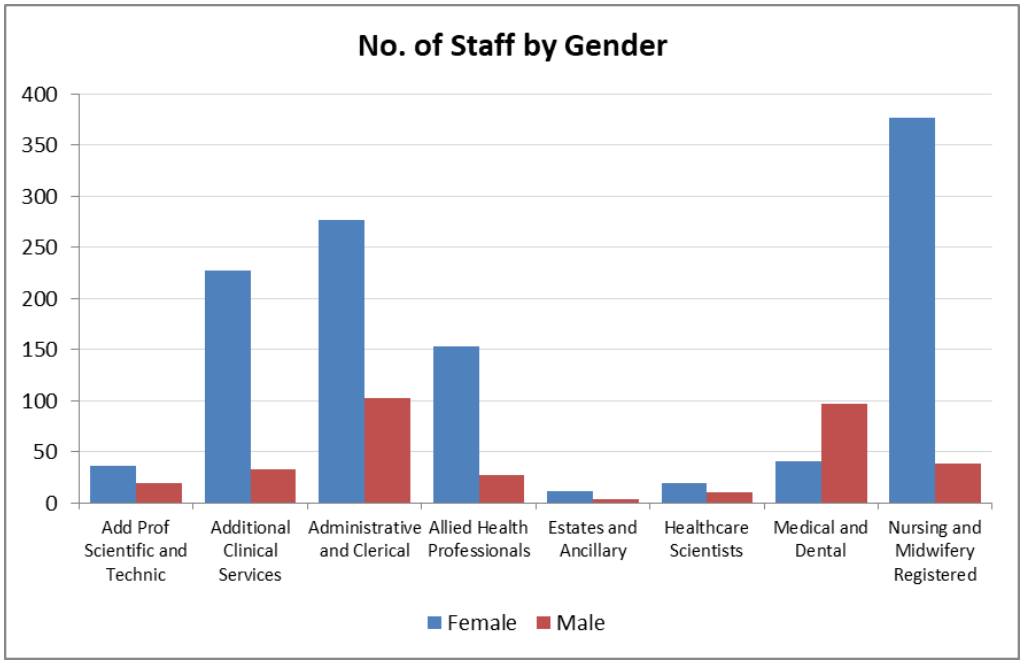
5.2 Workforce by Gender

Gender	No. Of Staff
Female	1143
Male	335
Grand Total	**1478**



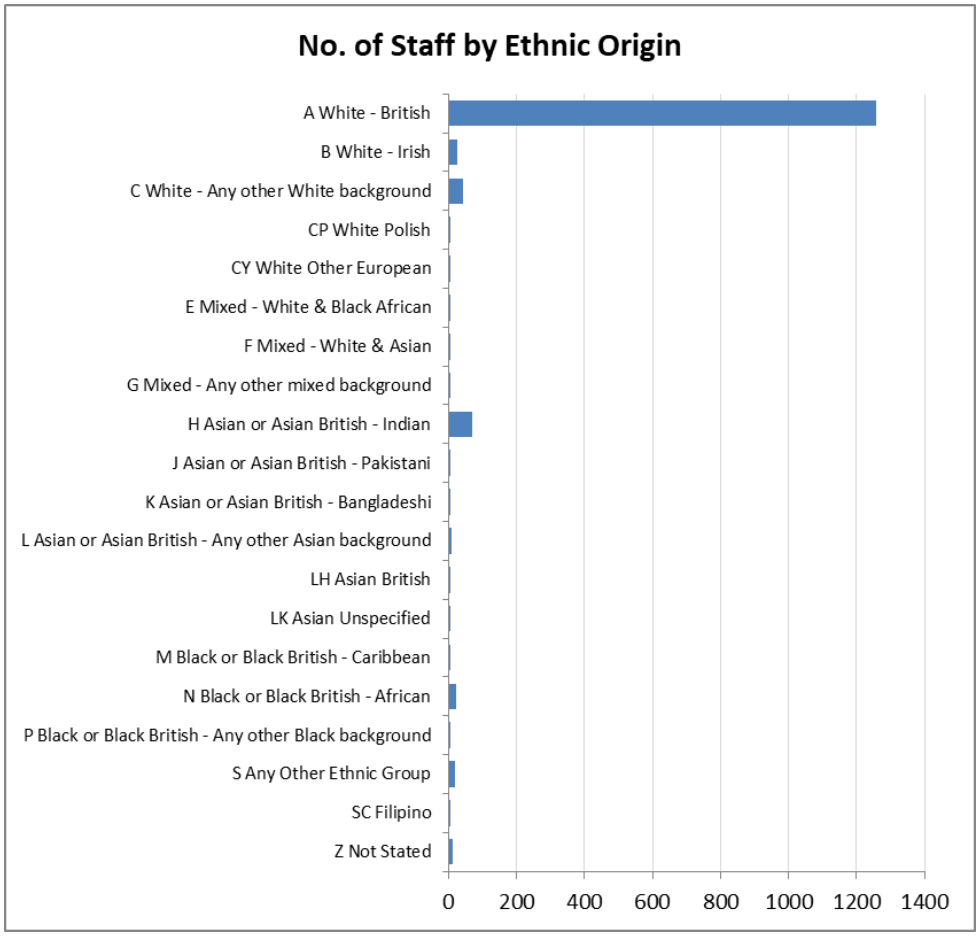
5.2.1 Staff Group by Gender

Staff Group	Female	Male	Grand Total
Add Prof Scientific and Technic	36	20	**56**
Additional Clinical Services	227	33	**260**
Administrative and Clerical	277	103	**380**
Allied Health Professionals	153	28	**181**
Estates and Ancillary	12	4	**16**
Healthcare Scientists	20	11	**31**
Medical and Dental	41	97	**138**
Nursing and Midwifery Registered	377	39	**416**
Grand Total	**1143**	**335**	**1478**



5.3 Workforce by Ethnic Origin

Ethnic Origin	*No. Of Staff*
A White - British	*1258*
B White - Irish	*24*
C White - Any other White background	*43*
CP White Polish	*1*
CY White Other European	*2*
E Mixed - White & Black African	*3*
F Mixed - White & Asian	*2*
G Mixed - Any other mixed background	*4*
H Asian or Asian British - Indian	*68*
J Asian or Asian British - Pakistani	*4*
K Asian or Asian British - Bangladeshi	*1*
L Asian or Asian British - Any other Asian background	*10*
LH Asian British	*1*
LK Asian Unspecified	*1*
M Black or Black British - Caribbean	*1*
N Black or Black British - African	*22*
P Black or Black British - Any other Black background	*1*
S Any Other Ethnic Group	*19*
SC Filipino	*1*
Z Not Stated	*12*
Grand Total	***1478***

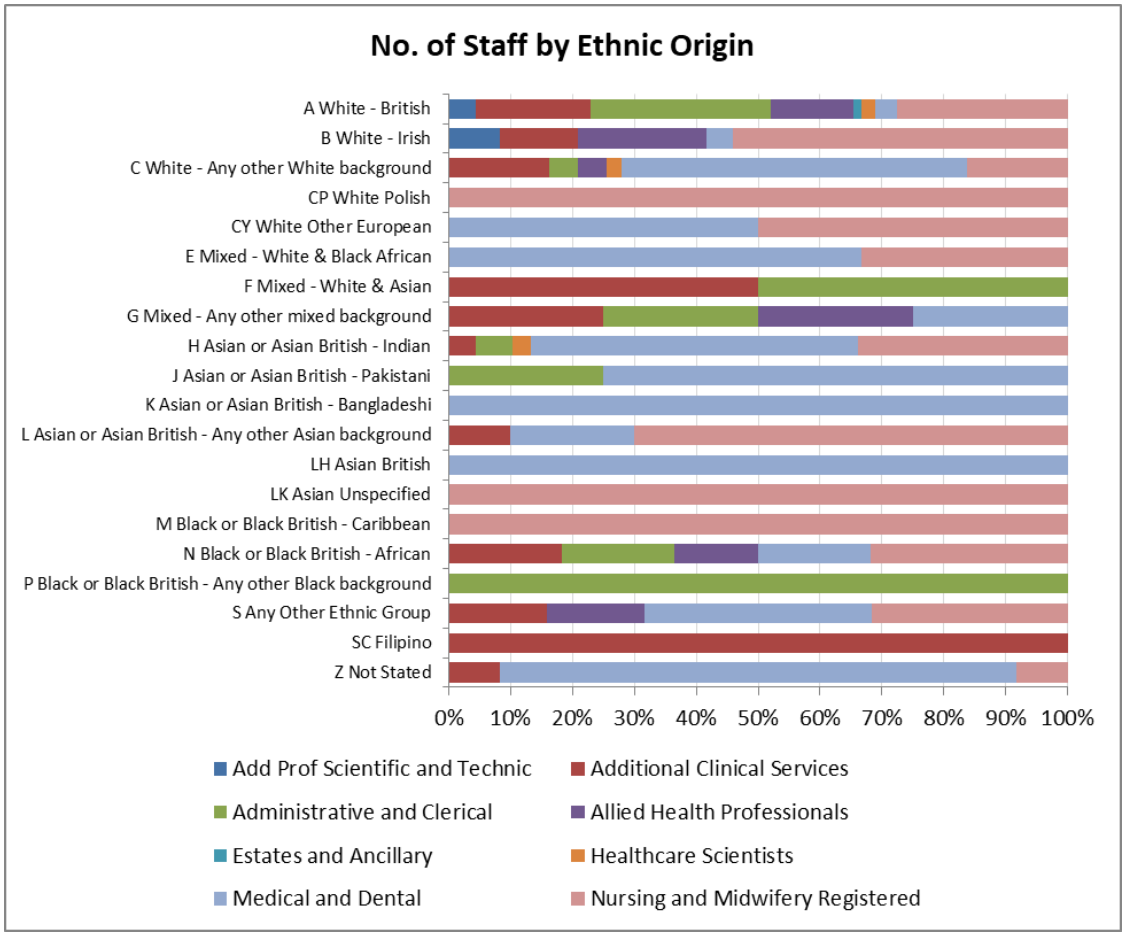


5.3.1 Staff Group by Ethnic Origin

Ethnic Origin	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
A White - British	*54*	*235*	*366*	*167*	*16*	*28*	*45*	*347*	***1258***
B White - Irish	*2*	*3*	*0*	*5*	*0*	*0*	*1*	*13*	***24***
C White - Any other White background	*0*	*7*	*2*	*2*	*0*	*1*	*24*	*7*	***43***
CP White Polish	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	***1***
CY White Other European	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*1*	***2***

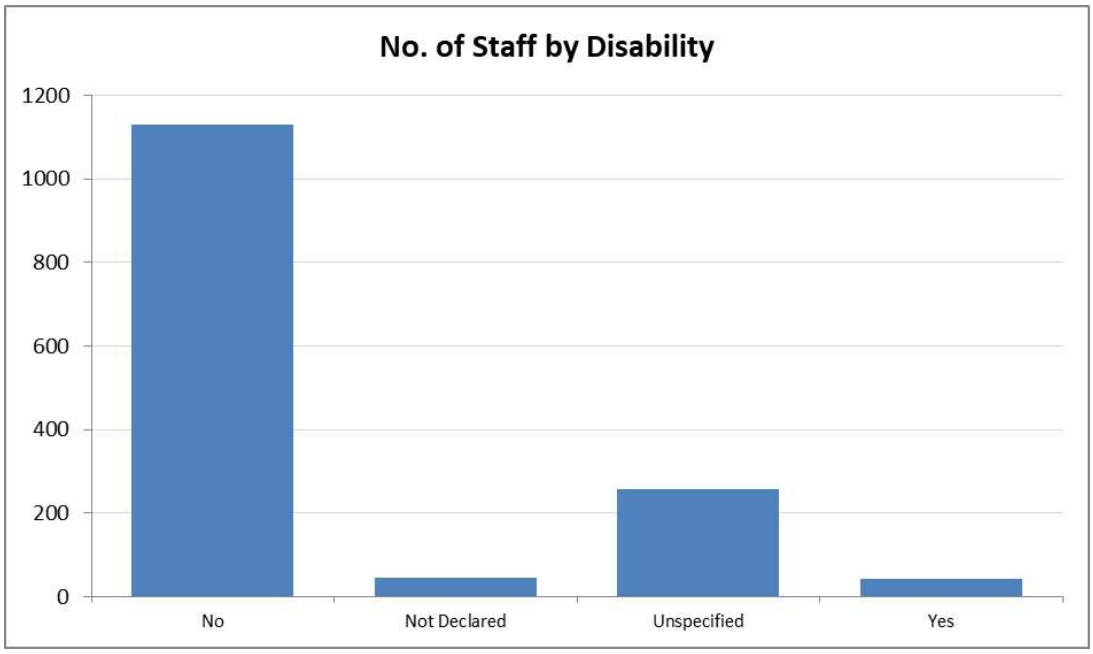
E Mixed - White & Black African	*0*	*0*	*0*	*0*	*0*	*0*	*2*	*1*	***3***
F Mixed - White & Asian	*0*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	***2***
G Mixed - Any other mixed background	*0*	*1*	*1*	*1*	*0*	*0*	*1*	*0*	***4***
H Asian or Asian British - Indian	*0*	*3*	*4*	*0*	*0*	*2*	*36*	*23*	***68***
J Asian or Asian British - Pakistani	*0*	*0*	*1*	*0*	*0*	*0*	*3*	*0*	***4***
K Asian or Asian British - Bangladeshi	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	***1***
L Asian or Asian British - Any other Asian background	*0*	*1*	*0*	*0*	*0*	*0*	*2*	*7*	***10***
LH Asian British	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	***1***
LK Asian Unspecified	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	***1***
M Black or Black British - Caribbean	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	***1***
N Black or Black British - African	*0*	*4*	*4*	*3*	*0*	*0*	*4*	*7*	***22***

P Black or Black British - Any other Black background	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	***1***
S Any Other Ethnic Group	*0*	*3*	*0*	*3*	*0*	*0*	*7*	*6*	***19***
SC Filipino	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	***1***
Z Not Stated	*0*	*1*	*0*	*0*	*0*	*0*	*10*	*1*	***12***
Grand Total	***56***	***260***	***380***	***181***	***16***	***31***	***138***	***416***	***1478***



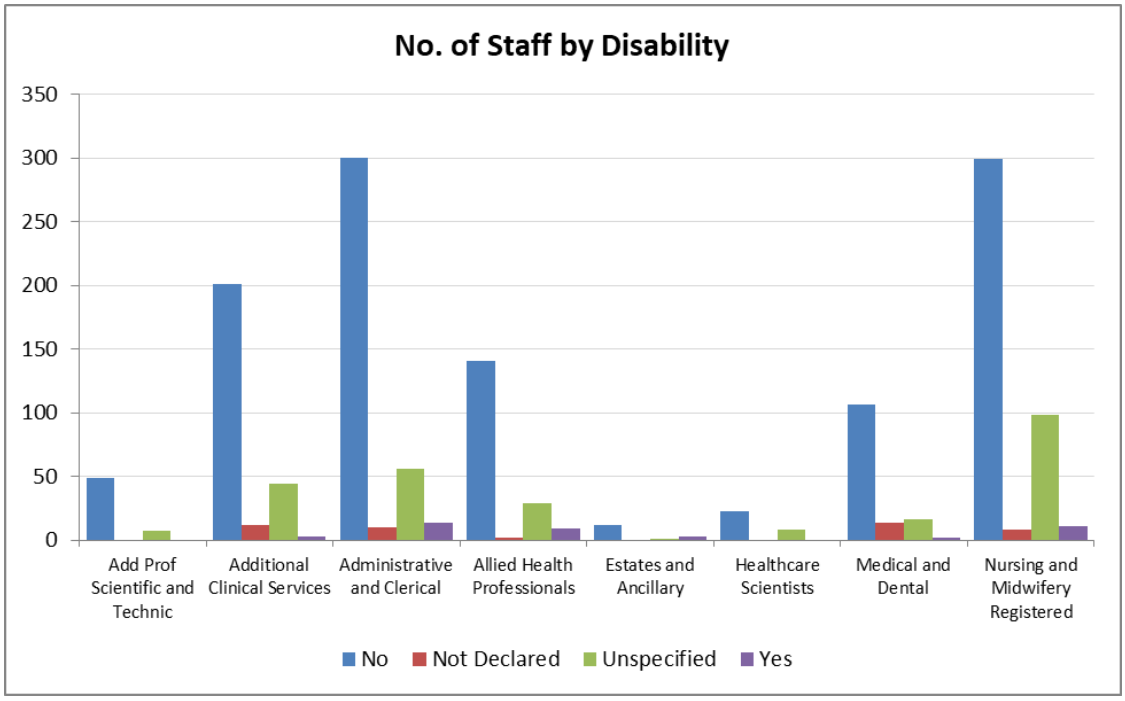
5.4 Workforce by Disability

Disability	No. Of Staff
No	1131
Not Declared	46
Unspecified	259
Yes	42
Grand Total	**1478**



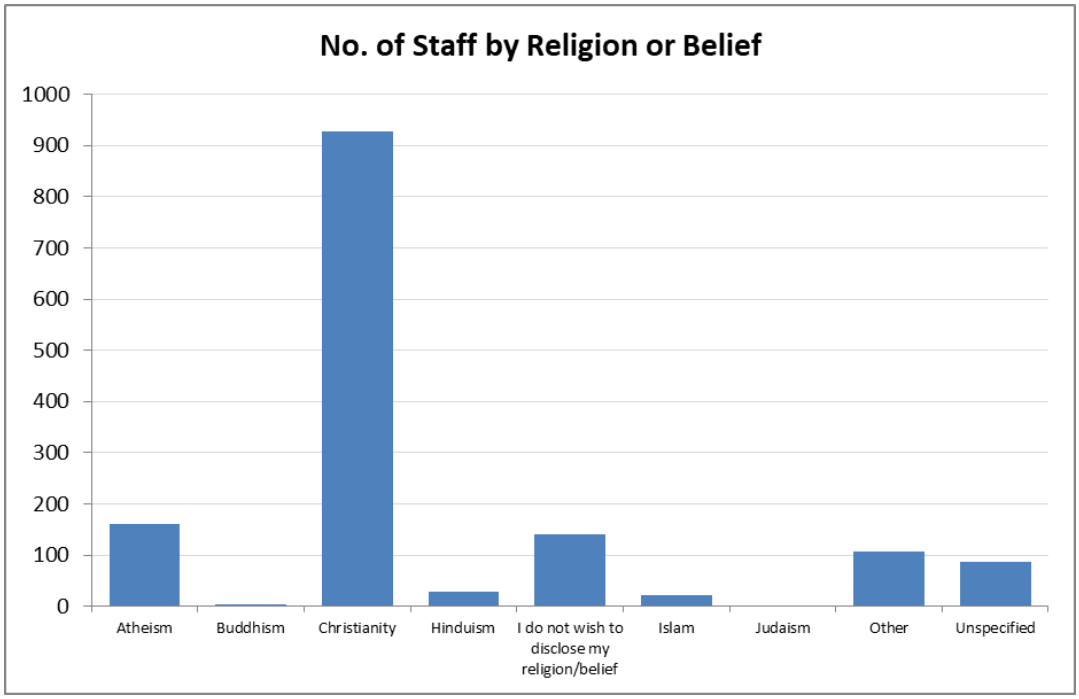
5.4.1 Staff Group by Disability

Staff Group	No	Not Declared	Unspecified	Yes	Grand Total
Add Prof Scientific and Technic	49	0	7	0	**56**
Additional Clinical Services	201	12	44	3	**260**
Administrative and Clerical	300	10	56	14	**380**
Allied Health Professionals	141	2	29	9	**181**
Estates and Ancillary	12	0	1	3	**16**
Healthcare Scientists	23	0	8	0	**31**
Medical and Dental	106	14	16	2	**138**
Nursing and Midwifery Registered	299	8	98	11	**416**
Grand Total	**1131**	**46**	**259**	**42**	**1478**



5.5 Workforce by Religion or Belief

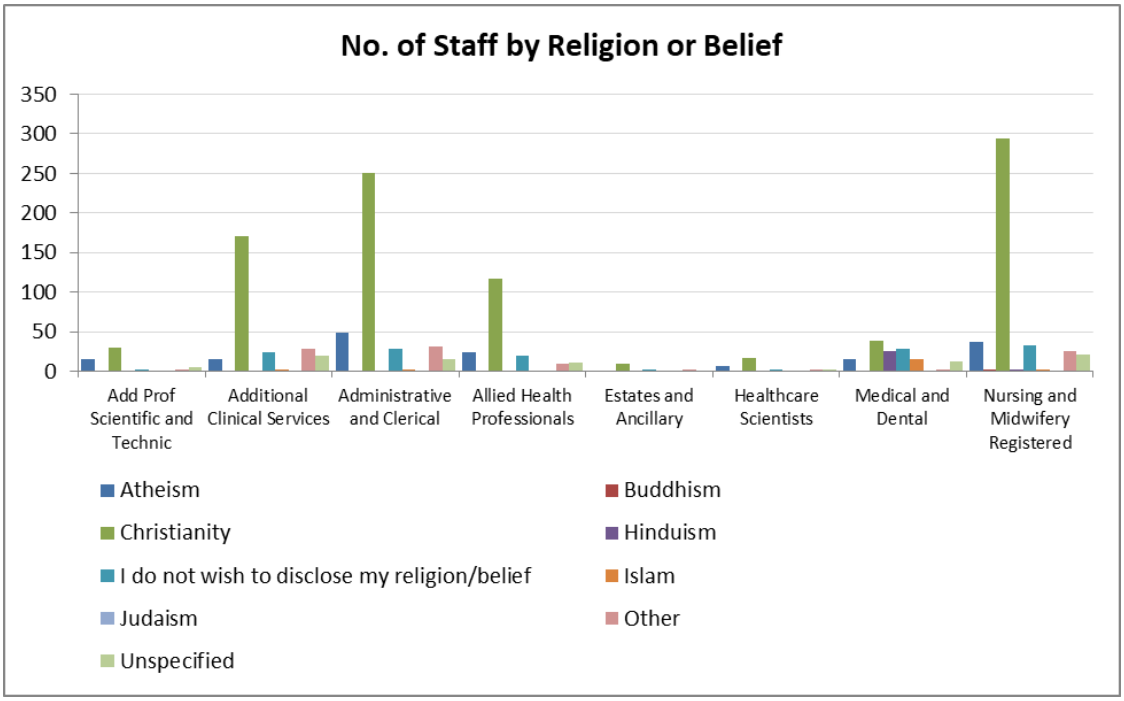
Row Labels	*No. Of Staff*
Atheism	*161*
Buddhism	*4*
Christianity	*927*
Hinduism	*29*
I do not wish to disclose my religion/belief	*141*
Islam	*22*
Judaism	*1*
Other	*106*
Unspecified	*87*
Grand Total	***1478***



5.5.1 Staff Group by Religion or Belief

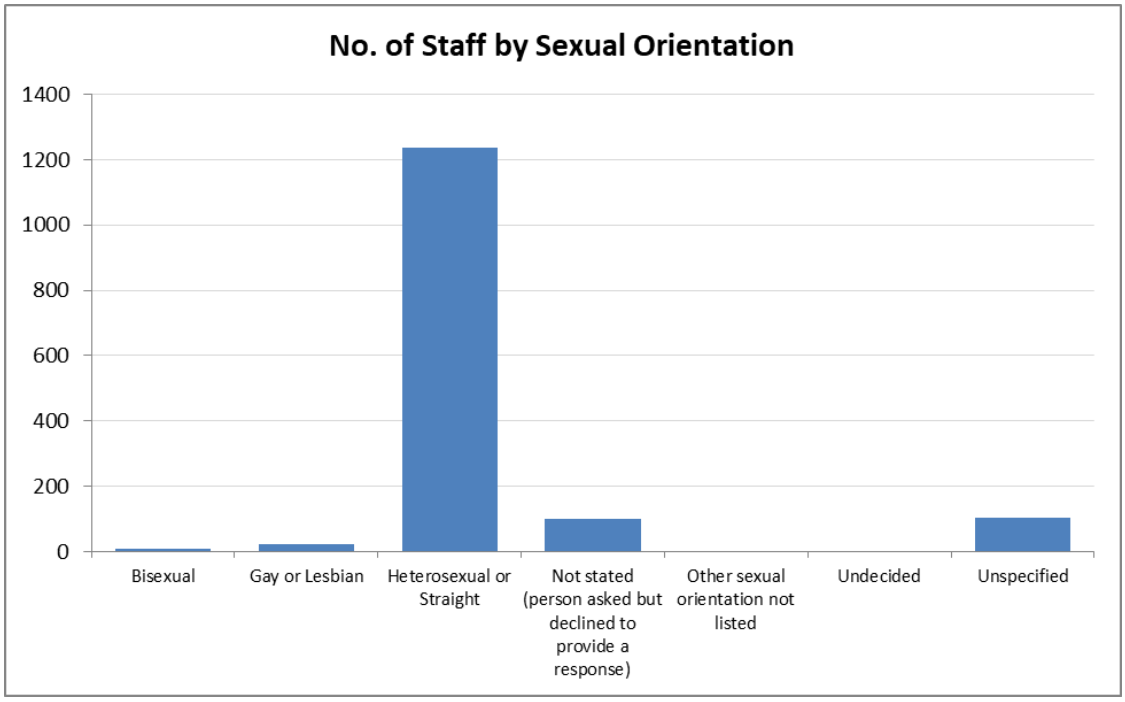
Staff Group	Atheism	Buddhism	Christianity	Hinduism	I do not wish to disclose my religion/belief	Islam	Judaism	Other	Unspecified	Grand Total
Add Prof Scientific and Technic	15	0	30	0	3	0	0	3	5	56
Additional Clinical Services	15	1	170	1	24	2	0	28	19	260
Administrative and Clerical	49	0	251	1	29	2	0	32	16	380
Allied Health Professionals	24	0	117	0	19	0	0	10	11	181
Estates and Ancillary	0	0	10	0	3	0	0	2	1	16
Healthcare Scientists	6	0	17	0	2	1	0	3	2	31
Medical and	15	1	38	25	28	15	1	3	12	138

Dental										
Nursing and Midwifery Registered	*37*	*2*	*294*	*2*	*33*	*2*	*0*	*25*	*21*	*416*
Grand Total	***161***	***4***	***927***	***29***	***141***	***22***	***1***	***106***	***87***	***1478***



5.6 Workforce by Sexual Orientation

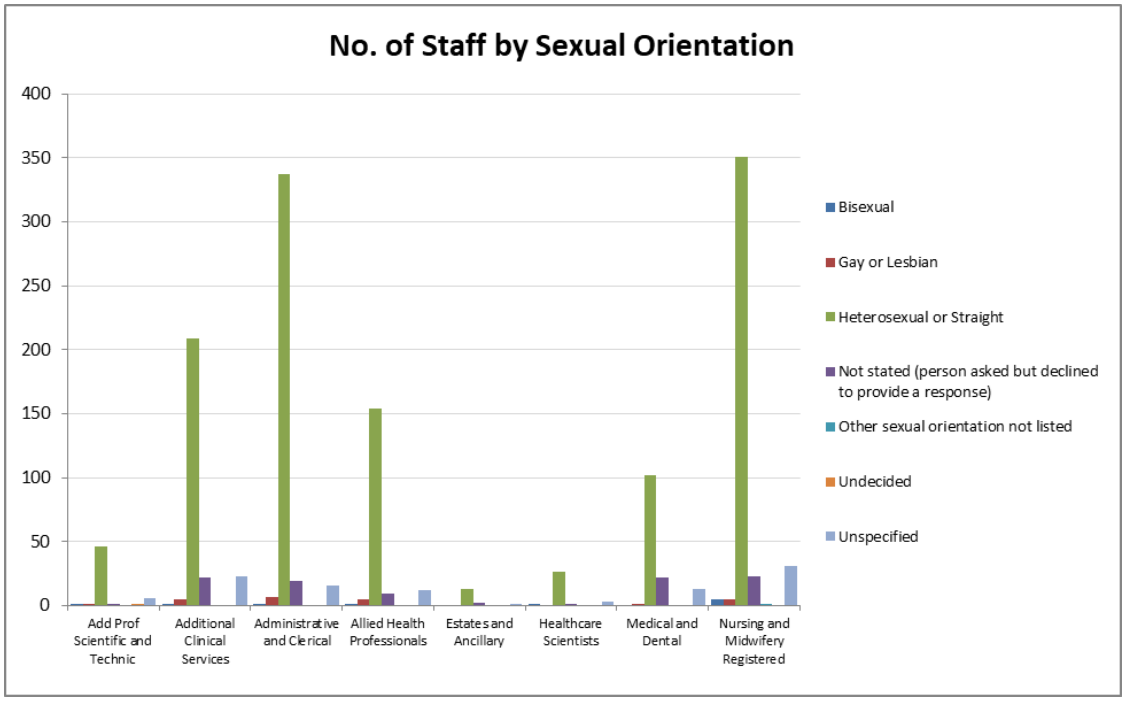
Sexual Orientation	*No. Of Staff*
Bisexual	*10*
Gay or Lesbian	*24*
Heterosexual or Straight	*1238*
Not stated (person asked but declined to provide a response)	*99*
Other sexual orientation not listed	*1*
Undecided	*1*
Unspecified	*105*
Grand Total	*1478*



5.6.1 Staff Group by Sexual Orientation

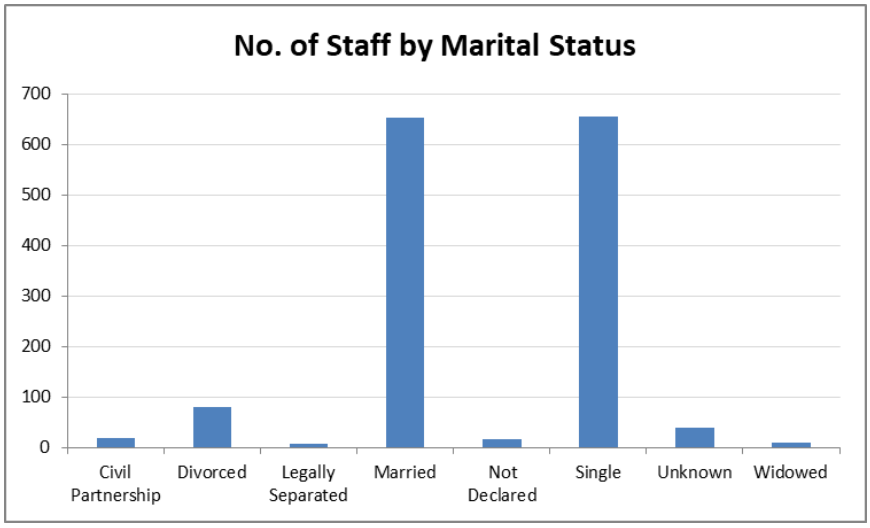
Staff Group	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	Grand Total
Add Prof Scientific and Technic	1	1	46	1	0	1	6	56
Additional Clinical Services	1	5	209	22	0	0	23	260
Administrative and Clerical	1	7	337	19	0	0	16	380
Allied Health Professionals	1	5	154	9	0	0	12	181
Estates and Ancillary	0	0	13	2	0	0	1	16
Healthcare Scientists	1	0	26	1	0	0	3	31

Medical and Dental	*0*	*1*	*102*	*22*	*0*	*0*	*13*	*138*
Nursing and Midwifery Registered	*5*	*5*	*351*	*23*	*1*	*0*	*31*	*416*
Grand Total	***10***	***24***	***1238***	***99***	***1***	***1***	***105***	*1478*



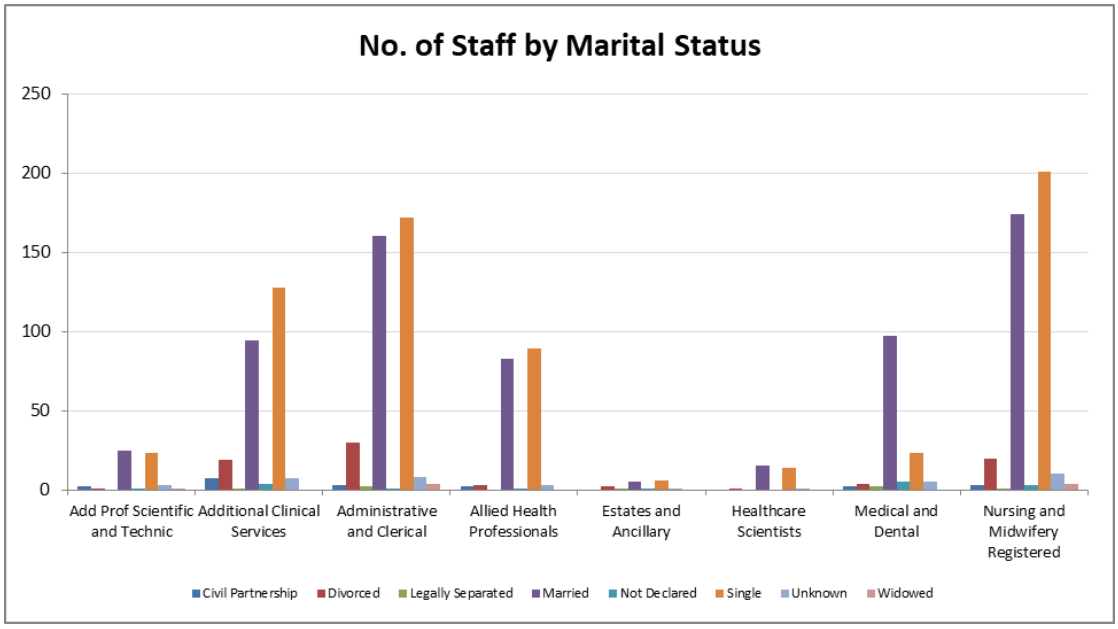
5.7 Workforce by Marital Status

Status	*No. Of Staff*
Civil Partnership	*19*
Divorced	*80*
Legally Separated	*7*
Married	*653*
Not Declared	*16*
Single	*656*
Unknown	*38*
Widowed	*9*
Grand Total	***1478***



5.7.1 Staff Group by Marital Status

Staff Group	Civil Partnership	Divorced	Legally Separated	Married	Not Declared	Single	Unknown	Widowed	Grand Total
Add Prof Scientific and Technic	2	1	0	25	1	23	3	1	56
Additional Clinical Services	7	19	1	94	4	128	7	0	260
Administrative and Clerical	3	30	2	160	1	172	8	4	380
Allied Health Professionals	2	3	0	83	1	89	3	0	181
Estates and Ancillary	0	2	1	5	1	6	1	0	16
Healthcare Scientists	0	1	0	15	0	14	1	0	31
Medical and Dental	2	4	2	97	5	23	5	0	138
Nursing and Midwifery Registered	3	20	1	174	3	201	10	4	416
Grand Total	19	80	7	653	16	656	38	9	1478



5.8 New Starters 1ST April 2019 to 31st March 2020.

Disability	*No. of Staff*
No	*255*
Unspecified	*3*
Yes	*8*
Grand Total	***266***

Gender	*No. of Staff*
Female	*197*
Male	*69*
Grand Total	***266***

Marital Status	*No. of Staff*
Civil Partnership	*7*
Divorced	*10*
Married	*89*
Single	*154*
Unknown	*3*
Widowed	*1*
Grand Total	***266***

Age Band	No. of Staff
<=20 Years	8
21-25	49
26-30	48
31-35	41
36-40	32
41-45	28
46-50	15
51-55	23
56-60	17
61-65	4
66-70	1
Grand Total	**266**

Ethnic Origin	No. of Staff
A White - British	217
B White - Irish	7
C White - Any other White background	9
G Mixed - Any other mixed background	1
H Asian or Asian British - Indian	12
J Asian or Asian British - Pakistani	3
L Asian or Asian British - Any other Asian background	3
N Black or Black British - African	10
S Any Other Ethnic Group	1
SC Filipino	1
Grand Total	**266**

Nationality	No. of Staff
Australian	1
British	233
Bulgarian	1
Egyptian	2
Filipino	1
Indian	6
Irish	7
Italian	1
Jordanian	1
Mauritian	1
Motswana	1
Pakistani	1
Polish	1
Portuguese	1

Romanian	*3*
South African	*1*
Swiss	*1*
Ugandan	*1*
Zambian	*1*
Not Stated	*1*
Grand Total	***266***

Sexual Orientation	***No. of Staff***
Bisexual	*3*
Gay or Lesbian	*2*
Heterosexual or Straight	*251*
Not stated (person asked but declined to provide a response)	*8*
Other sexual orientation not listed	*1*
Undecided	*10*
Grand Total	***266***

Religious Belief	***No. of Staff***
Atheism	*33*
Buddhism	*1*
Christianity	*175*
Hinduism	*6*
I do not wish to disclose my religion/belief	*21*
Islam	*9*
Other	*21*
Grand Total	***266***

5.9 Recruitment Data 1 April 2018 to 31 March 2019

Category	Description	Applications	%	Shortlisted	% shortlisted
Gender	Male	1,693	30.8%	402	24.4%
	Female	3,787	68.8%	1234	74.8%
	Undisclosed	24	0.4%	13	0.8%
Disability	Yes	303	5.5%	97	5.9%
	No	5,101	92.7%	1522	92.3%
	Undisclosed	100	1.8%	30	1.8%
Criminal Conviction	Yes	34	0.6%	10	0.6%
	No	5,424	99.4%	1594	99.4%
Ethnicity	WHITE - British	3,882	70.5%	1291	78.3%

Category	Description	Applications	%	Shortlisted	% shortlisted
	WHITE - Irish	61	1.1%	21	1.3%
	WHITE - Any other white background	281	5.1%	67	4.1%
	ASIAN or ASIAN BRITISH - Indian	284	5.2%	70	4.2%
	ASIAN or ASIAN BRITISH - Pakistani	166	3.0%	25	1.5%
	ASIAN or ASIAN BRITISH - Bangladeshi	27	0.5%	7	0.4%
	ASIAN or ASIAN BRITISH - Any other Asian background	67	1.2%	10	0.6%
	MIXED - White & Black Caribbean	24	0.4%	4	0.2%
	MIXED - White & Black African	48	0.9%	6	0.4%
	MIXED - White & Asian	20	0.4%	10	0.6%
	MIXED - any other mixed background	30	0.5%	9	0.5%
	BLACK or BLACK BRITISH - Caribbean	19	0.3%	5	0.3%
	BLACK or BLACK BRITISH - African	306	5.6%	38	2.3%
	BLACK or BLACK BRITISH - Any other black background	12	0.2%	2	0.1%
	OTHER ETHNIC GROUP - Chinese	16	0.3%	6	0.4%
	OTHER ETHNIC GROUP - Any other ethnic group	143	2.6%	25	1.5%
	Undisclosed	118	2.1%	53	3.2%

Category	Description	Applications	%	Shortlisted	% shortlisted
Age Band	Under 18	3	0.1%	2	0.1%
	18 to 19	46	0.8%	9	0.5%
	20 to 24	730	13.3%	171	10.4%
	25 to 29	1,187	21.6%	301	18.3%
	30 to 34	995	18.1%	263	15.9%
	35 to 39	647	11.8%	210	12.7%
	40 to 44	525	9.5%	176	10.7%
	45 to 49	481	8.7%	186	11.3%
	50 to 54	454	8.2%	173	10.5%
	55 to 59	302	5.5%	113	6.9%
	60 to 64	116	2.1%	39	2.4%
	65 to 69	9	0.2%	3	0.2%
	70 and over	4	0.1%	2	0.1%
	Undisclosed	5	0.1%	1	0.1%
Religion	Atheism	672	12.2%	239	14.5%
	Buddhism	30	0.5%	7	0.4%
	Christianity	3,206	58.2%	976	59.2%
	Hinduism	155	2.8%	33	2.0%
	Islam	410	7.4%	78	4.7%
	Jainism	2	0.0%	0	0.0%
	Judaism	19	0.3%	3	0.2%
	Sikhism	9	0.2%	4	0.2%
	Other	535	9.7%	139	8.4%
	Undisclosed	466	8.5%	170	10.3%
Sexual Orientation	Heterosexual	5,087	92.4%	1500	91.0%
	Gay/Lesbian	150	2.7%	40	2.4%
	Bisexual	59	1.1%	17	1.0%
	Other	7	0.1%	4	0.2%
	Undecided	8	0.1%	2	0.1%
	Undisclosed	193	3.5%	86	5.2%
Marital Status	Married	1,848	33.6%	600	36.4%
	Single	3,136	57.0%	855	51.8%

Category	Description	Applications	%	Shortlisted	% shortlisted
	Civil partnership	97	1.8%	21	1.3%
	Legally separated	30	0.5%	11	0.7%
	Divorced	205	3.7%	81	4.9%
	Widowed	30	0.5%	11	0.7%
	Undisclosed	158	2.9%	70	4.2%
Impairment	Physical Impairment	79	22.1%	21	18.6%
	Sensory Impairment	56	15.6%	23	20.4%
	Mental Health Condition	40	11.2%	16	14.2%
	Learning Disability/Difficulty	62	17.3%	24	21.2%
	Long-Standing Illness	90	25.1%	23	20.4%
	Other	31	8.7%	6	5.3%
Total	Total	5,504	100.0%	1649	100.0%

6 Patient ED&I Profile

6.1 WCFT Patient Diversity Breakdown: June 2019 to May 2020

Gender

Sex	Sex Desc	Inpatient	Outpatient	Grand Total	% of Total
F	Female	9095	64394	73489	58.59%
I	Indeterminate/Other		2	2	0.00%
M	Male	5838	46091	51929	41.40%
U	Unknown/Not Stated	3	5	8	0.01%
Grand Total		14936	110492	125428	100.00%

6.2 Age Band

Age Band	Inpatient	Outpatient	Grand Total	% of Total
Under 18	43	728	771	0.61%
18-24	697	5948	6645	5.30%
25-34	1589	12899	14488	11.55%
35-44	2394	15853	18247	14.55%
45-54	3533	22789	26322	20.99%
55-64	3232	22801	26033	20.76%
65-74	2341	17928	20269	16.16%
75+	1107	11546	12653	10.09%
Grand Total	14936	110492	125428	100.00%

6.3 Religion

Religion	Religion Description	Inpatient	Outpatient	Grand Total	% of Total
AGN	AGNOSTIC	16	105	121	0.10%
ANG	ANGLICAN	22	102	124	0.10%
ATH	ATHEIST	91	513	604	0.48%
BAP	BAPTIST	16	198	214	0.17%
BUD	BUDDHIST	32	115	147	0.12%
CHR	CHRISTIAN	616	3067	3683	2.94%
COE	CHURCH OF ENGLAND	3766	25324	29090	23.19%
CON	CONGREGATIONAL	2	18	20	0.02%
COS	CHURCH OF SCOTLAND	37	85	122	0.10%
COW	CHURCH OF WALES	44	314	358	0.29%
GO	GREEK ORTHODOX	6	43	49	0.04%
HIN	HINDU	21	118	139	0.11%
JEW	JEWISH	22	150	172	0.14%
JW	JEHOVAH'S WITNESS	40	297	337	0.27%
MET	METHODIST	134	984	1118	0.89%
MOR	MORMON	3	20	23	0.02%
MUS	MUSLIM	72	484	556	0.44%
NRP	NO RELIGIOUS PREFERENCE	3345	18900	22245	17.74%
NULL	NULL	2606	36129	38735	30.88%
OC	OTHER CHRISTIAN	135	1068	1203	0.96%
ONC	OTHER NON CHRISTIAN	29	122	151	0.12%
PRE	PRESBYTERIAN	1	48	49	0.04%
QUA	QUAKER		5	5	0.00%
RAS	RASTAFARIAN	1	3	4	0.00%
RC	ROMAN CATHOLIC	2879	16868	19747	15.74%
REF	PATIENT REFUSED TO GIVE INFO	7	22	29	0.02%
RO	RUSSIAN ORTHODOX	7	9	16	0.01%
SAL	SALVATION ARMY	3	30	33	0.03%
SEI	SEIKH	12	36	48	0.04%
SPR	SPIRITUALIST	2	47	49	0.04%
UNK	UNKNOWN	968	5257	6225	4.96%
WES	WESLEYAN		4	4	0.00%
WW	WHITE WITCHCRAFT	1	7	8	0.01%
Grand Total		14936	110492	125428	100.00%

6.4 Ethnicity

Ethnic Group	Ethnic Group Desc	Inpatient	Outpatient	Grand Total	% of Total
A	WHITE - BRITISH	13382	84645	98027	78.15%
B	WHITE - IRISH	42	319	361	0.29%
C	WHITE - ANY OTHER BACKGROUND	152	940	1092	0.87%
D	MIXED - WHITE/BLACK CARIBBEAN	31	110	141	0.11%

E	MIXED - WHITE/BLACK AFRICAN	14	105	119	0.09%
F	MIXED - WHITE AND ASIAN	24	183	207	0.17%
G	MIXED - ANY OTHER	23	142	165	0.13%
H	ASIAN - INDIAN	35	244	279	0.22%
J	ASIAN - PAKISTANI	20	121	141	0.11%
K	ASIAN - BANGLADESHI	24	75	99	0.08%
L	ASIAN - ANY OTHER BACKGROUND	23	172	195	0.16%
M	BLACK - CARIBBEAN	25	66	91	0.07%
N	BLACK - AFRICAN	15	143	158	0.13%
NULL	NULL	117	12142	12259	9.77%
P	BLACK - ANY OTHER BACKGROUND	24	157	181	0.14%
R	OTHER - CHINESE	19	157	176	0.14%
S	OTHER - ANY OTHER	44	471	515	0.41%
Z	NOT STATED	922	10300	11222	8.95%
Grand Total		14936	110492	125428	100.00%

6.5 Disability

Disability Risk Flag Y/N	Total	% of Total
No	122142	97.38%
Yes	3286	2.62%
Grand Total	125428	100.00%

Please note that patient disability the figures are compiled from aggregating known medical conditions that are considered to be disabilities, as patient data is not collected specifically under the general category of disability.

7 The use of interpretations services

7.1

Number of interpreter appointments conducted per language spoken 1st April 2019 to 31ST March 2020 Total appointments made 1437.					
Polish	Arabic	Cantonese	Farsi	Romanian	Kurdish
335	153	122	112	56	53
Portuguese	Turkish	Russian	Mandarin	Tamil	Urdu
53	45	44	41	35	36
Hungarian	Lithuanian	Spanish	Bulgarian	Slovak	Bengali
35	33	32	28	24	23

Czech	Somali	Amharic	Latvian	French	Italian
23	16	10	9	7	7
Albanian	Pashtu	Sylheti	Dari	Punjabi	Thai
6	5	5	3	3	3
Sinhalese	Oromo	Badini	Hindi	Sorani	Tigrinya
3	2	1	1	1	1
Vietnamese					
1					

7.2

Number of sign language interpreter appointments made 1st April 2019 to 31ST March 2020.			
Total number of appointments	99	Number of cancellations be the provider	3

8 Conclusion

This annual Equality, Diversity and Inclusion Report has set out how the Walton Centre has been demonstrating 'due regard' to our Public Sector Equality Duty' and the 2010 Equality Act's Specific Duties to publish equality information and set equality objectives.

9 Contact Details

For further information the Equality and Inclusion Lead can be contacted as follows:

Andrew lynch
Equality and Inclusion Lead
HR Department
The Walton Centre NHS Foundation Trust
Sid Watkins Building
Lower Lane
Liverpool
L9 7BB

Email: Andrew.Lynch2@thewaltoncentre.nhs.uk
Telephone: 0151 556 3396

Equality Delivery System – *EDS2* Summary Report

The Equality Delivery System – EDS2 was made mandatory in the NHS standard contract from April 2015. NHS organisations are strongly encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf
This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. Once completed, this Summary Report should be published on the organisation's website.
NHS organisation name:

The Walton Centre NHS Foundation Trust

Organisation's Board lead for EDS2:

Lisa Salter (Director of Nursing & Governance)

Organisation's EDS2 lead (name/email):

Workforce – Andrew Lynch (Andrew.Lynch2@thewaltoncentre.nhs.uk)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

- Staff Partnership Committee
- Patient Experience Group
- Business Performance Committee
- Healthwatch Liverpool

Organisation's Equality Objectives (including duration period):

2017-2021

- *Objective 1* – Extend patient profiling (equality monitoring) data collection to all protected characteristics
- *Objective 2* – Improve support for, and reporting of, disability within the workforce
- *Objective 3* – Ensure ongoing involvement and engagement of protected groups including patients, carers, staff, Healthwatch and other interested parties
- *Objective 4* – Ensure all staff members are paid equally for equal work done
- *Objective 5* – Increase the number of BME staff within management positions

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

In November 2017 the Trust published its ED&I 5 Year Vision.

This vision sets out the way forward for The Walton Centre to improve ED&I for both its patients and staff. This vision has come from both staff and patients sharing what good practice looks like and how we will know when we have achieved it, supported by a detailed strategy action plan. This will be delivered by the Operational ED&I Group, who will be held to account by the ED&I Steering Group. It will be monitored through the Quality Committee with an annual review of the vision and action plans progress in the same manner the Quality & Patient Strategy is currently monitored. This vision will guide the Trust towards making systematic improvements around ED&I in this year and in coming years.

EDS2 Grades (Date: 30/07/2020)		
Goal	**Outcome**	**Grade and reasons for rating**
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust believes that the highest quality services should be provided to all patients, which is reflected in the Trust's corporate objectives and mission statement. This belief is the key driver in the design and procurement of all its services. The Trust works in partnership with commissioners to shape their contract thus ensuring that services are commissioned to meet the needs of the local population and to reduce health inequalities. Equality performance is routinely monitored in the quality contract with the Trust's commissioners.** **Any new services or existing services undergoing change are assessed for possible equality impact on patients, visitors and staff. In addition, services are designed to be compliant with the Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) standards and guidelines, and are fully accredited by awarding bodies.** **The Trust believes that the services offered by the Trust are available to all irrespective of their protected characteristics, and data from the patient data report, complaints monitoring, patient surveys and engagement supports this belief. Patients, carers, Foundation Trust members and other stakeholders and local organisations and community groups are consulted with and involved in the design and delivery of services, thus ensuring that the health needs of the local communities are considered. All tenders assess equality and diversity, with responses considered as part of the tender process. All contracts include equality clauses.** **For this outcome, the Trust has good evidence and data to demonstrate that services are equality impact assessed. The Trust can also demonstrate that the health and well-being of its staff and patients is taken seriously through strategic planning processes and policy making. Patients from all protected characteristics are engaged with in the above processes, but the Trust currently does not capture all characteristics and therefore is unable to demonstrate a higher number of protected characteristics that fare well. Continuing actions will be implemented to address these issues in the next 12 months.**
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:**

		The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance. **The Trust remains in a similar position for sub goal 1.2. Due to the limited data captured the Trust is unable to evidence further progression to show all protected characteristics fair well. However, processes are in place to ensure that all patients' health needs are assessed and met regardless of protected characteristics. The Trust is committed to provide individualised patient care and, where required, protected characteristics are taken into account during the health needs assessment and through the patient journey. For example, the Trust ensures that reasonable adjustments are made for disabled patients, patients with learning disabilities, and patients with dementia. In addition, the Trust has access to 24-hour interpretation services that cover the languages or dialects that are spoken within the organisations catchment area.** **Following an individual health needs assessment, either in an outpatient, inpatient or in a community setting, all patients are provided access to the services they require in an appropriate and effective manner. The Trust ensures effective assessments are undertaken and case note and nursing quality audits support this process.** **Risk assessments are undertaken on all patients and therefore from all protected characteristics in relation to falls, pressure ulcers, venous thromboembolism (VTE) and nutrition, in line with Commissioning for Quality and Innovation (CQUIN) payment targets and these are reported in the quality accounts. The assessment includes review of patient's religious and cultural requirements, communication and care requirements, family support and carer needs. Individual care plans are developed for each patient and reviewed throughout their period of care. These plans are contributed to by all members of the Trust multidisciplinary team as and referrals made to subsequent services such as smoking cessation, dieticians, support groups or district nursing and rehabilitation services as appropriate.** **For this outcome, the Trust is satisfied that the processes in place across the organisation allow for all the patients who are referred to services or self-refer, where appropriate, are provided with individualised health needs assessments. Although quantitative data is not available for all protected characteristics, plans are in place to address this.**
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has numerous examples to demonstrate effective and appropriate transitions from services to support individual needs. This happens during transfer of patients into the Trust from the Trauma Network, from District General Hospitals, from other specialist Trust, for example Alder Hey, and GP referrals. We also transfer patients onto various points of care, including services within the Rehab Network, repatriating hospitals and social care or specialist services. This includes patients from Wales and the Isle of Man.** **Individual care plans are developed for each patient and reviewed throughout their period of care. The patient's assessment includes a review of their religious and cultural requirements, communication and care requirements, family support and carer needs. These plans are contributed to by all members of the Trust's multidisciplinary teams with input from the patient and carers, alongside health and social care professionals. Any change in services provided is planned and communicated with all concerned and any referrals are made to subsequent services with full handover of information.** **The Trust has good links with local communities and social services across its footprint. Holding multi-disciplinary meetings with internal and external stakeholders, as well as family members, to ensure arrangements are agreed and planned in the best interests of individual patients.** **The Trust is currently working to ensure that the needs of people with learning disabilities are fully taken into account in accessing services and in transitions. Patients who have learning disabilities are encouraged to utilise the Traffic Light Assessment system the Trust has in place which gives consistent and current information about the patient and ensures continuity of care.** **The Trust actively signposts carers to appropriate support, includes them as partners in care and has developed a Carer's Strategy identifying how the Trust will continue to support and work with carers in the future. The Trust is currently allocating space for a carers resource where it will provide information and a quiet space for carers to access. This resource will be supported by the Brain Charity in partnership with the Trust.** **For this outcome, despite good examples, the Trust cannot provide data to demonstrate that people from all protected groups are supported and have smooth transitions between services. However, complaints received by the organisation do not demonstrate that any protected characteristics are discriminated against during this process.**

	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust believes that patient safety and quality must be at the heart of everything it does. The Quality Accounts Annual Report provides the back drop to demonstrate the organisations commitment to improving the quality of services and safety of care. The Trust must ensure that it listens to and acts on feedback received.** **The Trust takes patient safety very seriously and has reported on several current work streams within the Quality Accounts report, including medication errors, cancelled operations and healthcare acquired infections. Data is available for 4 protected characteristics at the present time however, as previously stated, work is being undertaken to extend the data collection systems to improve data capture.** **Patient Led Assessment of Cleanliness and Environment (PLACE) inspections are carried out annually. Teams are made up of patient representatives and members of staff. The visits are unannounced and intended to review the hospital for standards in cleanliness, hand hygiene, quality of accommodation and food** **The organisation has a system in place whereby incidents of abuse must be reported by staff whether the abuse is directed at staff by patients, patient to patient or patient to staff, patient to patient and staff to patient. Abuse includes behaviours such as violence, verbal abuse, gestures, sexual or racial abuse. Reporting is web based, and all incidents are investigated thoroughly and actions undertaken to address the behaviours. All incidents are reported through the appropriate governance committee structures. Some incidents, such as neglect, abuse of vulnerable adults or children, are reported directly to the Strategic Executive Information System (STEIS) as per NHS standard procedures for external reporting.** **Reporting incidents by protected characteristic is difficult at the present time. Work is being undertaken to tie in together the three data systems required: the patient administration system, the electronic staffing record and the incident reporting system in order that data can be gathered for protected characteristics. The Trust seeks causes through incident reporting and whistle-blowing systems, which informs actions to be undertaken. Therefore, having a robust and safe complaints and whistle-blowing process is vital. Policies are in place to protect people making complaints and follow strict guidelines. Staff and patients are able to make complaints without fear of victimisation.** **The Trust has a Safeguarding Adults and Children team to ensure the Trust operates within national statutory and non-statutory guidance for on safeguarding vulnerable people. Policies have been introduced to provide guidance to staff on the management of allegations of abuse and deprivation of liberty safeguards. In addition, staffs have access to taught sessions and e-learning training packages on safeguarding issues.** **For this outcome, the Trust firmly believes that all people from all protected characteristics are given the same protection in accordance with its mission statement to provide the very best care for each patient on every occasion, which is at the core of everything it does. However, grading has been identified as developing. This is due to the good data and evidence to demonstrate patient safety across the protected characteristics available in comparison to the less adequate data available for incident reporting of bullying or harassing behaviours. Patients from all protected characteristics are engaged with in the above processes.**
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has an extensive range of health programmes and initiatives in place to support staff and patients alike in accessing public health, vaccination and screening programmes. The Trust is able to provide evidence to demonstrate that people are accessing services; however, due to the limitations of the patient administration system, this is only possible for 4 of the protected characteristics. Work is underway to enhance the current data collection systems to cover all protected characteristics.**

		Throughout the hospitals wards, outpatients and public areas there is an extensive range of public health information for staff and patients to access, examples being for infection control and smoking cessation. Audits are undertaken by volunteers to ensure sufficient coverage and appropriate placement of information is provided. All patient information is available on request in alternative formats. Interpreters are utilised to ensure communication is most effective. **Health, vaccination and screening programmes include: pre-natal advice for epilepsy patients, flu vaccination programmes and smoking and alcohol intake screenings. After a positive trial for epilepsy patients a number of Nurse advice lines have also been rolled out to enable patients to get disease specific advice and support between appointments.** **The Trust believes that a healthy workforce leads to safer and better patient care and is committed to improving the health and wellbeing of all staff. The Trust has also been re-accredited with the Workplace Wellbeing charter and continues to run regular schemes and initiatives including health checks, fitness classes, various mental well-being initiatives, discounted weight loss programmes.** **For this outcome, the Trust is again able to present data for 4 of the protected characteristics for patients, and all but 1 protected characteristics for staff (although not all staff services are monitored for equality purposes).**
Improved patient access and experience	**2.1**	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **All patients, carers and communities can readily access Trust services via referral from GP's and other health care providers and via intra-Trust referrals from service to service. Due to the limitations of the current patient administration system (PAS), the Trust is only able to provide quantitative data for 4 of the protected characteristics: namely, age, ethnicity, religion and belief and sex. Plans are already in place to update PAS to collect additional information regarding disability, sexual orientation and carer status.** **The Trust recognises that accessing services can be more difficult for some people – such as people with a disability, people with learning difficulties or people whose first language is not English. The Trust is committed to ensuring that reasonable adjustments are made for disabled patients and patients with learning difficulties where required. For example, where a patient is distressed by waiting rooms and bright lighting, staff arrange for the patients appointment to be first on the list and the patient seated in a quiet area to wait for their appointment, thus reducing anxiety for the patient and carer or relatives. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities.** **Pictorial menus have also been developed to support patients to choose their meals and interpreters are in place to support patients who are unable to read or comprehend English. The Trust has implemented the Accessible Information Standard and is working on ensuring this is fully implemented. Since its implementation we have received requests from a number of patients to meet their needs and have been able to accommodate all of these. When patients telephone to make appointments, the access, booking and choice receptionists ask patients whether they have caring responsibilities or any disability in order to ensure that the best appointment possible is provided to suit their needs. Patients are also able to make appointments via email if preferred. Text messages are also sent to patients to remind them of their appointment, and the Trust has a self-check in kiosk, which has been reviewed regarding its accessibility.** **The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings** **The Trust has an interpreting service that is readily available and covers languages and dialects required, there also a provision for British sign language. Language interpretation is available face to face and by telephone. The Trust has an interpreting policy to ensure that staff understand how to access the interpreting services.** **'Pathfinder' volunteers have been recruited to support patients to navigate around the hospital and the Trust is working with local communities and charities to ensure training is appropriate regarding peoples cultural and disability requirements, i.e. patients with vision impairment being guided appropriately.** **For this outcome, the Trust is able to demonstrate that patients, carers and communities from 4 of the protected characteristics readily access services and there are no obvious concerns as demonstrated in the patient data report.**

	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust is committed to ensure that all patients, irrespective of protected characteristics, are informed, supported and involved in their diagnosis and decisions about their care where appropriate.** **The National Inpatient Survey is the main source of reporting the perceptions of patients across the NHS and is used in comparative performance tables and quality indicators. Action plans have been developed and targeted work undertaken where patient perception has been less than anticipated. Improvements were made over the last few years, with the result that when asked, the majority of patients felt they had been involved in decisions about their care, had been kept informed about medication side effects and were provided with information in a way that was easy to understand. Local real-time surveys and the regular patient listening events undertaken across the Trust support the findings of the national survey.** **The Trust implemented a Ticket Home scheme on all wards. The aim of the scheme is to improve discharge planning through a focus on the predicted date of discharge, and recognizing as good practice to inform patients and their carers of their predicted discharge date and so improve patient experience by allowing patients to feel involved in decisions about their discharge. It also allows patients and their families to plan accordingly.** **All patients give consent to treatment in line with Trust and national consent policies. The Trust policy has recently been reviewed and reflects discussions with local communities.** **The Trust has an active Patient Information Group which includes patients and the public and supports patient information developed across the Trust. Standard, easy read and talking leaflets are being developed continually. The Trust strives to meet the communication needs of all patients with pictorial menus to support patients to make choices and the roll out of the Accessible Information Standard.** **Staff are able to access the interpreting services to ensure that patients whose first language is not English, or those patients who use British Sign Language, are fully able to understand their diagnoses and treatment. Indeed, where patients are to be given 'bad news' interpreting provision takes place face to face and not by telephone.** **For this outcome, the Trust is again able to demonstrate that patients from 4 of the protected characteristics are informed and supported to be as involved as they wish to be in decisions about their care. However, changes are underway to improve the data monitoring information collected at a local level. The national inpatient survey is limited to 6 protected characteristics at the present time.**
	2.3	**People report positive experiences of the NHS** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has been assessed as Outstanding by the CQC. As part of this assessment NHS England reviewed and assessed the delivery of care to patients and their experiences when accessing services. They also undertook a review of equality and diversity provision and compliance within the Trust and found the outcome to be good.** **Feedback through surveys and social media indicate a very good patient experience of services at the Walton Centre. In CQC National Surveys results do not indicate any discrimination due to a particular characteristic. Scheduled quarterly reports on all patient experience and dignity and respect activities are presented to the Trust Board and to the specialist CCG. In addition, the complaints department publishes a regular report to the Trust Board on the experiences of patients and how issues have been resolved. This information also goes to Patient Experience Group which has representatives from the Governing Body, Healthwatch and local charitable organisations.** **Local surveys are performed by Trust volunteers routinely on our wards with patients. Patients are asked to complete a questionnaire directly onto a tablet computer with the assistance of the volunteer if this is needed. Ad hoc surveys are also undertaken across the Trust using the real –**

		time electronic capture devices to enable service reviews, benchmarking and development of services to be achieved. Listening weeks are held quarterly across the organisation to listen to inpatients experiences of care and life on a ward. Results from the Listening weeks have been consistently good to excellent, and feedback informs the Trust Patient Experience Action Plan. **The Trust has Dignity Champions across the organisation with each ward having at least one Dignity Champion. The Champions act as role models, identifying breaches of dignity in care, addressing and challenging issues as they arise and promoting dignity in care for every patient.** **The Trust has already identified gaps in engagement with some seldom heard groups, such as gypsy, traveller and Roma communities and homeless people communities. Work will continue to forge better relationships with all community groups to ensure that their voices are heard through partnership working with local communities and interest groups, CCGs and Local Authorities and the Health watch.** **For this outcome, the Trust is firmly committed to listening to the views of patients, carers and other local interest groups and communities and ensuring positive patient experience. Evidence from all of the above leads us to suggest that we are Achieving with regards to this sub-goal.**
	2.4	**People's complaints about services are handled respectfully and efficiently** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Complaints about our services are taken very seriously and all concerns and complaints are investigated by Patient Experience Team, which incorporate the Patient Advice and Liaison Service and are recorded on the Trust's electronic database. Statistical information and lessons learnt are reported to the Patient Experience Group and the Quality Committee and Trust Board on a quarterly basis. This report also highlights actions taken as a result of complaints.** **A patient experience and engagement strategy has been developed and ratified in partnership with patients, carers, staff and other local interest groups to ensure that the Trust engages, involves and informs people from all backgrounds in the best ways possible.** **The Trust Board continues to recognise the importance of hearing the patients' voice directly through a patient story which is provided to the Trust Board at the start of the meeting.** **The Trust records only 3 protected characteristics when patients complain. This is an area we have identified as needing further work and will be included in the Trust Equality Action Plan. This will enable further detailed analysis to ensure there are no patterns or themes.** **The Trust has set itself targets for responding to formal complaints, based on an initial assessment and in discussion with the complainant. In most cases this target is within 25 working days of receipt but can be extended in consultation with the complainant. This is monitored and reported quarterly to Trust Board members and monthly to the Chief Executive and Executive Directors. Trends over the last few years indicate an increased level of efficiency in the complaints process for patients of most groups.** **For this outcome, whilst the Trust feels it has strong processes in place to respond to all complaints due to the lack of data capture we are unable to evidence this for many of the individual protected characteristics.**
A representative and supported workforce	**3.1**	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust uses NHS Jobs which collects data on 7 of the 9 protected characteristics (gender reassignment and pregnancy/maternity are currently not recorded). Recruiting managers are unable to see any of the monitoring information at any point and are also unable to see the applicants name or right to work status until after the shortlisting process has been completed either. All figures and demographics can be found in the E&D Workforce Annual Report 2019 however the following outlines a brief overview and some additional actions taken to support a fairer recruitment process.** **The Trust is now a DWP Disability Confident Level 2 employer (previously referred to as Two Ticks), and therefore continues to guarantee an**

		interview to all applicants who declare that they have a disability and would like to be considered under this scheme, providing they meet the essential criteria for the vacancy. The data shows that an equal percentage of applicants with a disability (5.9%) were shortlisted compared to those who applied (5.5%). **Although NHS Jobs is a web-based system hard copy application forms are also available in other formats upon request.** **All candidates are also asked in their invite to interview if they require any reasonable adjustments to be made for their interview and these are always accommodated. Once appointed, and throughout an employee's employment, where necessary the Trust's occupational health department will be consulted to advise on any reasonable adjustments which need to be made.** **Various initiatives to encourage and enable younger individuals to gain employment and experience within the NHS.** **Although not recorded via NHS Jobs work has been done to support applicants from 'trans' individuals. Guidance is provided on all adverts advising that if any trans applicants require a DBS there is a process they can use to protect any previous identity being disclosed. A transgender staff support policy has also been developed for any employees who are considering undergoing, currently undergoing or have undergone gender reassignment. The Trust was reaccredited with the Navajo Chartermark recognising this and other initiatives to support LGBT applicants and staff.** **The Trust is aware that there is a notable difference in the percentage of BME applicants appointed compared to White applicants. Changes to resident labour market test restrictions and changes to immigration rules may have in part affected this but this is an area we are investigating further in line with the WRES.**
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** • **Grade: Developing** • **Number of protected characteristics that fare well:** **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Gender Pay Gap** **The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and will be making use of the data to inform action planning for the coming year.**
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** • **Grade: Achieving** • **Number of protected characteristics that fare well: 7** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has done a lot of work around improving access to training and development over the last 12 months; this has been to support all protected characteristics but in particular to support BME staff. The Trust has also reviewed all mandatory training and has now made equality, diversity & human rights training mandatory on a 3 yearly basis, as opposed to a one off session. Furthermore, the Trust's OLM e-Learning allows employees to complete parts of their mandatory training at a time and place convenient to them. Adjustments have been accounted for to support individuals as needed including 1:1 support sessions.** **Following the findings from the WRES a BME Staff Network was established. Feedback from this group suggested BME staff were not always aware of opportunities available to them. In response to this targeted communications are sent to BME staff to increase awareness around certain courses and opportunities. This has included ensuring BME representation on a recent accredited Coaching Course, gaining representation for a regional BME group, circulating information about the Stepping Up Programme aimed at developing black, Asian and minority ethnic (BAME) colleagues in bands 5 – 7 and the Ready Now Programme for bands 8a and above. A Reciprocal Mentoring Scheme has also been continued this year to support the development of BME staff and support senior leaders in enhancing their awareness and understanding.** **All training opportunities are well publicised, through weekly communications and the monthly team brief. Data is collected on 7 of the protected characteristics (gender reassignment and pregnancy/maternity are not captured, although questions are asked around pregnancy where appropriate to ensure training can be adjusted where necessary). Analysis for all data can be found within the E&D Annual Report however the general findings show no concerning aspects. In comparison to last year there is no over-representation of females applying for training. There is however still an under-representation of BME staff, compared to the overall workforce demographics however the steps discussed above should hopefully address any differences observed. The percentages of applications by age group, sexual orientation and religion or belief are all comparable with the workforce demographics with the percentage by disability also being broadly in line.**

		The national staff survey results show no differences in the quality of non-mandatory training, learning or development with regards to age, or gender. There is a slightly lower response from individuals who have a disability but a much higher response from BME staff.
	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** • **Grade: Developing** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Data in respect of all employee relation cases (grievances, disciplinaries, and dignity at work) is monitored against the 7 protected characteristics currently recorded in ESR. The E&D Annual Report includes analysis of this.** **In relation to race, monitoring is also conducted via the Workforce Race Equality Standard (WRES).** **In relation to Disability, monitoring is also conducted via the Workforce Disability Equality Standard (WDES).** **Due to the nature of the patients treated by the Walton Centre aggression is quite common and is often a symptom of their illness. Whilst any patient behaving inappropriately will be spoken to it is often the case that they are either unable to help their actions or they forget the warning given, this makes it very difficult to eradicate this behaviour completely, however, the Trust does try to offer staff additional support in these case.** **Initiatives undertaken to try and ensure staff feel able to raise any concerns and to enable the Trust to address these issues include:** ○ **Staff listening weeks** ○ **CQC internal visits** ○ **Friends and family tests** ○ **Dignity at Work Policy** ○ **Raising Concerns Policy** ○ **Violence and Aggression Training** ○ **A number of trained mediators who can support in resolving conflict without escalation where necessary** ○ **The use of exit questionnaires and interviews**
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** • **Grade: Developing** • **Number of protected characteristics that fare well: 3** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust's Flexible Working Policy enables all employees from the point at which they join the Trust to request a flexible working arrangement. In addition to part-time working, flexible working options also include compressed or adjusted hours, job-sharing, flexi-time, term-time working, home working (where possible) and career breaks.** **The Trust also offers flexible retirement options, as detailed in the Trust's Flexible Retirement policy. This aims to support older employees in their retirement plans and therefore demonstrates our commitment, and appreciation of, a diversity workforce. Take up of flexible retirement has been at an all-time high over the last 12 months, more than doubling the previous year.**
	3.6	**Staff report positive experiences of their membership of the workforce** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Evidence can be taken from the National Staff Survey which reports against 4 of the protected characteristics, this can also be collaborated by**

		local data collected from the Trust Friends and Family Tests and Staff Listening weeks although these do not currently capture any protected characteristics. **Data from the National Staff Survey shows that the percentage of staff who would recommend the organisation as a place to work or receive treatment is very positive, at over 4 / 5 for all age groups, both genders and regardless of ethnic origin or disability. BME staff are actually most likely as a group to recommend the Trust and also view recognition and value of staff by managers and the organisation the highest. There is very little difference with regards to the other 3 groups captured. The percentage of staff agreeing that their role makes a difference to patients / service users is also extremely positive, being above 89% for all groups and the only notable difference being BME staff reporting 100% compared to 90% for White staff.** **Although the detailed results are not available for the most recent staff survey the initial results (not broken down by protected characteristics) have shown that 78% of staff have reported they often or always feel enthusiastic about their job; this remains consistent to last year, and a further 81% reported often or always to time passing quickly when they are working. Even more positively, 92% agree or strongly agree that feel that their role makes a difference to patients / service users.** **In Quarter 1, the Friends and Family Test was issued to 400 staff using an online survey, 80 surveys were returned. The results showed that 99% of staff were extremely likely or likely to recommend the Walton Centre to friends and family if they needed care or treatment and 79% of staff said they were extremely likely or likely to recommend the Walton Centre to friends and family as a place to work. In Quarter 2, the Friends and Family Test was issued to a further 400 staff with 109 being returned. The results showed that 99% of staff were extremely likely or likely to recommend the Walton Centre to friends and family if they needed care or treatment and 81% of staff said they were extremely likely or likely to recommend the Walton Centre to friends and family as a place to work.** **Whilst the data is very positive for this sub-goal, because equality information is not captured during listen weeks or CQC visits and the staff survey only captures 4 characteristics, the Trust only feels able to rate themselves as Developing.**
Inclusive leadership	**4.1**	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust board review and approve the Equality and Diversity Annual Report; which covers all the protected characteristics. All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed.** **The Director of Nursing and Governance is the Executive Lead for Equality within the Trust. Examples of when Board members and senior leaders have demonstrated their commitment to equality include; clear statements of the Trusts commitment to ED&I by the Chief Executive both in policy documents and in personal statements and online blogs, the creation of a designated Executive Lead for ED&I on the Board, an ongoing commitment form Board members to participate in reciprocal mentoring for BME staff, as well as becoming involved in the BME Staff Network; promotion of services for people with disability through the Vanguard Programme and National Rehab Conference held at the Trust; and the Trust has maintained its Navajo Chartermark which is also supported by the Executive Team.**
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** • **Grade: Developing** • **Number of protected characteristics that fare well: 9 (however not always completed, see below)** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed, unfortunately however this is not always done robustly and only a small number fulfil this requirement. EIA's are also expected to be completed before all policies are ratified by the appropriate committee. To support this, the EIA screening tool has been added to**

		the policy template. **Cost Improvement Plans (CIP's) and service changes should also complete an EIA before being presented to the appropriate committee. In order to increase compliance the EIA, along with Quality Impact Assessment (QIA), an electronic form has been developed to ensure that this is completed before the individual can continue with the submission.**
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** • **Grade: Developing** • **Number of protected characteristics that fare well: 3** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **ED&I Champions** **The Trust has created new ED&I Champions recruited from staff to create a higher profile for ED&I and to drive positive culture change towards the Trust's equality commitments:** • **We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.** • **We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity.** • **We are committed to ensuring that staff and patient have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre.** • **We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.** **Cultural Ambassadors Programme** **The Walton Centre is also part of a pilot programme with the RCN around Cultural Ambassadors. The Trust has recruited some of our Black and Minority Ethnic (BME) staff to receive training to be able to support colleagues through various Human Resources (HR) Processes to ensure fairness e.g. Disciplinary, Grievance and Capability processes. There is also potential to widen their programme out into supporting fairness in recruitment processes.**

REPORT TO Trust Board
July 2020

The Walton Centre NHS Foundation Trust

Title	Equality, Diversity and Inclusion (E,D&I) Next Steps & Commitments to Tackling Racism.
Sponsoring Director	Hayley Citrine, CEO
Author (s)	Hayley Citrine CEO Andrew Lynch Equality and Diversity Lead
Previously considered by:	• Executive Team Meeting July 2020 • Two Non-Executive Directors
Executive Summary Paper recognises that with the increased risk of COVID-19 with BAME communities' staff and patients and recent world events there is a need to increase the measures taken within the Trust to tackle racism. The paper outlines suggested next steps and commitments in line with national and regional work for discussion and consideration by the Trust Board.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be financially strong • Support education • Be recognised as excellent in all we do
Risks associated with this paper	BAME communities increased risk to COVID-19. Risk of staff not feeling supported in their workplace and reducing health and wellbeing of patients and staff.
Related Assurance Framework entries	None
Equality Impact Assessment completed	• Yes, will positively discriminate BAME staff and patients as they are at a higher risk than other groups.
Any associated legal implications / regulatory requirements?	• Supported by Equality Act and NHS Constitution.
Action required by the Board	Delete as Appropriate • To consider and approve approach

Equality, Diversity and Inclusion (E,D&I) Next Steps & Commitments to Tackling Racism.

1. Situation

In 2017 we published our 5 year ED&I Trust vision making a number of commitments, with goals and actions to be taken to improve equality and diversity within the Trust. As the Trust Board Update paper notes this month, we are making steady progress on these and moving in the right direction. That said recent events not least – the killing of George Floyd in Minneapolis and the increasing evidence of the greater risk the BAME community has to COVID-19 demonstrate that inequalities still exist and that further focus and increased pace is required.

This has been recognised by many leaders and groups nationally and regionally in the NHS. For example Simon Stevens CEO of the NHS wrote to NHS staff recently highlighting how the health service needs to do much more to address inequalities, and that its position in society means it has the ability to be a key part of the solution to these issues. His message also reiterated how system-wide action is required, and that we need to speed up the progress we are making in this area.

Regionally Bill McCarthy Regional Director of NHS England and NHS Improvement has set up a formal Strategic BAME Advisory Group with board level BAME staff to ensure a BAME perspective on management of the COVID-19 epidemic in our region. Both Professor Nalin Thakkar and Su Rai have agreed to be part of this advisory group, the first meeting was held at the end of June and its anticipated it will meet quarterly going forward.

2. Actions taken to date

Within the Trust we have undertaken a number of actions to date in addition to the visions progress;

- Designed a risk assessment recognising the increased risk factors for COVID-19 for staff to complete with line managers.
- Provided detail response for Anthony Hassall Regional Chief People Officer on approach and experiences of supporting BAME staff and undertaking risk assessments in relation to COVID-19.
- Completing the SITREP report required on the offering of risk assessments to all staff, percentage completed, percentage completed for BAME staff and mitigating steps taken where necessary and support.
- Undertaken a number of communications and strategies to increase update of the risk assessments. Including Medical Director/Director of Workforce and Innovation and HR staff supporting groups of staff to complete.

- CEO has released a blog recognising the fight against racism and signalled our intention to discuss at Trust Board our next steps on the equality agenda.
- Two NEDS volunteered to be part of Bill McCarthy's BAME Advisory Group
- ED&I lead has set up a number of virtual meetings with BAME staff around race and black lives matters agendas.
- CEO has attended a Microsoft teams meeting with BAME/BLM staff to hear their stories, understand key issues and what's important in the next steps.
- CEO taken part in a number of regional events including NHS provider's event on race inequality and supporting our BAME colleagues and a round table with Baroness Doreen Lawrence OBE as well as a personal conversation with Bill McCarthy on lived experience of inequalities.

3. Suggested Next Steps

These actions have made it clear that it is time to build on our ED&I vision and understand the need at times to disaggregate BAME groups so that certain groups are appropriately emphasised at all relevant points recognising their further risks, so that a more targeted approach to race related COVID-19 inequalities can be taken. That the Trusts response should be in line with the regional approach and concentrate on inequalities of our staff and patients, hearing their stories and understanding the nuances of change required within the Trust as well as the external requirements.

Our aim must be to ensure equal rights for BAME staff and patients, this means we want steps to be taken to ensure that our organisation and those we work with and individuals recognise and act to correct the injustices and inequalities that BAME people are subjected to.

Such recognition requires organisations and individuals to examine and acknowledge the following;

- In relation to black lives, the history in relation to slavery and imperialism and the wealth and material advantages accrued from these.
- The witting and unwitting psychological, cultural and institution levels of exclusion that operate against equality for BAME communities.
- The ongoing damage to BAME communities and in particular to black groups caused by pervasive racism.
- The many costs to our society and to all people perpetuating a system that racializes people to justify exploitation and inequality.

We need to be explicit and demonstrable in our equality of protection from discriminatory behaviours and institutional racism. To have a vision of more BAME staff in senior positions, targeted roles that address the gap in the middle pay scales and in non clinical roles. More BAME staff overall and disaggregate BAME. Have

BAME staff that are happy in their workplace and believe the Trust is a safe and good place to work, visible BAME role models with positive BAME stories of patients and staff. To advocate and work with the BAME communities as part of our anchor institute ambitions.

4. Measuring Progress

Measurement of success would be seeing an increase in BAME staff overall and in senior positions. Positive staff and patient BAME stories and visibility at Trust Board, in neuromatters and all communications. Year on year improvement in our WRES data; a more diverse workforce visible, hearing different voices, different experiences and the Trust would feel a multi-cultural, diverse richer more rounder and more representative workforce. We would see, hear and feel the difference in what our staff and patients say. All of this would be qualified in metrics to measure progress effectively and review approaches when necessary. We will also review our patient and staff data by ethnicity so we can determine areas of focus to create a positive change.

5. Walton's Approach

To achieve this we need to update our vision to take account of the additional actions we agree. To build a senior team to lead with desire, and passion to make a difference. To be able to change hearts and minds with experience and seniority to push through resistance and achieve change at pace. The approach will need to be multifaceted and aligned with national, regional and local strategies. It will need communication as an integral part to tell the story and link to E, D&I lead groups as well as Bill McCarthy's Strategic Advisory BAME group to ensure conduit of information and actions flows in and out of all groups fluidly.

We need to recognise and work through zones of fear, learning to growth and transformational symbolised below;

Further we need to create a Walton approach with milestones and timelines on

- Roger Kline 10 suggestions for Boards and ICS leaders, following his 'Beyond the Speeches; what now for NHS staff race discrimination?'', follow up to 'the Snowy White Peaks'.
- Issues raised by our BAME healthcare workers, our data and our patients
- Actions required on our WRES latest results (already in place)
- Recent WRES briefing for boards and COVID-19 EPRR membership in the NHS (publication approval reference 001559 – How Boards and COVID-19 EPRR structures can improve representation in decision making – steps to make changes and 'Beyond the data; Understanding the impact of COVID-19 on BAME groups' recommendations.
- Embed our ED&I vision and next steps into our anchor instate work with the community.

A further report will come to next Trust Board and then quarterly to update the Board on progress

6. Recommendations

- The Board are asked to consider this paper
- To agree that further additional steps are required to complement our vision.
- To support the direction of travel in this paper including the disaggregation of BAME further to ensure targeted support for certain groups in recognition of increased risk of COVID-19 and recent world events.
- Approve the approach of a senior group led by a Board member to work in this area and put forward a Walton approach to the national recommendations and local data outlined in section five of this paper.
- Agree quarterly update to Trust Board on progress.

Hayley Citrine, CEO

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date: 30th July 2020

Title	**Freedom to Speak Up Guardian Report – 2019/20 and Quarter 1 2020/21**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	• Committee None • Group None • Other None

Executive Summary

The report provides an update on the progress of the role and plans for strengthening current speak up arrangements.

The report also highlights concerns raised with the Freedom to Speak Up Guardian.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations. There are a number of risks to having a culture where staff do not feel able to raise concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as reputational risk.
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations.
Action required by the Board	• To consider and note

Freedom to Speak Up Guardian Report

1. INTRODUCTION

1.1 The purpose of this paper is to provide the Board of Directors with assurance on the effective working of the Trust's Freedom to Speak Up arrangements.

1.2 Speaking up is about anything that gets in the way of providing good care. When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that all staff feel able to speak up so that potential harm is prevented. Even when things are good but could be even better, we should feel able to say something and should expect that suggestions are listened to and used as an opportunity for improvement.

1.3 The Freedom to Speak Up Guardian (FTSUG) for the Trust is Julie Kane who is also the Quality Manager and works as part of the corporate nursing team. The Executive Lead for raising concerns is Lisa Salter, Director of Nursing and Governance and the Non-Executive Lead for raising concerns is Seth Crofts.

1.4 The Trust's approach to developing and supporting a 'speak up' culture is essential to ensuring the organisation is well led. Staff who are encouraged and supported in raising concerns and know their concerns will be acted upon will have a positive impact on patient safety, promote good practice and ensure lessons are learnt.

2. LEADING BY EXAMPLE

2.1 There are three dedicated Freedom to Speak Up Champions within the Trust whose substantive posts are clinical and non-clinical. The Champions have received the NGO training and are named below:

- Dr Martin Bamber - Consultant Anaesthetist
- Tina Hughes - Medical Secretary
- Andrew Sharrock - Senior Business Intelligence Developer

The Champions role is promoted via the Walton Weekly, Team Brief and posters are displayed across the Trust which provides contact details for each of them.

2.2 The Trust was rated 'outstanding' again following the Care Quality Commission (CQC) inspection in 2019. The FTSUG was interviewed by two members of the CQC Inspection Team who asked questions relating to internal systems and processes and received positive feedback from the inspectors.

3. AWARENESS RAISING

- Walton Weekly/Articles in Team Brief/Neuro Matters
- Separate email address freedomtospeakup@thewaltoncentre.nhs.uk
- Attendance and hosting Regional Meetings
- Presents monthly at Corporate and Medical Induction Days
- Undertakes Surveys
- Business cards attached to each payslip
- Drop-In Sessions scheduled throughout the year
- Holds 'speak up' events to promote the Guardian and Champions roles

The FTSUG attends team and departmental meetings across the Trust throughout the year to ensure staff members are aware of the role, how to make contact with her or the FTSU Champions and encourages staff to speak up and raise their concerns.

4. MONITORING

4.1 The NHS staff survey 2019 has been undertaken and the results have been published. The FTSUG has reviewed the findings of the national NHS staff survey and has provided key findings below.

Equality, Diversity & Inclusion (White & BAME figures included from WRES Data)				
	Acute Specialist Trusts (Ave) 2019 *Brackets = best score*		Trust Score 2018	Trust Score 2019
Q14 Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	86.2%	*(91.4%)*	91.2%	91.4%
White		*(88.4%)*	92.8%	92.5%
BAME		*(75.6)*	91.7%	77.8%
Q15b In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	7.3%	*(4.3%)*	5.8%	5.9%
White		*(5.5%*	4.3%	4.5%
BAME		*(13.0%)*	10.7%	13.5%
Q15c On what ground have you experienced discrimination?				
• Ethnic Background	38.1%	*(17.0%)*	35.6%	35.8%
• Gender	20.0%	*(10.3%)*	35.9%	22.9%
• Religion	4.5%	*(0.0%)*	1.6%	5.0%
• Sexual Orientation	3.8%	(0.0%)	1.6%	9.8%
• Disability	6.4%	*(2.7%)*	7.7%	3.7%
• Age	18.9%	(7.7%)	28.9%	19.0%
• Other	28.9%	*(20.2%)*	26.3%	29.5%
Q28b Has your employer made adequate adjustment(s) to enable you to carry out your work?	76.6%	*(86.7%)*	74.6%	86.7%
Bullying & Harassment				
Q13b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers? (results of staff saying at least one incident)	11.6%	*(7.2%)*	8.4%	7.2%
Q13c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? (results of staff saying at least one incident)	*18.7%*	*(13.9%)*	17.1%	15.8%
White		*(23.2%)*	19.3%	16.4%
BAME		*(29.4)*	23.2%	21.6%
Q13d The last time you experience harassment, bullying or abuse at work, did you or a colleague report it?	49.1%	(53.7%)	52.2%	50.4%
Safe Environment – Violence				
Q12b In the last 12 months how many times have you personally	0.3%	*(0.1%)*	0.8%	0.4%

experienced physical violence at work from managers?			
Q12c In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	1.2% *(0.2%)*	2.1%	2.7%
Safety Culture			
Q17c When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again	75.4% (*85.6%)*	76.4.%	74.7%
Q18a If you were concerned about unsafe clinical practice, would you know how to report it?	95.4% *(97.5%)*	95.3%	95.6%
Q18b I would feel secure raising concerns about unsafe clinical practice	74.0% *(78.5%)*	71.3%	72.8%
Q18c I am confident my organisation would address my concern	65.8% *(76.6%)*	64.4%	68.3%
Staff Engagement – Recommendation of the organisation as a place to work/receive treatment			
Q21c I would recommend my organisation as a place to work	73.9% *(80.9%)*	76.9%	80.9%
Q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	90.0% *(94.8%)*	89.6%	92.8%

4.2 In order to ensure monitoring takes place the FTSUG attends the Equality, Diversity and Inclusion (ED&I) Steering Group and works with the ED&I Lead for the Trust to review what information is currently being captured regarding BAME staff and make changes as necessary.

5. EXTERNAL BENCHMARKING

5.1 Simon Stevens (CEO of NHS England) asked the NGO to help measure how free nurses, doctors and other staff felt to raise concerns at different organisations as it was felt that not enough NHS organisations had done enough to make staff feel that they could speak out. Following discussions the National Guardian's Office and NHS England published the first Freedom to Speak Up (FTSU) Index Report in October 2019 and the second in July 2020.

5.2 The Index was designed to help trusts understand how their staff perceives the speaking up culture. Trusts can compare their scores with other organisations and learn more about their own freedom to speak up culture, as experienced by their workforce. The Index creates a single measure from four questions in the survey and the NGO states "this is not a perfect tool as it is based on a sample of staff and there are additional limitations such as students, volunteers and others not included".

5.3 Improvements have been seen in people's sense of power to speak up, with this year's results showing the national average for the FTSU Index score has increased each year from 75.5% in 2015 to 78.7% in 2019 which is great progress.

5.4 The FTSU Index is calculated by taking the average percentage of respondents who agree or strongly agree to the four questions from the NHS Staff Survey.

Question 17a % of staff agreeing that their organisation treats staff who are involved in an error, near miss or incident fairly

2018 2019 WCFT 61.5%

58.3% 59.7% (Highest 72.9% / Lowest 40.3%)

Question 17b % of staff agreeing that their organisation encourages them to report errors, near misses or incidents

2018	2019 WCFT 91.2%
88.1%	88.4% (Highest 95.3% / Lowest 79.1%)

Question 18a % of staff agreeing that if they were concerned about unsafe clinical practice, they would know how to report it

2018	2019 WCFT 95.6%
94.8%	94.6% (Highest 99.3% / Lowest 89.5%)

Question 18b % of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

2018	2019 WCFT 72.8%
70.7%	71.7% (Highest 82.1% / Lowest 58.6%)

All regions saw an improvement in their index score over the last year.

	2018	2019
South West	78.6%	79.8%
South East	78.6%	79.6%
North West	78.5%	79.1%
Midlands	78%	78.8%
London	78.4%	78.7%
North East and Yorkshire	78.3%	78.5%
East of England	78.3%	78.5%
Acute Specialist Trusts	81.7%	81.2%

Benchmarking figures against other Trusts within the region:

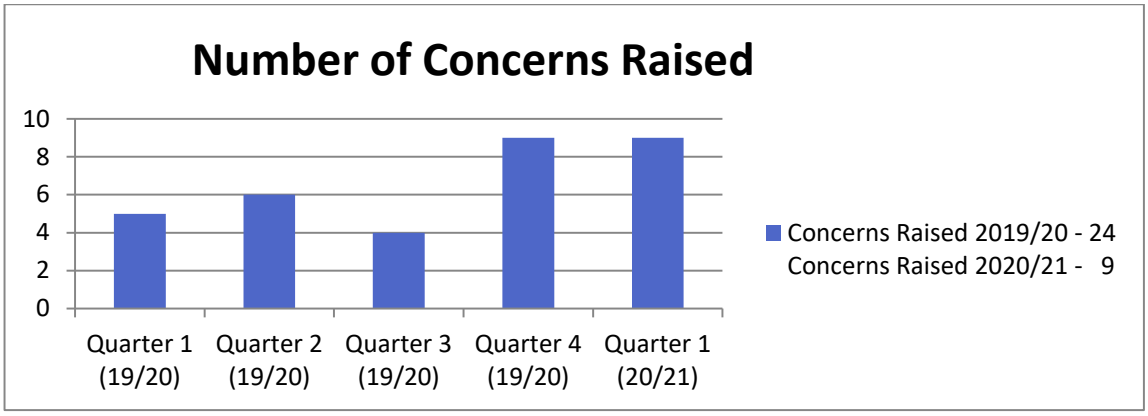
	2018	2019	
Liverpool Heart & Chest	86%	84%	↓
Clatterbridge Cancer Centre	82%	81%	↓
The Walton Centre NHS FT	79%	80%	↑
Warrington and Halton	78%	79%	↑
Liverpool Women's Hospital	76%	79%	↑
Aintree University Hospital	75%	77%	↑
Alder Hey Children's NHS FT	78%	77%	↓
Royal Liverpool and Broadgreen	77%	77%	↔

5.5 What the National Guardians Office will do next:

- Use the index as an indicator of potential areas of good practice and concern when it comes to the speaking up culture in trusts
- Share the index with stakeholders, the Care Quality Commission (CQC) and NHS England and NHS Improvement, so it may also inform their work to support trusts
- Will work with the survey team at NHS England to develop the index to provide a more holistic understanding of speaking up culture

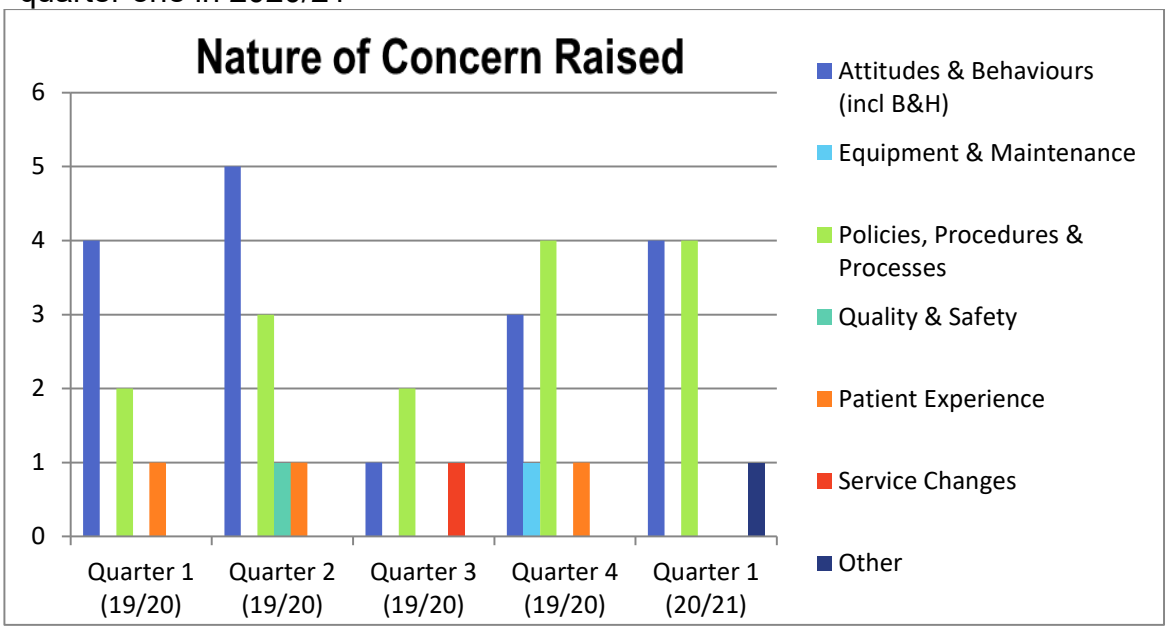
6. LOCAL ACTIVITY – 2019/20 and Quarter One 2020/21

6.1 The graph below indicates how many concerns have been raised during 2019/20 and quarter one in 2020/21



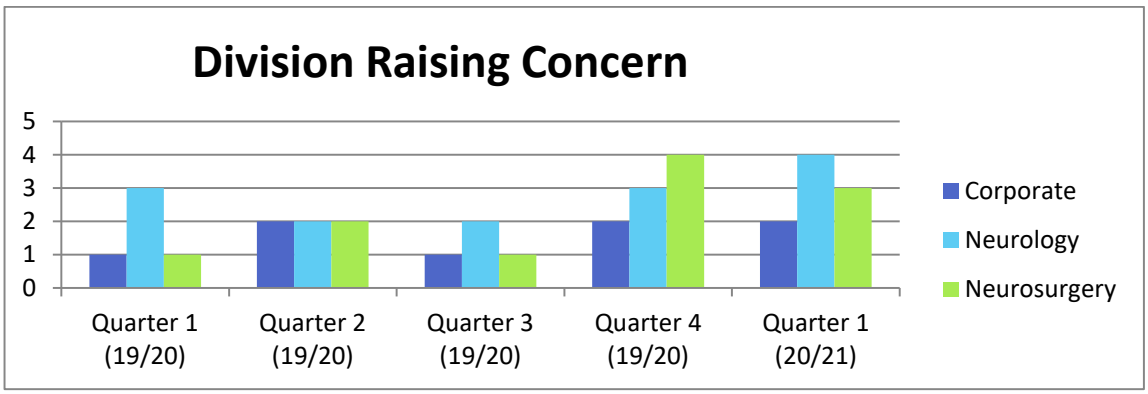
Note: Zero concerns were raised anonymously during 2019/20 or during Q1 2020/21

6.2 The graph below indicates the nature of the concerns raised during 2019/20 and quarter one in 2020/21



Note: Some concerns raised have more than one element and are displayed across a number of categories

6.3 The graph below indicates the division raising the concerns during 2019/20 and quarter one in 2020/21



6.4 Throughout the year staff have met with the FTSUG not only to raise concerns but to seek advice which they found beneficial as the Guardian is independent and impartial. The role of the FTSUG/Champion is not to investigate a concern which has been raised or to mediate. Most concerns are resolved locally and by signposting

individuals to appropriate personnel. However, further guidance regarding a specific issue is escalated immediately and links are made with the Executive/Non-Executive Leads for raising concerns and/or the Chief Executive.

6.5 The FTSUG continues to meet monthly with the Non-Executive and Executive Lead for Raising Concerns to discuss issues which have been raised and review progress made. She meets with the Head of Business HR and HR Manager for Neurology each month to discuss and review themes and provide progress against reviews which may have been undertaken. Meetings are also scheduled quarterly with the Chair and Chief Executive to keep them appraised of activity.

6.6 The FTSUG has access to all Board members and the 'open door' approach within the Trust is extremely positive and encouraging should a concern need immediate attention/action.

7. SUBMISSIONS TO THE NATIONAL GUARDIAN'S OFFICE (NGO)

7.1 The NGO issued a minimum dataset for Trust's to assist with internal and external reporting. Each quarter the FTSUG submits a return to the NGO to enable benchmarking to be undertaken.

The information required is listed below:

- Number of cases raised within the quarter
- Number of cases including an element of patient safety/quality of care
- Number of cases including elements of bullying and harassment
- Number of incidents where the person speaking up may have suffered detriment
- Number of anonymised cases received

7.2 The total number of cases raised nationally with Freedom to Speak Up Guardians within NHS Trusts are as follows:

	2017/18	2018/19	2019/20
Quarter 1	1447	2348	3173
Quarter 2	1515	2604	3486
Quarter 3	1939	3600	4120
Quarter 4	2186	3406	TBC
Total	**7087**	**11958**	**10779** to date

The figures above confirm more cases were raised during 2018/19 than in the previous year which is very encouraging. The figures for 2019/20 to date are extremely positive as each quarter has increasing numbers of cases raised.

The figures submitted by the FTSUGs confirm 1 in 10 cases are reported as being raised to guardians anonymously which is concerning as these can sometimes be more difficult to investigate and difficult to provide feedback on. Equally, they can be an indicator that there is a general lack of trust or fear associated with speaking up. During 2019/20 and quarter one of 2020/21 no concerns were raised anonymously to the FTSUG.

7.3 The Trust's FTSUG collects information from staff members who have raised concerns by asking the following questions:

- Given your experience, would you speak up again
- Please explain your above response

To date all respondents have confirmed they would speak up again and have given positive feedback. Some of the feedback received is below:

- ❖ Thankful to you for giving a passionate ear to my vows and resolving them for me on a priority basis
- ❖ I would speak up again as I feel confident my concerns have been taken seriously
- ❖ I found the service very beneficial to have someone who listened, acted upon the information and gave feedback regularly. It was also good to be able to vent my feelings without judgement
- ❖ I am happy to say that there was a positive outcome and I would recommend that staff should feel able to speak up as it helped me
- ❖ I could feel the difference within days and things improved out of nowhere
- ❖ Thanks for taking the time to listen to me. I would speak up again as help was given to me and the monitoring has continued
- ❖ I would definitely speak up again as the experience I had I felt completely listened to, treated with respect, and you are so friendly and approachable

8. NATIONAL GUARDIAN'S OFFICE UPDATES & REPORTING

8.1 The NGO has undertaken eight case reviews looking into the handling of concerns and the treatment of people who have spoken up. These reviews have identified areas where the handling of NHS workers' concerns do not meet the standards of accepted good practice and have made recommendations to each of the organisations.
Case reviews have been undertaken in the following trusts:

- Whittington Health NHS Trust
- Brighton and Sussex University Hospitals NHS Trust
- Derbyshire Community Health Services NHS Trust
- North West Ambulance Service NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Southport and Ormskirk Hospital NHS Trust

All reports and recommendations for the above trusts are accessible via the following link: https://www.nationalguardian.org.uk/case-reviews/

8.2 The FTSUG has reviewed the Trust's position against each of the individual recommendations for all but one of the above organisations. Most of the recommendations are specific to the individual trusts which makes it difficult to benchmark. However, the FTSUG will present any applicable recommendations to the Quality and Patient Safety Group.

8.3 The North West Region has a Regional Liaison Lead (RLL) following a request from NHS England to the National Guardian's Office. It is envisaged the RLL will support the implementation of the guardian role in primary care organisations and develop an integrated approach to speak up across primary and secondary care boundaries.

8.4 The NGO has published guidelines regarding the provision of FTSU training for all staff. The FTSUG attended a regional meeting and asked the Regional Liaison Lead to liaise with the NGO regarding the standardisation of training for all staff groups to ensure consistency within the NHS as they did with the Raising Concerns Policy. The FTSUG awaits a response.

8.5 The national conferences have been disbanded but regional meetings will continue to ensure the RLL leads on the continued development of networks to support the expanding cohort of FTSUGs. The Trust's FTSUG attends the regional meetings throughout the year to keep appraised of national guidance, plans going forward and to meet with her peers. The Walton Centre also hosts the regional meetings.

9. NEXT STEPS AND ACTIONS

9.1 The Freedom to Speak Up Guardian, Champions, Executive and Non-Executive Leads will continue to promote the role, encourage speaking up and support staff engagement sessions.

9.3 Ensure future collaborative working takes place across the Trust.

9.4 Once the intranet site has been redesigned the FTSUG will ensure current information is readily available and accessible.

9.5 Continue to work with other organisations to review, discuss and support speaking up.

10. RECOMMENDATIONS

10.1 The Board are requested:

- to receive and note the report and the Freedom to Speak Up arrangements in place within the Trust.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date: 30th July 2020

Title	**Quality Account 2019/20**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	Quality Committee
Executive Summary The aim of the quality report is to improve public accountability for the quality of care. The report comprises the requirements for the quality account as required by the NHS Act 2009, in the terms set out in the NHS (Quality Accounts) Regulations 2010. External auditors have not provided limited assurance on the content of the report for 2019/20 as this work ceased due to COVID19. Commissioners, local Healthwatch organisations and overview and scrutiny committees will be asked for statements on the Quality Account. Their commentaries will be added to the document in October 2020.	
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	The report provides assurance on patient safety, clinical effectiveness and patient and staff experience. Not achieving the agreed indicators throughout the year would not be ideal and may well impact on the reputation of the trust.
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Quality Account is a requirement as per the NHS Act 2009 in the terms set out in the NHS (Quality Accounts) Regulations 2010
Action required by the Board	The Board is requested to: • To consider and note the report

The Walton Centre
NHS Foundation Trust

Quality Account

2019 – 2020

Part 1 Statement on Quality from the Chief Executive

Part 2 Priorities for improvement and Statements of Assurance from the Board

Improvement Priorities

2.1 How well have we done in 2019-20?

2.1.1 Patient Safety
2.1.2 Clinical Effectiveness
2.1.3 Patient Experience

2.2 What are our priorities for 2020-21?

2.2.1 Patient Safety
2.2.2 Clinical Effectiveness
2.2.3 Patient Experience

2.3 Statements of Assurance from the Board

2.3.1 Data Quality
2.3.2 Participation in Clinical Audit and National Confidential Enquiries
2.3.3 National Audits
2.3.4 National Confidential Enquiries
2.3.5 Participation in Local Clinical Audits
2.3.6 Participation in Clinical Research and Development
2.3.7 CQUIN Framework & Performance
2.3.8 Care Quality Commission (CQC) Registration
2.3.9 Trust Data Quality
2.3.10 Learning from Deaths
2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services
2.3.12 Speaking Up

Part 1 Statement on Quality from the Chief Executive

We are delighted to share the Quality Account 2019/2020 for The Walton Centre NHS Foundation Trust which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families, enabling, “Excellence in Neuroscience”. This report details our performance over the last year whilst also highlighting our key priorities for 2020/2021.

2019/2020 was an extremely proud year for The Walton Centre.

The Care Quality Commission (CQC) undertook an inspection, including well led, during March and April 2019. In August The Walton Centre received the fantastic news that it had been given an Outstanding rating again which was first gained in 2016. In the report the CQC cited that we were the first hospital in the North using intra operative MRI scanning during operations for adult patients, reducing the need for surgery. The high level culture of support for staffs health and wellbeing was observed and our partnership work with Shiny Mind and the Innovations Agency to create, with staff, a resilience app accessible to them 24/7 for support. The CQC praised the Trust for its work in collaborating across the local health economy, with partners such as the Liverpool Health Partners and the Joint Research Project. The report also highlighted the important work we all do in working together to bring care closer to patients and their families.

The CQC inspection demonstrated the Trust strategy is making good progress in delivering our vision and to meet our purpose by delivering best practice care and treatment, leading innovation, adapting advanced technology, enabling our teams to deliver excellent care and providing care close to patients’ homes and working in partnership with others.

The Trust received two ‘Centre of Excellence’ awards for spinal treatment and muscular dystrophy as well as a high commendation from international awards.

The Trust continues to deliver on quality care in relation to patient safety, clinical effectiveness and patient experience and our vision encapsulates this with our drive to achieve patient and family centred care. The Executive Team are committed to leading change to ensure patients receive outstanding care both within The Walton Centre and in the other hospitals and centres across Cheshire and Mersey where we deliver care.

The quality priorities for 2019/2020 have been achieved and are detailed within this Quality Account.

In addition, this year we have achieved:

- Top Industry Award
- International Engage Award (ShinyMind App)
- International Engage Lifetime Contribution Award
- BBC Two Hospital Episode
- Director of Clinical Academic Development – October 2019 (University of Liverpool)
- Applied Research Collaboration North West (ARC NW)
- CQC Inspection
- Launch of Childrens Book
- Official Opening of Garden Room
- Surgical Spine Centre of Excellence (SSCoE)
- Roy Ferguson Compassion Award
- Centre of Clinical Excellence Award
- Joined Rainbow Badge Initiative (ED&I)

Quality initiatives are discussed and debated through various Committees which include the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These Committees report to Trust Board to ensure that patient safety is a priority and is progressed.

The Professional Nurses Forum, Quality Committee and Trust Board all receive information related to the quality agenda and progress of each indicator is assessed and rated as Red, Amber or Green against expected performance levels.

The daily Safety Huddle continues, which offers the opportunity for clinical and non-clinical staff across the Trust (regardless of role or band) to share concerns that have arisen during the previous 24 hours and that may occur in the next 24 hours. This huddle supports discussions each day to share learning and prevent harm to patients, families, visitors and staff. The CEO Huddle also continues to take place on a bi-monthly basis which also offers the opportunity for staff to ask questions and raise concerns they may have.

Staff within the Trust continue to deliver year on year improvements in care and this is recognised by their achievements of 2019/2020 whilst working in partnership with our patients and their families to meet and exceed expectations. The commitment to patient safety, clinical effectiveness and patient experience is appreciated and enables our successes. The contribution of our members and Governors who give their time voluntarily are extremely important to the hospital and we are grateful for their input and efforts.

In detailing our achievements and forthcoming priorities, I confirm that the information provided in this quality account is accurate and to the best of my knowledge.

Hayley Citrine, Chief Executive

Part 2 Priorities for Improvement and Statements of Assurance from the Board

Towards the end of each financial year, the Trust works closely with various stakeholders to identify areas of focus for improvement for the forthcoming year. At this time it also allows the Trust to reflect on the year's previous performance against the identified quality improvement priorities.

The delivery of the quality improvement priorities are monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with sub groups focussing on the 3 domains of quality: patient safety, clinical effectiveness and patient experience. The Director of Nursing and Governance is the Executive Lead responsible for delivering the plan and designates duties to operational leads for each of the priorities.

All of the priorities were identified following a review by Trust Board on the domains of quality reported in 2018/19. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2019/20.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three improvement priority areas for 2019/20.

2.1 Update for Improvement Priorities for 2019–2020

In February 2020, the Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. At this review, quality priorities were identified and agreed for 2020/21. The improvement priorities all contained specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

Performance has been managed through subcommittees to Trust Board. Operational groups within the Trust have been responsible for the implementation of the quality priorities and reporting to committees as required. Merseyside Internal Audit Agency (MIAA) has been fully engaged in the Trust during 2019/20, providing regular reviews and assurance via the Audit Committee and this process will continue into 2020/21. Bi-monthly quality meetings to review quality assurance reports have taken place with the commissioners, ensuring external scrutiny and performance management.

2.1.1 Patient Safety

Priority 1: Support Religious beliefs and cultures within the Theatre Department

Reason for Prioritising:
Whilst a lot of work has been undertaken for Equality, Diversity and Inclusion it has become apparent further work is required regarding cultural and religious beliefs.

The aim is to provide patients with an information leaflet regarding the products used within the theatre environment, for specific cultures, such as Jehovah Witnesses, to support patient religion / choice.

Outcome: Achieved
Each patient who attends Theatre has an assessment for any support required regarding their religious beliefs. A protocol has been devised to ensure staff are aware of the products and requirements for each religion.

Priority 2: Implement Aseptic Non Touch Technique

Reason for Prioritising:
An aseptic technique is used to deliver a wide range of care interventions to patient's e.g. intravenous medicines/fluids and wound care. Ineffective standards of aseptic technique are a significant cause of healthcare associated infection.

Aseptic Non Touch Technique (ANTT) is a recognised national standard that has been shown to support the reduction of healthcare associated infections.

Whilst there has been lots of work undertaken in respect of infection control, the introduction of ANTT will enhance infection prevention practice; improve safety and quality of care for patients.

Outcome: Achieved
Key staff have been trained in ANTT and are now able to cascade the training within their clinical areas.

Priority 3: Pre and post-operative discussions with the Theatre Team

Reason for Prioritising:
Whilst conversations take place during pre-operative assessments, patients often have further questions/anxieties regarding their forthcoming admission that may not necessarily be a clinical related question and may be related to the 'experience' of the day itself and the expectations of being in theatre. This priority is following feedback from the inpatient questionnaire in conjunction with the Head of Patient Experience.

The conversation will take place on the day of surgery, before the patient's procedure, and is separate to pre-operative assessments (which will take place prior to the admission). This will be part of a bespoke theatre patient experience proforma. This conversation will enable recovery staff to gain an understanding of the emotions, expectations and wellbeing of patients at that point, as we do not currently capture this additional information. The patient's journey will be followed to ensure we gather feedback regarding their experience to ensure we get a better understanding of the patient journey.

With the introduction of a pre and post-operative discussion with a member of the theatre team, we aim to ensure future patients have a positive and safe experience and an opportunity to ask questions they may not feel there is a place for in other appointments they may attend.

Outcome: Achieved
There is a process in place for all patients attending Theatre to be offered a pre-op visit prior to having surgery. During post operative discussions any issues/concerns raised regarding pain control a referral is made to the acute pain nurse.

2.2.2 Clinical Effectiveness

Priority 1: Introduce In-house Masters Neurosciences Training Module

Reason for Prioritising:
This is a level 7 Masters module that will provide an overview of the neuroscience speciality. It will be available to the multi-disciplinary team (MDT) to enhance staff knowledge of care and management of patients within the neuroscience specialty.

Outcome: Achieved
The module has successfully been rolled out and a course evaluation was undertaken with positive feedback. A further module is taking place in March 2020.

Priority 2: Contacting patients who require telemetry tests prior to admission to reduce the rate of DNAs (appointments where patients do not attend)

Reason for Prioritising:
EEG Telemetry is a type of long term EEG monitoring to aid the diagnosis of epilepsy. Telemetry tests require a hospital admission and during this time the patients is confined to bed (whilst their brain activity is monitored together with a video recording of the patient). Demand for this test is significantly high and waiting times can be long.
Patients referred for telemetry will be contacted to obtain a detailed clinical history. This will ensure the telemetry test is still warranted and the patient understands what the admission involves.

Patients can be on the waiting list for many months. Two weeks prior to admission the patient will be contacted again to ensure their seizure frequency has not changed/or seizure type changed. If it has changed then tests may no longer be required and the appointment can be re-allocated.

Outcome: Achieved
Patients who are due to attend the Trust for telemetry testing are now contacted to ensure the test at the time is still appropriate which has reduced the rate of DNAs.

Priority 3: Introduce the A3 methodology for Quality Improvement

Reason for Prioritising:
Whilst the Trust undertakes numerous projects to enhance patient care, the A3 Methodology supports a ‘plan on a page’ concept which will provide staff with a project plan to deliver clear defined outcomes.

Staff will have a streamlined approach to project delivery, saving valuable time and enabling success

Outcome: Achieved

A3 methodology is embedded across the Trust for all service improvement projects. Staff present their projects to the Executive Team.

2.2.3 Patient Experience

Priority 1: Introduce Patient and Family Centred Champions

Reason for Prioritising:

A scoping exercise will be undertaken to identify staff who would like to become a champion for patient and family centred care.

The role will involve supporting patients throughout their journey by way of undertaking shadowing, walkabout exercises and obtaining patient and family stories.

This will enable the Trust to ensure patients and families have the best possible experience.

Outcome: Achieved

Champions have been identified and promote PFCC across the Trust. Monthly meetings have been introduced which oversee a work plan of improvements.

Priority 2: Offer neurovascular follow up patients the opportunity to receive scan results via post

Reason for Prioritising:

These patients routinely have scans at 6 months, 18 months and 60 months post treatment. They often attend clinic simply to be told things are fine. At a patient's 6 month clinic appointment they will be offered the opportunity to receive the results of their scan via letter. If there is an issue with the scan they will be given a clinic appointment.

This will result in improved patient experience as no travel will be required and no expenses (as per previous feedback) whilst releasing further car spaces for others.

It should also free up some capacity within the outpatient department and reduce waiting times for appointments within the neurovascular service.

Outcome: Achieved

A neurovascular follow up service for patients to receive their scan results via a postal service has been introduced.

Priority 3: Refurbishing of Patient and Family Day Rooms within the ward areas

Reason for Prioritising:

The day rooms within the surgical wards will be refurbished into a patient and family centred environment which will support the healing process for patients and enable families to spend quality time with their loved ones.

The rooms will be equipped with a small kitchenette, dining area and comfortable seating.

Outcome: Achieved

The proposal for funding was approved and the refurbishment work in the patient and family day rooms is complete.

2.2 What are our priorities for 2020 – 2021?

In December 2019, the Board of Governors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was successfully implemented and monitored. After this review, quality priorities were identified and agreed for 2020/21 with the Quality Committee, Health watch and Specialist Commissioners identifying the final priorities from those initially identified.

How progress to achieve these priorities will be monitored and measured:

Each of the priorities has identified lead/s who has agreed milestones throughout the year. Monthly meetings are held to review progress and support given as required.

How progress to achieve these priorities will be reported:

Updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Merseyside Internal Audit Agency (MIAA) will be fully involved providing regular reviews and assurance via the Audit Committee. Quarterly quality meetings are held with the commissioners to review quality assurance and provide external scrutiny and performance management.

2.2.1 Patient Safety

Priority: Improve the number of staff trained in Immediate Life Support (ILS)

Reason for Prioritising:
To ensure all clinical staff (band 4 and above) will be trained in ILS, and the training will be delivered on site by the SMART and Resuscitation team.

Outcome Required:
Increase the level of staff trained to deliver ILS across the Trust within the next 12 month period.

Priority: FOCUS – Free of Criticism for Universal Safety

Reason for Prioritising:
FOCUS will provide the opportunity in the Theatre Department to pause practice if they feel the need to do so and if staff feel there is a safety risk to both staff and patients.

Outcome Required:
The implementation of a Trust Wide Safety word for both staff and patients. The implementation of “Focus Points” within policy and procedure based on audit data, datix, serious incidents (not exhaustive) to further highlight safety and critical parts of a process.

Priority: Introduction of MITEL System

Reason for Prioritising:
Upgrading the telephone system in the Patient Access Centre (PAC) will ensure patients are able to leave a message and receive a call back. Patients will also be given their queue position and estimated wait time.

Outcome Required:

- Support with the workload of Patient Access Centre
- Improve patient experience as patients will have a voice over of their call position,
- Run efficient reports for the patient access team

2.2.2 Clinical Effectiveness

Priority : Introduce Multitom Rax 3D Imaging

Reason for Prioritising:

There will be no requirement for patients to attend another hospital to undergo 3D spinal imaging as it would be in-house. Less positioning and transfers are required as these images are undertaken in one room.

Outcome Required:

The Multitom Rax will be installed and will operational to ensure Robotic Advanced X-Ray (RAX) technology is available to deliver standing 3D spinal imaging.

Priority: HCA Apprenticeship Training

Reason for Prioritising:

The training will develop the Health Care Assistant (HCA) workforce and offer career progression. The training will support the Trust with retention of HCAs and also to progress with recruitment of our Trainee Nurse Associates.

Outcome Required:

To recruit at least 12 members of staff onto the HCA apprenticeship training within the next 12 months.

Priority: Bespoke Spinal Module

Reason for Prioritising:

Offering a spinal module for the Trust will enhance the knowledge and expertise of clinical staff to be able to support spinal patients. This will also support retention and recruitment within the Trust.

Outcome Required:

For staff to have an enhanced knowledge of the spine and to be able to continue to deliver specialist care to our patients. This will also support with retention of staff onto a career pathway.

2.2.3 Patient Experience

Priority : Introduce the Road to Recovery

Reason for Prioritising:
Patients who have had a subarachnoid haemorrhage are currently not able to attend the Trust to take part in a pathway as they live in Wales and are unable to travel to the classes.

Outcome Required:
All patients will be invited to attend a programme which will be in their locality (Wales) and have the opportunity to participate in a road to recovery and rehabilitation programme, consisting of nursing staff, therapy staff and medical staff.

Priority: LASTLAP – Looking After Staff That Look After People

Reason for Prioritising:
Introducing the LASTLAP will improve the health and wellbeing of staff. All staff members will be invited to a huddle to discuss their shift/work day and reflect on any issues or concerns which may have affected them.

Outcome Required:
Staff support with health and wellbeing to look after and retain our staff. Different methods of working with patients who have reduced capacity and need further assistance with behaviours.

Priority: Outsourcing Mail

Reason for Prioritising:
Introducing the outsourcing of mail to an external company for large volumes or clinical correspondence will reduce the need for a significant amount of manual work and reduce the number of incidents due to human error. Outsourcing will provide greater control and traceability of documents.

Outcome Required:

- To provide greater control and traceability of documents
- More efficient systems of working in the Patient Access Centre to support staff and patients

2.3 Statements of Assurance from the Board

During 2019/20, The Walton Centre provided and/or sub-contracted four relevant health services:

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

The Walton Centre has reviewed all the data available to them on the quality of care in four of these relevant health services. We have interpreted this as services covered by our Quality Committee that are monitored by internal and external indicators and not necessarily a formal review.

The income generated by the relevant health services reviewed in 2019/20 represents 93.8% of the total income generated from the provision of the relevant health services by The Walton Centre for 2019/20.

2.3.1 Data Quality

The data reviewed covers three dimensions of quality – patient safety, clinical effectiveness and patient experience which are all encompassed within the Quality Committee Terms of Reference and Trust Board.

The Walton Centre takes the following actions to improve data quality:

- The Trust continues to develop internal data collection systems to provide assurance to the Quality Committee in relation to the accuracy of data quality.
- The Trust continuously reviews its internal processes in relation to the measurement and reporting of the quality indicators reported both to the Board and reported externally. This includes reviewing the quality indicators outlined within the Quality Accounts ensuring that there are standard operating procedures and data quality checks within each quality indicator process.

Ward to Board nursing quality indicator data has been collated over the last eight years which includes data collection of not only information to support progress against the Quality Accounts but additional nursing metrics to provide internal assurance and allow a clear focus for improving patient experience and delivery of quality care.

This information supports the Trust in building year on year metrics to show progress against important aspects of the patient journey.

2.3.2 Participation in Clinical Audit and National Confidential Enquiries

During 2019/2020, 10 national clinical audits and 1 national confidential enquires covered relevant health services that The Walton Centre provides.

During that period The Walton Centre participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2019/2020 are as follows:

2.3.3 National Audits

- Adult Critical Care (ICNARC / case mix programme)
- Severe Trauma – Trauma Audit & Research Network (TARN)
- National Emergency Laparotomy Audit (NELA)
- The Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Care at the End of Life (NACEL)
- UK Parkinson's Audit
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- National Neurosurgery Audit Programme (NNAP)
- Getting it Right First Time (GIRFT) – Surgical Site Infection Audit

2.3.4 National Confidential Enquiries

- Dysphagia in Parkinson's Disease

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2019/2020 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	100%
Severe Trauma (Trauma Audit & Research Network)	Yes	100%
National Emergency Laparotomy audit (NELA)	Yes	100%
The Sentinel Stroke National Audit Programme	Yes	100%
UK Parkinson's Disease Audit	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
Getting It Right First Time Audit (GIRFT)	Yes	100%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT) – Re-audit of the medical use of blood	N/A	N/A – No cases to submit
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	N/A	N/A – No WCFT cases met the inclusion criteria
National Confidential Enquiry into Patient Outcome and Death		
Dysphagia in Parkinson's Disease	Ye	100%

The reports of 5 national clinical audits were reviewed by the provider in 2019/20 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

National Audit	Actions
Adult Critical Care (ICNARC / Case Mix Programme)	• Findings are discussed quarterly • The Trust will continue participating in the ICNARC/Case Mix Programme by submitting data for all patients admitted to Critical Care • A new admission booklet for ITU has been produced with digitisation of notes
Severe Trauma - Trauma Audit & Research Network (TARN)	• The Trust will continue to submit data to TARN and will review individual cases as appropriate
The Sentinel Stroke National Audit programme (SSNAP)	• A regional thrombectomy MDT group has been set up and meets quarterly to discuss and review all thrombectomy cases and regional pathway

National Audit of Care at the End of Life (NACEL)	• The published report is being reviewed collaboratively with the palliative care team at Aintree hospital, who provide our specialist palliative care service, this is being monitored by the End Of Life Committee
UK Parkinson's Disease Audit	• The findings demonstrated the Walton Centre is generally compliant with guidelines • A summary report will be produced and circulated to the relevant groups

2.3.5 Participation in Local Clinical Audits

The reports of 83 local clinical audits were reviewed by the Trust in 2019/20 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

Neurology Clinical Audits & Service Evaluations

Audit title	Actions
Documentation in outpatient letters (N 199)	• Doctors to be made aware that patients are increasingly using psychoactive medication that cannot be prescribed but may have an effect (both positive and negative) and may interact with prescribed medication – importance of documenting this • Further investigation to determine the scope of the problem
NICE guidelines in sleep and Parkinson's disease (N 180)	• Disseminate and discuss • Present at Grand round • Raise awareness of the importance of documenting about sleep disorders
Assessment of the variation in patients creatinine prior and during rehabilitation, looking at red flags and whether they were appropriate (N 178)	• AKI flags aren't always accurate for long stay patients due to limitations within the algorithm – When flag occurs an assessment needs to be in context of the patient history and presentation / rehabilitation team discussed and agreed • Presented within rehabilitation training and at a regional rehabilitation meeting
Evaluating prescribing of valproate to women of childbearing potential against Trust policy (N 231)	• Ensure valproate prescription templates are fully distributed to outpatients • Improve documentation of counselling that has taken place • Disseminated findings to Neurology grand round and Aintree medicines safety group
Audit of outcomes of X-ray guided LPs performed by Advance Practitioner Radiographer (N 258)	• Successful transition of service from consultant led practice to practitioner led practice • No actions necessary
Audit of WHO surgical checklists in radiology (N 254)	• Radiologists and radiographers reminded to complete team brief and checklists
Audit of standards of communication of radiological reports and fail safe notifications (N 259)	• Office manager reminded staff of correct procedure • Clinical Director raised at consultant radiologist meeting and reminded all to follow procedure • Policy CLO13 updated

An evaluation of compliance with report writing standards following video-fluoroscopy – re-audit (N 250)	• Reports continue to be fit for purpose with standards generally well adhered to Results were discussed at Speech and Language Therapy team meeting and staff encouraged to aim for 100% compliance in the areas where this has not been achieved
An evaluation of compliance with case note writing standards – Speech and Language Therapies (N 251)	• Case note standards are generally well adhered to for both acute and rehabilitation areas of the service • Results were discussed at Speech and Language team meeting and staff encouraged to aim for 100% compliance in the areas where this has not been achieved
Audit of biopsies and post-mortem tissue undergoing investigation for suspected encephalitis at WCFT (N 191)	• Dissemination of findings with discussion around evidence of this topic with clinicians and lab staff • Presented at Clinical Audit Half day
Audit of exam time to report availability to report availability (N 264)	• No actions necessary – continue monitoring and re-audit
Parkinson's disease kinetograph (PKG) influence the Parkinson's disease treatment (N 208)	• Discussed at movements disorders group meeting • Funding of the PKG monitor has been secured
On-going survey of patient satisfaction within clinical neurophysiology department (N 216)	• No actions necessary • Staff encouraged to hand out surveys
Re-audit of volume of prescribed enteral feed given in the rehab setting following pump training for therapists (N 229)	• Pump training continues to be effective • On-going training continues to be effective • On-going training as required for new starters / rotational staff will continue • Share results – submit to book of best practice
Audit of goal setting meeting processes of the hyper acute and complex rehabilitation unit (N 237)	• Escalate room availability issues for Lipton through risk register, HUB operational meeting and evaluation of room use • Speech Therapy and Psychology to work on flowchart for supporting patient attendance at meetings • Meet with nursing and medical staff groups to highlight issues around attendance and discuss support measures • Dietitians awareness of GAS processes and attendance at meetings • Dissemination of findings to appropriate staff groups • Present findings to HUB operational meeting
Review of all invasive telemetry patients including background history events / localisation and outcome (N 142)	• No specific actions required / MDT planning meetings with specific aims and audit measures • Future findings will contribute to patient information
Retrospective audit of early management of spasticity and outcome (N 185)	• Roll out spasticity ward round to Lipton ward

Audit of CT Pulmonary Angiograms (N 255)	• Education of staff of CTPA scanning technique and how to alter scanning parameters to improve the diagnostic quality of scans – presented to staff • Encourage patients who are well enough to do so to place their arms above their head to improve scan quality and reduce dose
Audit of medical ward round notes on Lipton ward (N 248)	• Develop and implement a ward round pro-forma that prompts to fill in key aspects – pro-forma developed and currently in use • Raise awareness of the outcomes of the audit and highlight the importance of good medical documentation
DOLS application process and documentation on CRU (N 276)	• Improvements in documentation and Ep2 documentation • Findings disseminated
Audit of the use of Comaneci device in the treatment of intracranial aneurysms (N 182)	• No actions necessary
Protected meal times and red tray policy audit (N 225)	• Ward managers to support staff to undertake mealtime co-ordinator role • Policy updated with changes / recommendations as discussed in the steering group meeting
An evaluation of patients experience of the long term conditions team using the CARE measures (N 227)	• No concerns were raised from this service evaluation and no actions are necessary
Evaluation of the usability of an MS self-reported assessment tool for people with multiple sclerosis (N 266)	• Findings disseminated • Findings presented by poster presentation at the MS Trust annual conference • Consideration of future use of the tool in WCFT service
An evaluation of provision of supported communication training to families of patients with acquired communication difficulties (N 278)	• Devise on-line training package that can be accessed remotely by families • Ensure that family training / education is planned by first goal setting meeting • Ensure that family training / education is recorded as a goal on goal attainment
Incidence of depression in headache patients at WCFT (N 228)	• Psychology / psychiatry input for headache patients – To expand psychology services
Antibiotic point prevalence audit (N 232)	• Discussion at the multidisciplinary stewardship meetings • On-going education to prescribers on induction and at weekly antimicrobial ward rounds
Speech Therapy referrals audit for rehabilitation for the complex rehabilitation unit and Lipton (N 196)	• Improve quality of note taking and documentation within the Speech and Language Therapy team – This has subsequently been raised through a wider case note audit • Issues around timely receipt of handover from external agencies – letter to local Speech and Language therapy departments / referring hospitals documenting direct contact details and most available times to receive handovers to ensure these are timely

Audit of compliance in Radiology of the WHO surgical checklist – re-audit (N 272)	• Complete, retain and scan onto CRIS all team brief documentation – staff reminded
Audit of Tracheostomy care quality indicators (N 265)	• Escalate to managers re: lack of input to tracheostomy ward rounds and number of patients requiring this • Complete staff training and roll out to 5 day service • On-going review of tracheostomy quality indicators
Clinical psychology 1:1 referrals after PMP assessment (N 277)	• Need to develop more consistency / clarity regarding 1:1 referrals for psychological work on the PMP and in outpatient work – Psychology team to develop appropriate documentation
A retrospective audit on protein provision on the intensive care unit (N 279)	• Update dietitians re new protein requirements • Present to neuro dietitians
Audit of the recording of CT doses and missing images (N 262)	• New PACS breach tool highlights when images have not been viewed on PACS • Reminder in staff monthly brief of what needs to be sent to PACS and staff to be careful around completion of scans • CT core trainers reminded staff • Findings circulated
Re-audit of contrast CT protocols adherence (N 256)	• Booking staff educated estimated glomerular filtration rate (EGFR) should be checked in all inpatients, and in outpatients who are diabetic or over 70 years of age • Match paper and electronic formats – new contrast policy finalised
Prolonged disorders of consciousness (PDOC) (N 260)	• Feedback results to the prolonged disorders of consciousness Committee • There is currently a PDOC working party that is reviewing both the inpatient and community input received by PDOC patient's within the network with the aim of developing a pathway for our PDOC patients. The gaps in service provision are to be presented to Cheshire and Merseyside Rehabilitation Network Strategic Board on 20th January. Therefore, the information obtained from the audit will hopefully be able to be used in the future for a wider service development. In addition, we are currently awaiting the publishing of new RCP guidelines which are expected in January 2020 to guide the pathway development.
Management of sialorrhoea with botulinum toxin (N 261)	• Agreed to document clear goals in the medical notes • Use as first line and sooner prior to trialling other medications – early identification and early injections
Review of cases of intracranial hypotension treated with IV caffeine (N 267)	• This is an off license medication for which there is very little safety / efficacy data – audit results to factored into IV caffeine pharmacy policy
MDT assessment of self-feeding (N 280)	• Liaise with teams regarding documentation compliance. Feedback audit outcome to team members. Trial weekly Interdisciplinary Team Feeding Group (IDT) • Create inventory of current. Research into other appropriate equipment. Identify essential equipment and source funding • Feedback audit outcome to team members. Encourage

	OTs to document feeding recommendations on nursing handover sign in patient room. Encourage SLTs to liaise with OT colleagues regarding specific recommendations for assistance / equipment. Trial weekly IDT feeding group
Audit of standards of communication of radiological reports and fail safe notifications – Re-audit – (N 273)	• Clinical Director reminded all consultant Radiologists to all follow the agreed department policy • PACS manager reminded office staff of correct policy and advised to adhere to it at all times
Audit of the accuracy of voice recognition software in radiology (N 263)	• Proof reading of radiology reports • Radiologists double check the VR report
Focus group testing of patient and family perceptions of rehabilitation goal setting meetings (N 268)	• **Issue**: Ongoing need to critically examine goal setting processes in Hyper Acute Rehabilitation Unit and Complex Rehabilitation Unit. **Action:** Will reconvene Goal Setting Meeting working party
Audit to assess the suitability of line algorithm for visualisation of NG tubes (N 274 & N 275)	• **Issue:** Update protocol on CRIS required. **Action:** Email staff and discuss at staff meeting
Neurology satellite ward consultation service (N 247)	• Update the satellite referral datasheet to include A & E as a place patients are seen, also, remove option of 'no further action required'
Audit of patient satisfaction in general department of Radiology (NRP 1)	• Report circulated • Patient experience boards updated
Standards for reporting and interpretation of ultrasound images in line with RCR and BMUS guidelines (NRP 2)	• Staff reminded all images are to be labelled in full
Audit of the need for an on call physiotherapy service (N 257)	• Yearly training and competences for prescribed use of cough assist training log trained staff MDA competency form • Look at initial costings for on call physiotherapy service / changes to service – Present to therapies manager • If appropriate consider business case / gathering of evidence
Standards for reporting and interpretation of fluoroscopy guided lumbar punctures (N 270)	• No issues or errors identified / no actions necessary Continue to send random sample of reports to consultant radiologists for double reporting on a quarterly basis
Audit to determine the need for occupational therapy assessment and intervention in neurovascular clinic (N 285)	• There is not always documented evidence that an occupational therapist has provided written or verbal advice regarding cognitive problems prior to discharge – feedback to senior lead occupational therapist • Submit a service evaluation application to complete a pilot occupational therapy clinic

Neurosurgery Clinical Audits & Service Evaluations

Audit title	Actions
Re-Audit of Dexamethasone Review Compliance of Blood Glucose Monitoring for Patients with Brain Tumours on High Dose Steroids (NS 190)	• Feedback to ward managers. • Ward Practice Facilitators to educate staff. BM chart to be added to EP2 to prevent missing charts/HCS's to obtain access.
The development of a metastatic spinal cord compression (MSCC) pathway with The Walton Centre (NS 202)	• Review of CT guided biopsy service within the Merseyside and Cheshire / North Wales MSCC network • Internal / External publication of MSCC policy
Making every contact count New nutritional screening tool (NS 207)	• Pre-operative strategies need to be considered to support weight loss in overweight and obese individuals • Introduction of a nutritional screening and assessment pathway within the outpatients department is required to identify all patients with high nutritional risk Combined dietetic and physiotherapist group interventions should be considered in the longer term that are aimed at increasing lean body mass and reducing body fat, particularly central adiposity.
Critical Care Nurses knowledge, skills and perceptions of aseptic technique and ANTT (NS 219)	• Aseptic clinical practice audit- direct observation of practice, 25 observations, critical care staff aseptic technique • ANTT implementation to include further theoretical education in ANTT plus practical based teaching prior to competency assessment • Focus theory on the following topics :- • Asepsis, ANTT in practice, Terminology in ANTT, Glove choice and risk assessment, basics of aseptic practice, key-part cleaning & key-part protection, aseptic fields.
Clinical outcome and management of patients with radiation-induced meningioma (NS 222)	• Convene with Clatterbridge earlier in the project regarding radiation treatment requests and not when the rest of the data has been collected. • Identify and contact off-site storage upon recognition of patient data there to enable it to be incorporated into the dataset. Continue to examine volumetric growth rates of the dataset acquired as a separate project.
The use and handling of surgical instruments in Theatre (NS 225)	No issues - All Staff are aware that there is a system in place that ensures the safe use and handling of surgical instruments.
The Use of Electrosurgery in Theatre (NS 226)	Spinal Lead and procurement to source smoke evacuators for Theatres
Post Anaesthetic Care in Theatres (NS 227)	• Estates and heating system upgrade completed and additional heaters provided if needed. • Look into the purchase of padded bed rails which has been difficult as Trust has so many different beds and not all padded bed rails are universal.
Accountable Items, Swab, Instrument and Needle	• Discuss with staff the importance of the Theatre Team engaging when counts are being performed.

Count (NS 230)	• Discuss with Scrub Staff the importance of informing the Surgeon that count is correct before closure of a cavity
Surveillance of weekend prescribing of antibiotics on Horsley (NS 232)	• Improve documentation of 'indication' and 'review / stop date' on prescription kardex. • Consider adding a 'printed' section for prescriber's name in addition to signature. • Feedback audit results to practice on Horsley, inclusive of all prescribers
Compliance with Trust guidelines for use of antimicrobial prophylaxis for elective neurosurgery (NS 235)	If Cefuroxime cannot be administered, then a combination of Teicoplanin and Gentamicin is recommended
Trust Consent to Treatment Audit 2018/19 (NS 236)	• No actions necessary
Review of overall activity regarding shunt admissions and procedure at WCNN during 01/04/18 – 20/09/18 (NS 238)	• Reiterated the operating surgeon is responsible for putting data on the registry • Provided assistance in reporting by highlighting draft operations that need completing to improve compliance
Audit of follow-up of small bands detected on serum protein electrophoresis (NS 240)	• Education for clinicians regarding the importance of follow-up and the potential for a small band on a polyclonal background to develop into a paraprotein. To be discussed at clinical audit meeting. Copy of audit report to be sent to the Divisional Clinical Director • Update the interpretation/reporting sections of the laboratory SOPs to clarify report comments and actions to be taken on receiving repeat samples with no obvious protein band detected. Note that these sections were initially included in 2017. Actions to be included in the SOP are: clinical scientist(s) to review all patient requests to ensure that immunofixation is performed on repeat patient samples with small band detected on a polyclonal background to confirm absence/presence of a paraprotein band.
HTA 59 Coroner's and Hospital Post Mortems Horizontal Audit 2018 (NS 241)	• No non-conformances were raised as part of this audit as the neuroscience laboratories have followed all instructions accordingly. • There is compliance with HTA rules and regulations.
HTA 61 Research Request Forms R1, R2 & R3 Horizontal Audit 2018 (NS 242)	No usage of R1 forms to be reviewed and discussed in Walton Research Tissue Bank Committee meetings.
Outcome of surgical management of glioblastoma & cerebral metastasis in patient over 75 years of age (NS 245)	• Appropriate for certain patients >75 y.o. with malignant tumours to be considered for debulking / resective surgery, provided they remain well enough for adjuvant radiotherapy.
Development of a prognostic score to reduce avoidable referrals for mild Traumatic Brain Injury (TBI) (NS 246)	• Begin to introduce and implement the scoring system locally at Walton Centre on a prospective basis • Liaise with other centres that have requested to use the score following its publication in the literature

BIOC 152: Vertical audit of CSF Xanthochromia test (NS 252)	No issues were identified.
HTA 60: REC & RGC approvals Audit 2018 (NS 253)	The process is going well no further actions are required.
HTA 62: Research Consent forms Audit 2018 (NS 254)	• Patients signing wrong line on consent forms to be raised with specialist nurses by the Biobank Manager. • Incorrect colour of consent form to be raised with Theatre staff. Laboratory staff will also review forms upon receipt and highlight any issues immediately with the tissue bank manager who will look to rectify ASAP. • The importance of patient signing the consent will be highlighted to both specialist nurses and theatre staff to avoid any invalidity of the consent forms by the Biobank Manager.
IMMU 62: Immunology vertical audit – Glycolipid antibodies 2019 (NS 255)	• The SOP needs updating • Staff need reminding that any change in process, no matter how minor, should be documented in the SOP
Medium term outcomes after trans-callosal approach for intra-ventricular tumours (NS 256)	Interhemispheric transcallosal approach is an acceptable approach to remove tumours in the lateral and third ventricles.
Patient views after potential CJD exposure (NS 258)	• In patients who were not being followed up by the neurosurgical services, a further routine follow up at six weeks and 1 year, either in person or by phone, that could be cancelled by the patient if not required For patients that described the most anxiety, more rapid access to phone or outpatient clinic appointment (less than two weeks), would have been helpful.
Audit of molecular data obtained on gliomas between January 2018 to May 2019 at the Walton Centre (NS 273)	• MGMT status for all high-grade gliomas. To consider hTERT testing for IDH-wildtype gliomas.
CSF cell count comparison audit 2019 (NS 275)	• Discuss the missing LCL differential counts at the SLA meeting to establish if there is an electronic reporting issue or if there is another reason why they were not done. • Include CSF cell count as a representative test for LCL in the annual referral labs audit.
Venous thromboembolism (VTE) prophylaxis prescribing in neurosurgical patients (NS 281)	• Auditing a new VTE prophylaxis policy to see if there are any improvements in the compliance. • Clear guidelines published and available. • Patients, unless clearly contraindicated, should have VTE pharmacological prophylaxis prescribed. • Discussion with the team involved responsible for individual patient care in cases which may be controversial; review of the documentation and a clear plan in the notes. • Familiarising staff, doctors and pharmacists with the new VTE policy.
HIST 315 Cytology VA audit (NSRP 2)	• No time was provided for when the sample was taken. • The sample was reported just outside the target

	turnaround of 3 days, this was due to extra immunohistochemistry stains being requested to confirm the diagnosis.
Specimen Acceptance Policy Audit 2019 (NSRP 6)	There are no recommendations, the percentage of samples that have the correct data set on both the pot and card is high and the details that are missing more frequently are the 'location' which isn't part of the minimum data set and can be found by ringing medical records.
Audit of accuracy of voice recognition software in Neuropathology 2019 (NSRP 3)	• Use of dictation templates where appropriate • Simultaneous review of reports at same time as dictation • Final review of reports before authorisation • Re-audit

Trust wide Clinical Audits & Service Evaluations

Audit title	Actions
Audit of patient preferences regarding sharing information with their partners, family members and / or carers – NICE CG 138 – Patient experience	• **Issue** – Documentation of patient preferences. **Actions** – raise awareness of the importance of establishing patient preferences and ensure they are recorded on Ep2. Circulate findings and NICE guidance recommendations regarding family involvement and sharing information. Disseminate findings to the nursing documentation group
Inpatient Health Records Documentation Audit	• Disseminate results • Develop summary sheet highlighting the record keeping standards to focus on improving compliance • Clinical audit team continue audit
Outpatient Health Records Documentation Audit	• Disseminate results to all medical staff and emphasise the importance of documenting within the case notes in accordance to the trust policy • Continue to audit
Inpatient Nursing Documentation Audit	• Disseminate findings to the nursing documentation group – to be fed back to nursing staff
Mental Capacity Act Audit	• To provide more in depth MCA / DOLS / LPS best interests training sessions – sessions have been arranged and will be ongoing • Presentation with complex scenarios and case law regarding MCA / DOLS / Consent is scheduled to be delivered to the clinical senate • Revised MCA DOLS process utilising a live working document to provide oversight of all DOLS applications and associated actions including mental capacity assessment. This will ensure timely actions and compliance with MCA DOLS processes

NB. If implementation is not deemed appropriate then outstanding actions are placed on the divisional risk registers.

Recommended actions resulting from clinical audit projects are reviewed and monitored monthly by the Clinical Audit Group.

The divisional clinical audit teams produce a monthly clinical audit activity progress report which includes registered audits, recommended actions from all completed projects for each division and the progress made towards implementation, these reports are discussed at the relevant Divisional Governance & Risk Group monthly meetings.

2.3.6 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority was 1219 set against and yearly target of 1200.

In total there are currently 72 clinical studies currently open to recruitment at The Walton Centre. The Trust has a research pipeline of new studies in the set-up phase that will be ready to open at different points throughout the coming year.

The Neuroscience Research centre has secured new local collaborations which means that we are now able to offer our patients access to participation in Phase 1 clinical trials for the first time. The Phase 1 clinical trials are being offered to patients with Parkinsons Disease and Huntingdons Disease and will be conducted at a specialist clinical research facility within Liverpool Health Partners.

The Trust's participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Our clinical staff actively maintain their involvement in the latest possible treatments and as a Trust recognise that active participation in research leads to successful patient outcomes.

During 2019/20 the Trust has worked collaboratively with the following networks and organisations to attract NIHR funding to deliver and disseminate clinical research and innovation to inform service transformation and improvement:

- Clinical Research Network: North West Coast (CRN)
- Liverpool Health Partners (LHP)
- Innovation Agency, the North West Coast's Academic Health Science Network
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC) now the ARC (Applied Research Collaboration)
- Local Higher Education Institutions
- Other NHS organisations
- Pharmaceutical companies (industry)

The collaboration with all members of Liverpool Health Partners has resulted in the set up of the Liverpool SPARK – Single Point of Access to Research and Knowledge. We are delighted to be part of such an innovative approach to offering wider access to clinical trials for our patients and look forward to the SPARK becoming embedded in all Trusts throughout 2020/21.

2.3.7 CQUIN Framework & Performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between The Walton Centre and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at enquiries@thewaltoncentre.nhs.uk

A proportion of the Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINS in 2019/20 equalled £620, 828. The total payment received in 2018/19 was £1,620, 000. The Reduction in CQUIN between the two years is due to a change in the national payment system, as funding was transferred from the CQUIN allocation into the national payment by results payment tariffs. In 2019/20 the amount of income that could be generated through CQUIN was 1.25% of clinical activity compared to 2.5% in 2018/19.

The CQUINS agreed for 2020/21 are the following:

- CUR
- Staff Flu vaccines
- Rehabilitation
- Shared Decision Making

2.3.8 Care Quality Commission (CQC) Registration

The Walton Centre is required to register with the Care Quality Commission and its current registration status is registered without conditions. The CQC had not taken enforcement action against The Walton Centre during 2019/20. The CQC undertook an inspection, including well led, during March and April 2019. The overall rating from the CQC was Outstanding.

During 19/20 the Trust continued to self-assess against the CQC regulations. The self-assessment is supported by a governance process which enables oversight of findings and identification of areas for further review and includes a process to escalate exceptions to the Quality Committee which is a sub-committee of the Board.

Ratings for The Walton Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Good → ← Aug 2019	Outstanding ↑ Aug 2019	Good → ← Aug 2019	Good → ← Aug 2019	Outstanding ↑ Aug 2019	Outstanding ↑ Aug 2019
Critical care	Good → ← Aug 2019	Good ↓ Aug 2019	Outstanding ↑ Aug 2019	Good → ← Aug 2019	Good → ← Aug 2019	Good → ← Aug 2019
Outpatients	Good Oct 2016	Not rated	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Rehabilitation services	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016
Overall*	Good → ← Aug 2019	Outstanding → ← Aug 2019	Outstanding → ← Aug 2019	Good → ← Aug 2019	Good → ← Aug 2019	Outstanding → ← Aug 2019

2.3.9 Trust Data Quality

The Walton Centre submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

% TBC (due to COVID extension deadline) for admitted patient care

% TBC (due to COVID extension deadline) for outpatient care

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code was:

% TBC (due to COVID extension deadline) for outpatient care

% TBC (due to COVID extension deadline) for admitted patient care

The Information Governance Toolkit was replaced in April 2018 by the Data Security and Protection Toolkit (DSPT). The new toolkit was designed by NHS Digital to encompass the National Data Guardian reviews and the 10 data security standards and supports the key

requirements under the General Data Protection Regulation (GDPR) and new Data Protection laws. The DSPT does not include levels in the same way as it did in previous years; instead it requires compliance with 40 assertions and the entire mandatory evidence items.

The Trust is on target to provide evidence for 100% of the mandatory evidence items in addition to completing and meeting 40 of the 40 assertions by the extension deadline of 30th September 2020 due to Covid19. The Trust has implemented additional action plans to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 19-20 DS&P audit requirements has provided the Trust with a level of Substantial assurance for the tenth year.

The latest figures from the NHS IC Indicator portal are for 2011/12 and the national readmission rate was 11.45%. The website link is https://indicators.ic.nhs.uk/webview/

The Walton Centre undertook a Clinical Coding Data Quality Audit during the reporting period. The following table reflects the results of an audit carried out by an Approved Clinical Coding Auditor and the error rates reported for this period for diagnoses and procedure coding (clinical coding) was as follows:

The Walton Centre Internal Clinical Coding Audit 2019/20

Coding Field	Percentage Extended Deadline due to COVID
Primary diagnosis	TBC – 30.09.20
Secondary diagnosis	TBC – 30.09.20
Primary procedure	TBC – 30.09.20
Secondary procedure	TBC – 30.09.20

The Walton Centre will be taking the following actions to improve data quality by continuing the monthly Data Quality and Systems Assurance Group meetings and overseeing Data Quality improvement. The group includes leads from all stakeholders within the organisation and reporting/monitoring feedback is provided via KPIs with full trend analysis.

The group reports to the Information Governance and Security Forum each month which is chaired by the Trust's SIRO. The KPIs, from the group, are shared within the monthly digital update and with the Executive Team each quarter and is presented by the Head of IM&T to the Business and Performance Committee.

2.3.10 Learning from Deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendments Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning from Deaths' to quality accounts from 2017/18 onwards.

2.3.10.1 During 2019/20 92 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

17 in the first quarter

13 in the second quarter

37 in the third quarter

25 in the fourth quarter

By 31st March 2020 92 case record reviews and 0 investigations have been carried out in relation to 92 of the deaths included in item 2.3.10.1

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter
- 0 in the second quarter
- 0 in the third quarter
- 0 in the fourth quarter

2.3.10.2 0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the structured judgement review methodology. Prior to the National Quality Board report on Learning from Deaths, The Walton Centre had a robust mechanism of mortality review where all deaths were reviewed in detail and reviewed in the mortality review group.

Since the NQB report, WCFT have published an updated Mortality Review Policy, which encompasses the structured judgement review methodology for the mortality review, but also in cases where there are potential issues highlighted, a root cause analysis (RCA) is undertaken.

0 case record reviews and 0 investigations completed after 31.03.19 which related to deaths which took place before the start of the reporting period

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the process embedded within the Trust including a full health record review of each death and discussion at the respective Divisional Mortality Meetings.

0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

In the 7 day services framework, clinical standards 2,5,6 and 8 have been prioritised. We are fully compliant with clinical standards 5, 6 and 8.

The Trust continues to make progress with CS2. In the 7 day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a Consultant presence for review throughout 7 days. As a specialist Trust there has been discussion with the 7 day services team regarding difficulties that arise for us with this standard. All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, usually will have had investigations such as scans, and in neurosurgery admissions (which are the vast majority) the diagnosis will usually be clear. All admissions are discussed with a Consultant prior to transfer and a management plan is formulated. There is a two tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially

assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach critical care trained nursing staff. Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%. The mortality report continues to be reviewed quarterly at Quality committee and Trust Board.

This has not shown any trends in deaths by day of the week and day of admission. In summary, the Trust continues to show an improvement in compliance with CS2 but due to being a tertiary centre some patients may appropriately be treated on arrival by a senior trainee but are reviewed in a timely manner following this by a Consultant.

There are the other clinical standards which the Trust continues to progress well with.

Feedback from local patient experience surveys and reports from listening events held by Healthwatch Sefton and Healthwatch Liverpool continue to be excellent on the standard of medical care. There have been no concerns raised over quality of care / Consultant presence on weekday or weekends. This is also not an issue which has arisen in patient complaints.

There is an MDT ward round for all neurosurgery and critical care patients. This comprises medical, nursing, ANP and pharmacy staff. The SMART team join the ward round at weekends. In neurology there is a weekday daily board round involving medical, nursing, pharmacy and therapy staff. This has been developed since 2015, particularly with the involvement of pharmacy and therapies.

Shift handovers - each morning at 8am there is a neurosurgical handover meeting led by the Consultant on-call - all patients referred overnight (whether transferred or not) are discussed and scans reviewed. This is an MDT meeting involving medical, ANP staff, SMART team coordinator and bed management team. There is a formal handover meeting at 8pm each weekday, coordinated by the SMART coordinator and involving junior medical staff. There are well defined procedures for medical handover following each shift. At weekends at 8.30am there is a handover meeting attended by the Consultant neurosurgeon on-call, the trainee medical staff and SMART coordinator. In neurology there is a daily board round, including weekends. The role of SMART coordinator in safe handover is documented in the Trust policy 'Operational Guidelines for the Surgical and Medical Acute Response Team (SMART)'.

Transfer to community, primary and social care – There are daily Consultant reviews to support discharge. There is a complex discharge coordinator working during the week but

not at weekends. This service is covered by the bed management team or bleep holder at weekends. Ward based pharmacists support the ward rounds and medications to take away (TTA) are completed by the pharmacist or ANP. There are referral pathways for community settings and access and referral systems in place for all providers, social care and continuing health care. There is pharmacy support for TTA at weekends.

There is a process in place for repatriation to other Trusts. There is a weekly delayed discharge meeting to discuss any patients with a long length of stay and these are escalated as appropriate.

Quality improvement - the Trust mortality report is reviewed quarterly by Quality Committee in detail and reported also to Trust Board. The Trust Board receives a quarterly report from the Guardian of safe working hours on junior doctor working hours. The Clinical Effectiveness and Services Group and Quality Committee regularly review clinical outcomes, with a view to driving continuous improvement. We collect robust clinical outcome data in 75% of all neurosurgical procedures, which is far higher than most neurosurgical units.

2.3.12 Speaking Up

The Trust's Freedom to Speak up Guardian (FTSUG) is proactive in ensuring staff members are given the opportunity to raise concerns. The FTSUG presents to clinical and non-clinical staff members during their induction. Each individual staff member receives a business card with specific contact details should they wish to raise a concern, arrange a meeting on/off site. Posters are displayed across the organisation and the Trust's intranet site also provides relevant information. Drop-in sessions are scheduled throughout the year across each of the areas within the Trust. There are also 3 FTSU Champions in post to support the guardian. There is a dedicated email address for those wishing to raise concerns. The FTSUG will agree the frequency of contact with the individual/s and following a meeting/investigation information will be gathered regarding speaking up, which has been positive to date. The FTSUG also undertakes exit interviews for those leaving the organisation in order to give staff the opportunity to raise any issues/concerns. The Trust has adopted the NHSI Raising Concerns Policy and has a Grievance Policy and Bullying and Harassment Policy which is readily available for all staff to access offering contact details such as email addresses, contact names and telephone numbers.

Part 3 Trust Overview of Quality 2019/20

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2019/20.

Presented are quantitative metrics, specific to aspects of safety, effectiveness and patient experience which are measured routinely to assure the Trust Board regarding the quality of care provided, having also been shared at a number of assurance committees within the hospital.

Patient Safety Indicators

Trust Acquired	2016/17	2017/18	2018/19	2019/20
C Difficile	9	7	7	5
MRSA Bacteraemia	1	1	0	0
Ecoli	12	11	9	13
Minor and Moderate Falls	36	35	31	37
Never Events	3	2	2	1

Clinical Effectiveness Indicators

Mortality – Procedure	2016/17	2017/18	2018/19	2019/20
Tumour	8	8	8	11
Vascular	47	37	27	23
Cranial Trauma	21	21	14	32
Spinal	3	4	11	6
Other	15	14	17	20

Patient Experience Indicators

Patient Experience Questions	2017/18	2018/19	2019/20
Were you involved as much as you wanted to be in decisions about your care and treatment?	91%	91%	95%
Overall did you feel you were you treated with respect and dignity while you were in the hospital?	98%	99%	99%
Were you given enough privacy when discussing your condition or treatment?	93%	96%	94%
Did you find someone on the hospital staff to talk to about your worries and fears?	84%	85%	82%

3.1 Complaints

3.1.1 Patient Experience, Complaints Handling and Patient & Family Centred Care

We recognise that attending hospital can be a difficult and frightening experience for all. The Patient & Family Experience Team provides confidential support and advice to patients and their families, as well as helping to resolve concerns quickly on their behalf. This can be prior to, during or after their visit to the Trust. The Patient Experience Team can be contacted in various ways including telephone, email or in person whilst in the Trust.

Where concerns cannot be easily resolved or are of a more serious nature, the Patient & Family Experience Team are responsible for supporting the patients and their families in managing the complaint. We pride ourselves on working together (as staff with patients and their families) throughout the Trust to resolve complaints in a timely way, explaining our actions and evidencing how services will be improved as a result of a complaint. We recognise that a family member is not always a blood relative of a patient and we respect this at all times.

3.1.2 Complaints Management and Lessons Learnt

We will always try hard to adapt our processes in order to manage complaints to meet the needs of each individual patient or family member, this may involve meeting with patients in their preferred place, including their homes in order to reach the best outcome for them.

Every informal concern and formal complaint is investigated and each complainant receives the outcome of the investigation. This can be in a detailed response from the Chief Executive / Deputy Chief Executive or at a meeting with the staff involved.

We ensure the responses to complaints are comprehensive addressing all the issues raised and are open and honest. We aim to provide meaningful apologies and acknowledge when we have knowingly or unwittingly hurt or upset a patient or family member. We aim to explain why we think a situation has happened and what we plan to learn to prevent a reoccurrence.

Every effort is made to address each issue highlighted within complaints to the satisfaction of the complainant, even if, after investigation, evidence reveals the allegations made within the complaint are unfounded. Outcomes from complaints are reported monthly to various committees and meetings within the Trust and to the Executive Team. Trends and actions taken are discussed in detail in the Governance and Risk Quarterly report, the monthly divisional governance and risk group meetings and Quality Committee. Any trends in subject, operator or area are escalated in real time to the Executive team.

We aim to ensure that complainants are kept informed and updated during the process by regular contact from members of the Patient & Family Experience Team. We use feedback from those who have used the complaints process to help us improve and shape the service we provide.

Examples of lessons learnt from complaints during 2019/20 include improvements to the patient referral system/telephone system, improved communication processes with patients and families. In addition to this complaints form part of the consultant appraisal process and other individuals involved in complaints are required to personally reflect on the impact complaints have had on patients and families.

3.1.3 Complaints Activity

We use feedback from patient and families who have used the complaints process to help us improve the service we provide. We have developed a person centred approach so that complainants are kept informed during the investigation, with regular contact from members of the Patient Experience Team.

Complaints received 01 April 2019 – 31 March 2020

	Quarter 1 April–June 19	**Quarter 2** July–Sept 19	**Quarter 3** Oct– Dec 19	**Quarter 4** Jan–Mar 20
Number of complaints received	31	36	37	25

The Trust received 129 complaints during 2019/20 which was 36% increase compared to 95 complaints received during 2018/19. This increase in numbers is reflected in the subject matter mainly relating to appointment arrangements and communication.

A key element of the person centred approach is focusing on the individual outcomes patients and families are seeking when they raise concerns. The Patient Experience Team acknowledge all complaints and agree the best way of addressing their concerns. The Trust work in partnership to investigate any joint complaints with all other NHS organisations whereby care received within The Walton Centre is highlighted as a concern as part of any complaint they receive.

3.1.4 Duty of Candour

The Trust fully acknowledges its duty of candour which supports one of its core values of openness. Incidents which fall into the requirements of the regulations for this are identified through the weekly scrutiny of the Datix system.

Relevant incidents are identified and entered onto a tracker which manages Trust compliance against the Duty of Candour regulations. All patients, or in some circumstances family members, who fall into the duty of candour requirements are offered an apology by the relevant clinician as soon as possible and this is recorded appropriately. The patient or family member receive a letter offering an apology which is signed by the Chief Executive. The letter includes an offer to receive a copy of the root cause analysis investigation.

3.2 Local Engagement – Quality Account

The Quality Account has evolved by actively engaging with stakeholders and using external feedback and opinion combined with thoughts and visions from staff within The Walton Centre. Trust Executives have also participated in discussions with the local health economy and sought views on the services provided by the Trust. The Trust has developed strong stakeholder relationships with local Healthwatch organisations, who have conducted numerous engagement events with patients and visitors at our Trust. The Trust has further developed relationships with charities including, The Brain Charity and Headway.
The Trust has actively engaged with Governors through a forward planning event on all aspects of quality including choice of indicators for 2020/21.

3.3 Quality Governance

A Quality Governance framework was designed as a tool to encourage and support current good practice for quality governance in healthcare organisations. The Trust developed a Quality Governance Strategy to define the combination of structures and processes at and below Board level to lead on Trust-wide quality performance to ensure that required standards are achieved. This now forms part of the Quality strategy which sets out key priorities and the principles that the Trust will continue to develop and apply to current and future planned services and patient experience.

The Quality Strategy is underpinned by the Trust Strategy work internally to further improve patient safety and quality, and learning from national work such as the Francis Report and Berwick Review.

The Quality Strategy is built on the ambitions of the Trust strategy:

- Deliver
- Invest
- Adopt
- Provide

- Lead
- Recognise

The Quality strategy is monitored via Quality Committee, Patient and Family Experience Group and the Senior Nursing team. A risk has also been put on the BAF in regards to achieving the Quality Strategy ambitions to ensure this is monitored at board level and an oversight of any risk is addressed.

3.4 Top Industry Award – Nov 2019

Director of Finance for the Trust won Finance Director of the Year award for the Liverpool City Region.

3.5 International Engage Award (ShinyMind App)

The staff health and wellbeing app was highly commended in the prestigious Engage Awards. The app is available to every member of staff, ensuring they feel valued and connected, proactively supporting their wellbeing and resilience every day of the year.

3.6 International Engage Lifetime Contribution Award

The Trust's Director of Workforce and Innovation was honoured to receive the Lifetime Contribution Award for the work undertaken in staff and patient engagement. Each year the International Engage Media Awards, the largest of its kind in Europe, recognises outstanding engagement from companies all over the globe.

3.7 BBC Two Hospital Episode

Production company Label 1 announced they will be returning to Merseyside to film a further series at The Walton Centre.

3.8 Director of Clinical Academic Development – Oct 2019 (University of Liverpool)

The Walton Centre's senior neurosurgeon has been appointed as Director of Clinical Academic Development which is aimed at improving health outcomes throughout the Liverpool City Region and beyond.

3.9 Applied Research Collaboration North West (ARC NW)

The Trust are poised to take part in the new research initiative into health inequalities which launches in October. The National Institute for Health Research (NIH) will be transforming research collaborations across the region into the ARC NW which is a national £135m health research programme announced earlier in the year.

3.10 CQC Inspection

Following the CQC inspection the Trust were delighted to be rated Outstanding by the Care Quality Commission (CQC) for a second time. This makes the hospital the only specialist neurosciences trust in the country to get the rating twice in a row.

3.11 Launch of children's book

The Pain Management Team produced a childrens book for relatives of patients with chronic pain.

3.12 Official opening of the garden room

The Metro Mayor officially opened the innovative garden room which is located in the Intensive Therapy Unit (ITU). This area acts as an outdoor extension for ITU patients, particularly those experiencing delirium which is a common condition for brain injured patients. The room is fully equipped with piped oxygen and suction systems so as long term ventilated patients can enjoy the greenery with family and friends.

3.13 Surgical Spine Centre of Excellence (SSCoE)

The Trust was awarded the European wide quality standard from Eurospine which means the hospital joined a certification programme for reputable spine institutions. The goal is to enhance the quality of spinal surgery and treatment and also to provide guidance for patients with spinal disorders.

3.14 Roy Ferguson Award

A pager system designed to alert relatives of patients in intensive care of any changes has won the Roy Ferguson Award. The annual accolade, set up in memory of a former patient, award thousands of pounds in funding to a project or idea that can demonstrate compassionate care for patients, their relative and carers.

3.15 Centre of Clinical Excellence Award

The Trust has been recognised by Muscular Dystrophy UK for providing outstanding care for people with muscle wasting conditions and was awarded the Centre of Clinical Excellence status by the charity. The award recognises excellence across a range of criteria including the care received by patients and helps to drive up the standards of clinical support for people with the conditions.

3.16 Joined Rainbow Badge Initiative (ED&I)

Staff signed up to wear the rainbow badge and pledge to be committed to creating a welcoming and open environment for LGBT staff, patients and visitors.

3.17 Overview of Performance in 2019/20 against National Priorities from the Department of Health's Operating Framework

The following table outlines the Trust's performance in relation to the performance indicators as set out in the Department of Health's Operating Framework.

Performance Indicator	2018/19 Performance	2019/20 Target	2019/20 Performance
Incidence of MRSA	0	0	0
Screening all in-patients for MRSA	95%	95%	98.88%
Incidence of Clostridium difficile	7	9	5
All Cancers : Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	94%	98.6%
All Cancers : 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers : Maximum waiting time of 31 days from diagnosis to first treatment	99%	96%	100%
All Cancers : 2 week wait from referral date to date first seen	100%	93%	98.9%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	94.27%	92%	N/A
Maximum 6 week wait for diagnostic procedures	0.06%	<1%	0.17%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant		Fully Compliant

Note: The Trust is currently taking part in the NHSI Pilot to measure average wait and is not required to measure against 18 weeks from referral to treatment.

3.18 Overview of Performance in 2019/20 against NHS Outcomes Framework

The Department of Health and NHSI identified changes to Quality Account reporting requirements for 2012/13 and subsequent rounds of Quality Accounts, following consideration by the National Quality Board of introducing mandatory reporting against a small, core set of quality indicators.

The indicators are based on recommendations by the National Quality Board, are set out overleaf. They align closely with the NHS Outcomes Framework and are all based on data that trusts already report on nationally.

If the indicators are applicable to us the intention is that we will be required to report:

- Our performance against these indicators
- The national average

- A supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

The data within this report is local data that has not been validated nationally.

During 2019/20, the Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.19 Indicators

The indicators are listed below and a response is provided if they are deemed applicable to the Trust. If the indicators are deemed not applicable a rationale for this status is provided.

1. **Summary Hospital-Level Mortality Indicator (SHMI):**
   NOT APPLICABLE

Rationale: This indicator is not deemed applicable to the Trust, the technical specification states that Specialist Trusts are excluded from this measurement and that this decision was made by the CQC in June 2011

2. **Percentage of Patients on Care Programme Approach:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health services

3. **Category A Ambulance response times:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

4. **Care Bundles - including myocardial infarction and stroke:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

5. **Percentage of Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as gatekeeper during the reporting period:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health services

6. **Patient reported outcome scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery:**
   NOT APPLICABLE

Rationale: The Trust does not perform these procedures

7. **Emergency readmissions to hospital within 28 days of discharge:**
   APPLICABLE

Response:

	No. of readmissions	% of Inpatient Discharges Readmitted
2018/19	266	5.00%
2019/20	244	4.82%
Change	-22	-0.18%

Calculation of readmission rates is based on the national standard as defined within the Compendium of clinical and Health Indicators. (https://indicators.ic.nhs.uk/webview/). The rates are for patients 16 years and over as The Walton Centre does not treat patients under the age of 16.

Actions to be taken

The Walton Centre considers that this data is as described for the following reasons:
The Trust recognises that the main causes for readmissions are due to infection and post-operative complications

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- Consultant review of all readmissions to ensure any lessons learnt are embedded into future practice.

8. **Responsiveness to inpatients' personal needs based on five questions in the CQC National Inpatient Survey:**
   APPLICABLE

Response:

This year our designated company carried out the National Patients Survey and a total of 62 questions were asked. Picker were commissioned by 74 other Trusts.

- 1250 patients were invited to complete the survey and 50% (613) completed this – the average response rate for other trusts being 44%, so we were slightly above average.
- The Trust were ranked 9th out of 74 in the overall positive score ranking with Picker this year. The overall positive score is the average positive score for all positively scored questions in the survey.
- The Trust's scores improved significantly for 43 questions which demonstrates an overall improvement.
- There were 3 questions where the Trust scored slightly below Picker average, these related to discharge

National Inpatient Survey Question	2016 Result	2017 Result	2018 National Comparison	2019 result
1. Were you involved as much as you wanted to be in decisions about your care?	8.0	7.8	About the same	About the same
2. Did you find a member of hospital staff to talk to about your worries or fears?	7.0	6.0	About the same	About the same
3. Were you given enough privacy when discussing your condition or treatment?	9.1	8.6	About the same	Slightly worse
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.6	5.1	About the same	Better
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.5	8.7	Better	Better

To note: National Inpatient scores are out of a maximum score of ten

In addition, to the National Patient Survey, The Trust undertakes regular patient and family engagement through several methods including ward round to speak directly to patients and families in order to put any concerns right in real time. This will be continued over the next twelve months to ensure that we share both positive feedback and address any issues raise.

Friends and Family Test results for 2019/20 based on the question "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" The recommend rate throughout 2019/20 was extremely positive with 97.8%-100% patients each month saying they would recommend the Trust.

Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
97.73%	97.86%	99%	97.77%	97.45%	98.04%	99%	98%	98%	98%	97.73%	Na*

*In March the FFT return was suspended until further notice due to Covid-19

9. Percentage of staff who would recommend the provider to friends or family needing care:
APPLICABLE

Response:

The Trust had a response rate of 46% for the 2019 national staff survey; the national average for acute specialist trusts in England for 2019 was 58%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work increased from 77% to 81% the best score within its benchmarking group and the percentage of staff who would recommend the Trust as a place to receive treatment" increased from 89% to 93% The reporting outputs for the 2019 Staff Survey have changed; results are themed across 11 areas as follows:

- Equality Diversity & Inclusion
- Health & Wellbeing
- Immediate Managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment (Bullying and Harassment)
- Safe environment (Violence)
- Safety Culture
- Staff Engagement
- Team Working

The 2019 results show two statistically significant change improvements in Immediate Managers and Safety Culture.

Some Key Highlights are as follows:

- Has your employer made adequate adjustments to enable you to carry out your work?- increase from 74.6% in 2018 to 86.7% in 2019- best score in the benchmarking group
- Does your organisation take positive action on health and well-being?- increase from 48.7% in 2018 to 50% in 2019- best score in benchmarking group for the 5th consecutive year.

- The support I get from my immediate manager- increase from 70.7% in 2018 to 78.6% in 2019- best score in benchmarking group
- My immediate manager values my work- increase from 70.9% in 2018 to 78.4% in 2019- best score in benchmarking group
- In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?- decreased from 8.4% in 2018 to 7.2% in 2019- best score in benchmarking group
- I am able to make suggestions to improve the work of my team/department- increase from 76.9% in 2018 to 80.9% in 2019- best score in benchmarking group

In addition to the annual staff survey, a staff Friends and Family Test has also taken place on a quarterly basis this year. The purpose of these is to assess how likely employees are to recommend the Walton Centre as a place to work and also as a place to receive treatment. The results have been extremely positive.

In Quarter 1, (June 2019) the Friends and Family Test was issued to approximately 400 staff using an online survey and 122 surveys were returned. The results showed that 97% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 87% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

In Quarter 2, (September 2019) the Friends and Family Test was issued to a further circa 400 staff with 186 being returned. The results showed that 98% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 85% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Quarter 4 (March 2020) results had 172 complete the survey, 98% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 84% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Key staff survey questions:

Organisation and management interest in and action on health and wellbeing:

The Trust score for 2019 was 50% with the national average being 35% the Trust had the best score for an acute specialist trust for the 5th year.

Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse from patients:

The Trust score was 25.5% with the average score for acute specialist trusts being 19.1%.

The Trust has encouraged staff over the past year through various staff engagement events to raise concerns, we work closely with staff side to address any issues raised and have highlighted the role of the "Freedom to Speak Up Guardian" across the Trust.

KF26 Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months: (the lower the score the better)

The Trust score was 15.8% the average score for acute specialist trusts being 18.7%. This was a decrease from the 2018 score of 17.1%.

KF21 Percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard: (the higher the score the better)

The Trust score was 77%% a decrease from 91% last year.

- The Trust intends to continue to work with staff side and staff through various engagement sessions to increase the response rates and percentage scores for the 2020 survey. A Trust action plan and Divisional action plans covering all 11 themes will be formulated and approved by Board.

10. Patient Experience of Community Mental Health Services:
NOT APPLICABLE

Rationale: The Trust does not provide mental health services

11. Percentage of admitted patients risk-assessed for Venous Thromboembolism:
APPLICABLE

Response: * To be updated once National data published

YEAR		Q1	Q2	Q3	Q4
2016/17	Walton Centre	98.77%	98.68%	99.16%	98.9%
	National Average	95.64%	95.45%	98.16%	95.53%
2017/18	Walton Centre	99.09%	99.69%	98.34%	97.17%
	National Average	95.20%	95.25%	95.36%	95.21%
2018/19	Walton Centre	98.52%	99.00%	98.86%	96.78%
	National Average	95.63%	95.49%	95.65%	95.74%

2019/20	Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Awaiting Publication

The Walton Centre considers that this data is as described for the following reasons:

The risk assessments are carried out by nursing staff within 6 hours of admission, mechanical VTE prevention interventions (use of anti-thrombolytic stockings) are carried out by nursing staff with a medical review regarding pharmacological interventions (medications).

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- All VTEs are subject to a full Root Cause analysis, where any lapses in care, processes or practice are identified. In keeping with the Duty of Candour, the patients are given details of how the reports can be shared with them.

12. Rate of C. difficile per 100,000 bed days amongst patients aged two years and over: APPLICABLE

Response:

Quality Accounts use the rate of cases of C. difficile infections rather than the incidence, because it provides a more helpful measure for the purpose of making comparisons between organisations and tracking improvements over time.

WCFT Clostridium difficile infections per 100,000 bed days:

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Walton Centre	20.4	15.6	21.0	21.6	15.7	14.5	13.3	13.7	9.5

The Walton Centre considers that this data is as described for the following reasons:

In 2019/20 The Walton Centre had a total of 5 Clostridium difficile infections against the trajectory set by NHSE/I of 8. To achieve such a reduction is a fantastic outcome which is a consequence of the outstanding work undertaken by all of the staff Trust wide.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- Setting clear objectives, implementation and monitoring of the Healthcare Associated Infection (HCAI) reduction plan
- Robust programme of infection prevention control audit
- Monitoring and reporting infection prevention outcomes to the Quality Committee
- The Infection Prevention Ambassadors programme to enable engagement of all staff groups to promote ownership, and support effective infection prevention in the clinical areas
- Use of technology e.g. Ultra V and Hydrogen Peroxide Vapour (HPV) to enhance our cleaning programmes
- The appointment of a antimicrobial pharmacist to support excellence in antibiotic prescribing and support education and training of clinical staff

The Trust will continually strive to review and improve the quality of its service and aims to reduce healthcare associated infection, including Clostridium difficile to ensure that all of our service users within the Trust, are not harmed by a preventable infection.

13. Rate of patient safety incidents per 100 admissions

Response:

In 2019/20 1177 incidents occurred against 7,451 admissions (excluding OPD as per NLRS figures) this equals 14.05 per 100 admissions.

The Walton Centre considers that this data is as described for the following reasons:

- Increased patient acuity
- Increase in capacity and activity

The Walton Centre will take the following actions to improve this score, and so the quality of its services, by:

- The Trust investigates all incidents that are reported and ensures that any lessons learned can be shared across all relevant staff groups. Where there are found to be gaps in care delivery, processes and policies are updated and put in place to support the delivery of safe and quality care to ensure these incidents do not re-occur.

The Trust will continue to:

- Discuss all root cause analysis at the relevant meetings to ensure the sharing of learning Trust wide

- Conduct SBAR (Situation, background, assessment, recommendation) investigations where required
- Share lessons learnt via the Governance safety bulletin
- Improve the reporting of incidents through discussions at the Trust safety huddle
- Continue to Implement the use of the new ERCA (electronic root cause analysis) form

Annex 1

ADD COMMENTARY ONCE RECEIVED

Annex 2 Statement of Directors' Responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality report 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period XXX to XXX
  - Papers relating to quality reported to the Board over the period XXX to XXX
  - Feedback from the commissioners including Liverpool, South Sefton and Southport and Formby and Knowsley Clinical Commissioning Groups dated XXX
  - Feedback from governors dated XXX
  - Feedback from local Healthwatch organisations – XXX
  - Feedback from overview and scrutiny committee dated XXX
  - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated XXX
  - The National Patient Survey dated XXX
  - The National Staff Survey dated
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated XXX
  - Care Quality Commission's inspection report dated XXX
- the quality report presents a balanced picture of the NHS Foundation Trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Signature of Chair

Chair

Date

Signature of Chief Executive

Chief Executive

Date

Glossary of Terms

ANTT	Aseptic Non Touch Technique
CMRN	Cheshire and Merseyside Rehabilitation Network
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DOLS	Deprivation of Liberty Safeguards
ED&I	Equality, Diversity and Inclusion
EEG	Electroencephalogram
EP2	Electronic Patient Record System
FFFAP	Falls and Fragility Fractures Audit Programme
FOCUS	Free of Criticism for Universal Safety
FTSUG	Freedom to Speak Up Guardian
GIRFT	Getting It Right First Time
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit & Research Centre
ILS	Immediate Life Support
IRMER	Ionising Radiation Medical Exposure Regulations
KPI	Key Performance Indicator
LASTLAP	Looking After Staff to Look After People
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
NCABT	National Comparative Audit of Blood Transfusion
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
NQB	National Quality Board
OT	Occupational Therapist
PACS	Picture Archiving Communication System
PFCC	Patient and Family Centred Care/
RCA	Root Cause Analysis
SALT	Speech and Language Therapist
SJR	Structured Judgement Review
SIRO	Senior Information Risk Owner
SMART	Surgical and Medical Acute Response Team
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
VTE	Venous Thromboembolism
WCFT	Walton Centre Foundation Trust

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

REPORT TO PUBLIC TRUST BOARD

Date – 30 July 2020

Title	**National Adult Inpatient Survey 2019 Review**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Lisa Gurrell Title: Head of Patient & Family Experience
Previously considered by:	Quality Committee

Executive Summary

The Trust is required to participate in the CQC National Inpatient Survey annually to allow benchmarking of the patients' experience with other NHS providers. The survey is recognised as being a key indicator of overall care for the organisation and regulators including the CQC and commissioners. Picker was commissioned to collate and present the organisation's results by the Trust.

The results highlight a 50% response rate and that the Trust scored better on 8 of the 12 sections of the survey (1 section is not applicable as relates to A&E); therefore the Trust was rated 6th in England for overall patient experience. An excellent result.

The Trust's results were better than most Trusts for 26 questions and worse than most Trusts for only 2 questions. Demonstrating an overall very positive survey. Two areas for improvement were identified including discharge and collating feedback. An action plan is included in this paper.

The CQC have confirmed that the Trust has been identified as performing '**Better than expected'.** This is because the proportion of respondents, who answered positively to questions about their care, across the entire survey, was significantly above the trust average. The survey highlights the excellent results for The Walton Centre and aligns to our outstanding rating by the CQC.

Related Trust Strategic objectives	1. Improving quality by focusing on patient safety, patient experience and clinical effectiveness; 2. Sustaining and developing our services;
Are there any risks associated with this paper?	N/A
Related Assurance Framework entries	N/A
Are there any associated legal implications / regulatory requirements?	Compliance with Commissioners and national requirements identified in CQC regulation
Equality Impact Assessment completed?	NA
Action required by the Board	The Board is requested to: • Note the report and action plan which will be monitored by Quality Committee

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

CQC Inpatient Survey 2019

1. Introduction/Background

The national inpatient survey is the largest scale patient feedback initiative about hospital services enabling year-on-year comparison for organisations and also the opportunity to benchmark with others. The survey is recognised as being a key indicator of overall care for an organisation and is used by regulators such as the CQC and commissioners. The Trust's ambition to improve quality utilises the national in-patient survey results as a measure of progress and year on year improvement is set as one of the aims of the Quality Strategy with a drive to be in the top 20% of Trusts for all categories.

The CQC will use the results of the survey in regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQCs Insight, which provides inspectors with an assessment of performance in areas of care within NHS trusts that need to be followed up. Survey data will also be used to support future CQC inspections.

2. Methodology

The Trust utilised the Picker Institute to undertake the survey. The scores collated are returned to the CQC who statistically standardise the results to provide a system where the results of every acute hospital can be compared despite their location or variations in patient factors e.g. age, ethnicity, levels of deprivation.

The results are then published as a 'worse than most other Trusts', 'same as 'and 'better than most other Trusts'. These groupings are based on statistical analysis. Full details of the methodology of the survey can be found at: www.nhssurveys.org

The benchmark reports are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses are scored on a scale of 0 to 10, with 10 representing the best possible response. The survey itself covers the patients' pathway from source of admission to discharge.

3. Demographics & Scoring

The 2019 survey of adult inpatient's experiences involved 143 NHS acute trusts in England. The CQC received responses from 76,915 patients, who had stayed in hospital for one night or more, a response rate of 45%. Of the 1221 eligible, 613 completed the survey, at a response rate of 50.16%, which is 5% above national average. This was an excellent response rate as previous years have been much lower.

For each question, individual responses are converted into scores on a scale of 0-10, 10 being the most positive, and 0 the least positive. The higher the score, the more positive the results.

4. Results

A varied number of Trusts take part in the survey and not all of the 68 questions asked are applicable to every Trust. Section 1, which pertains to trusts who have an Accident & Emergency Department of two

questions, is not applicable. There were two questions (Q51 & Q66) that had been amended so it was not possible to compare to previous years.

There were no historical comparisons available this year for our Trust due to the discrepancies noted in 2018 survey.

It was noted that The Walton Centre was better than most Trusts for 26 questions and about the same as other Trust's for 33 questions.

The Trust was only worse than most trusts for 2 questions only, highlighting a very positive and encouraging survey.

The CQC report that the Trust has been identified as performing '**Better than expected'.** This is because the proportion of respondents to the survey who answered positively to questions about their care, across the entire survey, was significantly above the trust average. This demonstrates that our patients received a positive experience with outstanding care and treatment.

Section scores

	Section Scores	
Section	2019 Score	Band
1. The accident and emergency department		
2. Waiting list or planned admission	8.9	
3. Waiting to get to a bed on a ward	9.3	Better
4. The hospital and ward	8.5	Better
5. Doctors	9.1	Better
6. Nurses	8.8	Better
7. Your care and treatment	8.6	Better
8. Operations and procedures	8.1	
9. Leaving hospital	7.3	
10. Feedback on care and research participation	2.3	Better
11. Respect and dignity	9.5	Better
12. Overall experience	8.9	Better

The two questions that the Trust rated lower than other Trusts are highlighted below and related to post discharge.

54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? There were 323 respondents – score was measured at 5.3/10

66. After being discharged, was the care and support you expected available when you needed it?
There were 416 respondents, and the score was measured at 7.2/10

These results are the best The Walton Centre has ever received for the inpatient survey thus demonstrating the positive impact of the many Trust initiatives that have been implemented in the last few years including:

- ✓ Patient & Family Centred Care (PFCC) and introduction of PFCC Champions
- ✓ A3 Improvement Projects
- ✓ Action plans following engagement and feedback from Healthwatch
- ✓ Open-visiting
- ✓ Patient Stories
- ✓ Matrons and Patient Experience Rounds
- ✓ Discharge improvement work
- ✓ Call for Concern
- ✓ Trust safety huddle

The above, together with the commitment, passion and drive from our staff, have provided our patients with a positive experience and a high quality standard of care and treatment. This is a great testament to the leadership and staff at The Walton Centre.

5. Findings & Themes

The areas of achievement and areas for improvement are detailed below:
Key: ↑ Better than other Trusts highlighted sections ↓ Worse than other Trusts ↔ Same as other Trusts

Section	Result
2. Waiting list/Planned Admission	↔ *Length of time on the waiting list prior to admission* ↔ *Was admission date changed* ↔ *Specialist had been given enough information about condition in the referral*
3. Waiting for a bed	↑ **Time waiting for a bed on the ward** ↔ *They were satisfied with the length of time they waited* ↔ *Their admission date did not change prior to admission*
4. Hospital & Ward	↑ **Hospital staff explained the reasons for being moved in an understanding way** ↑ **Cleanliness of the hospital** ↑ **Enough help provided with personal care** ↑ **Hospital food and the choice offered** ↑ **Provided with enough refreshments** ↔ *They did not share a sleeping area with people of the opposite sex* ↔ *They were not bothered by noise at night* ↔ *Provided with enough support with meals* ↔ *Were able to take their own medicines if they brought them into hospital* ↔ *Felt well looked after by non-medical staff* ↔
5. Doctors	↑ **Doctors answered important questions in a way the patient could understand** ↑ **Confidence in the Doctors providing care and treatment** ↔ *Doctors did not talk in front of them as if they were not there*
6. Nurses	↑ **Nurses provided information and answered questions in a way the patient could understand** ↑ **Confidence in the Nurse providing care and treatment** ↑ **Nurses did not talk in front of patient** ↑ **Aware of which nurse in charge of care and informed after shift change** ↔ *Were provided with enough nurses on duty*

	↔ *Received enough support during their stay*
7. Care & Treatment	↑ **Confidence and trust in all other clinical staff involved in treatment** ↑ **Caring team worked well together** ↑ **Involved as much as I wanted to be about decisions regarding care and treatment** ↑ **Found someone to discuss my worries and fears with** ↑ **Staff did all they could to manage my pain** ↑ **Staff attended to me in a reasonable time** ↔ *Were given enough privacy during discussions as well as when being examined or treated* ↔ *Given enough privacy when being examined* ↔ *Provided with enough information and emotional support* ↔ *Sometimes a member of staff would say one thing and another would say it differently*
8. Operations & procedures	↔ Their questions were all answered prior to operation ↔ Were informed how they would expect to feel following operation or procedure ↔ Were informed that the operation or procedure had been done in a way they could understand
9. Leaving Hospital	↑ **Provided with printed information on what to do following discharge** ↑ **Informed of danger signs to look out for** ↑ **Provided with contact details if worried about condition** ↓ Enough support after leaving hospital from health/social care ↓ Care and support expected was available following discharge ↔ *They were given enough notice regarding discharge and discharge was timely without delay* ↔ *Knew what to expect when leaving hospital* ↔ *Received an explanation regarding their discharge medication, the purpose and side effects* ↔ *Social and domestic situations were considered prior to discharge* ↔ *Provided families and carers with the information they required* ↔ *Discussed if patients required additional equipment or adaptions in their home* ↔ *Staff discussed if they required input from other services such as social care or other providers* ↔ *They were involved in decisions about care*
10. Feedback on care/research	↑ Met with and/or provided with information on how to complain ↔ Did anyone discuss your views about quality of care ↔ Information was provided about participation in research
11. Respect & Dignity	↔ Overall treated with dignity and respect during admission
12. Overall Experience	↑ **Very good experience**

6. Improvements Identified

As detailed above the two main areas for improvement relates to post discharge which may include care provided by other NHS care providers and/or support services. We recognise, however, that an

improvement is required to improve the patient experience and expectations in this area. Details of how will achieve this is detailed in the action plan.

Whilst the results from the survey are better than other Trusts for 26 questions, for 33 questions we remain the same as other Trusts. Further improvement can be made to better this score and to go from good to great and we will be able to shape our services to achieve this.

7. Summary

This report brings together the outcomes from CQC inpatient survey of our patient's experiences of care and treatment in our Trust. The results are good; however, we recognise that there is always room for improvement to the care we deliver to every patient.

Our vision in the Trust is Excellence in Neuroscience and we acknowledge that we will only achieve this by truly placing the quality, safety and experience of our patients and families at the heart of what we do. Our approach to care recognises each patient as part of a wider group including families, friends and carers and we embrace this with our patient and family centred approach to care.

During 2020/21 and beyond we will continue to build on this work to ensure we are working together with patients and their families as equal partners in care, in line with The Walton Way.

The action plan in Appendix 1 outlines the actions required and learning identified to progress care delivery at The Walton Centre to where we want to be. These actions not only include the actions relating to the 2 questions for which the Trust scored lower than other Trust but actions to improve the experience of patients in areas where we have remained the same, demonstrating that we are committed to improving the experience of our patients. This action plan will be monitored via the Divisional Risk and Governance meetings and presented to Quality Committee for monitoring the actions until the Committee are satisfied that they are closed.

In the next year and beyond we will continue to build on this work to ensure we are all working together with patients and their families as equal partners in care, in line with our Walton Way values.

The CQC have confirmed that this year they will undertake the survey in November, as opposed to August and to speed up the process are changing the format so there will be no comparison to the previous year.

8. Recommendations

The Committee are asked to:

- receive the report noting the significant improvement in the results of the audit.
- be assured that the Trust actively engages with patients under our care
- be assured that the Trust learns from the feedback they receive to continually improve how care is delivered
- note the action plan within the report and to receive a further update from the Divisions in 6 months
- note the survey will take place in November 2020 and the CQC are changing the format to speed up the process and the report will not provide a comparison to the previous year

Appendix 1 **National Inpatient Survey 2019 - Action Plan**

KEY CODE	Not Achieved	To Commence	Partially Achieved	Achieved

Section	Areas where we could improve further	Actions	Lead	Due Date	Update November 2020
2. Waiting list or planned admission	↔ Improve waiting times	• Due to capacity/demand GP pain referrals currently closed due to lack of secondary care capacity. • Divisional teams working through lists in line with clinical priority/following C-19 gov restrictions. *No further actions can be implemented until the above is complete.*	Divisional Directors of Operations	*Aug 20	**Although plans for improvement are in place, this is somewhat restricted in line with Government guidance for Covid-19 and introducing urgent/routine activity*
3. Waiting for a bed	↔ Improve length of time waiting for a bed ↔ Minimise date changes prior to admission	• Patients are contacted on the day of admission when beds are ready to prevent a delay when arriving in hospital. • Same Day Admission Lounge in operation, staggering of TCI times has been explored but not feasible as anaesthetists are required to review patients prior to surgery and this needs to occur before they commence their daily list. • Information regarding the above to be added into patient information leaflets upon review. • Dates will continue to be changed on occasion due to clinical priority but patients are informed at the earliest opportunity and reschedules asap.	Bed Managers Divisional Director of Operations Patient Info Lead/Head of PET	Aug 20	**Although plans for improvement are in place, this is somewhat restricted in line with Government guidance for Covid-19 and introducing urgent/routine activity* **Practice to continue**

Section	Areas where we could improve further	Actions	Lead	Due Date	Update November 2020
4. Hospital & Ward	↔ Reinforce and raise awareness of single sex areas ↔ How can we support further with meals? ↔ How patients are supported by non-medical staff	• Mealtime volunteer buddies • Meal observations • Information added to all newly reviewed patient information • Continue with virtual visiting • Explore option of large adaptable screens to support virtual visiting & use for inpatients on wards	Head of PET Matrons	Oct 2020	Plans for volunteers to safely resume some roles following risk assessments commenced July 2020 Work has commenced on new patient information project
5. Doctors	↔ Drs not to talk in front of patients	• Drs to include patients in conversations as much as possible • Bedside handover	Medical Director Clinical Directors Matrons	Oct 20	Bedside handover is in place in all areas. Awareness to be raised at Matron's rounds
6. Nurses	↔ Support provided by nurses on duty	• Visual assurance – safe shift – enough staff on duty – review to move to electronic board • Comfort checks • PFCC Champions on all wards /areas	Matrons Divisional Nurse Directors	Oct 20	PFCC Group to recruit more Champions Review feasibility of electronic board in wards/clinical areas
7. Care & Treatment	↔ Privacy during examination ↔ Consistent information provided by staff	• Series of small videos from staff promoting care/treatment/safety raising awareness on social media • Raise awareness of chaperone policy for inpatients	Communications Matrons	Oct 20	To be commenced
8. Operations & Procedure	↔ Improve communication to patients and families so they know what to expect and receive timely updates	Improve communication by: • Theatre staff to visit patient prior to and post op • Theatre staff ring relatives to inform them when they are out of theatre	Lead Nurse/Theatres/ ITU	Aug 20 On-going	ITU staff call families as soon as this is practical/possible with updates

Section	Areas where we could improve further	Actions	Lead	Due Date	Update November 2020
9. Leaving Hospital	↓ Improve the experience and expectation of patients leaving hospital including: • Improving information provided on support planned from external agencies including other NHS providers and social care. • Ensuring we are clear in informing patients what to expect when leaving hospital • Provide patients with detailed summary of discharge plans in timely manner • Involve family members where possible in decisions regarding discharge/care to support patient further	• Improve written discharge information to include details of referrals to external sources. • Provide contact details of external agencies eg social care/ district nurse upon discharge • Review feasibility of follow up courtesy call following discharge. • Review timeliness of discharge summaries with a view to improvement. • Include patients & families in MDT meetings for complex discharges – option of using zoom for patients who live outside the area whose families are not present.	Divisional Nurse Directors/Matrons Ward Managers Divisional Nurse Directors Divisional Nurse Directors Divisional Nurse Directors	*Aug 20	*Although actions to improve will be implemented current Government restrictions/guidance may have an impact progress. Introduced during Covid-19 for discharges including complex one for patients being transferred to other NHS settings.
10. Respect & Dignity	↔ Treat with dignity & respect at all times	• Raise awareness and reinforcement of Walton Way and Trust values & behaviours. • Matron walkabouts • Matron availability posters • Patient Experience walkabouts	Divisional Nurse Directors/Matrons Matrons Head of PET	Aug 2020 Aug 2020 Aug 2020	Matron Ward Rounds are in operation PET on hold due to Covid-19 will recommence August 20.

Section	Areas where we could improve further	Actions	Lead	Due Date	Update November 2020
11. Feedback on care & research participation	↔ Raise awareness of research studies and how we can communicate this during admission.	• Benchmark with other Trusts who score highly	Head of Research	Dec 2020	Matron Ward Rounds are in operation PET on hold due to Covid-19 will recommence Sept/Oct 20
	↔ Improve measures for collating patient feedback.	• Matrons/Patient Experience Rounds • Patients & Families encouraged to share their stories – now included in complaints leaflet.	Matrons/Head of PET	Aug 20 **Complete** June 2020	

Title	**Corporate Governance Report**
Sponsoring Director	Janet Rosser, Chair
Author (s)	Jane Hindle, Corporate Secretary
Previously considered by:	• Charity Committee • RD&I Committee • Remuneration Committee • Audit Committee

Executive Summary

The purpose of the report is to update the Board of Directors on matters of corporate governance and to seek the approval for changes to the terms of reference for three Board Committees

In summary the report

- Proposes changes to the terms of reference for the Charity Committee, RD&I Committee and Remuneration Committee
- Reports the use of the Trust Seal during 2019/20

Action required by the Board:	The Board is requested to: • To approve the revised terms of reference for the Committees of the Board • Note the position in relation to the register of the trust seal
Related Trust Ambitions	• Best practice care • Be financially strong • Support education • Be recognised as excellent in all we do
Risks associated with this paper	None identified
Related Assurance Framework entries	None
Equality Impact Assessment completed	Not required
Any associated legal implications / regulatory requirements?	It is a constitutional requirement for the Board to ensure any committees it appoints are formally established with terms of reference.

1.0 Introduction

1.1 The purpose of the report is to update the Board of Directors on matters of corporate governance and to seek the approval for changes to the terms of reference for three Board Committees.

2.0 Committee terms of reference

2.1 Further to work undertaken in November 2019 a review of the remaining committees of the Board has been completed and revised terms of reference are attached.

2.2 Each committee has reviewed and agreed to the proposed amendments.

2.3 The key changes to note are as follows:

- in line with the objectives within the Research and Innovation Strategies it is proposed that Medical Education reports into the Committee rather than to the Business Performance Committee and therefore this is reflected in the name; Research, Innovation and Medical Education (RIME) Committee

- changes to membership of RIME in line with the above and removal of the Chief Executive as a permanent member of the Committee

- Where relevant the role of the Committees' in relation to their oversight of the Board Assurance Framework and operational risks is now explicit
- Inclusion of a quoracy rule for Remuneration Committee

3.0 Use of the Trust Seal

3.1 In accordance with Section 37 of the Standing Orders, it is a requirement to report to the Board of Directors the detail of all documents that have been authorised and sealed with the trust seal during the financial year.

3.2 Between 1 March 2019 and 31 March 2020, no documents have required the use of the trust seal.

The last recorded use of the seal was in December 2015

4.0 Recommendations

The Board are requested to:

- Approve the revised terms of reference and membership
- Note the position in relation to the use of the trust seal

THE WALTON CENTRE CHARITY COMMITTEE
Terms of Reference

1.0 CONSITUTION

1.1 The WCFT's Charitable Funds Committee is constituted as a standing committee of the Board of Directors to exercise the Trust's functions as sole corporate trustee of The Walton Centre Charity registered charity number 1050050. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

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

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

2.0 PURPOSE

2.1 The Committee is appointed to discharge the Trust Board's responsibilities as Corporate Trustee in the effective management of the Charity, including compliance with statutory and regulatory requirements in accordance with the guidance on NHS Charities set out by the Charity Commission.

In discharging its role members must act solely in the best interests of The Walton Centre Charity and in a manner consistent with the Charity Commission's requirements and expectations of Charity Trustees.

3.0 DUTIES AND RESPONSIBLITIES

3.1 The main functions of the Committee are to:

(a) inform the development of the Fundraising Strategy and objectives for the Charity's work for consideration by the Board and oversee their delivery.

(b) monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met

(c) receive reports detailing balances of the Charity's Funds.

(d) receive reports on all individual charitable non-pay transactions in excess of £1000

(e) approve expenditure of all individual charitable non-pay transactions valued £5,000 up to £100k , above which they will be referred to Trust Board

(f) in line with charity law establish the strategy, policies, budget, spending priorities and criteria for spending decisions for each fund.

(g) appoint appropriate Investment Managers to provide investment advice

and manage the Charity's investment portfolio.

(h) in conjunction with the investment managers, agree an investment policy which lays down guidelines in respect of:

- the balance required between income and capital growth.
- the balance of risk within the portfolio.
- any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds.

And keep performance against these investments under review

(i) review the impact on the Charity of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met.

(j) ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation.

(k) receive audit reports on the charity controls.

(l) approve new fundraising appeals and monitor fundraising targets.

(m) consider the Charity's annual report and accounts prior to approval by Trust Board

3.3 **Policies**
To consider and approve all policies relevant to the Committee's remit including the Investment Policy, the Fundraising Policy and the Ethical Donations Policy.

3.4 **Risk**
The Committee will keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed e.g reputational risks, fraud, business continuity.

4.0 MEMBERSHIP AND ATTENDANCE

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

Voting members

- 2 Non-Executive Directors (one of who will chair the committee)
- Director of Finance and IT
- Director of Nursing and Governance

Core members

- Director of Workforce and Innovation
- Consultant Neurosurgeon or nominated Deputy
- Consultant Neurologist or nominated Deputy
- Named Consultant or nominated Deputy
- Head of Fundraising or Deputy

4.3 Both voting and core members are expected to attend a minimum 75% of

Committee meetings during each financial year.

4.4 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint another Non-Executive to be Chair for that meeting.

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

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

Quoracy

4.7 The Committee will be deemed quorate provided three members are in attendance one of whom must be a Non-Executive Director.

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Committee will report in writing to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

5.3 The Committee may establish management groups to support it in fulfilling its duties.

5.4 The Committee will approve the terms of reference and annual work programme of any management groups on an annual basis and keep their effectiveness under review.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will normally meet on a quarterly basis.

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

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

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

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

7.0 EQUALITY ACT (2010)

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

8.0 REVIEW

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

Research, Innovation and Medical Education (RIME) Committee

Terms of Reference

1.0

CONSTITUTION

1.1 The Research, Innovation and Medical Education Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference are set out below, subject to any future amendments by the Board of Directors

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

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

2.0 PURPOSE

2.1 The purpose of the Committee is to give strategic direction and provide the Board of Directors with assurance there is a comprehensive and integrated approach to research, innovation and medical education, and that risks to patient safety and the trust's reputation have been identified and mitigated.

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3.0 DUTIES AND RESPONSIBILITIES

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

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

- Research and Development Strategy
- Innovation Strategy
- Education Annual Report
- Research and Development Annual Report

To give consideration to the strategic direction and funding plans for the Trust relation to research, innovation and medical education, and make recommendatio to the Board of Directors on these matters.

The main duties can be classed as follows:

3.2 **Research**

(a) To receive reports, recommendations on national and local priorities to guide activities in relation to research

(b) To seek assurance that research undertaken within the Trust is delivered efficiently and safely, is compliant with research legislation and meets the national high level objectives and local metrics

(c) To consider the implications of outcomes arising from relevant review, audit or inspection and review progress with resulting corrective and preventative action plans

(d) To review and ratify all sponsorship decisions made by the Sponsorship Oversight Group including;

- Sponsorship for non-interventional studies
- Clinical Trials of Investigational Medical Product (CTIMP) studies
- Withdrawals of sponsorship or studies that have been rejected

(e) To review the Sponsorship Risk Management Plan at least annually ensuring appropriate actions have been taken where breaches of research regulations have occurred.

(f) To approve the Trust's Operational Capability Statement annually

(g) To monitor research and innovation finances including grant income

(h) The Committee will facilitate collaborative partnerships and receive presentations/reports from partners including Liverpool Health Partners (LHP), Innovation Agency, North West Coast, Collaboration for Leadership in Applied Research Collaborative (ARC) North West Coast and Clinical Research Network: North West Coast.

3.0 Innovation

(a) To consider the implications for the Trust of emerging national and international initiatives this may provide opportunities for innovative working or enhance the reputation of the Trust.

(b) To identify the synergies between proposed innovations and partnerships within the research agenda.

(c) To receive progress updates on the Trust's Innovation Strategy and key initiatives.

3.4 Medical Education

(a) To understand the interdependencies between medical education research and innovation to ensure that they are strategically aligned and sustainable

(b) To seek assurance in relation to the quality of educational provision for medical students across the Trust to in order to enhance the reputation of the Trust as a centre of excellence.

3.5 **Policies**
To consider and approve all policies relevant to the Committee's remit including those for Research Governance, ethics and Investment Policy, Ethical Donations Policy.

3.6 **Risk**
The Committee will keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed.

4.0 MEMBERSHIP AND ATTENDANCE

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

Voting members

- 2 Non-Executive Directors (one of who will chair the committee)
- Medical Director
- Director of Finance

Core members

- Director of Workforce and Innovation
- Clinical Director for Research and Development and Consultant Neurologist - Dementia Lead
- Clinical Director for Medical Education
- Clinical Lead for Innovation
- Research and Development Manager
- Research, Development & Innovation Management Accountant
- Public Governor
- Head of Commercial Engagement and Marketing
- Consultant Neurosurgeon x2
- Consultant Neurologist - Stroke Lead
- Consultant Neurologist - Pain Medicine Consultant Neuropsychologist
- Consultant Neuroradiologist
- Clinical Lead for Neurorehabilitation
- Allied Health Professional (AHP) – MS Specialist Physiotherapist
- University of Liverpool representative x2
- Clinical Research Network NWC Representative
- Internal Clinical Research Network NWC Lead for Neurosurgery
- Internal Clinical Research Network NWC Lead for Neurology
- Liverpool Health Partners Representative

- Applied Research Collaborative NWC Representative

4.3 Both voting and core members are expected to attend a minimum 75% of Committee meetings during each financial year.

4.4 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting.

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

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

4.7 **Quoracy**
The Committee will be deemed quorate provided three voting members are in attendance one of whom must be a Non-Executive Director.

In the event a vote is tied, the Non-Executive Chair will have a second and casting vote.

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Committee will report in writing to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

5.3 The Committee has established the following management groups to support it in fulfilling its duties.

- Sponsorship Oversight Group
- The Research Capability Funding Sub-committee.
- Medical Education Committee
- Medical Innovation Group
- Workforce Innovation Group

5.4 The Committee will approve the terms of reference and annual work programme of all management groups on an annual basis and keep their effectiveness under review.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will normally meet on a bi-monthly basis.

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

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

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

6.5 **Administration**
The Committee shall be supported administratively by the Innovation Co-ordinator, whose duties shall include: agreement of the agenda with the Chair, collation of papers; production of the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas. They will also work in partnership with the Trust's Corporate Secretary to ensure compliance of governance processes and procedures.

7.0 EQUALITY ACT (2010)

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

8.0 REVIEW

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

REMUNERATION COMMITTEE
Terms of Reference

1.0 CONSITUTION

1.1 In accordance with the requirements of Schedule 7, 17(3) of the National Health Service Act 2006 (the Act):

1.2 The Remuneration Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

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

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

2.0 PURPOSE

2.1 The purpose of the Committee is to keep under review the structure, size and composition of the Board of Directors, and report to the Board and the Council as appropriate: having regard to future challenges, risks and opportunities facing the Trust and the skills and expertise required within the Board of Directors to meet these.

3.0 DUTIES AND RESPONSIBLITIES

The main functions of the Committee are as follows:

3.1 Succession Planning

(a) Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board, and the Council of Governors, as applicable, with regard to any changes.

(b) Give full consideration to succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

(c) Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

3.2 Appointments and terminations

On the basis of an evaluation of the balance of skills, knowledge, experience and diversity on the Board, where a vacancy is identified, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall:

(a) Determine the method of advertising to be used and / or the need to engage external advisers to facilitate the search, having due regard to the cost of such services

(b) Consider candidates from a wide range of backgrounds

(c) Consider candidates on merit and against objective criteria and take into account the views of the Chief Executive as to the skills, experience and attributes required for each position

(d) Constitute the membership of interview panels and determine the need for the incorporation of representatives from internal and external stakeholders

(e) Ensure that a robust and effective process is in place to meet the requirements of the Fit and Proper Person Test for all existing and future Director appointments

(f) Consider any matter relating to the continuation in office of any Executive Director or Very Senior Manager including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

(g) Agree the procedure for the suspension and termination of any Director or Very Senior Manager

3.3 Remuneration

(a) Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors and Very Senor Managers while ensuring that increases are not made where the Trust or individual performance do not justify them;

(b) Approve all aspects of remuneration and terms of service of Directors, including the Chief Executive and Very Senior Managers who report directly to the Chief Executive to ensure that they are fairly rewarded for their individual contribution including:

(c) salary, including any performance-related pay or bonus;
(d) provisions for other benefits, including pensions and cars;
(e) allowances;
(f) payable expenses; and
(g) compensation payments.

(h) In adhering to all relevant laws, regulations and Trust policies:

Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

(i) Be sensitive to pay and employment conditions elsewhere in the Trust.

(j) Review and assess the output of the evaluation of the performance of individual Directors, and Very Senior Managers and consider this output when reviewing changes to remuneration levels.

(k) Advise upon and oversee contractual arrangements for Executive Directors and Very Senior Managers including but not limited to termination payments to avoid rewarding poor performance.

(l) Review the Remuneration Report sections of the Annual Report and Accounts, prior to consideration by the Audit Committee and approval by the Board

(m) Consider and approve matters in relation to extraordinary and additional payments in relation to all staff employed by The Trust i.e. Mutually Agreed Resignation Schemes, Voluntary / Compulsory Redundancy.

4.0 MEMBERSHIP AND ATTENDANCE

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

Voting members

- Chair of the Trust (Committee Chair)
- All Non-Executive Directors

Attendance

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

4.4 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint another Non-Executive to be Chair for that meeting.

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

4.6 The Chief Executive, other Directors and any other officers in attendance at the meeting shall not be present for discussions about their own remuneration and terms of service.

4.8 **Quoracy**

No business shall be transacted unless the Chair and at least two members are present.

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Chair will report to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will normally meet on a quarterly basis.

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

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

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

7.0 EQUALITY ACT (2010)

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

8.0 REVIEW

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

The Walton Centre NHS Foundation Trust

Chair's Report

**Prepared by Lisa Salter, Director of Nursing and Governance,
on behalf of Seth Crofts, Non-Executive Director and Quality Committee Chair**

The following report summarises the discussions held on 23 July 2020 by the Quality Committee. Agenda items are listed in order of the meeting and areas of discussion that the Board may wish to consider and have additional commentary alongside.

Agenda item	Discussions at the meeting
CMRN Quality Presentation by Ms J. Peacock	All patients seen by a single point of contact (SPOC) so journey through the network is positive and rehabilitation potential and expectations are clear. The MDT approach is key to the success and includes doctors, therapists, psychologists and neuropsychiatry as well as vocational rehabilitation. This is all monitored by UKROC administrators. The network have a Quality Committee which takes an MDT approach where they share lessons learned and essential information. The teams are currently writing a rehab book, which will support the Masters' Module. Links with other Trusts, especially in Cheshire, Wales and Isle of Man, have been encouraged within the last 12 months to ensure people are clear regarding how the C& M Network can support patient care,
Medical Director's update by Dr. A. Nicolson	Funnel plots shared and explained. These highlighted that WCFT had a low number of patients with Covid-19 with low numbers of deaths. Organ donation information was presented noting that from April 19 – February 202 there had been 17 organs donated with 38 patients receiving transplants. Between March 2020 and May 2020, there have been 5 organs donated with 14 patients receiving transplants.
Mortality & Morbidity Report Dr. Nicolson , Mr Carter & Dr. Wilson	New data was shared in the report which gave assurance to the committee, albeit the CHKS data is 3 months behind. It was explained that the stroke death data was to be reviewed in line with other national data.
Integrated Performance Report Input from Divisions	Some challenges experienced for visiting due to other Trusts changing rules although the WCFT have maintained the regional agreement to only enable visiting when patient is at EOL/has enhanced needs. The Divisions shared information related to quality of care and patient experience. During Covid-19, the Divisions have worked hard to deliver all aspects of excellent and safe patient care and they should be praised for working stronger as triumvirates/quadrumvirates. Despite lower numbers of patients, quality is on track to be delivered.
Patient Safety Strategy Mr. T Fitzpatrick	A full review of the policy in WCFT will be undertaken and how learning takes place so assurance is gained for incident management. Patient safety incident management system (PSIMS) will replace National Reporting Learning System (NRLS). A task and finish group will be set up to review changes.

SOP – Reasonable Adjustments **Mr. A Lynch**	This document needs to be shared at the next Equality, Diversity & Inclusion (E, D &I) group and personalised to WCFT to ensure all elements are captured.
Medicines Management Report **Mr. D Thornton**	Well-presented report for last 12 months, despite Covid-19. The report also identified plans and areas for development in 2020/21, which were accepted by the Committee. A full upgrade to the EPMA system will need to be installed with full training and ITU support, however further discussions will need to be held. Thanks noted for an excellent service and for maintaining and updating policies and SOP especially during COVID-19.
Controlled Drugs Accountable Officer Report	Management of controlled drugs (CDs) continues to be monitored. Handling of patients' own CDs requires further improvement, although it was noted significant progress has been made over the past 12 months.
IPC Q1 Report **Ms. C Chalinor**	Universal decolonisation introduced Trust wide to support reduction in hospital acquired infections (HCAI). Data shared regarding HCAI. Catheter acquired infection information and service improvements noted. CPE outbreak data from HDU given and shared with our commissioners. Extensive work undertaken during Q1 with COVID-19 and a Trust-wide approach was promoted. Changes in PPE, in accordance with PHE, has been maintained but had its challenges. Excellent work has been achieved in the occurrence of no EVD infections in the last 4 months. FIT testing work has been led by Laura Abernethy who should be praised for this.
Visibility Update **Ms. L Vlasman**	Assurance give to the Committee that although walkabouts have not happened due to COVID-19, other walkabouts and interventions have been put in place together with opportunities for the NEDs to speak to senior managers which has worked well.
In-Patient Survey **Ms. L Gurrell**	Excellent results highlighted by the CQC and noted to be the best to date for WCFT. WCFT was better than most Trusts for 26 questions. The next survey will be in November however the questions and process will change.
Quality Strategy **Ms. L Salter**	Committee noted that year 1 actions had been undertaken and some elements due in years 2 & 3 had already been progressed. Some good progress noted.
Pressure Ulcer Policy **Ms L Salter**	This was written by Cheshire & Merseyside Pressure Ulcer group and tailored to WCFT. A new Tissue Viability Specialist Nurse – Angela King (TVN) due to commence in 3 months' time. Committee ratified both documents
Review of Serious Incidents & Mortality and Morbidity process **Mr. S Crofts**	It was noted that there is a good clear policy in place with a Serious Incident (SI) meeting in place. The SI meeting requires further attendance at times. Mortality review is strongly medically led but an MDT approach is required and work needs to be progressed. Divisional Governance groups are key to sharing learning from these. This approach forms part of the Quality Strategy.
Governance & Risk Management Report **Mr. T. Fitzpatrick** **Ms L. Gurrell**	There were 2 new themes logged within the framework for the increase in medicine incidents and increase in catheter acquired infections (CAUTI). Improvement actions were noted. Legionella and water flushing system discussed. Further water testing is due next week and this will be presented at IPC Committee
Work Plan	The work plan was agreed by the Committee
CESG (Minutes) **Mr. Nicolson**	The minutes noted that the status epilepticus guidelines have been progressed and signed off by the group. Agreed this document would also be shared with the Royal College.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
30 July 2020

Report Title	**Chair's Assurance Report – RD&I 01/07/20**
Sponsoring Director	Seth Crofts – Non-Executive Chair
Author (s)	Mike Gibney, Director of Workforce and Innovation
Purpose of Paper:	
The Research, Development and Innovation Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Research, Development and Innovation Committee held on 1 July 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's Attention

a) Research, Innovation and Medical Education (RIME) Committee

Through the Trust's Strategy, there was recognition that there should be alignment of the research, innovation and medical education functions in order for The Walton Centre to remain a centre of excellence. It was proposed for Medical Education to report into the Committee rather than the Business Performance Committee and would be reflected in the name; Research, Innovation and Medical Education (RIME) Committee. Committee members were in support of the proposal and the revised Terms of Reference were considered and approved. The associated committee cycle of business was also approved and welcomed by members in light of the additional elements to the Committee's remit. It was noted that the cycle of business was an indicative work programme and that additional priority items would be included when required.

b) R&D Finance and Performance Report

The R&D Management Accountant informed Committee that due to COVID-19, NHS funding arrangements, income and expenditure were only reported to the first 4 months of 2020/21 as national financial guidance only related to this period. Guidance for months 5-12 was due to be released imminently and future reports would reflect the national guidance once published.

It was anticipated that the Neuroscience Research Centre (NRC) would break even as although there had been no changes to the grant payment schedules, it was estimated that the income received from NHS Improvement would make up the shortfall in income from commercial trials due to activity ceasing during this period.

The Chair noted the current financial position and reminded members that the fundamental financial challenge was related to business as usual. The NRC would need to be flexible and responsive to changes from governing bodies i.e. NHS England, NIHR. It was noted that due to the staffing challenges within the department, the reduction in activity over this period had been less detrimental and that it would therefore be less exposed if changes were introduced.

A request was made by Dr Frank for research data facilities to be provided as a part of the IT infrastructure post COVID-19 as an enabler for the Trust to be responsive to future research study requests.

The Committee was informed that nationally, there were clinical trial units that had returned to operating at 80-90% capacity and therefore presented a risk to the Walton Centre in terms of access to feasibility studies. Although this was the national picture, it was noted that a high percentage of commercial research operated internationally and therefore the Trust was competing in a robust market place for Neuroscience trials.

2.0 Items for the Board's Information and Assurance

a) Data Transfer and Intellectual Property

The Head of Commercial Engagement and Marketing updated the Committee on how data transfer and intellectual property had been historically managed within the Trust with regards to research studies. It was reported that for commercial studies, it had been resourced via the individual companies. For investigator led studies, historically, advice has been sought from the Trust's Information Governance Department, the NRC and the principal investigators. Going forward, the Trust needed to consider how to resource the legal assessments of intellectual property and data transfer and it was recommended that the funding of these elements be built into the research contracts. There was agreement that there had been missed opportunities for the Trust to benefit from some of the research projects that had been undertaken and to retain credit.

It was felt that each study would need to be reviewed on an individual basis rather than implementing a general policy, due to the diverse nature of projects. This was the approach being taken for innovation projects where intellectual property arrangements can be complex. It was noted that work was being undertaken to explore some aspects of TONiC, where industry wants to collaborate with the programme.

The Director of Research Infrastructure and Education for LHP informed the Committee that similar discussions were being held by a number of the specialist trusts across the region and therefore suggested that a working group be held to gain a greater understanding of how other trusts were managing intellectual property, enable shared learning and agreed to share some background information on intellectual property management.

There was agreement that there needed to be a more systematic approach within the Trust with regards to intellectual property and that an update would be brought to the next Committee meeting in September 2020.

b) LHP Partnership Update

An update was provided on the Neuroscience theme and that there was a focus on neurology and mental health. In the process of recruiting a theme manager to which there had been a significant number of strong applications. It was noted that the University of Liverpool was working with the Walton Centre to develop a faculty of Neuroscience.

c) STrategic One Liverpool Partnership for COVID

The Director of Research Infrastructure and Education for LHP gave an overview of the STOP COVID programme the aims of which were to:

- Develop new diagnostics, drugs and treatments for COVID-19
- Better understand the impact of social inequality on viral transmission, disease and recovery
- Understand risks for development of severe clinical disease and protective immunity
- Understand and address the impact of the COVID pandemic on our residents, health and social care services and other economic issues.

A command and control structure had been implemented which enabled multiple stakeholders to be in the same place who could make strategic decisions on how the workforce should be prioritised and mobilised across the system whilst also listening to member trusts to support new research when managing the workforce to deliver the COVID studies. Although the structure had worked well, LHP was starting to transition into the clinical restarting and system reset phase. This included looking at how to support member organisations to restart their research portfolios and continue to building capacity.

As part of the next steps, conversations were being held with research leads from member organisations to gain feedback of their experiences of being part of the STOP COVID programme. Recommendations would be taken to the LHP Board in July 2020 to outline key principles for moving forward.

d) Medical Innovation Group Update

Although the Medical Innovation Group had not formally met during the COVID period, the Director of Workforce and Innovation gave an update on the following projects:

Elementary Routine Nutritional Screening Tool (ERNST) - This product will enable patients at risk of malnutrition and obesity to access appropriate care and treatment more efficiently and consistently. Uniquely, ERNST will provide quick and easy digital screening to detect risk for both conditions. This is an exciting, innovative development by Vicky Davies, Principal Dietician for Neuroscience. Key points of note were:

- An MoU between The Walton Centre and ERNST Nutrition Limited (Vicky Davies' company) had been signed off
- £8K of funding had been agreed by the Executive Team for the development of a prototype
- Proposal received from Citrus Suite Limited for prototype development
- A future funding application to be made to the Walton Charity Committee for IT development

Virtual Engagement Rehabilitation Assistant (VERA) - An interactive virtual platform that supports holistic rehabilitation of patients and carers in inpatient and community settings. Key points of note were:

- £60K funding had been confirmed from the Stroke Association for research and evaluation
- £37K funding application was being made for IT development to the Walton Charity Committee at the 9 July 2020 meeting
- Dr Rose was working on a Collaboration Agreement between The Walton Centre, University of Central Lancashire (UCLAN) – research and evaluation support and Citrus Suite – IT development company.

Trajectories of Outcome in Neurological Conditions (TONiC) – Professor Young provided the following update:

Currently working with a genetics company based in Ireland who had made an offer of approximately £2 million in either direct or in-kind funding to genotype 5,000 of the TONiC participants in whole geno sequence. This would enable a biobank of MS samples to be created. As it would exceed the capacity of The Walton Centre's biobank to hold the samples, it was proposed for the biobank to be held at the University of Liverpool's biobank. It was noted that the consent process attached to this would include consent for later use in service studies which would be a valuable resource not only for the Trust, but for external researchers including pharmaceutical companies with regards to commercialisation.

The majority of the contractual work was being undertaken by the contract officers and Legal Department at the University of Liverpool due to limited internal resources. However, it was confirmed that the clinical data would remain at The Walton Centre.

The geno sequences and contract would be returned to Professor Young which would enable them to be shared with other parties in due course either for research or commercial purposes. Also, under the ethics, anonymised data would be placed under national and international repositories for wider use. Concerns were expressed regarding the ability to hold the data files due to the file sizes.

Negotiations were taking place with Roche to undertaken phase 7 of TONiC. It was noted that an application that had been made to the MRC for the programme grant had not been successful and that revisions were being made for resubmission.

Ethics permission had been received for the COVID amendment of TONiC and would be commencing for MS. TONiC had been approached by the patients' organisation MND and the MND register as was the preferred method to look at the affects of COVID on MND with having 38 sites across the UK.

The Committee was informed that TONiC largely worked independently from the NRC. It was noted that the internal financial support for the programme was of a high calibre.

The Chair requested that as a Trust, need to ensure that all opportunities in terms of infrastructure, finance and reputation were capitalised.

3.0 Progress Against the Committee's Annual Work Plan

The Research, Innovation and Medical Education (RIME) Committee Terms of Reference would be taken to the Trust Board on the 30 July 2020 to be ratified following which a revised cycle of business would commence from the next Committee meeting scheduled for the 2 September 2020.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
30 July 2020

Report Title	**Chair's Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Mike Burns, Director of Finance and IT
Purpose of Paper:	
The Walton Centre Charity Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Walton Centre Charity Committee held on 9 July 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Recommendation from the Committee to approve the application for Endoscopic Spinal equipment.
- Recommendation from the Committee to approve the Revised Terms of Reference.

2.0 Items for the Board's information and assurance

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

a) Application for Lab Diagnostic Work

Mr Brodbelt, Consultant Neurosurgeon, presented the application to pay for molecular markers to be performed by pathologists for a group of 31 patients who had survived Glioblastoma for more than 5 years (which was very unusual). The pathology of these patients needed to be relooked at and further molecular markers done taking the overall lab costs to a total of £6,668.00 rather than the initial cost of £3,800.00 which had not required Committee approval. Following discussion and an understanding that the lab tests were important for research study rather than a service issue the Committee approved the application from the Neuro-oncology Fund.

b) Part funding of PhD fees for Christopher Millward

Mr Brodbelt presented an application to part fund PhD fees (up to £3,000 for 3 years) for Christopher Millward who is undertaking research into Core Outcome Sets and Common Data Elements in meningioma. The Committee acknowledged the requirement to commit to fund the entire project over 3 years and approved the application from the Neuro-oncology Fund.

c) Application for Endoscopic Spinal Equipment

Mr Rath, Consultant Neurosurgeon, presented the application which had previously been recommended by the Committee at the meeting in February as a potential fundraising project. Following subsequent presentation at Trust Board in May, due to the amount of the application and financial limits of the Charity Committee, the Board agreed to support the application. The Committee were given a presentation on the new procedure by Mr Rath demonstrating the goal of the new technique was to achieve results that commensurate if not better with current results, while at the same time minimising traumatisation and reducing the long-term effect of spinal surgery. The Committee acknowledged that the project had been through Clinical Effectiveness and Services Group and Capital Management Group in addition to Trust Board and it received overwhelming support and acknowledgment that the Trust needed to be at the forefront of new methods such as this. Trust Board would be notified of the decision of the Charity Committee who would recommend the amount of £131,648.75 (inc VAT) should be funded by the Charity (fund to be determined). It was also noted that the application would be VAT exempt if purchased through charitable funds.

d) Update on Investment Position

The report summarised the Q1 performance of the Charity's two investors CCLA and Ruffer who the Charity invested £500,000 in each respectively in July 2018. The impact of the COVID 19 pandemic had been felt swiftly and directly and activity fell sharply in the first quarter however it was noted that both funds had recovered and currently stood at £545k for CCLA and £511k for Ruffer.

The Committee had requested that for future meetings a more detailed report would be produced showing the ESG ratings of the fund; what the funds were investing in and how we measure against the Trust's Ethical Policy.

e) Finance Report as at 31 May 2020

The Committee were presented with the Finance Report. To 31 May 2020 the Charity had received £100,896 income and incurred £34,747 of fundraising and administration costs. Due to the Coronavirus pandemic many of the annual fundraising events had been cancelled. The loss in income had been partly offset by two grants from NHS Charities totalling £45,500. It was noted that this year could be difficult in terms of raising funds for the charity, given the limitations placed on fundraising by the pandemic.

f) Fundraising Activity Report

The report outlined some of the activities and initiatives that had been undertaken since the last meeting in February. During this time the Trust had operated under very challenging circumstances due to the COVID 19 pandemic and this had affected the charity. Regular reports had been submitted to keep the Committee informed during the past 15 weeks.

The Committee acknowledged that the period had been a positive time for the Charity in being able to facilitate gestures of goodwill and raising the profile. Some things had emerged such as the need for a staff communal area (highlighted through the Project Wingman experience). On a different note it was highlighted that it was the perception of some staff that the Trust didn't support staff well allowing the Charity to fund all day free breakfasts rather than through Trust revenue. It was noted that the next couple of months would be interesting to reflect the landscape of fundraising going forward.

g) Applications for funding from T&D Department

The Committee received the applications which were all approved. At a previous meeting the Education Co-ordinator had been requested to show YTD figures for applications towards Level 2 study. This was noted by the Committee, as was the low number of applications from the Neurology division compared to Neurosurgery. Division leads would be informed about potential support from the Charity towards professional development.

h) Application for Virtual Engagement Rehabilitation Assessment (VERA) Initiative

Dr Bavikatte, Consultant in Rehabilitation Medicine, presented the application for £37,000 to develop the VERA Portal and Patient App. In 2018 the Trust hosted a hackathon to identify innovations that were needed by patients and staff to facilitate treatment/recovery and the concept of a Virtual Engagement Rehabilitation Assistant (VERA) was launched. Since the hackathon the Walton Rehabilitation team have worked in collaboration with the private sector and UCLAN with additional support from University of Liverpool and the Innovation Agency to develop the App to benefit patients going through the rehabilitation journey.

Questions from the Committee included who would provide any future costs if required and if the intellectual property (IP) would reside at the Walton Centre. The Committee noted that much work on IP was underway and that the agreement on the allocation of IP was still to be finalised. Clearly the Walton Centre would own a significant element. Mr Burns said that the Charity should be reimbursed initially from any commercial returns from the App in the future. The Committee agreed to the investment subject to finalising the share of IP.

i) Application for Falls Prevention Equipment

- ***Tabs Falls Alarms Kit***
- ***Safe Presence bathroom sensors***

Ms Flynn, Divisional Nurse Director for Neurology and Rehabilitation / Falls Prevention, presented the 2 applications totalling £9,791.15 (excluding VAT) to supplement the current fall prevention strategies currently in place. Ms Salter was in full support of the application highlighting as well as injury how the psychological impact of a fall impairs recovery. The application was approved, however the applicant was asked to determine whether the equipment qualified as medical equipment because if not VAT would need to be paid in addition to the amount presented.

j) Application for Patient Transfer Scale

Ms Fletcher presented the application for £2,964 (inc VAT) for a Marsden M-999 Patient Transfer Scale. The application was below the threshold of £5,000 to be considered at Committee level but was presented for approval as it had not been successful in gaining funding from the annual Roy Ferguson Award (for bids up to £5,000.). As it would be used in the main on ITU any ongoing costs would be supported by the Neurosurgery Division. Amy Carter, Advanced Dietician, had said that the preference would be for 2 scales to be purchased. Discussion took place and it was queried whether the ITU fund could support the application as it currently had £79k in funds including commitments. Ms Fletcher would take back and it was agreed by the Committee if the fund managers for ITU agreed to the purchase Mr Burns would approve and inform the Committee via email.

k) Review of Charitable Projects Process

The Committee discussed a number of possibilities in order to make the approval process more streamlined. This had come about following a request by the Trust Chair. Discussion covered:

- Changing approval levels of the Charity Committee;
- How best to determine if a project fitted into the strategic direction of the Trust;
- Prioritisation of projects;
- Horizon scanning;
- The involvement of the RDI Committee in the prioritisation of projects; and
- How to encourage applications from staff who found the process too difficult to apply for funding.

The Committee agreed to establish a small sub group of 4/5 members to come up with a solution to streamlining the process. It was noted that the potential formation of a Trust Operational Management Board bringing divisions together would help in establishing priorities of the Trust.

l) Report on longer term commitments to the Charity

The Committee received the report highlighting commitments of the various funds. The Committee found the report useful and requested it be presented at every meeting.

m) Revised Terms of Reference

Mr Burns presented the revised Terms of Reference on behalf of Ms Hindle with all changes noted in red. The main change was that an approval limit of £100k had been incorporated although the Committee queried larger expenditures and asked for it to be stated that the Charity would give its recommendation to Board on any applications over £100k.

Going forward the Committee agreed to a regular item discussing risks associated with the charity and fundraising.

The Committee agreed to the Terms of Reference being presented to Trust Board for approval.

n) Draft Annual Report and Accounts

External Audit would carry out an independent review of the accounts in October 2020 and the draft annual report and accounts were presented for comments. It was noted that the final version would include the impact that COVID 19 had had on fundraising.

o) Home from Home Forecast (refurbishment)

The Committee received the report providing a strategic evaluation of possible timescales and costs for refurbishment / replacements for Home from Home accommodation. This was estimated to be approximately £5,000 over the next 3 years. This was welcomed by the Committee as being a lower expense than anticipated.

***p)* Fundraising Strategy Update**

The Strategy was presented. It had been due at the cancelled meeting in April 20. It was highlighted that income at the end of March 2020 was £808k so did not quite meet the target of £847k but overall this was a pleasing amount to receive without a specific appeal. It was noted that next year's target of £1m would prove to be a challenge following COVID 19 pandemic but the team were remaining positive.

***q)* Review of**

- Investment Policy – Noted with no changes from the previous year,
- Reserves Policy – Agreed to reserve amount maintained at £60k.

The Committee approved both policies.

***r)* Consultancy Annual Report**

The Annual Report was presented to the Committee. Following the decision in April 2019 to continue the strategic consultancy support it was agreed that a report would be brought back at the end of the 12 month period for monitoring and reviewing purposes. As April's meeting was cancelled a decision was made by Mr Burns and Mr Gibney to approve the continuation of the support for 3 months (April to June) to bridge the gap until the July meeting. The Committee considered the report and agreed to continue to support for the remainder of the year (£8k in total).

***s)* AOB**

Dr Moore expressed his concern on decisions made on applications when meeting via MS Teams. He did not think it was clear who had agreed to support applications and if any members had disagreed. Options were discussed and it was considered appropriate in the circumstances to have email approval for an audit trail on decisions made. Although it was considered there had not been any disagreements Ms Woods would circulate to ensure formal approval was received by all.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.