NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 7th July 2022

Agenda and Papers

Excellence in Neuroscience

PUBLIC TRUST BOARD MEETING
Thursday 7 July 2022
Boardroom
09:30am - 12.45pm

The Walton Centre NHS Foundation Trust

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies (v)	Chair	N/A
2	09.30	Declaration of Interests (v)	Chair	N/A
3	09.35	Minutes and actions of meeting held on 9th June 2022 (d)	Chair	Decision
4	09.40	Patient Story (v)	Chief Nurse	Information
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update (v)	Chief Executive Officer	Information
6	10.15	Chairs Reflections of First Three Months and Aspirations (v)	Chair	Information
7	10.20	Trust Strategy (d)	Chair	Decision
8	10.30	Board Assurance Framework Quarter 1 2022-23 (d)	Corporate Secretary	Assurance
INTEGRATED PERFORMANCE REPORT				
9	10.45	Integrated Performance Report (d)	Chief Executive Officer	Assurance
10	10.50	Business Performance Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
11	11.05	Quality Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
11.20 BREAK				
GOVERNANCE				
12	11.30	Major Incident Plan (d)	Chief Operating Officer	Assurance
13	11.40	Review of Covid-19 Board Emergency Powers (d)	Corporate Secretary	Assurance
14	11.45	Non-Executive Director Champion Roles (d)	Corporate Secretary	Information
15	11.55	Audit Committee Assurance Report (d)	Committee Chair	Assurance
FINANCIAL				
16	12.00	Update on Financial Plan 2022/23 (d)	Chief Finance Officer	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Pharmacy and Medicines Management Annual Report (d) • Controlled Drugs Accountable Officer Annual Report (d) • Risk, Governance and Patient Experience Annual Report (d) • Medical Revalidation Annual Report (d) • Medical Education Annual Report (d)				
CONCLUDING BUSINESS				
17	12.20	Any Other Business (v)	Chair	Information
18	12.30	Review of Meeting (v)	Chair	Information

Date and Time of Next Meeting: 9.30am, 1 September 2022, Boardroom, The Walton Centre

UNCONFIRMED

Minutes of the Public Trust Board Meeting

Meeting held via Microsoft Teams

9th June 2022

Present:

Max Steinberg	Chair
Karen Bentley	Non-Executive Director (NED-KB)
Su Rai	Senior Independent Director (SID)
David Topliffe	Non-Executive Director (NED-DT)
Ray Walker	Non-Executive Director (NED-RW)
Mike Burns	Chief Financial Officer (CFO)
Mike Gibney	Chief People Officer (CPO)
Jan Ross	Chief Executive (CEO)
Lisa Salter	Chief Nurse (CN)
Lindsey Vlasman	Chief Operating Officer (COO)

In attendance:

John Baxter	Corporate Governance Officer (CGO) (minutes)
Katharine Dowson	Corporate Secretary (CS)
Matt Holt-Rogers	Wellbeing Consultant – Wellbeing4Business (WC) (item 7 only)
Lisa Judge	Head of Patient & Family Experience (HFPE) (item 4 only)
Julie Kane	Freedom to Speak Up Guardian (FSUG) (item 13 only)
Nicola Martin	Deputy Chief Nurse (DCN) (item 11 only)
Jane Mullin	Deputy Chief People Officer (DCPO) (item 7 only)
Sacha Niven	Deputy Medical Director (DMD) (deputising for MD)
Helen Oulton	Lead Nurse Infection Prevention & Control / Tissue Viability (LN) (item 12 only)
Elaine Vaile	Communications and Marketing Manager (CMM) (item 6)

Observers:

Elaine Vaile	Communications and Marketing Manager (CMM)

Apologies:

Paul May	Non-Executive Director (NED-PM)
Andy Nicolson	Medical Director (MD)

1 Welcome and apologies

1.1 Apologies were received from Paul May, Non-Executive Director, and Andy Nicolson, Medical Director. The Chair welcomed everyone to the meeting.

2 Declarations of interest

2.1 The Chair declared that he was also Chair of both the Shakespeare North Playhouse and the Roy Castle Lung Cancer Foundation and a Board member of National Museums Liverpool.

3 Minutes of the meeting held on 5th May 2022

3.1 The minutes of the meeting held on 5th May 2022 were approved as an accurate record of the meeting.

Action tracker

3.2 Action ref 11.3 was updated and closed for removal from the tracker.

4 Patient Story

4.1 CN introduced the patient.

4.2 The patient informed that they had been referred to Neurology for a Magnetic Resonance Imaging (MRI) scan in 2016 and diagnosed with a significant arteriovenous malformation (AVM). The patient was anxious as no additional information was provided regarding the diagnosis until they were able to meet with the Consultant. The administration of appointments and communications could have been improved. Following discussions with a number of specialists, the patient was left with a number of differing opinions as to the best treatment options.

4.3 The patient opted to undergo a craniotomy at The Walton Centre, however suffered complications, including paralysis of their left side. The patient undertook physiotherapy and regained much of their physical function and was positive about the level of care provided whilst an inpatient. However, once discharged there was much less support in the community, so the patient opted to pay for private physiotherapy. The AVM was not completely removed during surgery and a Consultant from Germany was scheduled to attend to perform further surgery however this was cancelled on four occasions, initially due to the pandemic and now due to post-Brexit complications.

4.3 The patient reported that they wished to give something back following the care they had received and had began volunteering at the Trust before being employed by the Trust as a Patient Support Assistant within the Patient Experience Team. The patient informed that they had met with over 250 patients face to face within the first six weeks in post. 25 potential complaints had been averted by the two Patient Support Assistants and 54 compliments had been received regarding their care, empathy and approach.

4.4 SID queried what support was provided to the patient to assist them to make a decision on which option to take when they were initially provided with the four potential options. The patient stated that they had been left to make a decision on their own as each Consultant had a different opinion on the perceived best approach. It would be difficult to identify any further supportive measures that would have helped in making this decision. The patient felt that they had made the correct decision as the rupture would have occurred and at least it had ruptured in front of the Consultant who was able to deal with the rupture as it occurred. The biggest difficulty for the patient had been communications as there had been an 18 month gap between diagnosis and treatment.

4.5 CN informed that the Trust had introduced patient diaries to capture what happens to the patient while they are in the Intensive Treatment Unit to support patients to understand what had happened to them as part of their recovery.

4.6 NED-RW queried how assurance could be provided that the Trust had provided the right advice and DMD replied that AVM was an uncommon condition and there were no accepted pathways regarding treatment with differing points of view on different treatment options as there was limited evidence pointing to a best practice treatment.

4.7 The Chair recorded his thanks for such an uplifting story and commented that the Trust was very proud that the patient was now part of the team.

The Board recorded their thanks to the patient for sharing their story.

5 Chair & Chief Executive's Report

5.1 CEO updated that national COVID guidance had changed and infection prevention and control guidance no longer required staff, patients and visitors to wear a mask in many parts of the Trust due to a national fall in numbers of positive cases. It was also reported that there had been some unseasonal flu outbreaks across the region. National guidance around monkeypox had been issued and staff were aware of this guidance.

5.2 Sickness absence levels had improved and were currently at just below 5%, this had helped a recovery in appraisal compliance with numbers close to 80%.

5.3 A Senior Lecturer in Neurosurgery had been appointed jointly with Liverpool University.

5.4 The Integrated Care Board (ICB) had requested nominations for membership from all Trusts and there had been a regional agreement to nominate Ann Marr, Chief Executive at St Helens and Knowsley Teaching Hospitals and Joe Rafferty, Chief Executive at Mersey Care NHS Foundation Trust.

5.5 Requests for Neuroscience mutual aid were being received from outside of the region to support the reduction of the longest patient waits nationally. These were being prioritised via the Integrated Care System (ICS).

5.6 The Trust had recently held an online member's event on pain management and this had been well attended with good evaluation feedback received.

The Board noted the verbal update.

6 Communications and Engagement Strategy Update

6.1 CMM detailed the way the Trust uses social media and the effects this has had. The Trust had a presence on four social media platforms. Interactions on all social media platforms had increased in the last twelve months and examples of successful posts that had a wide reach were given as well as those that had generated less interest. It was recommended that this presentation was shared with senior managers.

6.2 CEO noted that discussions on Trust branding had started and an update would be presented to the September Board meeting.

The Board noted the Communications and Engagement strategy update.

7 Health and Wellbeing Strategy

7.1 DCPO and WC joined the meeting to present the Health and Wellbeing strategy.

7.2 NED-DT informed that the Health and Wellbeing strategy had been presented to Business Performance Committee (BPC) and this had been seen as a positive contribution to how

the Trust would differentiate itself within the health economy; the strategy had been enthusiastically endorsed for Board approval.

7.3 CPO agreed that a focus on health and wellbeing identified the Trust as a great employer and good place to work. Health and wellbeing was embedded across the Trust and there had been a lot of engagement with trade unions during the development of the strategy. It was recognised that further assistance was required to develop the strategy so the Trust had utilised Wellbeing4Business to assist with strategy development.

7.4 DCPO stated that the introduction of a health and wellbeing hub was key to the delivery of the strategy and an area had been identified to locate the hub. Work was also ongoing to identify staff break space away from staff work space.

7.5 NED-KB queried if health and wellbeing workshops had been held yet and it was confirmed these had started and the Trust was also offering health checks to staff. The feedback received from these had been extremely positive and all sessions were fully booked. Uptake of all health and wellbeing offers would be reported back to Board as progress reports.

7.6 NED-RW recognised that this had been a great example of utilising external expertise to deliver a strategy. Ward staff were traditionally the least likely to access services offered by Trusts and NED-RW queried how the Trust was tackling this. DCPO informed that there was a dashboard which would show uptake and availability would be cascaded down to all staffing groups. The Trust would meet to discuss this further with the Occupational Health team following approval of the strategy. CPO informed that there was a generic menu of services along with individual offers and emphasised that health and wellbeing needed to be front and centre within the Trust and communication of the offer and access to support were highly integral to the success of the offer.

7.7 DCPO added that development of the strategy had been funded by NHS Charities Together and wished to record thanks to the Walton Centre Charity for funding this work.

The Board approved the Health and Wellbeing Strategy.

8 Integrated Performance Report

8.1 The CEO informed that check and challenge of the Integrated Performance Report (IPR) had been undertaken at Board Committees and the Chairs of the relevant Committee would present this as part of their assurance reports. Work was underway to review and update the content of the IPR and an overview of proposed changes would be presented at a future meeting. There were currently no Nursing vacancies within the Trust and the Trust would assist LUHFT with their recruitment from the next international recruitment cohort.

8.2 NED-DT as Chair of Business Performance Committee (BPC) highlighted that the number of long waiters within the Trust had reduced. There were national discussions regarding the elimination of long waiters and good progress was being made within the Trust.

8.3 Criteria for accessing the Elective Recovery Fund (ERF) had changed and there was now a requirement for the Trust to achieve 104% of pre-COVID activity levels. The Trust had not met this target during April, largely due to staff sickness in theatres, however improvements had been recorded during May.

8.4 Staff sickness levels had decreased in month and turnover had stabilised for clinical staff, but an increase in turnover of staff in corporate roles had been noted.

8.5 The Trust's finance performance was in line with plan, with income and expenditure slightly below planned levels. This was partly due to a reduction in activity. It was also reported that capital spend was below plan during April following a high level of spending in March.

8.6 NED-RW updated on discussions held at Quality Committee and reported that the bed repurposing programme was progressing well with little disruption or disturbance to patients.

8.7 It was noted that all of the complaints received in month were from Neurosurgery division and this would be monitored going forward. A recent Mersey Internal Audit Agency (MIAA) audit of the complaints process had provided significant assurance.

8.8 The number of Health Care Associated Infections (HCAI) recorded were decreasing however it was recognised that this area remained a challenge. It was reported that targets for Clostridium Difficile were set externally and rates were very high within the community due to COVID. The basics of hand hygiene continued to be reiterated and the Trust had undertaken a big drive on appropriate use of Personal Protective Equipment (PPE).

8.9 There had been one serious untoward incident identified of a patient suffering a fracture neck of femur and this had been identified after the patient had transferred into the Trust.

The Board noted the Integrated Performance Report

9 Business Performance Committee Chair's Assurance Report

9.1 NED-DT updated that there had been a deep dive of the results of the People Pulse survey and highlighted that this survey promised to be a valuable indicator of staff mood providing more frequent feedback in a timely manner. The response rate was improving with ongoing work to maximise participation.

9.2 The initial capital allocation received by the Trust was £2m lower than ambition. Since this initial allocation a second bid for funding had been made which had resulted in an additional £1m of capital funding which had been welcomed. It was however recognised that there was still a shortfall of funding and capital programmes would still need to be prioritised.

9.3 CFO highlighted that there had been a reduction in the amount of bank and agency spend and wished to record thanks to CN and nursing teams for their work in reducing this expenditure.

9.4 SID informed that compliance with Better Payment Practice Code targets was improving.

The Board noted the Business Performance Committee chair's assurance report.

10 Quality Committee Chair's Assurance Report

10.1 NED-RW reported that the Care Quality Commission (CQC) Insight Report had been received and there was confidence that Trust performance under the Safe category would improve in the next quarter. Performance in this area had dropped due to two reported

Never Events and a number of of outstanding Central Alerting System (CAS) alerts and the Trust had provided updates on all to the CQC at the last engagement meeting held in April.

10.2 The committee were informed of a new risk relating to a national shortage of Omnipaque and a risk analysis had been undertaken. However the national shortage had now been resolved and this risk would be closed.

10.3 The Quality Accounts had been presented for review and discussion and the committee had recommended these for approval by Trust Board. Outstanding actions would continue to be reported and monitored at Quality Committee on a quarterly basis for assurance.

10.4 SID queried if any lessons had been identified from the Never Events reported and CN informed that both had been discussed and reviewed at Divisional Risk and Governance meetings and the outcomes shared at Divisional meetings and also at the Hospital Management Group meeting. NED-RW asked if a more formal route to Board for receiving assurance on lessons learnt from Never Events and Serious Incidents could be considered.

10.5 SID questioned if any key themes had been identified regarding complaints and it was recognised that an increase in the number of complaints had been identified in month however numbers were within regional benchmarking. There had been some re-opened complaints and these related to not understanding or agreeing with the diagnosis provided; key themes had remained unchanged.

The Board noted the Quality Committee chair's assurance report.

11 Nurse Staffing Bi-Annual Acuity Review

11.1 DCN joined the meeting to present the bi-annual nurse staffing acuity review and highlighted that national guidance had been followed for compiling the report. The Safe Care system would be rolled out across the Trust on 13th June 2022 and this would improve the recording and understanding of data around nurse staffing. This would provide more detail for assurance via completion of ward-based audits.

11.2 No staffing red flags had been recorded during the reporting period and it was recognised that training and education data was improving. Infection prevention and control metrics had improved during May with one case of E-Coli recorded during the month. Complex Rehabilitation Unit (CRU) had previously been an outlier for staffing incidents however there had been a change in management on the unit and no concerns had been raised since then.

11.3 An overview of international recruitment plans was provided and it was reported that the Trust had increased their offer of assistance to Liverpool University Hospitals NHS foundation Trust (LUHFT) and would be providing 28 nurses from the next international recruitment allocation to LUHFT; with 22 nurses to remain allocated to the Walton Centre.

11.4 A number of controls were in place regarding temporary staffing to provide assurance and the impact of this was detailed within the report. It was also noted that staff sickness data was much improved during May.

NED-DT queried the establishment recorded in the narrative of the report and shown in the data table. DCN clarified that the Trust sometimes used above their establishment due

11.5 to specialising and this required professional judgement to be utilised. The Safe Care system would provide additional levels of detail regarding acuity and this may demonstrate a need for improved staff usage rather than just a need for more staffing. CN informed that research showed that a number of layers of information would be required before funding for additional staffing could be approved and the Safe Care system would provide this information in real time.

11.6 NED-RW recognised that staffing was safe and sustainable and noted that sustainable was about deploying staff to the right areas at the right time and staffing focus should be on safety rather than numbers. The report could also be utilised to triangulate staffing data against numbers of complaints to understand if there was any correlation.

11.7 SID queried if the Trust would be able to quickly access international recruitment programmes if staffing levels were to change and it was clarified that the next allocation of internationally recruited nurses would be joining the Trust in the Autumn however a pipeline for staff recruitment was also in place.

The Board noted the nurse staffing bi-annual acuity review update.

12 Infection Prevention and Control Annual Report

12.1 LN joined the meeting noting that the annual report had been reviewed at Quality Committee. The annual report included a reduction plan, along with plans for how these reductions would be met and it was recognised that the number of infections during 2021/22 were above targets, however this fitted the national profile. There had also been a drop of 20% in the number of MSSA infections and the Trust was no longer an outlier in this area.

12.2 Significant work had been undertaken around data collection and how this data cold be improved, this would allow more targeted and focussed infection prevention and control interventions. It was recognised that COVID-19 had been the main focus with seven outbreaks identified and these were now being resolved in a more timely manner.

12.3 It had been a difficult year for staffing within the infection prevention and control team however staffing issues had since been resolved and plans were in place to complete all outstanding workstreams.

12.4 The Trust had not met flu vaccination targets in 2021/22 and it was highlighted that this was partially due to staff having to attend the vaccine hub at Aintree to receive the vaccine. The vaccination programme was being delivered within the Trust again this year and planning was underway for the programme with a Commissioning for Quality and Innovation (CQUIN) target set for the programme.

The Board noted the infection prevention and control annual report.

13 Freedom to Speak Up Guardian (FSUG) Annual Report

13.1 FSUG joined the meeting to provide an update on the Freedom to Speak Up process and activity during 2021/22. In addition to the Freedom to Speak Up Guardian (FSUG) role there was also a Non-Executive Director Lead, Freedom to Speak Up Champion and seven Freedom to Speak Up Advocates across the Trust with the aim of having a Champion or Advocate in every area of the Trust. Advice and guidance was offered and drop-in sessions

for all staff had been reintroduced. FSUG attended Junior Doctors forums and staff meetings across the Trust throughout the year and discussions were also held with the Non-Executive Director Lead to review Champion and Advocate roles and arrange walkabout sessions. An overview of the next steps identified was provided and a meeting had been arranged to progress these and it was highlighted that e-learning modules would be rolled out across the Trust in July.

13.2 The Trusts Raising Concerns policy was currently out of date however a review of the national raising concerns policy was underway. Following publication of the updated national policy the Trust policy would be reviewed in line with the national policy.

13.3 CN highlighted the importance of staff having opportunities to meet FSUG. SID queried if staff who work night shifts had access to the FSUG and it was confirmed that regular walkabouts were undertaken during evenings and all staff also had access to the FSUG email address. CEO also informed that Talking, Engagement, Actions (TEA) sessions had been included in the engagement events programme for staff who worked night shifts.

13.4 NED-RW questioned how the Trust could understand if improvements had been made and it was confirmed that regular staff surveys were undertaken along with drop-in sessions. FSUG also took part in mock CQC inspections.

The Board noted Freedom to Speak Up Guardian report.

14 Audit Committee Chair's Assurance Report

14.1 SID provided an update from the Audit Committee meeting held on 17th May 2022 and highlighted that the draft annual report and finance accounts had been reviewed prior to being submitted for approval and sign off. The Trust had met with external audit partners Grant Thornton to discuss the progress of external audits and there had been no concerns to report. The annual report and finance accounts would be presented for sign off on 20th June however it was noted that there may be some delay to completion of the Trust's Value for Money audit.

14.2 The Trust's Quality Account had been considered consistent with the annual report. Presentation of the Quality Account to external stakeholders would be held on 10th June.

14.3 Reports detailing the Board of Directors register of interests, fit and proper persons review and independence of Non-Executive Directors were presented for consideration. There were some factors for consideration around the independence of one Non-Executive Director however it had been agreed that there were no concerns regarding their independence.

14.4 A presentation of clinical audit had been provided and discussions were underway to review how to gain assurance around clinical audit from Quality Committee.

The Board noted the Audit Committee chair's assurance report.

15 Neuroscience Programme Board Chair's Assurance Report and Terms of Reference

15.1 MD provided an update from the Neuroscience Programme Board meeting held on 12th May 2022 and highlighted concerns raised regarding spinal patients in the secondary care setting. This was an issue that the Trust would be required to take the lead on regarding how to manage referral pathways.

15.2 The Trust had been allocated funding for a Pain Collaboration review, however the Trust had been unable to recruit a Project Manager and an alternative approach was now being considered.

15.3 The Neuroscience Programme Board terms of reference (ToR) were presented for oversight and noted. It was recognised that the Board was formally constituted by the Integrated Care Board (ICB) and the ToR had been submitted for formal approval there.

The Board noted the Neuroscience Programme Board chair's assurance report and terms of reference.

16 Research, Innovation and Medical Education Committee Chair's Assurance Report

16.1 A verbal update had been provided at the Trust Board meeting held in May. It was highlighted that Dr Andreas Goebel, one of the lead authors for the new UK clinical guidelines for the diagnosis of fibromyalgia syndrome had presented. Dr Goebel had also been involved in an auto-immune basis for fibromyalgia study which had been nominated in December 2021 by the Guardian newspaper as one of the top ten science stories of the year.

The Board noted the Research, Innovation and Medical Education Committee chair's assurance report.

17 Strategic Black, Asian and Minority Ethnic (BAME) Committee Chair's Assurance Report

17.1 SID provided an update from the Strategic Black, Asian and Minority Ethnic (BAME) Committee meeting held on 16th May 2022 and highlighted the committee effectiveness review that had been undertaken. It was recognised that a review of the aims and objectives of the committee was required and a working group would be formed to consider this. An overview of points of assurance regarding equality, diversity and inclusion communications across the Trust was provided.

17.2 The North West Strategic Black, Asian and Minority Ethnic Committee would offer Trusts accreditation against the Anti-Racist Framework. The Anti-Racist Framework was led by the Northern Care Alliance and there was an expectation for Trusts to develop an implementation plan.

17.3 The committee received a presentation regarding Indices of Multiple Deprivation (IMD) and this data showed that there was no correlation on waiting times however there was a correlation with Did Not Attend (DNA) rates for both face to face and virtual appointments. The data also demonstrated no correlation with rates of complaints.

17.4 It was reported that the Equality and Inclusion Lead and Head of Equality, Diversity and Inclusion had both unfortunately resigned from the Trust for differing reasons and a recruitment process was underway. The Head of Equality, Diversity and Inclusion position had been a joint appointment across three Trusts however there had been some divergence in how to move forward with the role and this approach would be reviewed.

The Board noted the Strategic Black, Asian and Minority Ethnic (BAME) Committee chair's assurance report.

18 **Consent Agenda**

18.1 The Board agreed the following actions in relation to each Consent Agenda item:

- **Infection Prevention and Control Board Assurance Framework** – noted the Infection Prevention and Control Board Assurance Framework
- **Safeguarding Annual Report 2021/22** – approved the safeguarding annual report 2021/22.
- **Request for Use of Trust Seal** – approved the use of the Trust seal.

19 **Any Other Business**

19.1 There was no other business to be discussed.

20 **Review of Meeting**

20.1 Those present agreed the agenda covered a lot of ground, that the meeting was open, strategic and well chaired with a good level of debate.

There being no further business the meeting closed at 12.30

Date and time of next meeting - Thursday 7th July 2022 at 09:30 Boardroom

Trust Board Attendance 2022-23										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Mr M Steinberg	✓	✓	✓							
Ms K Bentley	✓	✓	✓							
Mr P May	✓	✓	A							
Ms S Rai	✓	✓	✓							
Mr D Topliffe	✓	✓	✓							
Mr R Walker	✓	✓	✓							
Mr M Burns	A	✓	✓							
Mr M Gibney	✓	✓	✓							
Dr A Nicolson	✓	✓	A							
Ms J Ross	✓	✓	✓							
Ms L Salter	✓	✓	✓							
Ms L Vlasman	✓	✓	✓							

TRUST BOARD
Matters Arising Action Log
July 2022

	Complete & for removal
	In progress
	Overdue

Actions for Completion

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
03/02/22	11	**Reducing the Burden and Releasing Capacity** Board to review the continuation of emergency powers.	CS	On agenda – item 14	July 22	

The Walton Centre NHS Foundation Trust

Report to Trust Board
7th July 2022

Report Title	The Walton Centre NHS Foundation Trust Strategy 2022 to 2025
Executive Lead	Dr Andy Nicolson Medical Director
Author (s)	Executive Directors Julie Riley, Deputy Director of Strategy
Action Required	To approve

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- An ambitious but realistic strategy for the next 3 years
- Builds on and furthers the Trust's excellent reputation in neurosciences
- Developed using a fully inclusive approach

Next Steps

- To finalise the strategy
- Launch and market the strategy

Related Trust Strategic Ambitions	**Impact**		
Not Applicable	Choose an item.	Choose an item.	Choose an item.

Strategic Risks

Choose an item.	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ✓	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive away day and Trust Board development session	September 2021	Chair and CEO	To develop the strategy
Trust Board	December 2021	Chair and CEO	Agreement in principle
Trust Board	April 2022, May 2022, June 2022	Chair and CEO	Main ambitions agreed and to move to completion

The Walton Centre NHS Foundation Trust Strategy

2022 to 2025

Executive Summary

1. The sharing of the strategy with the Board is to obtain approval on content. Further work on style and presentation will take place ready for final completion by July 2022.

2. The strategy is focussed over a three-year period due to the pace of change within the NHS which has accelerated due to the impact of the COVID-19 pandemic and the changes in infrastructure brought about by the Health and Care Bill.

Background and Analysis

3. The Walton Centre is a National leader in the treatment and care of neurology and neurosurgery, placing the patient and their family at the heart of everything provided. As the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services we are proud to be rated as an 'Outstanding' Trust by the Care Quality Commission (CQC).

4. We serve a catchment area of 3.5 million people across Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man, north Wales and beyond with service partnerships with 18 NHS hospitals. Our 'Walton Clinics' model on 44 sites providing care for neurology means that many people are able to access outpatient consultations and many tests closer to home and takes specialist services as close to service users as possible.

5. Since the last strategy, which was developed in 2018, we have grown, developed and innovated for the benefit of patients and their families. This includes being the first neuroscience centre in the region to provide a 24/7 thrombectomy service, the introduction of the Rapid Access Neurology Assessment (RANA) service and developing a wide range of digital innovations such as Virtual Engagement Rehabilitation Assistant (VERA) and Elementary Routine Nutritional Screening Tool (ERNST). We have been recognised for the highest quality of service in several clinical areas, including achieving Tessa Jowell Centre of Excellence status for the care of patients with brain tumours, recognition as a Centre of Excellence for spinal services by Eurospine.

6. In this new strategy we are excited to expand our services further and will deliver on further innovation, research and development along with the key initiatives.

7. An inclusive approach has been taken to formulating this strategy and have met with staff from across the Trust, patients and carers, voluntary sector, support groups, our Governors and members and representatives from partner Trusts, primary care and the Integrated Care System (ICS).

8. This strategy sets out the ambitions for The Walton Centre which will inform decisions for the continuing journey to maintain the outstanding rating as both a regional and national centre. Further development of the services across Cheshire, Merseyside, North Wales and Isle of Man will continue as well as developing national neuroscience services. Working in partnership with the emerging Cheshire and Merseyside Integrated Care System (ICS) will show the value and unique position of the Trust as a key partner within that system.

9. The strategy aligns with national, regional and local system plans, including acute and primary care services along with voluntary and third sector, linking in with the Cheshire and Merseyside ICS, place-based plans and those of One Liverpool.

10. Covid-19 has dominated lives and the provision of healthcare since March 2020. As we move into a different phase of living with covid, there is a need to focus on the recovery of elective services and the inevitable backlog and longer waiting lists. It is therefore more important than ever to work collaboratively as part of the health and social care system, for the benefit of the population as a whole.

11. The positives that have emerged through the covid pandemic in the delivery of healthcare through collaboration and relationships will be maintained this includes our continuing offer of mutual aid as was clearly seen within the Stroke collaboration during the first phase of the pandemic. NHS organisations have come together and collaborated like never before, and relationships have been built which need to be maintained and developed further. IT infrastructure has been enhanced, through necessity, to provide remote consultations for patients where appropriate, and improve efficiency through remote meetings, which will be continued.

12. The new Health and Care Bill sets out legislative changes required to enable health and care to work more closely together. In our region the Integrated Care System (ICS) covers Cheshire and Merseyside, and as such is one of the largest ICSs in the country serving a population of 2.7 million, across nine boroughs or 'Places'. The ICS will become embedded as the body responsible for delivering health and social care throughout the duration of this strategy, and it is essential that this addresses the needs of our population. One of the main drivers of the development of the ICS is to address health inequalities, which has been highlighted in the 10 year review of the Marmot report (2020). This is of particular relevance in our region, which contains some of the most deprived boroughs in England, but also some of the widest health inequalities even within those 'places'.

The opportunities

13. The NHS faces unprecedented challenges currently as we emerge from the covid pandemic. This is on the backdrop of a staffing crisis, especially in nursing with almost 40,000 vacancies across England. The need to work together, with the population and staff to deliver high quality compassionate care for all is of paramount importance.

Our strategy

14. There are five strategic ambitions:
    - education, training and learning
    - research and innovation
    - leadership
    - collaboration
    - social responsibility.

15. There are seven enabling strategies which cut across all components of this strategy:
    Quality – Ensuring the delivery of the highest quality of care to our patients and their families
    People – Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background

Estates, facilities and sustainability – Taking a multidisciplinary approach to ensuring that sustainability in estates and facilities is at the heart of our work
Finance and commercial development – Maximising use of resources, improving productivity and developing market opportunities to deliver best value for the Trust and the wider system
Communications and Marketing – Promoting our work as the only specialist neurosciences NHS trust and ensuring patients and staff receive the best quality information
Charity – Supporting the work of the Trust through new opportunities and initiatives in particular digital fundraising
Digital – Developing and implementing industry leading digital solutions for our patients and our people

16. All of the above will be underpinned by sub strategies which will provide detail and action plans.

Conclusion

17. The document will be developed into the agreed format for launching and marketing both within and outside of the organisation

18. This strategy sets our ambition and direction for the next 3 years.

Recommendation

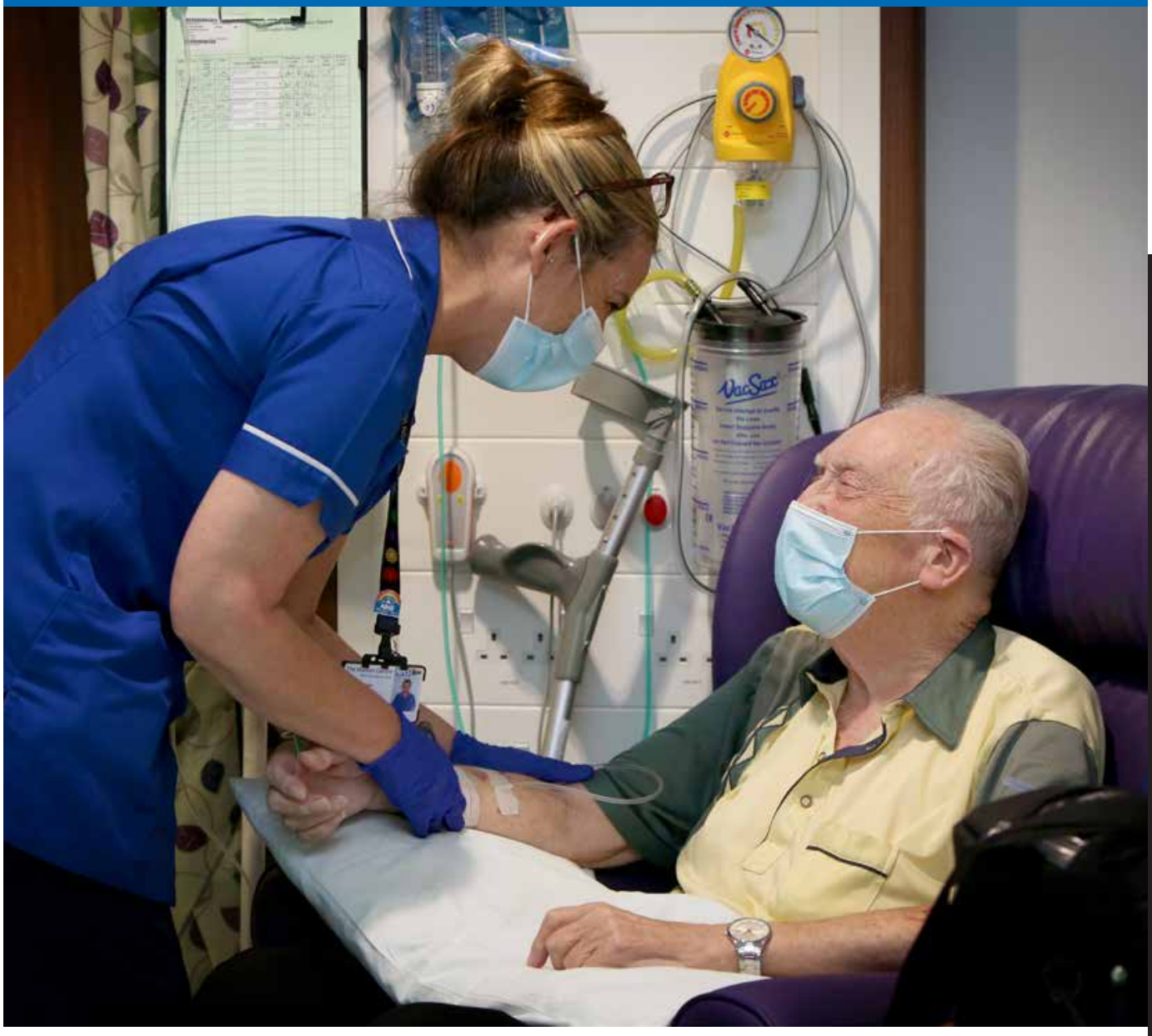
To approve the content of the Trust Strategy.

Author: Julie Riley
Date: 28th June 2022

NHS
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust
Strategy 2022 to 2025



Contents

Foreword

The Walton Centre is the only specialist hospital trust in the UK providing comprehensive neurology, neurosurgery, spinal and pain management services. Our three-year strategy sets out how we will continue to deliver excellent clinical outcomes and patient experience in brain, spinal and neurological care, both nationally and internationally.

The strategy covers the three years from 2022 to 2025, and reflects the pace of change in the NHS due to the COVID-19 pandemic and the infrastructure changes brought about by the Health and Social Care Bill 2021.

At The Walton Centre, we place our patients and their families at the heart of everything we do. We are a national leader in neurology and neurosurgery, and are rated as 'Outstanding' by the Care Quality Commission (CQC). We have leading specialists and dedicated staff across our site in Liverpool, and offer a world-class service in diagnosing and treating injuries and illnesses affecting the brain, spine and peripheral nerves and muscles, and in supporting people with a wide range of long-term neurological conditions.

We serve an area of 3.5 million people across Merseyside, Cheshire, North Wales, the Isle of Man, and parts of Lancashire and Greater Manchester, and have service partnerships with 18 NHS hospitals. Our 'Walton Clinic' model of care for neurology means that many patients are able to access outpatient consultations and some tests closer to home, at 44 satellite sites. Neurosurgery, highly specialised assessments and inpatient care is carried out at The Walton Centre itself.

Since our last strategy in 2018, we have grown, developed and innovated at pace. This includes being the first neuroscience centre in the region to provide a 24/7 thrombectomy service, the introduction of the Rapid Access Neurology Assessment (RANA) service and developing a wide range of digital innovations such as the Virtual Engagement Rehabilitation Assistant (VERA) and the Elementary Routine Nutritional Screening Tool (ERNST).

We have been recognised for our high-quality service, including achieving Tessa Jowell Centre of Excellence status for the care of patients with brain tumors, and recognition by Eurospine as a centre of excellence for spinal surgery and service.

This new strategy sets out how we will expand our services further and will continue to innovate, research and develop. We also highlight what the key initiatives will be over the next three years, and how we will further develop our services across our regions, as well as developing national neuroscience services.

We will work in partnership with the emerging Cheshire and Merseyside Integrated Care System (ICS), cementing our unique position as a key specialist partner within that system.

Our strategy aligns with national, regional and local system plans, including acute and primary care services, along with the voluntary and third sector, linking in with the Cheshire and Merseyside ICS' place-based plans and those of One Liverpool, North Wales, and across Merseyside.

In developing this strategy, we involved staff from across the Trust, patients and carers, the voluntary sector, support groups, our Governors and members, and representatives from partner trusts, primary care and the ICS. There has been positive engagement from staff and stakeholders, who clearly hold The Walton Centre dear to their hearts. We will continue to listen and engage, and use that feedback to further influence our plans as we implement our strategy.

Jan Ross
Chief Executive

Max Steinberg CBE
Chairman

About us

The Walton Centre is the only specialist neurosciences NHS trust providing a high-quality, integrated and multidisciplinary service to Merseyside, Cheshire, North Wales, the Isle of Man and parts of Lancashire and Greater Manchester – a population of 3.5 million people.

We were rated as 'Outstanding' for a second time by the Care Quality Commission (CQC) following its inspection in April 2019.

Our 'hub and spoke' clinical model means we have satellite clinics in multiple sites across our region, enabling patients to be seen closer to home by the most appropriate specialist, with an average of 180,000 patients per year seen in clinics. We have one of the busiest neurosurgical units in the country, with over 50,000 procedures carried out each year. We are partners in the Merseyside Major Trauma Centre Collaborative with our neighbouring trust, Liverpool University Hospitals NHS Foundation Trust. We also host the Cheshire and Merseyside Rehabilitation Network and the Cheshire and Merseyside Critical Care and Major Trauma Network.

The hospital is five miles from the centre of Liverpool, in a purpose-built building which opened in 1998. We have around 150 acute beds, 30 complex rehabilitation beds, 10 acute rehabilitation beds, and it is one of only a few centres in the UK with a dedicated Neurocritical Care Unit. We are also one of a small number of trusts that has an intraoperative MRI suite, in addition to six other operating theatres. We have four additional high-resolution MRI scanners and two CT scanners, ensuring our patients have access to the best diagnostic facilities possible. We perform over 40,000 scans per year.

The Sid Watkins building at The Walton Centre, which opened in 2015, houses the Cheshire and Merseyside Complex Rehabilitation Unit, together with outpatient facilities, the 'Home from Home' centre for use by patients' families, and a dedicated Education Department.

We are proud to be one of the best places to work and have achieved the industry standard Investors in People Gold for our organisational culture and our health and wellbeing support for staff.

The Walton Centre Charity

The Walton Centre Charity supports the vital work of the trust by investing charitable funds in areas and projects that enhance patient, family and staff experience, treatment and care.

The Walton Centre Charity
Supporting Excellence in Neuroscience

The Charity focuses on four key areas
Improved environment and facilities for patients and their families
Innovation and new technology
Research and development
Enhanced staff training and wellbeing

Our vision

Excellence in Neuroscience

Our vision at The Walton Centre is underpinned by a shared set of values. These behaviours are encouraged in all we do.

Our mission

Specialist staff working collaboratively to reduce health inequalities and achieve excellent clinical outcomes and patient experience.

The Walton Way

At The Walton Centre we are guided by clear values which were developed and are upheld by our staff.

These values include a learning culture that empowers staff to make and lead change, be curious and seek continuous improvement.

The Walton Centre serves an area of 3.5 million people

The Walton Centre is rated Outstanding by the CQC

Service partnerships with 18 hospitals in the region

Our 'Walton Clinic' neurology model serves 44 satellite sites

The Walton Centre employs 1,511 members of staff

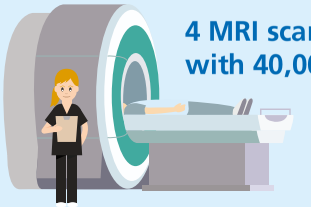
The Walton Centre hosts:

- Cheshire and Merseyside Rehabilitation Network
- Cheshire and Merseyside Critical Care Network
- Major Trauma Centre Collaborative

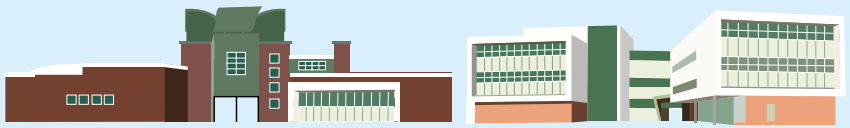
180,000 patients per year seen across all our clinics

50,000 neurosurgical procedures carried out every year

150 acute beds, 30 complex rehabilitation beds, 10 acute rehabilitation beds



4 MRI scanners and 2 CT scanners, with 40,000 scans per year



The health landscape

The COVID-19 pandemic has dominated lives since March 2020, and has had a huge impact on healthcare provision. As we emerge from the pandemic, there needs to be a sustained focus on the recovery of clinical services and tackling the backlog of patients needing care and treatment. It is therefore more important than ever that the health and social care system works collaboratively, for the benefit of the population as a whole.

The NHS has demonstrated its resilience and adaptability during this unprecedented period. There has been increased collaboration in the delivery of healthcare, which will continue to be needed to ensure equity of access. IT infrastructure has been improved, to enable remote consultations for patients during COVID restrictions. The efficiencies that this led to need to be continued.

The Health and Social Care Bill 2021 set out the legislative changes needed to enable health and care to work more closely together, setting up Integrated Care Systems (ICS) across England. In our region, the ICS covers Cheshire and Merseyside, and is one of the largest ICSs in the country. The ICS will be responsible for delivering health and social care for the duration of our strategy.

> **The Cheshire and Merseyside Health and Care Partnership will serve a population of 2.7 million people, across nine boroughs, or 'places'.**

One of the main drivers of the development of the ICSs was to address health inequalities. This is a key issue in our region, which contains some of the most deprived boroughs in England and has some of the widest health inequalities.

There is a staffing crisis across the country in health and social care, especially in nursing which has almost 40,000 vacancies across England. The Walton Centre is working hard to recruit and retain the best people, to remain an outstanding place to work, and to prioritise the health and wellbeing of our workforce.

Our strategy

This strategy comprises five strategic ambitions which outline the key direction for the Trust and our focus for delivering the very best patient-focused treatment and care. There are seven enabling strategies which will feed into every element of our work.

The strategy comprises five strategic ambitions

Education, training and learning	Research and innovation	Leadership	Collaboration	Social responsibility

Underpinning these ambitions are seven enabling strategies:

Quality
Ensuring the delivery of the highest quality of care to our patients and their families

People
Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background

Estates, facilities and sustainability
Taking a multidisciplinary approach to ensuring that sustainability in estates and facilities is at the heart of our work

Finance and commercial development
Maximising use of resources, improving productivity and developing market opportunities to deliver best value for the Trust and the wider system.

Communications and Marketing
Promoting our work as the only specialist neurosciences NHS trust and ensuring patients and staff receive the best quality information

Charity
Supporting the work of the Trust through new opportunities and initiatives, in particular digital fundraising

Digital
Developing and implementing industry-leading digital solutions for our patients and our people

Strategic ambitions

These five strategic ambitions outline the key direction for The Walton Centre and our focus for delivering the very best patient-centred treatment and care. They are the basis for how the Trust will expand its services and continue to innovate and develop, ensuring we stay at the forefront of neurosciences and provide the very best outcomes for patients and their families.

Education, training and learning

We are a national leader in neurosciences education and training, and aim to improve the quality of care for patients with neurological symptoms in all settings. We are one of the leading providers of medical education in neuroscience in the UK and beyond.

We have close links with universities in north west England and North Wales, and deliver training of the highest standard to the next generation of doctors, nurses and allied health professionals. Consistently excellent feedback is received from undergraduate medical students and in the General Medical Council (GMC) trainee survey.

Through our system leadership role in neurosciences, we will share our knowledge and expertise, and provide support to our colleagues. We will have closer clinical interaction with colleagues in the ICS, and will provide teaching sessions and learning packages.

We will continue to be involved in regional neuroscience conferences and will share our expertise at national and international teaching courses and conferences.

Our staff are trained to the highest level using the most up-to-date techniques and innovations to enable the best outcomes for patients.

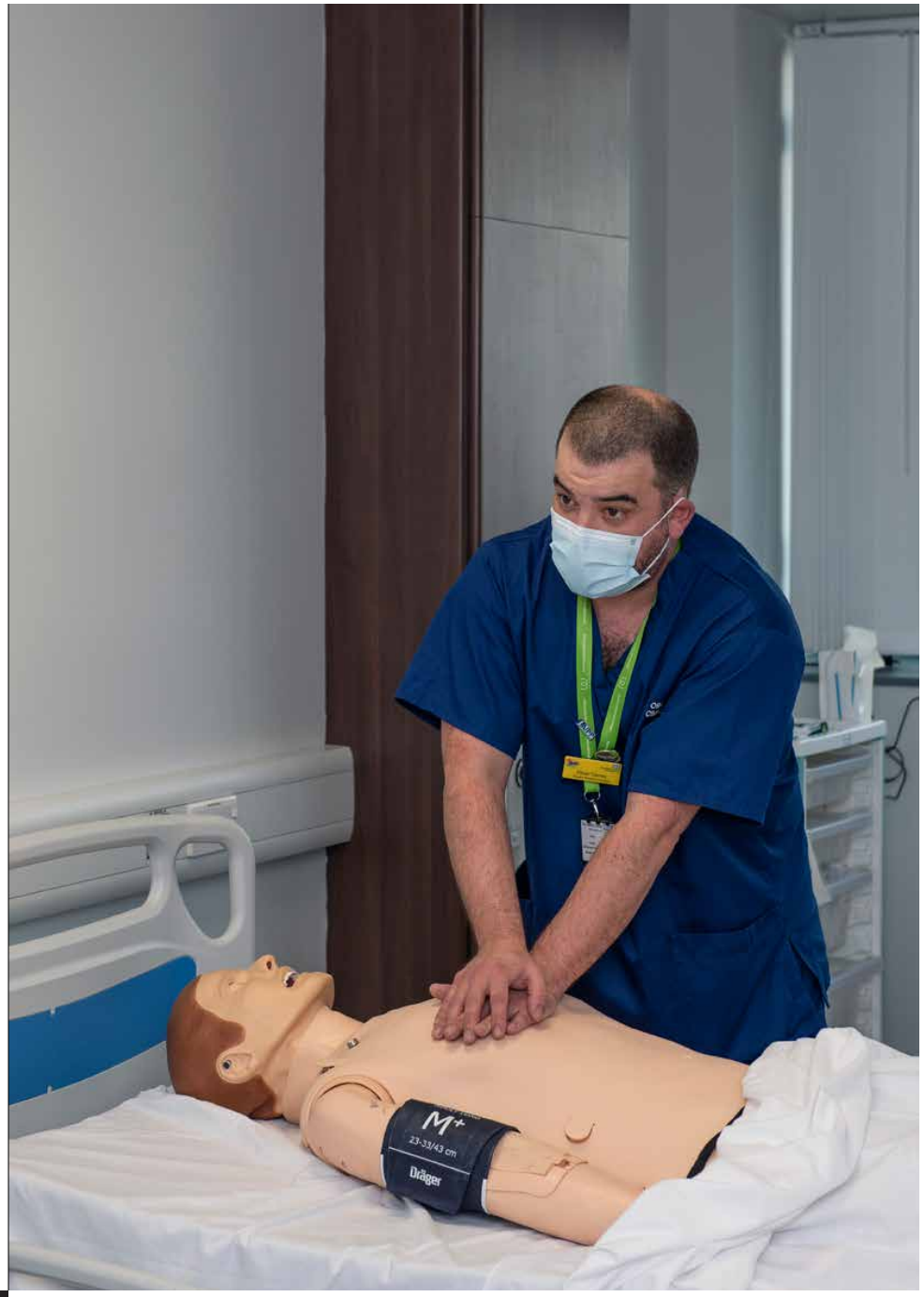
We will expand national training opportunities in neurology including the Neuropodcases web resource and the NeuroPACES course for physicians in training.

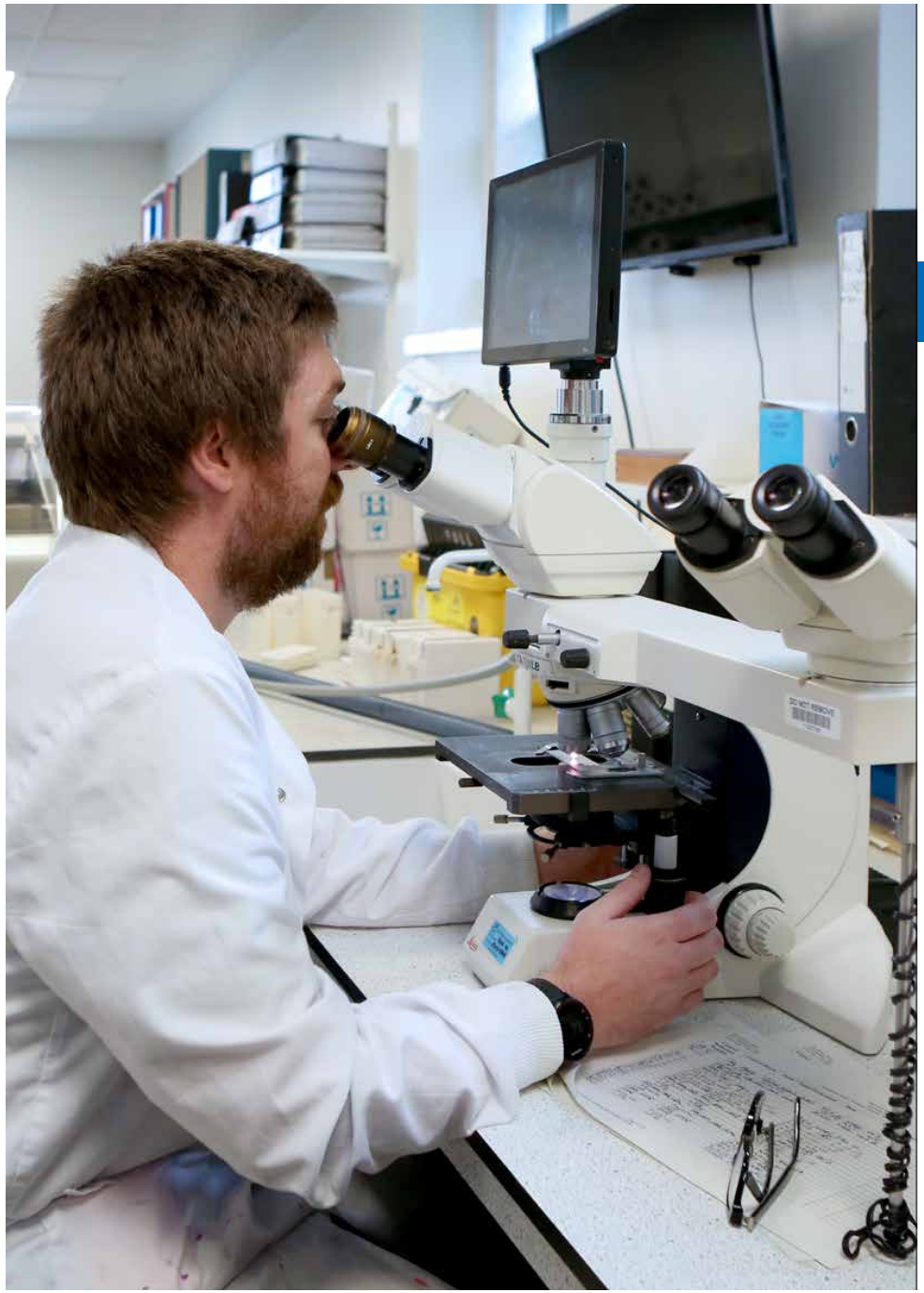
How we will know we have succeeded
Achieve year-on-year improvements in feedback in the GMC trainee survey
Expand delivery of undergraduate medical education
Establish national virtual reality training programme in neurosurgery
Lead and deliver a national neuroscience conference
Develop a national hub for training in robotic and endoscopic spinal surgery
Develop advanced training modules for non-medical staff jointly with higher education institutions

> **Over the coming years, our spinal team will develop a national hub for training in innovative, minimally invasive robotic and endoscopic spinal surgery. We are the first NHS trust to invest in a virtual reality simulator for neurosurgical training. We will expand the training opportunities that this provides to regional neurosurgical trainees and deliver national training courses.**

We will continue to provide training and further education opportunities, such as advanced modules in rehabilitation, developed in collaboration with local higher education institutions.

By investing in education and training, we will attract the best staff to work with us and ensure we have a workforce fit for the future.





Research and innovation

The Walton Centre has a proud tradition of delivering high-quality clinical neuroscience research, in collaboration with our local universities and commercial partners.

Our clinicians have research expertise in areas including epilepsy, neuroinflammatory disease, neurological infections, neuro-oncology, spinal disorders, pain and neurodegenerative disease. During the pandemic, clinicians from The Walton Centre led UK research into the neurological manifestations of COVID-19.

> **We will continue to focus on research to ensure that patients can benefit from evidence-based**

We will support our staff and provide opportunities for them to undertake research by developing areas of focus, based on the needs of the population we serve. We have excellent links with academic institutions and these will be strengthened further as we recruit to more combined academic posts for both medical and non-medical staff. We will work with universities to expand research in neurosciences and pain, with collaborations between clinicians and scientists.

We want to become a world-leading neurosciences research centre and will do this by developing a business model for research and development, and offering opportunities for reinvestment and growth.

We attract the most highly skilled and motivated people, who want to support our research and innovation ambitions. We will foster and develop a culture of innovation to enable our teams to improve services to patients through advanced technologies. All staff will be empowered to develop innovative solutions to any issue they identify. Our culture will be one of openness, continual learning and curiosity for ways to improve our own practice.

How we will know we have succeeded
Increase the number of active research studies from baseline by 20%
Increase the number of research active clinical staff by 20%
Increase the number of our patients offered the opportunity of participation in clinical trials by 20%

Leadership

Clinical leadership is key to the successful delivery of high-quality patient care. Developing the right people with the right skills and the right values is a key priority to enable the sustainable delivery of health services, as leadership is one of the most influential factors in shaping an organisational culture.

We want to attract and retain the best leaders. Our aim is to develop leaders who embrace change and lead through positivity. Our succession planning and talent management will ensure we have the right staff in the right roles, and that they personally develop as well as improve our services.

Ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental. The trust needs high-quality leaders at every level and in every area to ensure that it is able to deliver high-quality, compassionate care to the people it serves. Leaders come in many different forms and can operate at any level; leadership can bring about positive outcomes for staff and the organisation.

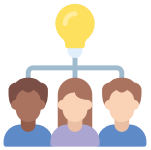
We are the first trust to become an affiliate member of the Faculty of Medical Leadership and Management (FMLM). We will develop this association, with specific input into leadership development, both medical and non-medical, and medical appraisal. We will continue to offer non-clinical leaders' opportunities to develop.

> **We believe in a consistent and fair approach to leadership, which runs through the organisation and our Walton Way values.**

We will lead on developing expertise in neurosciences in the region through our system leadership role and with greater involvement along the whole patient pathway, from the community through to secondary and tertiary care services.

How we will know we have succeeded
Develop a clinical leadership programme with the FMLM
Lead on the development of clinical pathways regionally for neurological and spinal conditions
All staff in leadership roles will have the opportunity to complete and internal leadership programme

We have developed pathways of care for common conditions such as headache, seizures and back pain. In association with patient groups, primary care and partner trusts, we will work to enhance care so that patients are managed in the correct setting, in a timelier manner, and only access specialist services when needed. Examples of current work in this area include the multiple sclerosis optimum pathway and the Parkinson's Disease Excellence Framework.



Collaboration

We have for many years had a wide geographical footprint. Our services cover the whole of the Cheshire and Merseyside ICS, but also beyond into North Wales, the Isle of Man and parts of Lancashire and Greater Manchester. We have therefore always collaborated with partners in the health system to improve patient care. Within the new ICS, we will further develop our clinical and non-clinical collaborations, which will build on existing services.

The Walton Centre plays a pivotal role in the region in addressing the challenge of unwarranted variation and ensuring quality of care. As the sole provider of neurosciences within Cheshire and Merseyside, we are committed to demonstrating to the Integrated Care Board how we can add value to the wider health system through positively impacting patient flow, length of stay and accident and emergency capacity. We will work closely with our acute partners, social care and voluntary groups to achieve this.

Neurology

We currently deliver the highest quality neuroscience services regionally. We will continue to build on our successful 'hub and spoke' model, which provides care closer to home for many patients. We will enhance this further by developing an acute neurology service with our external clinical partners, based on 'Getting It Right First Time' (GIRFT) recommendations.

The newly formed Rapid Access Neurology Assessment (RANA) service will be developed into a one-stop-shop service. This service will contribute to a significant reduction in inpatient bed days in our partner trusts, in addition to a reduction in investigations, both of which will results in savings for the wider system. Most importantly, patients with acute neurological conditions will be assessed and investigated by an appropriate specialist in a timely manner, which will improve patient outcomes and experience.

Stroke

We are the only neuroscience service in the north west to provide a 24/7 thrombectomy service for stroke patients. We will work with partners on the optimum pathways so that the best outcomes for patients can be achieved, which will be monitored through the regional multidisciplinary team.

We will increase the number of patients treated with this life-saving technique by 20 per cent. We will continue to work to support the development of the Mid-Mersey stroke model.

Rehabilitation

The Walton Centre has a unique complex rehabilitation service, supported by state-of-the-art facilities. We host the Cheshire and Merseyside Rehabilitation Network, an example of an existing collaborative network across providers. We aim to be the lead provider in this network and believe that we can work with our current partners and others to enhance rehabilitation further for all patients and to work in collaboration with the stroke rehabilitation services.

Within the three-year duration this strategy, by working collaboratively with partner organisations, we will:

- Reduce mean length of stay for patients with neurological conditions by two days
- Reduce admissions to acute trusts by 10% for patients with neurological symptoms by expanding the acute neurology model
- Increase the number of patients with acute stroke treated by thrombectomy by 20%
- Enhance care and experience for patients with spinal and neurosurgical conditions across the region by collaboratively developing pathways of best care
- Establish a new region-wide pain service with partners, to address equity of access and unwarranted variation

Pain

Chronic pain is a significant issue within our population and it severely impacts patients' quality of life. Spend on prescription medication for pain in the region is high, which has been shown to be closely linked with social deprivation. However, there is significant variation in how easily patients can access pain services across our region.

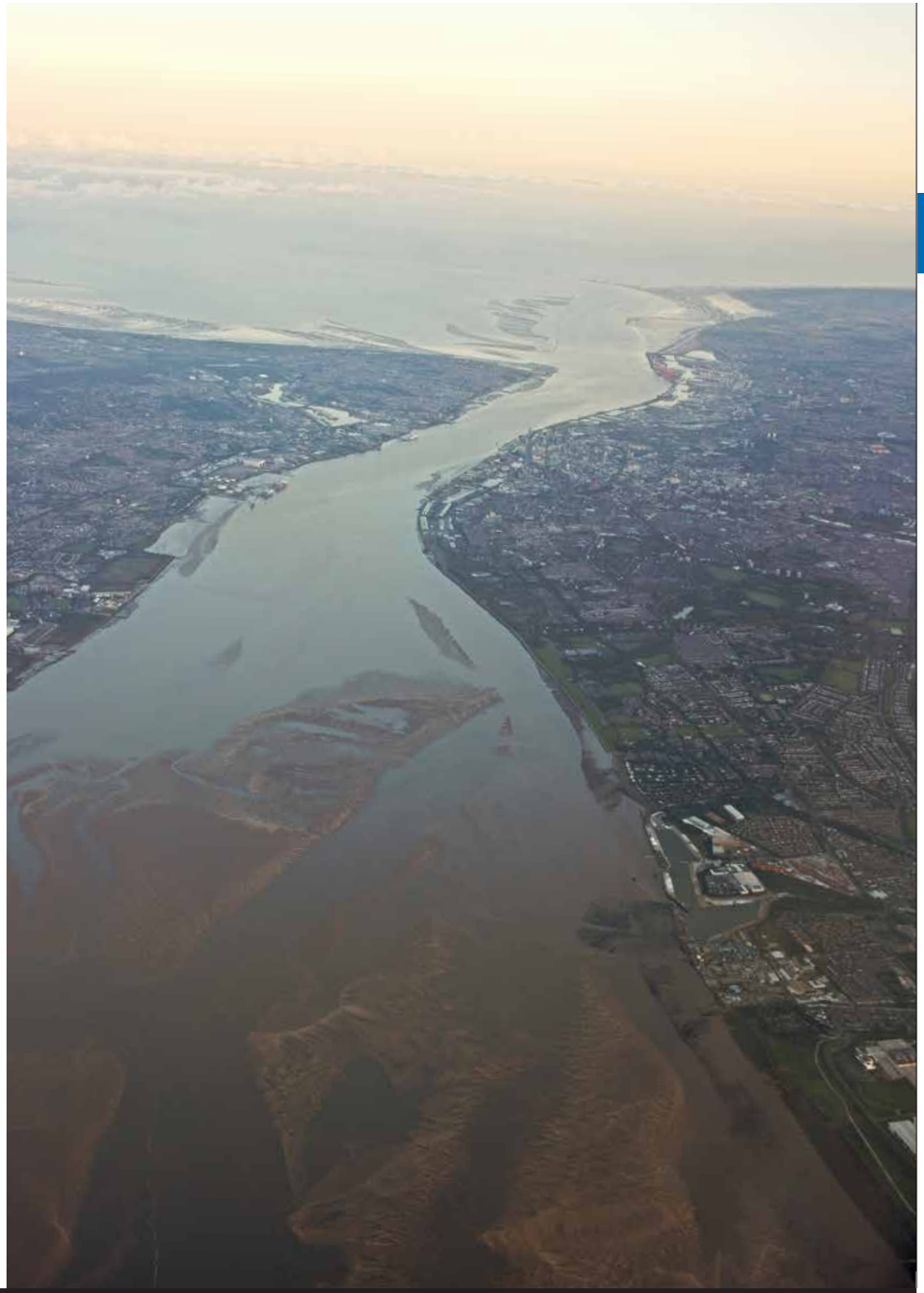
The Walton Centre has a successful track record of providing specialist pain services and is recognised as the regional service for complex pain. There is an opportunity for our ICS to reconfigure services to greatly improve care for the large proportion of the population who have chronic or complex pain.

In collaboration with our acute partners, we will lead on the Pan-Mersey pain programme to ensure that services are standardised and resources are used effectively. This will mean there is a more equitable service across our region, with a focus on non-medical interventions and subsequent reduction in spend on pain medication and attendances at accident and emergency departments. The aims of this service redesign are to improve patient outcomes and to have health economic benefits.

Neurosurgery/spinal surgery

We provide neurosurgical care for our population and attract referrals from further afield. We work collaboratively with our partners to ensure the highest quality, joined-up pathways for patients with brain conditions such as tumours, vascular abnormalities, infection and trauma.

The Walton Centre is now the only provider of spinal surgery services in Cheshire and Merseyside, following a review of the regional services, with input from GIRFT, to improve quality of care and reduce unwarranted variation. Our service is a joint neurosurgical/orthopaedic service and, for the first time in our region, spinal expertise across specialties has come together to provide a truly integrated service. This shared expertise will be used to improve patient-reported outcomes in degenerative, malignant and infective spinal disease. Working closely with our community and acute providers on pathway development, will ensure that people with spinal conditions receive the best care possible when needed, by the appropriate professional.



Social responsibility

Although The Walton Centre provides services for patients within and beyond Cheshire and Merseyside, we are anchored in the Liverpool City Region, and we want to support the local community. Health and social care is the largest employer across Cheshire and Merseyside. By focusing on the wellbeing of our staff and committing to equality, diversity and inclusion, we are also supporting our local population.

There is huge variation in the population we serve in terms of deprivation and health. The 2020 Marmot Review highlighted that, nationally, health inequalities have grown in the last 10 years, and this particularly impacts the most deprived regions in the north of England. There is an urgent need to ensure all of our population have access to the best quality health and social care services. We will use data based on indices of multiple deprivation to analyse how our communities access our services, which will dictate where we need to focus our services so that we reach the most vulnerable and those who may not readily access the services they need.

It is well recognised that a number of neurological conditions may exacerbate health inequality as they can impact employment opportunities and independence. It is therefore vital that we understand the specific issues that people with neurological conditions can have by engaging with patient groups and addressing their needs in a personalised, holistic way.

The Cheshire and Merseyside 'Prevention Pledge' is a place-based approach to creating a sustainable and transformational shift in improving population health. We will work with local areas on interventions and strategies relevant to local communities.

We have committed to become a founder member of Liverpool Citizens, an alliance of active citizens and leaders from local institutions who are dedicated to working together for the common good.

In April 2022, the NHS adopted the Government's Social Value Model, which measures the positive impact NHS providers and suppliers have on their local population. Further to signing up to the Cheshire and Merseyside Healthcare Partnership Social Value Charter, we have committed to achieving the Cheshire and Merseyside Healthcare Partnership Award and the Social Value Business Quality Mark.

How we will know we have succeeded
Achieve the Cheshire and Merseyside Healthcare Partnership Award and the Social Value Business Quality Mark
By 2023, implement Health Coaches for people with long term conditions
Make progress towards 80% reduction in NHS carbon footprint by 2028
Become a member of Citizens UK
Through our sustainable procurement policy, develop partnerships with local companies

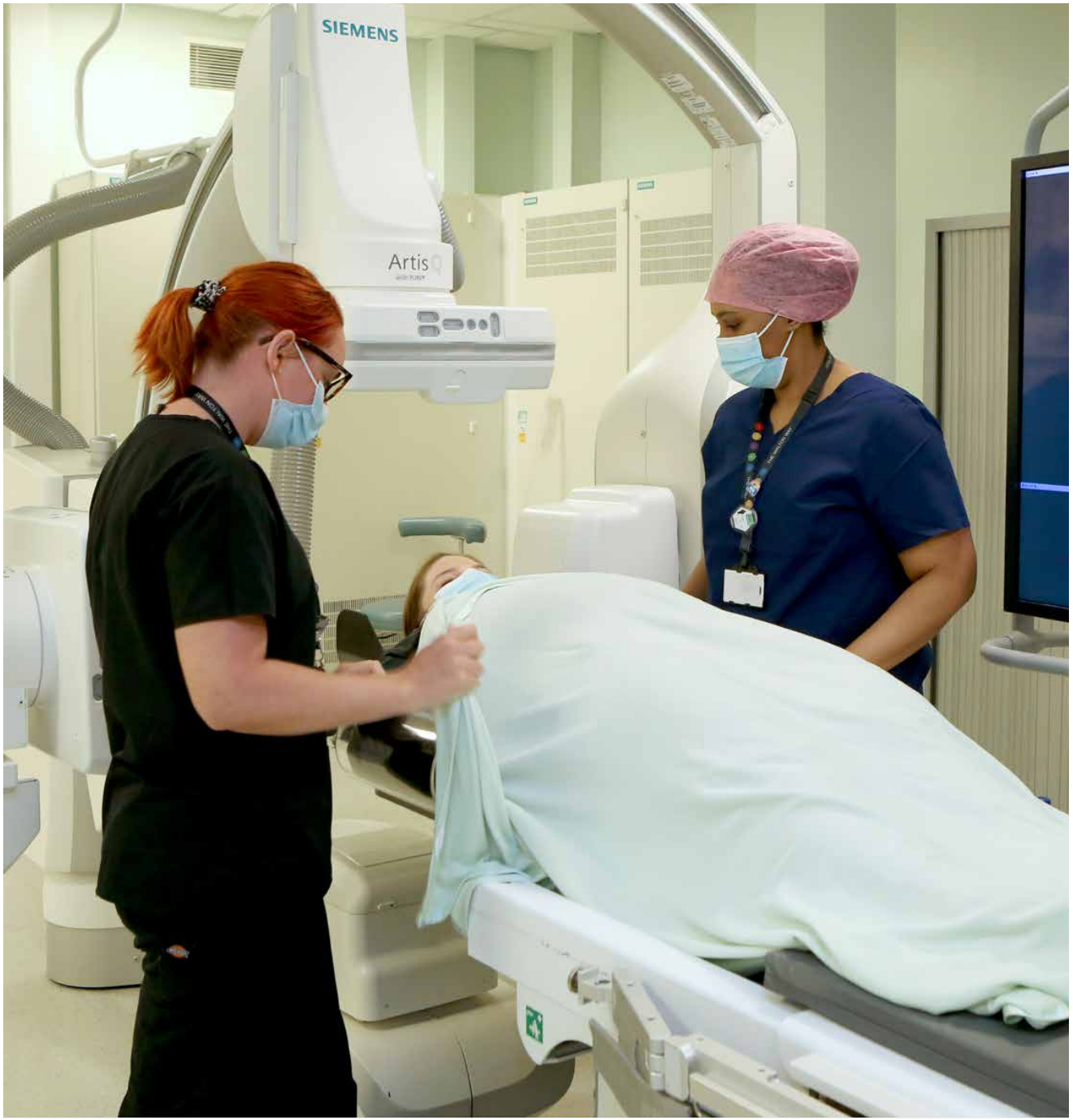
We will support the ICS on ensuring the principles of social value, inclusivity and citizenship are realised. By offering opportunities for support and employment. By 2025, we will have offered apprenticeships to 80 people. We will work with local schools to offer work experience to students from disadvantaged backgrounds, and to promote the Trust as an employer of choice.

We will continue to prioritise partnership working with staff side and trade unions, to deliver genuine change that will improve the quality of life for our workforce.

It is imperative that we provide care in a way that also protects our environment. We will develop a sustainability plan which will outline how we will reduce waste, reduce carbon emissions, and use our estate in the most energy efficient way.

Enabling strategies

Underpinning our five strategic ambitions are seven enabling strategies which feed into all aspects of the Trust's work, providing a critical link between our overarching ambitions and their delivery.



Quality

Ensuring the delivery of the highest quality of care to our patients and their families.

Providing the highest quality of care is at the heart of all that we do, as recognised by the Care Quality Commission, who rated us as 'Outstanding'.

We pride ourselves on meeting the highest possible standards for patient safety, experience and outcomes. We consistently achieve excellent clinical outcomes, as demonstrated by national benchmarking for:

- Trauma (TARN, as part of the Major Trauma Collaborative with Liverpool University Hospitals)
- Spinal (Spine Tango, British Spine Registry)
- Functional neurosurgery (DBS)
- Critical care (ICNARC)
- Skull base surgery (vestibular schwannoma and pituitary)
- Shunts (National Shunt Registry)
- Vascular (AVM registry)
- Cancer pain (National Cordotomy Registry)
- National Neurosurgical Audit Programme

We believe that it is essential to measure patient outcomes so that we can assure ourselves, our patients and the regulators that we provide the highest standard of care and that we are constantly striving to improve.

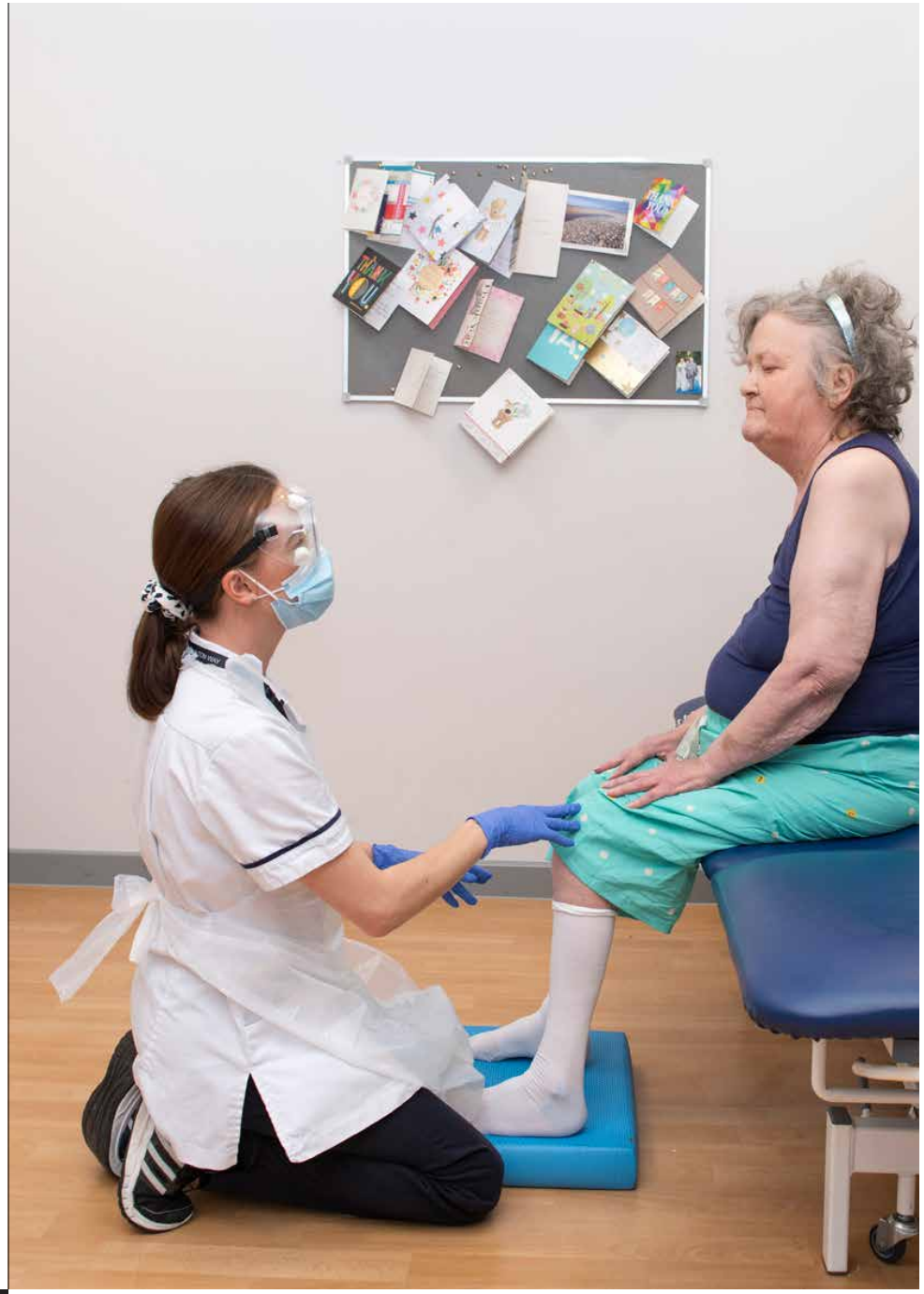
> **Over the next three years, we will continue to provide excellent care and support to patients with acute and long-term neurological/ neurosurgical conditions, and we will build on and improve the current service models.**

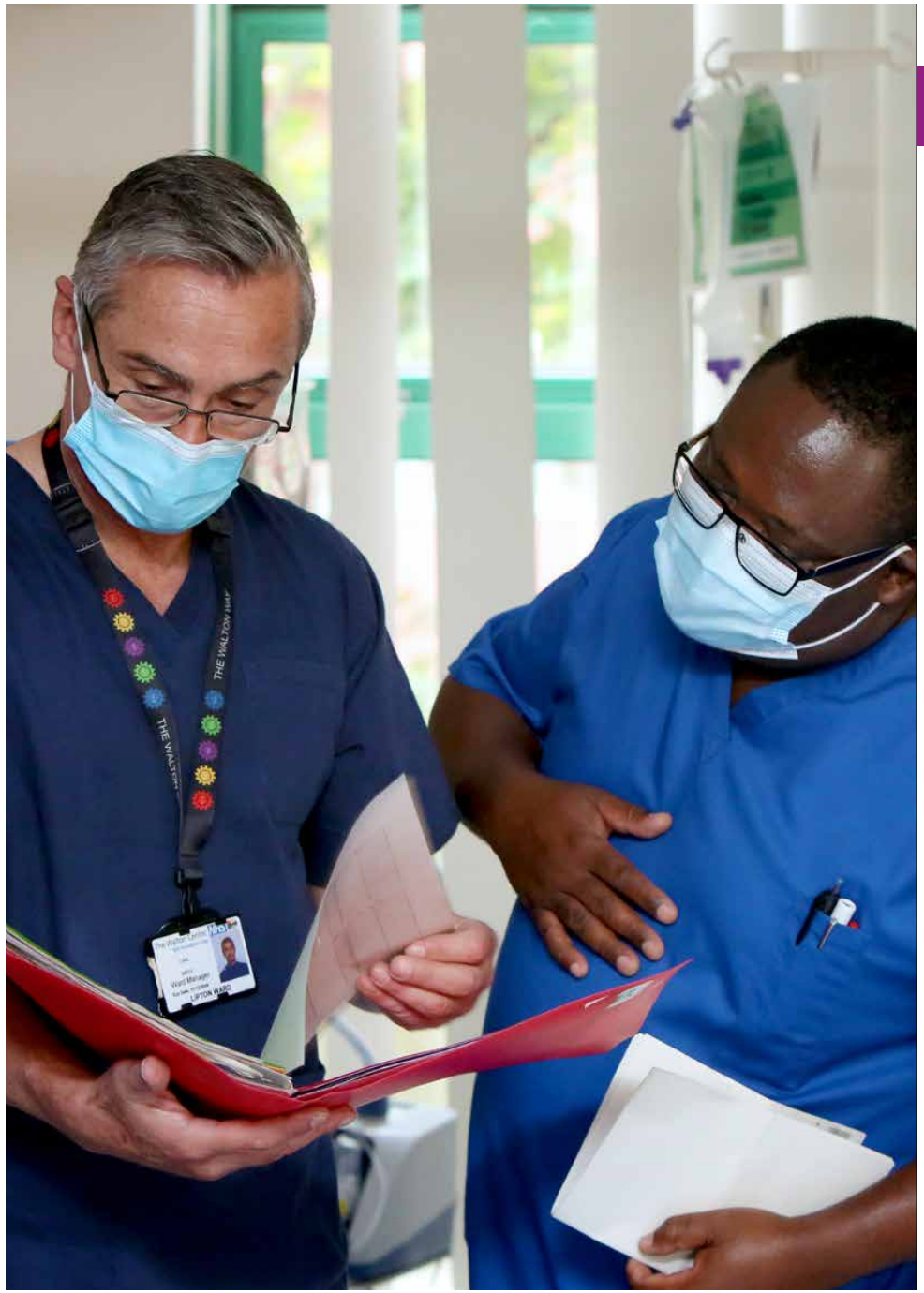
Our core clinical services are neurology, neurosurgery, pain, rehabilitation, and interventional radiology. We will engage with patients and families to improve the information they receive at the point of diagnosis of a long-term condition, and after diagnosis when they feel ready to know more about their condition.

We treat patients with any neurological condition, from the very common to the very rare. We provide the same high-quality service for all conditions, to ensure that each of our patients is treated according to their individual needs.

Our services for patients with very rare conditions continue to grow as medical knowledge increases, for example in neurogenetics. We currently provide two national services, and we will further embed and develop these. We are the Centre for the North of England for Neuromyelitis Optica (NMO), which is now a well-established multidisciplinary service for this rare neurological condition. We have recently become the second centre in England to use MRI-guided focused ultrasound thalamotomy for essential tremor. This provides the opportunity for life-changing treatment for many patients with this disabling condition, as part of an integrated multidisciplinary movement disorders service. We will embed this service so that people living in the north of England can access this treatment. Our functional neurosurgery service will further expand the availability of treatment for patients with Parkinson's disease, epilepsy and pain.

Our multidisciplinary vascular service provides unrivalled quality of care for patients with serious vascular conditions such as stroke, brain aneurysms and vascular malformations, and achieves excellent patient outcomes. We attract many out-of-area referrals, which we will expand for some of the rarer conditions so that we can provide this very specialist service for even more patients.





People

Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background.

We will recruit and retain the best people, prioritise the health and wellbeing of our workforce, and provide training opportunities for all staff.

Our people are fundamental to the delivery of high-quality healthcare at The Walton Centre. We want our staff to feel valued and supported, and to create the conditions for them to deliver the highest possible standard of healthcare.

We want to attract the very best talent to our centre of excellence and be known as being a great place to work. We will build upon our well-established staff health and wellbeing programme, with a renewed focus on psychological support for our staff.

> **Our staff will be supported to develop, to have a voice that counts in the organisation, and encouraged by a culture of engagement, listening and action.**

We will strive to maintain our industry standard Gold accreditation by Investors in People, and aim to become the first NHS trust to achieve Platinum status.

It important that we attract, develop and celebrate a diverse workforce. It is essential that all staff feel comfortable to bring their whole selves to work. We will continue to wholeheartedly commit to the equality, diversity and inclusion agenda. We have developed the Strategic Black and Minority Ethnic Group, which reports directly to Trust Board, and have formed a workforce disability group. We will continue to learn and develop in this area and will achieve improved scores in the WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard) year on year.

Our focus is on providing the highest quality of care for the population we serve and meeting the needs of all patients. We will carry out an expanded engagement programme with our communities, which will inform how and where we deliver services in future.

The NHS Staff Survey offers a snapshot in time of how people experience their working lives, gathered at same time each year. The results help inform improvements in staff experience and wellbeing. The health and wellbeing of staff is front and centre of The Walton Centre's Staff Survey action plan.

The NHS Staff Survey has nine themes:

- Compassionate and inclusive
- Recognised and rewarded
- A voice that counts
- Safe and healthy
- Work flexibly
- Teamworking
- Staff engagement
- Morale
- Always learning

In the 2021 survey The Walton Centre was better than average in five of these themes. We will increase the number of themes where we score better than average.

Estates, facilities and sustainability

Estates and facilities are fundamental to the operational management of the trust and form a part of a multidisciplinary approach to keep our patients, staff and visitors safe and comfortable within the environment.

The NHS produces approximately 5.4% of the UK's greenhouse gas emissions and 40% of UK public sector emissions. On a global level, healthcare generates so much carbon dioxide equivalent (CO_2e) that if it were a country, it would be the world's fifth biggest polluter.

Climate change is the greatest health threat facing the world. However, it also offers the greatest opportunity for us to redefine the social and environmental determinants of health to provide sustainable health services across Cheshire and Merseyside and to deliver the ambitions set out in Delivering a Net Zero National Health Service.

In developing a comprehensive Sustainability Plan, The Walton Centre will strive to exceed the emission reduction targets set by the Government and the NHS.

We will develop an 'Estates, facilities and sustainability strategy' to meet the needs of future developments.

As an organisation, we acknowledge the impact we have on the environment and are therefore committed to continuing the work to actively reduce the Trust's carbon footprint.

We are therefore investing significant funds in plant replacement and the introduction of new technology which will deliver reductions in the organisation's carbon footprint.

As part of the Sustainability Plan, all directorates within the Trust will be required to embed carbon reduction into their day-to-day activities and business planning processes.

The Walton Centre plans to focus on the following initiatives:
Estates and facilities
Travel and transport
Medicines
Theatres/Anaesthetics
Digital systems
Anchor Institutions and system leadership

Finance and commercial development

We will maximise use of resources, improve productivity and develop market opportunities to deliver best value for the Trust and the wider system.

Although Cheshire and Merseyside and the wider health system are facing unprecedented financial challenges, The Walton Centre has continued to perform well financially, delivering against the targets set by the Health and Care Partnership, and as a result, bringing additional income into the region. The Trust will continue to strive to meet the ongoing financial challenges and to perform well financially through ensuring it achieves the best value in its use of funding.

We will work with our partners in health and social care as a member of the Cheshire and Merseyside ICS to achieve financial stability across the region.

There will undoubtedly be tough financial efficiency targets to achieve following the COVID-19 pandemic. In working to meet these and delivering the best value services, we will focus on service transformation and maximising productivity, while ensuring high-quality care and using resources responsibly. Our aim is financial stability for The Walton Centre and delivering the highest rating of level 1 on the System Oversight Framework (SOF).

We will review service development opportunities across Cheshire, Merseyside and beyond that ensure our services are known and recognised, so that all patients who can benefit from our expertise are able to do so. We will also look at non-NHS opportunities to diversify our income. All income generated through these areas will be invested directly into patient care. Where viable, the Trust will also look to partner across corporate services to maximise scale and efficiency. For example, through Health Procurement Liverpool, the Trust has partnered with other specialist trusts on procurement services to provide scale and opportunity across purchasing and contract management, which delivers greater benefits across the partners.

Making use of digital initiatives and artificial intelligence within corporate services could also help to streamline workflows and generate efficiencies that can help us to achieve the savings that will be required to deliver financial stability at the Trust.

The Trust will ensure it gets maximum return on capital investments, as capital resources become more constrained in the Cheshire and Merseyside system. We will use rigorous business case processes to ensure that investments are prioritised and sound investment decisions are made, that not only make best use of resources, but maximise benefits to our patients and staff.

The implementation of the Cheshire and Merseyside Integrated Care Board provides The Walton Centre with an opportunity to influence the development of neuroscience care across the region. As the single provider of neuroscience services, the Trust is in an excellent position to help its acute hospital partners to manage some of their ongoing pressures following the pandemic.

Being the clinical leader for neuroscience care in the region, we can have an impact on how patients are cared for in the community and secondary care, and can directly help reduce hospital admissions, length of stay and unnecessary investigations. Through this influence on the wider delivery of neuroscience services, The Walton Centre can help to deliver best value to the health system through our clinical model and ongoing innovative approach to patient care.

Communications and marketing

We will engage with the wider health and care system, raise our profile as the only specialist neurosciences NHS trust and ensure patients and staff receive the best quality information.

As the UK's only specialist neuroscience hospital, it is essential The Walton Centre has a strong brand, to ensure maximum recognition locally, regionally and nationally for the benefit of patients, family and friends, staff and our stakeholders.

A strong brand supports research funding and investment, recruitment and retention and the work of The Walton Centre Charity, as well as providing reassurance to patients and the wider community about the Trust's status as the best place to receive treatment and care for neurological, spinal, pain and rehabilitation services.

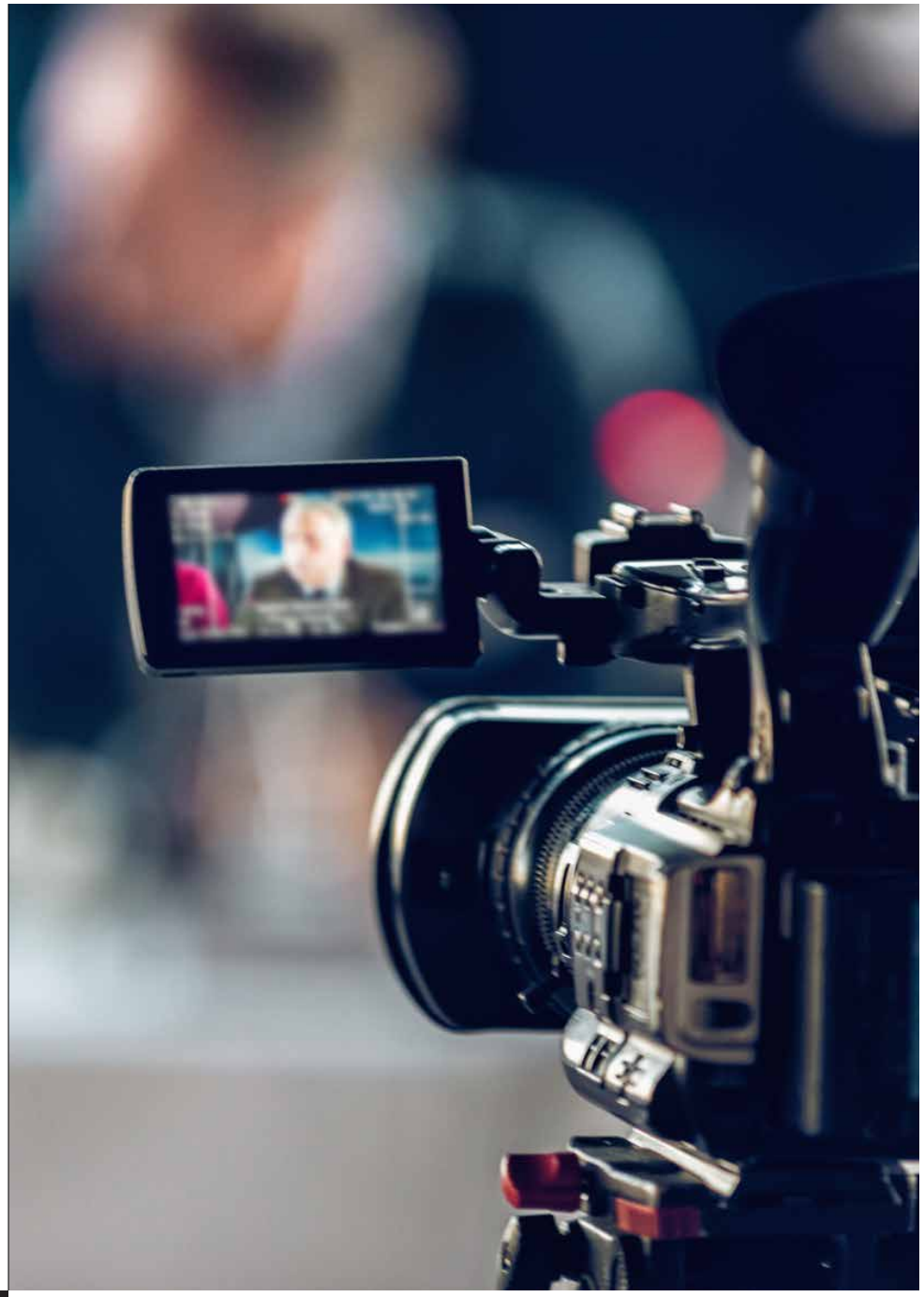
We want to raise the profile of The Walton Centre as a nationally leading trust, and as a trusted voice in neuroscience both regionally and nationally. Internally, we will ensure that staff are communicated with effectively and efficiently and are able to participate in two-way communication and engagement, at all levels of the organisation.

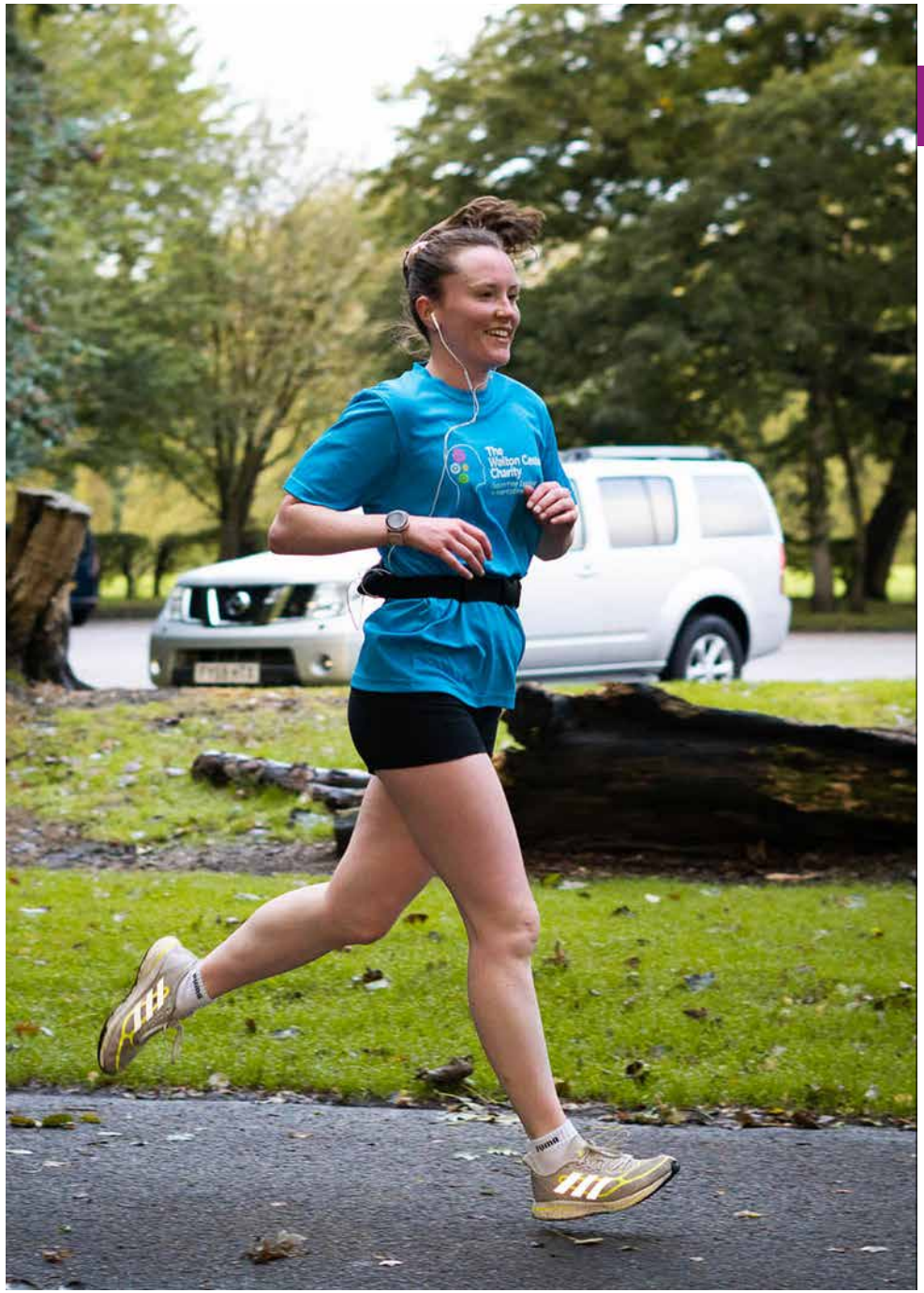
We will work to ensure that all interactions with The Walton Centre, whether as a patient, family member, visitor, stakeholder or staff member are of the highest standard, through a focus on the different communication channels including printed staff and patient materials, the hospital environment, patient information, the recruitment process, fundraising, and digital, including the trust website, social media and staff intranet.

Every contact with The Walton Centre should be professional, accessible, and engaging. We will work with teams across the Trust to improve processes and outputs where possible through communications – for example, the recruitment journey, patient communications, and the in-hospital experience.

Digital communication is an ever-growing and developing channel for patients, staff and stakeholders. The new Walton Centre website launched in September 2021 and has seen increased visitor numbers and accessibility ratings. We will continue to manage and enhance the website in line with the Trust's strategy and objectives, national and local initiatives, and best practice. We will support the production of engaging online content (including exploration of webinars and podcasts) and explore emerging platforms, tools and technologies to ensure a positive and productive user experience.

Our focus on internal communications will ensure effective two-way communications and engagement with Trust staff, on-site partners, and volunteers to sustain an environment where staff feel informed, included and valued. As part of this, we will embed a new email marketing platform to improve the accessibility and engagement of internal emails. This will also feed into the development of alternative staff communications techniques for those staff for whom digital isn't a best practice channel.





Charity

New fundraising opportunities and initiatives will focus on digital, social media and virtual platforms, and enable a more focused approach for digital income generation.

The Walton Centre Charity supports the vital work of the Trust by investing charitable funds in areas and projects that enhance patient, family and staff experience, treatment and care.

The COVID-19 pandemic had led to a very different landscape in terms of how people work and socialise, and most aspects of the economy have been severely affected. The impact on income-generating potential will differ across income streams such as community, corporate and major donor fundraising. The Charity is therefore developing a new Fundraising Strategy that will take this into consideration.

New fundraising opportunities and initiatives will focus on digital, social media and virtual platforms, as well as offering hybrid event opportunities wherever possible. The new strategy will include a proposal for how to grow and develop the Fundraising Team to add skills and enable a more focused approach for digital income generation.

Emphasis will be placed on ensuring that the Charity's positive impact is shared both internally and externally in order to encourage further involvement and support for future fundraising. Working closely with the Communications and Marketing Team, we will develop a plan to improve existing supporter journeys, as well as develop and implement new digital stewardship programmes. In addition, charitable fund application procedures will be reviewed in order to develop a comprehensive Grant Making Policy which will incorporate assessment and prioritisation procedures for new projects, and impact reporting on initiatives funded.

The Fundraising Strategy will ensure the Charity can effectively contribute to the overall income of The Walton Centre NHS Foundation Trust, supporting and enabling developments, particularly in innovation and research.

The Charity focuses on four key areas:

- Improved environment and facilities for patients and their families
- Innovation and new technology
- Research and development
- Enhanced staff training and wellbeing

Digital

Industry leading digital solutions for our patients and our people.

We will harness the full potential of digital technologies, increase our digital maturity and prioritise digital inclusion.

Technology can support more efficient, user-friendly ways of working. We will work to harness the full potential of digital technologies to modernise operations and drive performance improvements. We will work in collaboration with clinical and support staff to foster an environment that facilitates digital solutions.

The Trust is in the top 20% of NHS organisations in terms of digital maturity, with our recent achievement of Healthcare Information and Management Systems Society (HIMSS) Stage 5 for Digital Maturity. We will work to achieve an even higher HIMSS level. We are part of the national Digital Aspirant programme, which helps NHS trusts raise their digital maturity by supporting organisations to deliver a set of core capabilities.

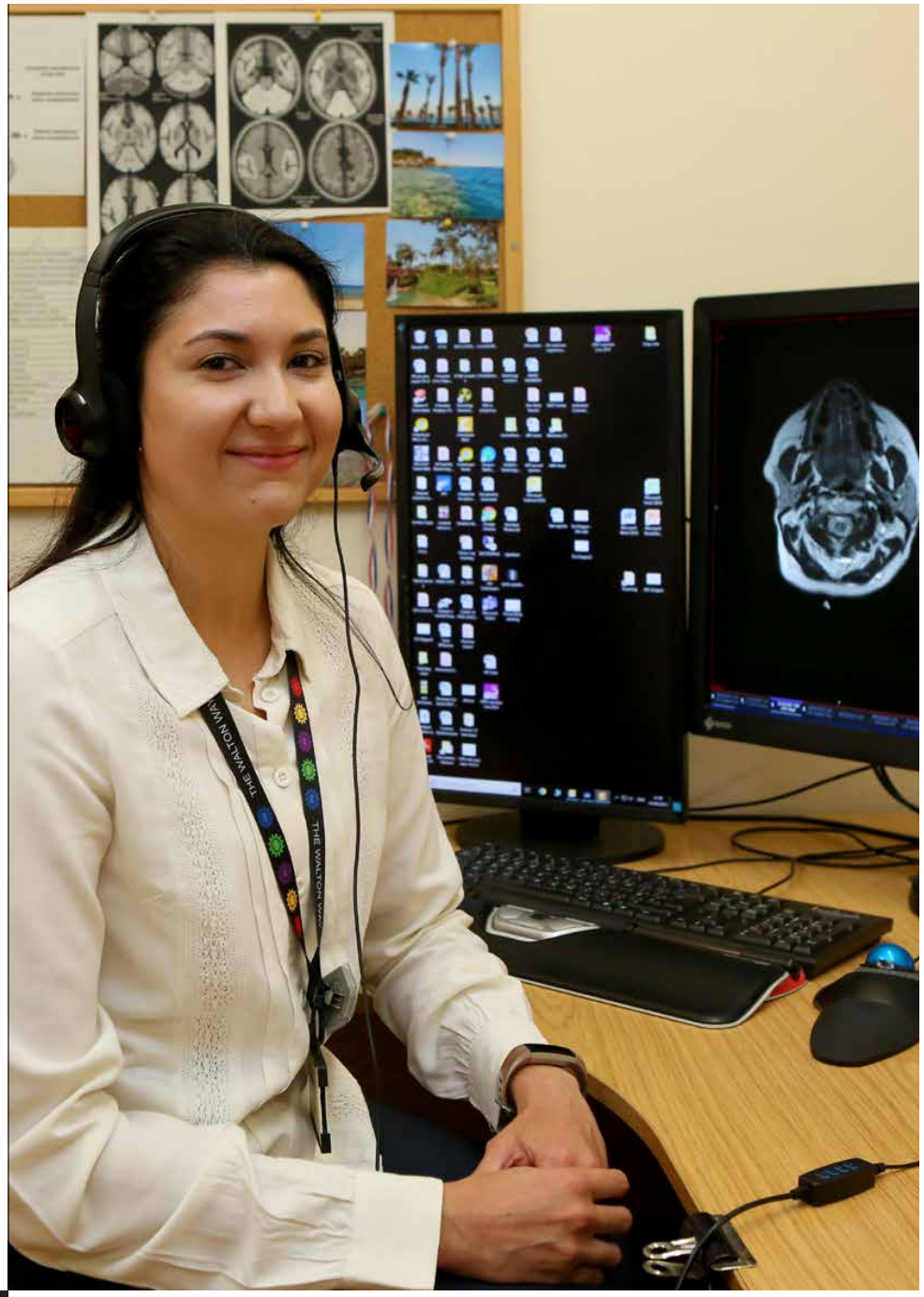
We are also committed to the national digital transformation agenda for the NHS, which is underpinned by seven pillars of 'What Good Looks Like':

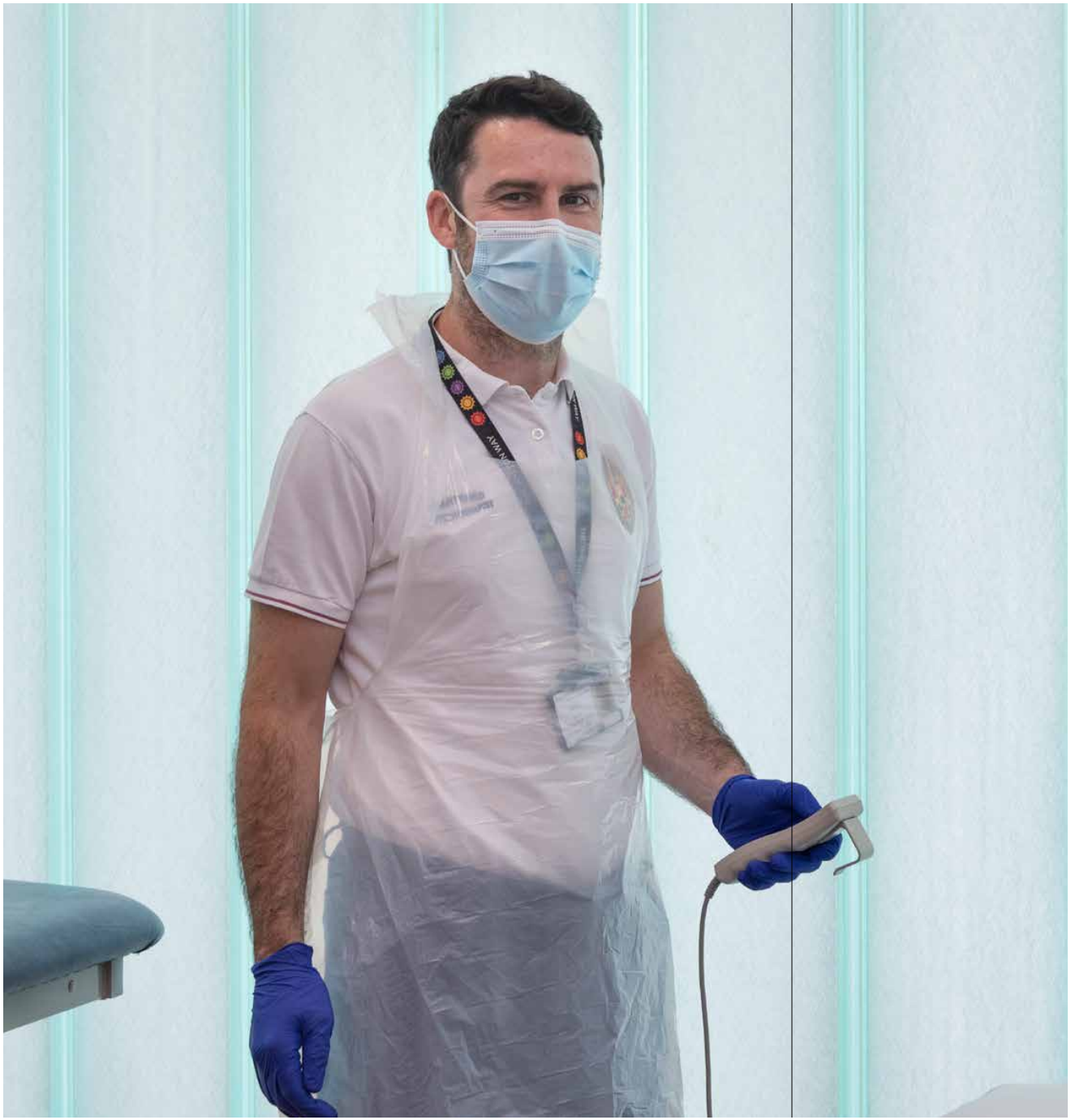
1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

We have combined all our portfolios and programmes into a virtual project management office, which enables visible assurance and governance against the digital transformation programme success measures. We will support both our staff and our patients and carers to thoroughly engage with the digitisation of services that can improve outcomes, experience and safety through the introduction of new tools and processes which will improve patient experience and efficiency of services.

The Trust will drive the digital agenda in the region it covers by leading on digital maturity, the green plan and interoperability on behalf of the Cheshire and Merseyside ICS. The Digital Team is actively involved in supporting digital enablement within the Liverpool community to ensure communities can access our digital services and that information is within easy reach of those who require it, be that a patient or carer.

Digital inclusion will be prioritised in all of our digital programmes and initiatives, to ensure either help is given to patients, be that hardware, software or training, or to provide a non-digital equivalent, to enable equity across our population.





Developing and delivering our strategy

In developing this strategy we have created a dynamic, innovative approach to the delivery of the leading treatment and care every patient of The Walton Centre needs. Developed in conjunction with our stakeholders, both internal and external, it provides the blueprint to drive our services even further forward, for the benefit of patients who need us.

Developing and delivering our strategy

We took an inclusive and integrated approach to developing this strategy. The steps taken included:
Trust Board development session to agree high-level external drivers and challenges
Executive away day to further develop the work undertaken in the Board development session
Communication and involvement of staff, patients, carers and support groups
Communication and involvement of acute, ICS and primary care colleagues
Feedback from communication sessions
Consolidation of information and development of content

We consulted and communicated with:

Internal stakeholders
Multidisciplinary clinical staff
Medical consultants
Departmental meetings
Clinical staff
Non-clinical meetings/departments
Governors
Trust members
Executive and Non-Executive Directors
The Walton Centre Charity

External stakeholders
Neuro Therapy Centre
The Brain Charity
Parkinson's UK
Epilepsy Action
MS Society
MND Association
Cheshire and Merseyside Neurological Alliance
West Cheshire and North Wales Neurological Alliance
Isle of Man Neurological Alliance
North Wales Neuroscience Board
Health Watch
Integrated care partners
General Practitioners
TIDE
NHS partners
Universities
Cheshire West Partnership
Public Health
Pain Relief Foundation
Social services
Public members

Developing and delivering our strategy

This is a bold but clear and ambitious strategy, developed by our staff, patients, families, carers and support groups.

A series of launch and engagement events will be held. The strategy will be a visible and dynamic framework for our organisation.

We will deliver the ambitions within the strategy using our existing transformational model, which is closely aligned with the operational teams within both our clinical and non-clinical divisions.

Annual priorities will be set which will form our strategic objectives and framework.

A new Board Assurance Framework reflecting the ambitions within this strategy will be developed and monitored by the Trust Board.

This strategy builds on our existing excellent leadership in neurosciences and provides a platform to further strengthen patient care, collaboration and transformation.

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre
NHS Foundation Trust
Lower Lane
Fazakerley
Liverpool
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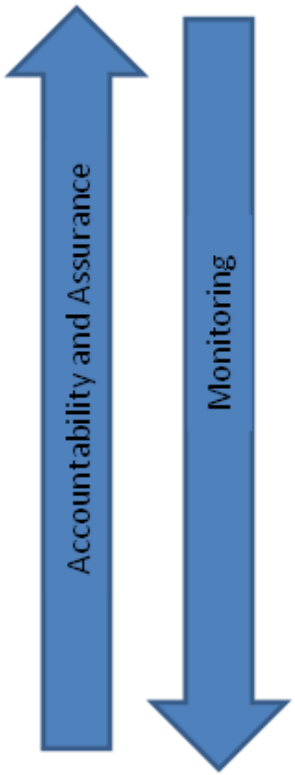
0151 525 3611

Visit
thewaltoncentre.nhs.uk

Published Month 2022

Appendix 1 Strategies Hierarchy

Document	Description	Oversight
Trust Strategy	The overarching strategy for the Trust setting out the strategic ambitions for the Trust over the next three years. This sets out the ambition and vision for the Trust.	Board
Sub-strategies	The key underpinning identified strategies to the Trust Strategy across a number of functions with more detail of what the Trust strategy will achieve. Template to be agreed.	Board Committees
Strategic Implementation Plans	Plans for functional areas, to support the achievement of the sub-strategies and overall Trust Strategy. These will focus on the how the strategies will be implemented over the three years.	Subgroups (under Board Committees)
Annual Plans	Plan covering one financial year, where more detail is required for a specific area.	Subgroups



Supported by:

Frameworks	A described series of internal controls and processes intended to facilitate the safe and robust delivery of high-quality services and functions e.g. Risk Management Framework
Action Plans	A time specific plan in response to a particular issue, e.g. report on new guidance that sets out the steps to be taken to reach compliance or an agreed level of delivery. To be monitored by a designated group and closed off when appropriate.

The Seven Sub-strategies

Sub-strategy	Incorporating the following areas through Strategic Implementation plans/ Frameworks:
Quality	- Patient and family centred care - Infection prevention and control - Risk management - Clinical governance - Clinical audit - Violence and aggression
Estates, Facilities and Sustainability	- Sustainability - EPPR - Capital planning
People	- Organisational development - Equality, diversity and inclusion - Learning and development - Talent management and leadership development - Recruitment and retention - Health and wellbeing - Innovative culture - Medical education - Innovation
Finance and Commercial Development	- Commercial - Financial planning - Cost improvement - Income generation - Capital planning
Communication and Marketing	- Branding - Membership engagement - Stakeholder engagement - Charity communications - Social media
Digital	- Cyber Security - Digital maturity - Digital inclusion - Intelligence
Charity	- Fundraising - Digital income generation

Appendix 3 - Equality Impact Assessment (EIA) Form

The Walton Centre NHS Foundation Trust

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

1. Person(s) Responsible for Assessment: Julie Riley 2. Contact Number: 0151 556 3483

3. Department(s): Corporate 4. Date of Assessment: 30/6/22

5. Name of the policy/procedure being assessed **Trust Strategy 2022-2025**

6. Is the policy new or existing?

New

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

Staff X Patients X Visitors X Public X

8. How will these groups/key stakeholders be consulted with? **Wide and inclusive consultation with internal and external stakeholders has taken place throughout the production of the strategy**

9. What is the main purpose of the policy? **It is a new Trust strategy reflecting the changing landscape of the NHS following the Covid 19 pandemic and the introduction of the Health and Social Care Bill 2021.**

10. What are the benefits of the policy and how will these be measured? **The strategy has five strategic ambitions and seven enabling strategies. The clinical and non clinical areas will develop their priorities which will be aligned to these. The strategy will be monitored using our existing transformational model and will report to the Trust Board**

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? **This is a new strategy which will focus on service development and transformation. Projects will develop as the strategy is implemented and becomes embedded as business as usual**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? Minimal. **A major focus of the strategy is addressing health inequalities and improving our social responsibility.**

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age			X	Defines age within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Sex			X	Defines sex within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Race			X	Defines race within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics. It also specially discusses the WRES.	
Religion or Belief			X	Defines religion or belief within the context of Equality Act and discusses promotion of equality relating to all protected characteristics.	
Disability			X	Defines disability within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics. The policy also specifically refers to adjustments being made for recruitment or training purposes.	
Sexual Orientation			X	Defines sexual orientation within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Pregnancy / maternity			X	Defines pregnancy and maternity within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Gender Reassignment			X	Defines trans/gender reassignment within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	
Marriage & Civil Partnership			X	Defines marriage and civil partnership within the context of the Equality Act and discusses promotion of equality relating to all protected characteristics.	

Other			X	Makes reference to the inclusion of other, non-defined 'protected characteristics' such as carers and other vulnerable groups within the process of equality analysis/equality impact assessments (EIA's).	

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.

An inclusive approach has been taken to developing the strategy and views of patients, carers, staff and outside agencies have been taken into account. A major focus is on reducing health inequalities and inclusivity.

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

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

Action	Lead	Timescales	Review Date

Declaration

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

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

Name: Julie Riley

Date: 30/6/22

Signed:

The Walton Centre NHS Foundation Trust

Board of Directors
7 July 2022

Report Title	**Board Assurance Framework (BAF) Report Q1 2022/23**
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- Q1 BAF is based on the new principal strategic risks approved by Board on 5 May 2022
- New risk scorings, risk targets, and risk appetite have been set
- Where no operational risks have been identified work is ongoing to address this

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- BAF to be reviewed for quarter 2 in October 2022

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

All Risks	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	25 May 2022	K Dowson Corporate Secretary	All risks reviewed by Executives
Quality Committee	16 June 2022	K Dowson Corporate Secretary	No changes proposed.
Business Performance Committee	28 June 2022	K Dowson Corporate Secretary	
Research, Innovation & Medical Education Committee	6 July 2022	K Dowson Corporate Secretary	

Board Assurance Framework (BAF) Report Q1 2022/23

Executive Summary

1. This paper summarises the detailed current position against the twelve strategic risks approved at Board on 5 May 2022. The initial, current and target scoring and risk appetites have now all been set and a BAF report developed for each risk.

2. It is proposed that the two risks currently retained by the Board of Directors are assigned to a Board Committee. This is because while there are particular Board level responsibilities encapsulated within these two risks i.e culture and stakeholder relationships the risks also cover areas that are within the remit of the appropriate Board Committees.

3. Through the Board Committee process there were minimal changes proposed apart from a proposal by Business Performance Committee (BPC) to reduce the risk scoring for BAF 7 (Capital Investment) to reflect an improved position since April.

4. The Committee are asked to consider whether the BAF entries are an accurate reflection of current risk exposure.

Background and Analysis

5. The purpose of this report is to present the Board Assurance Framework (BAF) entries to the Committee for review. There are now twelve principal risks identified on the Board Assurance Framework (BAF). This follows the development of new strategic risks by the Board which align to the new draft Trust Strategy 2022-25.

6. The new strategic ambitions which form the strategic objectives for the Trust are:
   - **Collaboration:** Working closely with partners and across internal teams to develop high quality standardised services
   - **Education, Training and Learning:** Expand the teaching offer to deliver at a national level for neurosciences education and training
   - **Leadership:** Clinically led leadership, embedded across all staff to deliver high quality patient care at the Trust and through the Integrated Care System
   - **Research and Innovation:** Develop the department to attract world class researchers and embed a culture of innovation
   - **Social Responsibility:** Supporting local communities and staff to prevent and support physical and mental health issues and become an Anchor Institution

7. These ambitions are supported by five cross-cutting themes: People, Quality Care, Digitalisation, Health Inequalities and Best Value. The BAF risks have been mapped across these ambitions and themes (Appendix 1) and this was approved by the Board in May 2022.

8. The BAF aligns principal risks, key controls, and assurances to each objective with gaps identified where key controls and assurances are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gaps. A summary of each BAF risk assigned to the Committee is included in the appendices.

9. An effective BAF:
   - Provides timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues
   - Provides an opportunity to identify gaps in assurance needs that are vital to the organisation, and to develop appropriate responses (including use of internal audit) in a timely, efficient and effective manner
   - Provides critical supporting evidence for the production of the Annual Governance Statement.

10. A number of actions have been identified for each BAF risk to address the gaps in controls or assurances identified. Target dates for completion have been included and where there was a clear map across from the actions in the 2021/22 BAF these have been included.

11. The BAF risks have been assigned to Board Committees to review and provide assurance and this has taken place during June and July. BPC and Quality Committee reviewed their delegated risks and any changes have been incorporated within this document. Research, Innovation and Medical Education (RIME) Committee meet on 6 July and any changes will be reported to Board at the meeting.

Quarter 1 Summary of Changes

12. Ten of the risks were originally assigned to Board Committees and two were retained by the Board of Directors as per Appendix 1. These were BAF 003 Finance and System and BAF010 Innovative Culture. It is now proposed that these are allocated to BPC and RIME respectively. The Board would continue to hold overall responsibility and should continue to play close attention to these two risks which relate to organisational culture and stakeholder management.

13. A summary of the current risk scores and risk appetites are in Table 1. The previous risk score has been included where the new risk is very close or the same as the risks in the 2021/22 BAF. The risk descriptors which define the scoring of the risks and the risk appetite are included at Appendix 2.

14. BPC recommended that the score for BAF007 was reduced to 9 (3x3) as the gap between the capital requirement for 2022/23 and the allocation provided had been significantly addressed and therefore the risk to estates and equipment had been reduced.

Table 1

Risk ID	Risk Appetite	Title	Q4 22/22	Q1 22/22	Q2 22/23	Q3 22/23	Q4 22/23
001	**Cautious**	**Quality Patient Care** Impact on patient outcomes and experience	**n/a**	**12**			
002	**Open**	**Collaborative Pathways** Inability to develop further regional care pathways	**n/a**	**9**			
003	**Open**	**System & Finance** Inability to deliver financial plan and targets within the system	**8**	**9**			
004	**Cautious**	**Operational Performance** Inability to deliver the operational plan	**9**	**9**			

005	**Cautious**	**Leadership Development** Inability to attract, retain and develop sufficient numbers of qualified staff	**n/a**	**16**			
006	**Open**	**Prevention and Inequalities** Inability to improve equitable access to services	**n/a**	**9**			
007	**Cautious**	**Capital Funding** Inability to secure capital funding to maintain the estate to support patient needs	**6**	**9**			
008	**Open**	**Medical Education Offer** Inability to develop a national training offer	**n/a**	**12**			
009	**Open**	**Research and Development** Inability to develop and attract world class staff	**12**	**12**			
010	**Adventurous**	**Innovative Culture** Inability to attract a world class workforce	**n/a**	**12**			
011	**Averse**	**Cyber Security** Inability to prevent Cyber Crime	**16**	**12**			
012	**Cautious**	**Digitalisation** Inability to deliver the Digital Aspirant plan and associated benefits	**8**	**6**			

15. There is now notably more variation in the risk appetite assigned to each risk which reflects that these risks are linked to the new strategy for the Trust. This is because the Trust may need to consider taking more risks to achieve these ambitious objectives.

16. There is an acknowledged area of development to improve the linkages between the BAF and the operational risk registers and this will continue to be an area of focus through this year.

Conclusion

17. The new BAF reflects the risks relating to the achievement of the new strategic ambitions and the actions that have been started to reduce these risks.

Recommendation

- To review the current BAF content
- To consider the control and assurance gaps and identify any further actions required or additional assurances to be presented
- To agree the change to the BAF scoring for BAF007
- To agree the change of Board Assurance Committee for BAF003 and BAF010

Author: Katharine Dowson
Date: June 2022

Board Assurance Framework Glossary

BPC	Business and Performance Committee
C&M	Cheshire and Merseyside
CDRD	Clinical Director of Research & Development
CEO	Chief Executive Officer
(D)CFO	(Deputy) Chief Finance Officer
CIP	Cost Improvement Plan
CMAST	Cheshire & Merseyside Acute and Strategic Trusts (Provider Collaborative)
(D)CN	(Deputy) Chief Nurse
COO	Chief Operations Officer
(D)CPO	(Deputy) Chief People Officer
CQC	Care Quality Commission
CRL	Capital Resource Limit
CRN	Clinical Research Nurse
DHSC	Department of Health and Social Care
DME	Director of Medical Education
EPR	Electronic Patient Record
ERIC	Estates Returns Information Collection
ERF	Elective Recovery Fund
FoSH	Federation of Specialist Hospitals
FFT	Friends and Family Test
GDPR	General Data Protection Regulations
GMC	General Medical Council
HCP	Health & Care Partnership (Cheshire& Merseyside) in place to 30 June 2022
HEE(NW)	Health Education England (North West)
HFAI	Health Facility Acquired Infection
HiMSS	Healthcare Information and Management System (Digital Maturity Model)
ICB	Integrated Care Board
ICO	Information Commissioners Office
ICS	Integrated Care System (Cheshire & Merseyside) in place from 1 July 2022
IG	Information Governance
IT	Information Technology
IOM	Isle of Man
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
ITU	Intensive Therapy Unit
KPI	Key Performance Indicator
LoA	Letter of Authority
LHP	Liverpool Health Procurement
LUHFT	Liverpool University Hospitals Foundation Trust
MD	Medical Director
MHRA	Medicines and Healthcare Products Regulatory Agency
MIAA	Mersey Internal Audit Agency (Internal Auditors)
MSSA	Methicillin-sensitive Staphylococcus Aureus
MoU	Memorandum of Understanding
NHSD	NHS Digital (information, data, IT systems)
NHSE	NHS England
NHSEI	NHS England and NHS Improvement
NHSI	NHS Improvement
NHSP	NHS Providers
NHSX	NHS X (IT transformation)
NICE	The National Institute for Health and Care Excellence
NRC	Neuroscience Research Centre
NWC	North West Coast (Innovation Agency)

RAG	Red-Amber-Green (scoring)
RCA	Root Cause Analysis (Investigatory Technique)
RN	Registered Nurse
PMO	Project Management Office
QIP	Quality Improvement Programme
RIME	Research, Innovation and Medical Information (Committee)
SFI	Standing Financial Instruction
SOP	Standard Operating Procedure
SORD	Scheme of Reservation and Delegation
SPA	Supporting Professional Activities
SPARK	Single Point of Access to Research and Knowledge
SRO	Senior Responsible Officer
UoL	University of Liverpool
WCFT	The Walton Centre NHS Foundation Trust

Risk ID: 001	Date risk identified April 2022	Date of last review:	-
Risk Title: Quality Patient Care If the Trust does not deliver high quality day to day care for patients, then this will lead to adverse outcomes for patients and family and a deterioration of patient and family experience which would reduce staff morale and impact on the reputation of the Trust.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 12 Safe Care and Treatment
		Ambition:	Quality of Care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks (highest scoring only)		
47	If hospital acquired infections (HCAI) (MSSA, E.coli, CDIF)) continue to increase then there is a risk to patient experience, safety and KPI trajectories.	12
912	If the Risk & Governance Team continues with its current establishment of staff, then there is a risk the team will be unable to progress the work required for the implementation of the new Patient Safety Strategy and Patient Safety Incident Response Framework. This will also have an impact on patient and staff safety in relation to lessons learnt from incidents and investigations.	16
899	If patient receive the incorrect nutrition and hydration then there is a risk to patient safety, care and experience	16
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Major 4	Likely 4	16
Current	Major 4	Possible 3	12
Target	Major 4	Unlikely 2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor outcomes for patients - Poor patient and family experience - Reputational damage - Increased incidents - Increased morbidity and mortality - Quality standards not met - Lower CQC rating - Lower staff morale - More difficult to recruit workforce - Increased staff turnover - Widening of health inequalities - Worsening staff and patient survey results - Worsening Friends and Family Test results	- Number of complaints received - Zero Never Events in 2020/21, two in 2021/22 - Increase in Nosocomial Infections - Increased incidence of HCAI in 2021/22 - Mortality rates better than national average - Staff vacancy rates (nursing now minimal) - Staff retention – turnover figures - Improved performance in inpatient survey in 2021, moving from ninth to eighth - Integrated Performance Report – Quality metrics
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Quality Improvement Strategy 2020 – 23 – approved Sept 2019 2. KPIs for Year 3 of the Quality Strategy approved March 2022 3. Theatre Utilisation Programme 4. IPC BAF reviewed at Trust Board quarterly - March 2022 5. Trust Recovery Roadmap 6. Partial patient visiting recommenced March 2022 7. Ward Accreditation Programme in place for 2022/23 8. Implementation of Tendable Audit System for ward based Quality metrics for 2022/23 9. Board Walkabout Programme – reporting to Quality Committee 10. NICE Exception Report 11. CQC Mock Inspection – May 2022 12. Specialist Nurse Support in place e.g tissue viability and IPC 13. Health and Wellbeing Strategy approved at Board June 2022	1. Impact of Covid-19 variants on staff sickness levels 2. Lack of open-ended national guidance on Covid-related IPC 3. Lateral flow testing not generally available to the public 4. Key plans for HCAI and Clinical Audit not yet approved for 2022/23 5. Timely completion and reporting of NICE exception reports 6. Lack of awareness of patient and family centred plan and methods to implement it

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – Daily Ward / Departmental Huddle Theatre User Group Divisional Governance Meetings – monthly Mortality Review Group – monthly Serious Incident Group - monthly Transformation Board Balance Score Cards – monthly Hospital Management Group - monthly Hand hygiene audits – monthly **Level 2** Integrated Performance Report Quality metrics – Quality Committee – monthly Quarterly reports from Governance Team (incidents & risks, Patient Experience Team, Pharmacy, Pathology, Tissue Viability, Mortality and Morbidity) – Quality Committee IPC Annual Report to Board – June 2022 Safeguarding Annual Report to Board – June 2022 Annual Governance Report 2021/22 to Quality Committee – May 2022 Medicines Management Annual Report to Board – June 2022 Quality Strategy Progress Report to Quality Committee Visibility and Walkabout update quarterly report to Quality Committee from July 2022 Quality Account to Board June 2022 Ward Accreditation and Tendable reports to Quality Committee **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meetings with Commissioners – Quarterly National Inpatient Survey Results –- published October 2021 CQC Mental Health Inspection – December 2020 CQC Interventional Radiology Inspection – published December 2021 Getting it Right First Time (GIRFT) reports Investors in People Gold Award 2020 (reaccredited 2021) Anaesthesia Clinical Services Accreditation (ACSA) visit 2021	1. Alignment of Quality Improvement Strategy to all Strategies 2. End of Life Care 3. Quality Impact Assessments 4. NICE Exception Reporting

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Action 2022/23 Quality Improvement Strategy Priorities	CN	July 2022	In progress
2	New HCAI plan for 2022/23 to be approved by Board	CN	June 2022	In progress
3	Patient and Family Centred Care initiative to be launched	CN	September 2022	Complete
4	Clinical Audit Plan 2022/23 to be approved: approved as part of annual report to quality and Audit Committees.	MD	June 2022	In progress
5	Review of NICE exception reporting process	MD	July 2022	In progress
6	Review process for gaining assurance for End of Life Care	MD	September 2022	In progress
7	To develop and launch a new Quality Impact Assessment tool	CPO	July 2022	In progress

Risk ID: 002	**Date risk identified** April 2022	**Date of last review:**	-
Risk Title: Collaborative Pathways If the Trust does not succeed in developing and leading well led high quality standardised regional care pathways and networks then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable patient care		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Collaboration
		Assurance Committee:	**Quality Committee**
		Lead Executive:	Medical Director

Underlying Operational Risks					
	None currently identified – work in progress			**Consequence**	**Likelihood**	**Rating**
			Initial	**Moderate** 3	**Possible** 3	9
			Current	**Moderate** 3	**Possible** 3	9
Risk Appetite	**Open**		**Target**	**Moderate** 3	**Unlikely** 2	6

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Equality of care for patients due to variation in system delivery and capacity - Potential for increased morbidity and mortality rates - Patient safety incidents - Patient outcomes worsen - Length of stay increases - Resource impact of excess unnecessary investigations - Sustainability of Trust - Inadequate funding to support development and growth in line with strategic ambition - Deterioration of patient and family experience	- Immature system governance, new people and new ways of working create uncertainty in the system - Regional governance arrangements determined at national/ regional level with limited consultation with Health and Care Bill still in process through Parliament - Development of Provider Collaborative Model arrangements - ICS Strategy not in place - New commissioning arrangements not yet known - Unwarranted variation in services - Health inequalities between different postcodes - Pressure on staff resources to develop new pathways and capacity regionally to support and drive change

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Revised Trust Strategy 2022-25 in final stages of development 2. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place-based partnerships and Provider Collaborative 3. Host of C&M Rehabilitation and Critical Care Networks and Neuroscience Programme Board 4. Successful delivery of regional services: Neurology / Neurosurgery / Thrombectomy/ Spinal Surgery 5. Existing relationships with partner organisations through current neurology / neurosurgery model 6. Existing relationships ongoing with Specialised Commissioning through the transitional period (2022/23) 7. Engagement with other specialist trusts both at local and national level 8. Communications and Engagement Strategy 2022-25	1. Profile of Trust and communication of specialist offer 2. Promotion of success of current regional services 3. Perception of specialist Trust's ability to deliver system-wide services 4. Some of Walton Centre patient population lies outside ICS (C&M) and therefore does not align with population basis for commissioning / funding allocations 5. Engagement with other providers can be challenging to promote new ways of working

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monthly reporting to Board on ICS development and development of strategy, processes and systems and also of operationalisation of 24/7 Thrombectomy and spinal surgery Weekly C&M ICS CEO meeting Regular ICS Chair meetings **Level 2** Monthly Chair and CEO reports to Board Project update e.g. Spinal Services to Executive Directors meeting on a regular basis Clinical Effectiveness and Services Group monthly meeting reviews and reports to Quality Committee through Chair's assurance report Regional Thrombectomy Meeting Spinal Provider Board with LUHFT Project Boards with partners eg Pain Collaborative HCP Transformation Board oversight of network boards Complex Rehabilitation Board **Level 3** GIRFT reviews of specialist services e.g. spinal, cranial neurosurgery, neurology monitored through Neurosciences Network Programme Board Regional neuroscience services monitored through Neurosciences Network Programme Board	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR. 3. Lack of clarity on future of specialist commissioning 4. Outcomes dependent on other statutory bodies 5. Comprehensive stakeholder engagement 6. System oversight of networks – currently under review

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Participation in review of Complex Rehabilitation Network – led by Liverpool Clinical Commissioning Group	MD	September 2022	In progress
2	Benefits realisation analysis of 24/7 Thrombectomy	COO	September 2022	Not yet started
3	Benefits realisation analysis of delivery regional spinal services	COO	December 2022	Not yet started
4	Leading Pain Collaborative Working Group to review of regional services and equity of access	MD	December 2022	In progress
5	Recommendations from GIRFT (Getting it Right First Time) action plans for spinal /cranial/ neurosurgery to be completed	MD	September 2022	In progress

Risk ID: 003	**Date risk identified** April 2022	**Date of last review:**	-
Risk Title: System & Finance If the Trust does not deliver its financial plan for 2022-23 the Trust's standing and influence in the system will be diminished and this may result in less resource and opportunities in the future for the Trust to grow and meet it strategic ambitions.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Collaboration
		Assurance Committee:	**Business Performance Committee**
		Lead Executive:	Chief Executive

Operational Risks		
135	If the move to the blended payment approach and population based commissioning allocations continue then this may lead to a risk of reduced allocations for the Trust.	16
Further operational risks regarding CIP and ERF in development.		
Risk Appetite	**Open**	

	Consequence	**Likelihood**	**Rating**
Initial	**Moderate** 3	**Likely** 4	**12**
Current	**Moderate** 3	**Possible** 3	**9**
Target	**Moderate** 3	**Unlikely** 2	**6**

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of decision-making responsibilities / influence as move to system based working and financial targets with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance and finance - Loss of autonomy - Potential deterioration of the Trust's financial position through funding / tariff changes - Change in funding provision for specialist services - Increased complexity to approaches with different tariff systems (Wales and Isle of Man) - Move of commissioning from NHSE Specialised Commissioning to ICS may lead to a lack of local service knowledge around decision-making - Equity of access to care for patients - Inadequate funding to support development and growth in line with strategic ambition - Reputational impact if isolated due to financial performance	- Developing system governance, new people and new ways of working create uncertainty in the system - Regional governance arrangements determined at national/ regional level with limited consultation with Health and Care Act due to come into force on 1 July 2022 - Development of Provider Collaborative Model arrangements - Recent NHSI/E consultation on system funding models - Tariff consultation on population-based funding. - Lack of detailed understanding how on commissioning will occur in future. - Requirement to meet system financial targets - Liverpool Providers Review - ICS Strategy not in place - Larger acute trusts with underlying structural deficits in the ICS. - Trust basis for funding based on historical local tariffs and disproportionate costs of delivery may not be taken into account for services leaving trust with a financial gap - Unidentified elements of Cost Improvement Programme - Inconsistent achievement of activity to deliver Elective Recovery Fund

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Revised Trust Strategy 2022-25 in final stages of development 2. Communication and Engagement Strategy 2020-25 3. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place based partnerships and Provider Collaborative 4. Host of C&M Rehabilitation and Critical Care and Major Trauma Networks and Neuroscience Programme Board 5. Existing relationships ongoing with Specialised Commissioning through the transitional period (2022/23) 6. Trust has fed back on consultations to changes in commissioning 7. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) and through FoSH Finance Group which is reviewing impact of the new financial framework on the system and engaging with the wider system on potential changes 8. Progression of commercial strategy to explore alternative sources of income 9. Tight management of financial position to ensure end of year position achieved and efficiency targets met 10. Healthcare Procurement Liverpool (HPL) established to improve efficiencies and provide value for money 11. Provider Selection Regime for procurement of healthcare services introduced with Health and Care Act	1. Profile of Trust and communication of specialist offer 2. Perception of specialist Trusts 3. A significant proportion of the Walton Centre patient population lies outside C&M, therefore does not align with population basis for commissioning / funding allocations 4. Regional governance arrangements potentially result in greater influence for larger providers 5. Review of stakeholder analysis

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monthly reporting to Board on ICS development and development of strategy, processes and systems Regular review of operational risks at Board level and on-going review of mitigations Review of financial position at every Board and ongoing monitoring through financial controls and processes. Weekly C&M ICS CEO meeting Regular ICS Chair meetings Bi-weekly ICS Directors of Finance planning meetings **Level 2** Monthly Chair and CEO reports to Board Risks review by FoSH Collation of a 5 year plan with specialist trusts in C&M to understand what the longer term finances look like for each of the trusts. **Level 3** External Audit of Annual Accounts and going concern considerations Internal Audit of financial processes and control systems including HPL ICS triangulation benchmarking C&M providers across finance, performance and workforce	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR. 3. Lack of clarity on future of specialist commissioning 4. Outcomes dependent on other statutory bodies

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with the ICS on system development and engage through regional roles in ICS.	ALL	Ongoing	In progress
2	Review of out of HCP referrals / activity to understand the largest Clinical Commissioning Groups and formulate what can be done to continue activity into 2022/23 with the Trust. Update - This will now form part of the Finance and commercial development strategy (currently in development).	CFO	~~Mar 21~~ ~~Sep 21~~ June 2022	Complete
3	Continue to work with FoSH around a national response on how specialised trusts will benefit the new way of system working and respond to tariff consultations	CEO/CFO	Ongoing	In progress
4	Continue to provide mutual aid during the pandemic response to enhance reputation as a system player.	COO	Ongoing	In progress
5	Prepare internal 5-year financial plan based on anticipated changes to tariff to understand longer term financial risks for the Trust and support strategic planning. Waiting for ICS guidance	CFO / COO	~~Sep 21~~ ~~June 22~~ December 2022	~~On track~~ On hold
6	Prepare a Branding and Marketing Strategy to promote the successes of the Trust and cement its reputation as a centre of excellence and ensure key decision makers engaged	CEO	September 2022	In progress
7	Input into the Liverpool Providers Review	CEO	tbc	In progress

Risk 004	Date risk identified April 2022	Date of last review:	
Risk Title: Operational Performance If the Trust does not deliver its agreed activity for the year and meet pre-pandemic levels of activity then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	Leadership
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Operating Officer

Linked Operational Risks		
858	If the elective recovery plan is not achieved then there is a risk that P1, P2 and Patients who have waited 52 weeks or more may be cancelled / postponed. This is due to the constraints within bed base as a result of red, amber and green pathways.	16
867	If staffing constraints do not improve then there is a risk that the elective recovery plan will not be achieved. There is a risk that the elective recovery plan will not be achievable and patients who have waited 52 weeks or more are cancelled/postponed due to the constraints within staffing.	16
323	If there is an increase in cancellations, capacity/demand and limitations on the number of patient visitors, due to Covid-19, then there is a risk of poor patient experience and outcomes.	12
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Major	Possible	
	4	3	12
Current	Moderate	Possible	
	3	3	9
Target	Minor	Unlikely	
	2	2	4

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Patients will wait longer for 1st and follow up appointments – which could result in harm or lead to poor patient experience. - Referral to treatment standard (RTT) / average wait pilot standard will not be met. - Cancer standards will not be met. - Diagnostic standards will not be met. - 52 & 36 week wait standard not met - Financial sanctions for not meeting targets to receive Elective Recovery Fund allocation - Reputational impact - If ERF not received, impact on system finances as well as Trust finances which my worsen reputation in ICS	- Average Wait Performance - Overdue Follow up waiting list in Neurology - Reduction in overall activity due to the impact of Covid-19 - IPC pathway control for electives - Increasing waiting list size - Volume of 52-week waiters - 104-week waiters following transfer of spinal patients - Good performance against trajectories – meeting ERF targets - Impact of further Covid variants on patient numbers, IPC requirements and staff sickness - Vacancies particularly in specialist roles and in nursing

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. COVID-19 Recovery Plan Phase 3 2. Performance Dashboard in real-time 3. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 4. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 5. Submission of Recovery and Restoration plans for 2022/23 6. Stretch recovery target set for 104% of 2019/20 activity 7. Daily COO-led performance catch up which focuses on performance targets and addressing issues that may impact on delivery such as operating list cancellations 8. Divisional recovery plans 9. 52 week recovery plan 10. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners. 11. All 52-week plus waiters have been clinically reviewed and validated (March 2022) 12. Rapid Access Neurological Assessment (RANA) supporting system partners 13. Staff wellbeing programme 14. Regular meetings with specialist commissioners and partners re Thrombectomy to escalate initial issues e.g. ambulance response times	1. Activity plans do not take into account impact of sickness due to Covid-19 2. Covid-19 Recovery Plan based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviors / compliance. 3. National Shortage of ODP theatre staffing currently requiring agency staff to support this gap 4. Reliance on other organisations capacity to provide services 5. National guidance on plan to return to pre-Covid infection and control pathways (implementation planned from early July 2022) 6. Pension tax implications for consultants which may preclude interest in Waiting List Initiatives

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily performance review with Divisions Weekly monitoring of performance of RTT – improvement in 52 and 104 week waits Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly Daily monitoring of critical staff absences at Huddle Live monitoring of performance dashboard	1. Thrombectomy demands on staff rotas 2. Transfer of Thrombectomy patients to and from the Trust in a timely manner 3. Sickness of critical staff 4. Recruitment and retention of key staff and succession planning 5. 52 week spinal waiters ar4e not fully clinically validated yet and are not included in 52 week figures 6. Challenging follow up outpatients target, to reduce by 25%

Level 2 Activity reported monthly in Integrated Performance Report (IPR) to Trust Board Workforce metrics on turnover, vacancies and staff sickness reported monthly in IPR to Board **Level 3** Meetings with Commissioners – monthly Internal Audit review of Waiting List Management - April 2022 System review of 52+ week waiters – April 2022 Check and challenge sessions with ICS on operational and workforce plans	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Implementation of Covid-19 Recovery Plan to increase activity	COO	Sept 2022	On track
2	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue. NHSI pilot ongoing.	COO	~~March 2022~~ March 2023	Pilot Extended
3	Job Planning for new spinal consultants for 2022/23	MD	September 2023	On track
4	Bed repurposing project to increase efficiency and respond to changing demand	COO	July 2022	On track (commenced December 2021)
5	Overdue follow up waiting list is to be monitored by the division by undertaking a validation exercise and a review of the patients to determine which patients can be moved over to PIFU. Dedicated project manager in post from May 2022	COO	November 2022	Ongoing
6	Thrombectomy working group to review at 6 month point to address any ongoing issues and report to Executives	COO	~~June 2022~~ July 2022	On track
7	Full integration of spinal team into WCFT	MD	August 2022	On track
8	Completed clinical validation of spinal patients transferring into WCFT	COO	August 2022	On track

Risk ID: 005	**Date risk identified** April 2022	**Date of last review:**	-
Risk Title: Leadership Devleopment If the Trust does not provide the right environment or opportunities for staff to develop, learn and progress the organisation will not have well led services or experienced staff. This will reduce the Trust's ability to provide well led, high quality services and lead to poor staff experience, higher vacancy rates and the requirement for additional resource to recruit and train new staff.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	Leadership
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked operational risks		
140	If the Trust fails to achieve the agreed internal compliance target rate for all statutory and mandatory training topics, there is a risk to the achievement of CQC standards and regulatory requirements.	12
221	If staffing levels fall below established levels, due to high sickness rate, government vaccination guidance and vacancies, then there is a risk to patient safety &experience and staff safety.	12
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
	Major	**Likely**	
Initial	**4**	**4**	**16**
	Major	**Likely**	
Current	**4**	**4**	**16**
	Major	**Possible**	
Target	**4**	**3**	**12**

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Reduced staff morale - Staff Turnover increases - Gaps in workforce will include hard to fill specialist roles - Costs of recruitment and training - Business continuity - Reputational damage - Sickness increases if vacancies increase - Staff capacity to attend training and development and complete annual appraisals	- Staff Turnover - Vacancy Levels - Sickness Absence - Statutory and Mandatory Training metrics - Quarterly Pulse Survey results - Feedback from staff engagement sessions - Appraisal Rates - Lack of engagement with national development opportunities - Staff Survey responses
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Mandatory Training Annual Plan 2. People Strategy 2022-2025 3. Regional Workforce Plan 4. Health and Wellbeing Strategy approved June 2022 5. Wellbeing Guardian in post 6. BAME Strategic Advisory Committee exercise 7. Staff Survey /Action Plan 8. Partnership working with universities to recruit newly qualified staff 9. Regional collaborations e.g. International Recruitment 10. WCFT Health and Wellbeing Programme 11. National Nursing Bursary – 2020/21 12. Hybrid training models developed to enable ongoing delivery of training with social distancing 13. Monthly deputy's engagement sessions 14. Annual Training Needs Analysis 15. E-rostering	1. Sickness levels including Covid, leading to pressures on workforce to cover and training and development can be seen as lower priority 2. Celebration of successful development outcomes 3. Consistent development offer for all band and all staff groups 4. Consistent national shortage in some staff groups 5. Lack of consistency across system in application of Agenda for Change staff pay bands

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Vacancy monitoring – weekly Staff training and development reports sent monthly to mangers Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events Staff Support sessions provided by NOSS as and when required HR\Finance\Nursing Vacancy renew meetings **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC (linked to People Plan) Quarterly Staff Pulse Survey Workforce report to People Group **Level 3** Outcomes of Staff Survey. 2022 Staff Survey to commence September 2022 Investors in People Accreditation 2021 – Gold Status Investors in People Wellbeing Award 2021 – Gold Status review 2022 Exit Interviews Review MIAA April 2022 Flexible working MIAA Review 2022	1. Delivery of National People Plan

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Recommendations of Exit Interviews Review	CPO	March 2023	In Progress
2	Communications Plan to celebrate development successes e.g. Apprenticeships	Head of Business HR	September 2022	In Progress
3	Potential in Talent for Growth	DCPO	November 2022	In Progress
4	Staff engagement events summer 2022	DCPO	September 2022	In Progress
5	More focused communication including Health and Wellbeing Newsletter	DCPO	July 2022	In Progress
6	Refresh of building rapport	CPO	January 2023	In Progress
7	Review of Performance and Development Report paperwork (annual appraisal)	Senior Education Manager	September 2022	In Progress
8	Deliver a leadership development programme with AQuA for nursing management	CPO	September 2022	In Progress

Risk ID: 006	**Date risk identified** April 2022	**Date of last review:**	-
Risk Title: Prevention and Inequalities If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Social Value: Supporting local communities and staff
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Executive

Linked Operational Risks				**Consequence**	**Likelihood**	**Rating**
455	If controls are not put in place to manage violent and aggressive patients, who are violent and aggressive then there is a risk to staff safety. (Neurology Division / Neuro Surgery Division)	12	**Initial**	**Major**	**Possible**	
				4	**3**	**12**
869	If an adverse incident relating to moving and handling should occur, there is a potential risk under the HSWA 1974 of prosecution by the HSE. This is due to not inducting staff in accordance with the requirements of the aforementioned act and specified under the Moving and Handling Operations Regulations 2002.	12	**Current**	**Moderate**	**Possible**	
				3	**3**	**9**
			Target	**Moderate**	**Unlikely**	
				3	**2**	**6**
Risk Appetite		**Open**				

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor patient outcomes - Deteriorating staff morale and wellbeing - Unable to retain staff - Reputation of Trust - Financial cost of staff leaving - Loss of goodwill and staff engagement - Fluctuating capacity and disruption to services - Failure to adapt to the changing health needs of the population - Failure to achieve duty to improve population health outcomes - Increasing pressure on services due to increasing acuity of patients - Loss of trust with local communities - Increase in violence and aggression towards staff - Inequitable patient waits for treatment	- Variance in outcomes for different socio-economic groups and those with protected characteristics - Aging Population - Deprivation Indices - Staff Survey Results - Incident Reporting - Vacancy/ turnover/ retention rates - Increase in long term sickness - Violence and Aggression incidents - Mandatory and Statutory Training compliance - Increasing waiting times for treatment following Covid-19
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Health and Wellbeing Strategy – approved June 2022 2. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 3. NHS Prevention Pledge adoption and action plan 4. Violence and Aggression Strategy - approved April 2022 5. Commitment to becoming an anchor organisation 6. Member of Citizen's Panel development group 7. Weekly operational monitoring of waiting list 8. People Plan 9. Wellbeing Non-Executive Director lead	1. Health Inequalities and patient access strategy 2. Identified Executive Lead for Health Inequalities 3. National issue with complex long-standing causes that cannot be easily turned around 4. Liverpool population recognised as area of high deprivation
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Health, Safety and Security Group – quarterly review of Violence and Aggression data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – every two months Violence and Aggression Group – every two months People Group – every two months **Level 2** Annual Governance Report – Quality Committee Quality IPR – Quality Committee – monthly Workforce IPR – BPC – monthly Board oversight of progress against NHS Prevention Pledge Quarterly Pulse Survey Staff Partnership Group with Trade Unions **Level 3** Staff Survey 2021 CQC Inspection Report 2019 Investors in People Health & Wellbeing Gold – re-accredited May 2019 and interim review in December 2021	1. Agreed KPIs for measuring patient access and outcomes against deprivation index 2. As only neuroscience provider Walton Centre will have a high proportion of highly complex patients with associated behavioural challenges

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	To establish a number of measures for patient and staff outcomes linked to deprivation data	CEO	July 2022	In progress
2	To work with partners to establish a Citizen's Panel for Liverpool	CPO	October 2022	In progress
3	To understand the process to become accredited as an anchor organisation	CEO	July 2022	In progress
4	To implement the Violence and Aggression Strategy	CN	April 2023	In progress
5	To implement the Health and Wellbeing Strategy	CPO	April 2023	In progress

Risk ID: 007	**Date risk identified** April 2022	**Date of last review:**	-
Risk Title: Capital Investment If the Trust does not maximise its opportunities to acquire capital funding then it may not have enough resource to deliver its estates strategy and provide a fit for purpose environment for staff and patients leading to poor staff morale, poor patient experience and the risk of increased backlog maintenance		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	Value for Money
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Finance Officer

Linked Operational Risks

323	If the aging Theatre air handling unit (AHU) fails to deliver correct air flow then there is a risk upon the Departments ability to run Theatre list.	16

	Consequence	Likelihood	Rating
Initial	Major 4	Possible 4	16
Current	Moderate 3	Possible 3	9
Target	Moderate 4	Unlikely 2	Rating 8

Risk Appetite **Cautious**

Key Impact or Consequence *What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated*	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Financial impact on revenue budgets if new risk to patient safety emerges - Unsafe environment for staff, patients and visitors - Compromised quality of care - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance - Overspend on capital against CRL would have to be covered by underspend by other Trust's in the system	- Capital Resource Limit (CRL) allocations have been set by ICS which is oversubscribed - Risk assessed backlog maintenance register - End of year opportunities for additional money were available late in 2021/22 which the Trust was able to utilise - Additional capital requests emerging following allocation for year

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Capital Management Groups reviews specific capital risks and all capital business cases – Executive Chair 2. Capital Risk Register 3. SFI's/SORD have appropriate approval levels for capital expenditure so CFO / COO are sighted on expenditure 4. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc. 5. Executive led capital prioritisation with operational finance and clinical staff 6. Monthly reporting of capital expenditure to Board 7. Estates Strategy – approved 2015 8. Operational Plan submitted for 2022-23 9. Revenue and Capital budgets - Ongoing 10. Costed Backlog Maintenance Register and Programme - updated May 2022 11. Estates related policies • Electrical Safety Policy: 2021-2023 • Water Management Policy: 2021-2024 • Fire Safety Policy: 2019-2022 • Control and management of Contractors: 2021-2024 • Health & Safety Policy: 2019-2022 12. Site based partnership/SLA with LUFHT last review 2016 13. Contractual agreements with specialist contractors 14. Water Management Action Plan inc. Legionella actions 15. Premises Assurance Model – completed 2021 16. Heating replacement scheme Phase 4 in design stage 17. Sustainability plan update in progress – draft approved by BPC and Board in December 2021 and to be submitted to NHSIE in January 2022	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post Covid-19 2. Further work on capital risk register to ensure estates risks recognised 3. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend 4. Some capital items are not specified in detail and therefore there is an ability for teams to substitute items in year which means capital spend is difficult to prioritise 5. Limitations of regional approach to capital allocations 6. Reliance on specific items which cause delays if not available 7. Priorities may change in year which may lead to pressures against the plan 8. Market prices may differ from estimates once equipment is purchased 9. Clarity of how future revenue costs associated with capital and digital investment will be funded in the long term. 10. Limited access to certain areas prevents visual inspection 11. Policies require review to ensure that they are reflective of current legislation 12. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 13. System capital management leaves little flexibility for Trust to invest surplus cash 14. Programme for Pipework replacement incomplete 15. The national Premises Assurance Model (PAM) outcomes 16. Service Level Agreement (SLA) with LUFHT due review

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular reforecasting of capital position and discussion at Capital Management Group Daily Safety Huddle Water Safety Group – reporting into IPC Committee	1. Allocations are system based from ICS so no longer freedom to generate surplus to spend on capital priorities 2. Timeliness of national/ system decisions on capital reduces the time in which it can be spent as cannot be carried forward into future years

Health & Safety Group Contract review meetings with LUHFT – monthly Heating and Pipework Project Board – monthly Medical Devices, Estates and Facilities Group (6 per year) **Level 2** Capital Programme approved by Trust Board Monthly updates received by BPC and Trust Board on capital BPC and Board approve higher value business cases as per SORD Estates Strategy monitored by BPC and updates received **Level 3** 6 Facet Survey – updated May 2022 CQC Inspection Report Aug 2019 Fire Brigade post-incident review of Fire Processes - 2019 Annual ERIC Returns - annually Reinforced Aerated Autoclaved Concrete (RAAC) review 2021 Premises Assurance Model (PAM) Assessment 2021	3. Capital allocations based on one year – limiting decision-making, resource allocations on longer term projects 4. Revised Estates Strategy delayed pending new Trust Strategy 5. Limited Aintree University Hospital planned maintenance/KPI reporting in place 6. Lack of reporting of sustainability data / KPIs 7. Business case for replacement of air handling unit not yet approved

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Prepare capital bids to be ready for additional allocation in year	COO	September 2022	In progress
2	Prioritise list of capital items to be ready should additional ICS capital become available	CFO	September 2022	New Action
3	Internal desk top review of SLA with LUHFT before discussions with LUHFT	COO/CFO	September 2022	New Action
4	Ensure that maintenance contracts are all up to date, so equipment is covered.	COO	March 2022	Complete
5	Work with NW specialist trusts North West QIP for specialist trusts to consider wider solutions for hard and soft FM. This work continues to progress with Soft Facilities Management Services being tackled in 1st wave	COO	~~March 2020~~ March 2023	Delayed
6	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of Aintree University Hospital via monthly meetings. Estates are currently reviewing resource and cost impacts in advance of recommendation	COO	~~March 2020~~ September 2022	Delayed
7	Integrate Trust Sustainability Plan into Estates Strategy review and develop local action plan	COO	September 2022	Ongoing
8	WC Estates Strategy to be incorporated into wider “system” strategy currently being led by LUHFT	COO	September 2022	Ongoing
9	Ongoing monitoring of Phase 5 Heating and Pipework Programme. Due to start in June 2022.	COO	March 2023	Ongoing
10	Design process initiated for upgrade works to Theatres 1-5 due to non-compliant Air Handling Units. Executive team has provided permission to proceed to tender stage	COO	April 2022	Complete

Risk ID: 008	Date risk identified: April 2022	Date of last review:	
Risk Title: Medical Education Offer If the Trust does not have the right staff with the right skills and the right processes and training it will not be able to deliver its ambition of developing a national medical education training offer in Neurosciences and will not deliver its strategic ambitions		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks			**Consequence**	**Likelihood**	**Rating**
In development		**Initial**	**Major** 4	**Likely** 4	**16**
		Current	**Moderate** 4	**Possible** 3	**12**
Risk Appetite	**Open**	**Target**	**Minor** 4	**Unlikely** 2	**8**

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• Failure to achieve key strand of Trusts Strategic ambition as leading in education. • Loss of current and future HEE/DHSC income streams for medical education • Failure to take advantage of opportunity to harness Trust's international profile and grow education offerings outside of HEE training programmes • Reduced ability to attract consultants and staff with a specialist interest in medical education • No obvious trajectory for developing future educationalists • Failure to build on Trust's external reputation as centre of academic excellence and subsequent ability to attract highest calibre undergraduate and postgraduate medics • Inability of Trust to grow innovative education programme and TEL delivery	• Difficulties recruiting to internal lead educator roles • Limited capacity to develop current resource and offer on a national scale • Inability to attract high quality medical education staff • Challenge in managing competing pressures of clinical service delivery and dedicated student support/supervision time. • Resource capacity limited with regards to hosting elective/observer programmes • Plan not yet in place to deliver national program • Training, Education and Learning programme in its infancy, infrastructure to be established to support implementation / expansion

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Established Medical Education Committee and clear reporting line to the Board of Directors via to Research, Innovation and Medical Education (RIME) Committee. 2. Lead educator roles established with Director of Medical Education (DME) engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and meets at least bi-monthly. Clinical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed. 6. SOPs have been created to standardise and assure processes. 7. New structure for delivery of education was consolidated in 2021 8. Consultants are now formally recognised for undergraduate educational supervision and remunerated through job planned activities 9. Guardian of safe working quarterly report to Board.	1. Plan to deliver a national programme of medical education is not currently in place 2. Assessment of resource required to develop national offer needs to be undertaken.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Medical Education Committee minutes • Medical Education overarching Action Plan • Medical Undergraduate Working Group minutes • Junior Doctor Forum (held alongside Guardian of Safe Working) **Level 2** • Medical Education Quarterly and Annual Reports to RIME Committee • HEENW Annual Education Return Board report • End of Placement Feedback – Undergraduate • Placement Exit Survey – Postgraduate	1. Support from key strategic partners for national programme. 2. Governance for development of a national offer to be developed and agreed. 3. Infrastructure is limited to support new and emerging work streams e.g. TEL and simulation 4. Coordination and management of medical elective and observer placements based on historic admin process, no data to evaluate satisfaction or quality

Level 3 • GMC National Training Survey – Postgraduate Trainee and Trainer • UoL Clinical Undergraduate placement RAG reports • Annual Education Self-Assessment Report – HEENW	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Effectiveness of new SPA funded enhanced education roles to be reviewed after 12 months	DME	July 2022	In progress
2	Medical Education SOPs to be reviewed/ratified by Director of Medical Education/relevant groups. Initial action complete, however two additional procedures have emerged	DME/CPO	~~Ongoing June 2022~~ October 2022	In progress
3	Educational Appraisal Lead is a new role (as part of the enhanced education roles created summer 2021), underpinning improved educator support. An appointment is still to be made; discussions are ongoing with potential candidates.	DME/MD	~~Ongoing June 2022~~ August 2022	On track
4	Education Fellows are helping the admin team overcome silo working with practical support to ensure equitable allocation of clinical experiences for Undergraduate and Postgraduate learners. Success to be evaluated via student and junior doctor satisfaction surveys	DME / Clinical Education Fellows	~~May 2022~~ Complete	Complete
5	Development of strategic plan to widen/strengthen the Medical Education offer	CPO	Jan 2023	New Risk
6	Scope out the potential to enhance the national offering through simulation and technology enhanced learning offerings, including the new neurosurgery VR	DME	Nov 2022	New Risk
7	Review governance and financial costing of electives and observers to support the national offering.	Medical Education Development Manager /DME	May 2023	New Risk
8	Appropriate operational risks are to be developed and entered onto risk register with risk manager	Medical Education Development Manager	July 2022	New Risk

Risk ID: 009	Date risk identified: April 2022	Date of last review:	-
Risk Title: Research and Development If the Trust does not develop the research department business model it will not attract the right staff or the research projects necessary for the Trust to become a world-class centre for Neurosciences and innovation		Date of next review:	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Innovation and Research
		Assurance Committee:	Research, Innovation & Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks		Consequence	Likelihood	Rating
None identified - in development.	Initial	Major 4	Likely 4	16
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Open**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Inability to recruit and retain the most ambitious clinical staff • Inability to meet the Clinical Research Network target • Negative impact to Trust's reputation and ability to attract commercial sponsors • Failure to attract the right research projects • Damage to key strategic partnerships (e.g. LHP, ICS) during a time of both significant changes to regional systems and increased external scrutiny (e.g. CQC). • Deleterious impact on Neuroscience Research Centre (NRC) workforce, lack of sufficient workplace capacity and capability to maintain, grow and develop the research function • Inability to recruit and retain the most ambitious clinical staff • Unsustainable financial model that balances income streams, notably commercial income • Inability to secure sufficient grant-based funding • Ineffective internal research strategy development through a lack of awareness and mitigation of external macro environmental influences and pressures	• 25+ studies have been declined in the past two years • 50+ studies in backlog which currently cannot be opened • Lack of study back-up nurses to ensure study continuity • Ability to recruit consultants with research interests • Failure to recruit to trials • Staff stress-related sickness absence • Challenges in team capacity due to sickness • Unable to meet timelines for setting up studies • Delays in meeting recruitment targets

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Research and Development Strategy 2019/24 2. MHRA Inspection Audit, peer review etc. 3. New partnerships with universities, other trusts and system level collaborations 4. Prioritisation of commercial trials and development of new income streams	1. Work ongoing in redesign of Neuroscience Research Centre (NRC) with resource implications 2. Governance to deliver research on a bigger scale 3. Completion of audit action plans 4. Clarity of purpose and roles in the emerging system infrastructure 5. Income generation model approved but contracts to be negotiated 6. Review/development of principles for time dedicated to research

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Principle Investigators Forum • Sponsorship Oversight Group • Research Capability Funding Sub-committee • Roy Ferguson Compassionate Care Award Group **Level 2** • Research updates to RIME Committee • RIME Committee Chair's Report to Board of Directors **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019 • Kings College external review of NRC 2020	1. Service redesign still in implementation phase, impact not assessed 2. Organisational change process suspended due to COVID-19 3. Engagement/utilisation of LHP and SPARK inconsistent

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	NRC organisational service change process supported by Human Resources.	CPO &CDRD	June 2022 (due to COVID 19)	~~On hold~~ On track
2	Senior Neuroscience Research Group in place.	CPO & CDRD	~~September 2020~~ June 2022	On track
3	Head of LHP SPARK, in an interim role to support with a review of governance practices including audit action plans and developing the administrative capabilities to support research on a bigger scale	CDRD	~~April 2022~~ August 2022	On track
4	CRN providing short term clinical research nursing leadership support and completing scoping exercise to establish capability and capacity of the team	CDRD	August 2022	On track
5	Strengthen links and collaborate with key local research partners such as universities to clarify NRC place in external local system	CDRD	October 2022	New action
6	Develop plan to promote research agenda with patients, carers and staff	CPO & CDRD	January 2023	New action
7	Review systems for medical education educator and other models emerging for capturing /quantifying activity to inform the development of a framework for robust governance /enhanced management of consultant time/ engagement in research activities	CDRD	January 2023	New action
8	Review of effectiveness of RIME Committee to be completed	Corporate Secretary	September 2022	On track
9	Review of Liverpool Health Partnership model	CEO	September 2022	On track

Risk ID: 010	Date risk identified: April 2022	Date of last review:	-
Risk Title: Innovative Culture If the Trust does not develop a culture where staff are empowered to innovate it will not be able to attract and retain a world class workforce to support the Trust's ambitions		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief Executive

Linked Operational Risks		Consequence	Likelihood	Rating
No linked risks	Initial	Major	Likely	
		4	4	16
	Current	Major	Possible	
		4	3	12
	Target	Major	Unlikely	
		4	2	8
Risk Appetite	**Adventurous**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Inability to improve patient care - Inability to retain or attract clinical staff if unable to fulfil their innovation ambitions - Insufficient workplace capacity and resourcing to ensure innovative practices, treatments and boundary scanning - Risk aversion and complacency - Innovations will not be fully implemented, acknowledged and celebrated - Reputational impact - External scrutiny e.g. CQC well led	- National Staff Survey 2021 themes; wellbeing, development and reward and recognition - Limited understanding of culture and sub-cultures on Trust - Reduced resource capacity due to Covid-19 pandemic pressures - Commercial management vacancy - Lack of staff and leadership engagement - Insufficient succession planning or development opportunities in innovation

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Innovation Strategic Objectives set in 2019/20 – majority of short and medium-term objectives completed 2. Innovation Strategy to be revised following Trust Strategy launch in May 2022 3. Innovation Strategy Communication Plan to be revised in line with renewed Innovation Strategy 4. Innovation Pipeline review being undertaken 5. Innovation Lead identified 6. Investors in People Gold accreditation (2021) 7. People Strategy 2022-25 8. Pulse and National Staff Surveys 9. Staff engagement sessions with Executive Team July-August 2022	1. Innovation project pipeline alignment to Trust Strategy priorities 2. Clinical and corporate divisional engagement of; internal initiatives, spread and adoption of external innovations and address risk aversion 3. Workforce capacity to have time to develop and implement initiatives 4. Wider engagement with Trust stakeholders and patient groups 5. Commercial Strategy development 6. Spinal Improvement Programme income generation model contracts to be finalised 7. Single project management office to be established 8. Competitor Analysis to be completed (to be finalised by Communications & Marketing Manager, subject to prioritisation)

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Medical Innovation Group • Monthly Innovation Team meetings • Regular meetings with procurement, IT, IG, service improvement, clinical and other teams as required • Collaborative working arrangement with external partners **Level 2** • RIME Committee approval of funding applications and oversight of project pipeline activity • RIME Committee Chair Report to Trust Board and Council of Governors • Executive Team approval of innovation business cases • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • Innovation sited in CQC Inspection report 2019	1. Benchmarking assessment and validation of innovation function 2. Risk appetite and strategic approach to innovation management 3. Organisational readiness enabling entrepreneurship, creativity and multi-disciplinary collaboration 4. Limited knowledge of intellectual property 5. Industry foresight and horizon scanning 6. Customer awareness and behaviours 7. Measurement of return of investment of innovations 8. Systematic process for measuring outcomes and continual improvement 9. Benefit realisation for innovative business cases not yet feasible due to lack of defined metrics

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Benchmarking assessment of innovation function via Investors in Innovations Standard aligned to ISO 56002 Innovation Management System – international industry standard	CPO/IC	June 2022	In progress
2	Revise Trust Innovation Strategy	CPO/IC	September 2022	In progress
3	Develop innovation communication plan in line with revised Innovation Strategy	IC	September 2022	In progress
4	Address innovation/commercial resource to align with revised Trust and innovation strategies and changes to service - Business Development Manager role to be recruited	CPO	June 2022	In progress
5	Review of innovation project pipeline to align to revised Trust Strategy priorities	IC	June 2022	In progress
6	Review of Medical Innovation Group function, responsibilities and membership in line with revised Innovation Strategy and RIME Committee review	IC	September 2022	In progress
7	Further stakeholder and patient engagement through revised Innovation Strategy and communication plan	IC	September 2022	In progress
8	Develop Innovation Risk Register	IC	September 2022	In progress
9	Five Year Workforce Plan	CPO	December 2022	In progress
10	Single project management office established	CPO	December 2022	O In progress
11	Benefits realisation of Multitom Rax Business Case to be presented to Executive Team and Trust Board	CPO/IC	~~April 2021~~ ~~April 2022~~ 2022 Q3	~~Delayed due to COVID~~ On track
12	Spinal Improvement Programme income generation model contracts to be finalised **Update January 2022** – COVID added > 1 year delay due to resourcing and project complexities limiting progress. Contracting in progress	CPO	~~October 2020~~ ~~March 2021~~ ~~August 2021~~ ~~October 2021~~ ~~February 2022~~ June 2022	~~Delayed due to COVID~~ On track
13	Innovation included within the NHS Pulse and Staff Surveys	CPO/IC	September 2022	In progress
14	Competitor analysis to be initiated and presented to Trust Board	CPO	~~TBC~~ ~~(due to COVID-19)~~ July 2022	~~On hold~~ Delayed due to COVID

Risk ID: 011	Date risk identified: April 2020	Date of last review:	May 2022
Risk Title: Cyber Security If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data and financial penalties		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee/ Audit
		Lead Executive:	Chief Finance Officer

Linked operational Risks			Consequence	Likelihood	Rating
	Operational risks in development				
			Initial	**Major**	**Almost Certain**	
				4	**5**	**20**
			Current	**Moderate**	**Likely**	
				3	**4**	**12**
			Target	**Minor**	**Possible**	
				2	**4**	**8**
Risk Appetite	**Averse**					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*

- Loss of operational and clinical disruption or a ransom
- Potential financial loss due to loss of activity
- Likely to lead to financial, business and operational impacts as well as reputational damage
- Potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover)
- Non-compliance with Data Protection Laws/Network and Information Systems Directive
- Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.
	- 2022 (up to May) - 87 Carecerts
	  ○ 5 High Level
	  ○ 16 Medium Level
	  ○ 3 Low Level
	  ○ 63 Information Only
	- 2021 - 245 Carecerts
	  ○ 13 High Level
	  ○ 49 Medium Level
	  ○ 34 Low Level
	  ○ 149 Information Only
	- Cyber security attacks are increasing, and ongoing work is required to keep up to date
	- Log4j High Vulnerability identified at global level
	- Heighten Cyber level due to Russian conflict

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Firewall in place and kept up to date on an ongoing basis 2. Security Information and Event Management (SIEM) monitors all live systems 3. Antivirus Installed on All Computers 4. Vulnerability Protection 5. Hard drive encryption (Laptops) 6. Endpoint Encryption on all computers to prevent local distribution of malware 7. 2 factor Authentication on Server Rooms 8. Swipe Access for staff areas 9. Smart water protection on all devices 10. Asset register and inventory in place 11. ISO27001 Accreditation process - Annual 12. Informatic Skills Development Accreditation Level 1 13. HIMMS Level 5 14. Data Security and Protection Toolkit 15. Member of the Cheshire and Mersey Cyber Security Group - Ongoing 16. Pilot for NHS Digital Programmes relating to Cyber security - Ongoing 17. CareCERT Processing on a regular basis - Ad Hoc 18. Network groups for IG - Radiology etc. 19. Proactive monitoring of national cyber alert status 20. Daily National update logging of log4j remedial work 21. Interoperability – Upgrade to the latest supported Microsoft Windows Operating System to continue to receive critical security updates Mar 22 22. NHS Mail – Migration in March 2022 to the latest supported Microsoft Exchange platform to continue to receive critical security updates 23. Backups – Transition to immutable “offline” backups to protect against Ransomware attacks 24. Datacentre – Upgrade in March 2022 to the latest supported VMware platform to continue to receive critical security updates 25. SQL – Migration in March 2022 to the latest supported Microsoft SQL platform to continue to receive critical security updates 26. Alerts and communications plan in place to educate and remind staff about IT security 27. Updated version of Antivirus rolled out April 2022	1. Limited funding and investment nationally regarding Cyber Security 2. Lack of skilled resources working in the area of cyber security and private sector competition pushing costs up 3. Increased activity due to geo-political events

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Review of CareCERTs - Weekly Annual Cyber Security Awareness Presentation to Board **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board Report to Audit Committee **Level 3** ISO27001 – accreditation, external audit annually MIAA audits of Data Security and Protection Toolkit –Substantial Assurance External Penetration Testing – May 2021 Date planned for 22 Regional Desktop Exercise – April 2022 Internal Desktop Cyber Exercise – May 2021 Date planned for 22 Trust Board Cyber Security Training – April 2021 Full Cyber Library completed by C& M HCP – August 2021	1. Third party assurances required regarding satellite sites 2. Ongoing work with NHS Digital to inform funding requirements 3. Local skillsets limited resourcing (001) 4. Log4J National systems status still unknown

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	On-going work with NHS Digital to inform funding requirements for Cyber Security post-Covid Working on regional solution 2022/23 with Digital Lead, awaiting ICS input	CFO	June 2022	Paused
2	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid. Revisiting with ICS with new digital lead and Cyber skillsets	CFO	August 2022	In progress
3	Expand Cyber service to underpin current processes with MIAA / C&M HCP. Desk top exercise complete, penetration test booked for July.	CFO	July 2022	Partially Complete
4	Attainment of HIMMS level 6 through Digital Aspirant programme	CDIO	April 2023	In progress

Risk ID: 012	Date risk identified April 2022	Date of last review:	
Risk Title: Digital If the Trust fails to deliver the benefits of the Digital Aspirant funding then the Trust may fail to secure digital transformation leading to poor staff experience, a deterioration of patient safety, reputational damage, financial penalties and missed opportunity.		**Date of next review:**	July 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Digital/ Cyber Security: To keep up with digital opportunities and threats
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks		Consequence	Likelihood	Rating
Operational risks in development	Initial	Moderate 3	Likely 4	12
	Current	Moderate 3	Possible 2	6
	Target	Moderate 3	Unlikely 2	6
Risk Appetite	**Cautious**			

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Investment does not result in anticipated benefits for patient care and safety - Missed objective - Reputational damage due to poor use of resources - Poor patient experience - Long term revenue commitments for under-par systems - Staff do not understand/use systems - Sanctions from regulators	- Trust bid successfully for Digital Aspirant funding approved by NHS Digital. This funding will help to deliver the EPR and wider Digital Strategy between 2021 and 2023 - Insufficient staff resource/sickness to deliver full performance - Impact of Covid on supply chain causing delays in delivery and equipment shortages - 2021/22 programme spending delivered

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Projects underway: i. Outpatient Transformation Project ii. Inpatient Transformation Project iii. Theatres Project iv. Paper Light Project 2. Digital Transformation Board aligned to governance groups across the organisation 3. IT Technical Programme of work 4. Cyber Security Programme 5. PMO Function underpinning the Digital Strategy 6. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 7. EPR rollout plan for 2020/21 completed 8. Digital Transformation Programme (LoA/MoU NHSD/X) 9. Digital Aspirant status to allow Digital Transformation 10. HiMSS Level 5 (working towards Level 6) 11. Digital Strategy 12. Representation on ICS Digital Programme Boards 13. Regular reporting to NHS Digital of progress against digital aspirant funding 14. Quarterly report to Business Performance Committee 15. Bi-monthly reporting to Executives	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy 3. Change in national priorities around Digital post-Covid response may not be aligned to Trust digital priorities 4. Lack of digital expertise on board

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Outpatient Digital Group monthly Inpatient Digital Group – monthly – digital champions within the Divisions Clinical Systems Safety Group – monthly Digital Programme Board – bi-monthly Information Governance & Security Forum – monthly Digital Prioritisation Group - quarterly Clinical Risk Group **Level 2** Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group Executive Team review of C&M Hospital Cell Digital Objectives C&M Chief Information Officers Digital Collaboration Group National Chief Information Officer Weekly Meetings **Level 3**	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. Workshops facilitated by MIAA Q2-3 2021/22.

Critical Applications Audit – Jan 2020 Healthcare Information and Management System Level 5 achieved 2021/22 Information Security Management Systems Certification IS27001 accreditation December 2021 Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to ICS by C&M Digit@LL NHSX monitoring Digital Aspirant via CORA against LoA. Data Security and Protection Toolkit annual audit and submission Information Security Management Systems Certification IS27001 accreditation September 2020	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	New Digital Strategy with MIAA / C&M ICS to be approved by Board. Paused while Trust Strategy approved	CPO	~~May 2021~~ ~~December 2021~~ September 2022	In progress
2	HIMMS level 6	CDIO	October 2023	In progress

Proposed strategic objectives and principal risks 2022/23

Cross Cutting Themes - People Quality Care Digitalisation Health Inequalities Best Value

Strategic Ambitions and Themes	Principal Risks	
Quality Care: Ensuring the delivery of the highest quality of care to our patients and their families	**BAF 001** If the Trust does not deliver high quality care for all patients then this will lead to adverse clinical outcomes for patient and a deterioration of patient experience which would reduce staff morale and impact on the reputation of the Trust. **Risk Owner: Chief Nurse** **Assurance Committee: Quality**	
Collaboration: Working closely with partners and across internal teams to develop high quality standardised services	**BAF002** If the Trust does not succeed in developing and leading well led high quality standardised regional care pathways and networks then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable patient care. **Risk Owner: Medical Director** **Assurance Committee: Quality**	**BAF 003** If the Trust does not deliver its financial plan for 2022-23 the Trust's standing and influence in the system will be diminished and this may result in less resource and opportunities in the future for the Trust to grow and meet it strategic ambitions. **Risk Owner: Chief Executive** **Assurance Committee: Board/ BPC**
Leadership: Clinically led leadership, embedded across all staff to deliver high quality patient care at the Trust and through the ICS.	**BAF 004** If the Trust does not deliver its agreed activity for the year and meet pre-pandemic levels of activity then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust. **Risk Owner: Chief Operating Officer** **Assurance Committee: BPC**	**BAF 005** If the Trust does not provide the right environment or opportunities for staff to develop, learn and progress the organisation will not have well led services or experienced staff. This will reduce the Trust's ability to provide well led, high quality services and lead to poor staff experience, higher vacancy rates and the requirement for additional resource to recruit and train new staff. **Risk Owner: Chief People Officer** **Assurance Committee: BPC**
Social Responsibility: Supporting local communities and staff to prevent and support physical and mental health issues and become an Anchor Institution	**BAF 006** If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population. **Risk Owner: Chief Executive** **Assurance Committee: BPC**	**BAF 007** If the Trust does not maximise its opportunities to acquire capital funding then it may not have enough resource to deliver its estates strategy and provide a fit for purpose environment for staff and patients leading to poor staff morale, poor patient experience and the risk of increased backlog maintenance. **Risk Owner: Chief Finance Officer** **Assurance Committee: BPC**
Education, training and learning: Expand the teaching offer to deliver at a national level for neurosciences education and training	**BAF008** If the Trust does not have the right staff with the right skills and the right processes, it will not be able to deliver its ambition of developing a national training offer in medical education Neurosciences and will not deliver its strategic ambitions **Risk Owner: Chief People Officer** **Assurance Committee: RIME**	
Research and Innovation: Develop the department to attract world class researchers and embed a culture of innovation	**BAF 009** If the Trust does not develop the research department business model it will not attract the right staff or the research projects necessary for the Trust to become a world-class centre for Neurosciences and innovation **Risk Owner: Chief People Officer** **Assurance Committee: RIME**	**BAF 010** If the Trust does not develop a culture where staff are able to innovate, develop solutions and put patient care first then it will not attract the right staff to support the ambitions of the Trust **Risk Owner: Chief Executive** **Assurance Committee: Board/ RIME**
Digitalisation: Industry leading digital solutions for our patients and our people	**BAF 011** If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence. **Risk Owner: Chief Finance Officer** **Assurance Committee: BPC**	**BAF 012** If the Trust fails to deliver the benefits of the Digital Aspirant funding then the Trust may fail to secure digital transformation leading to poor staff experience, a deterioration of patient safety, reputational damage, financial penalties and missed opportunity. **Risk Owner: Chief People Officer** **Assurance Committee: BPC**

Risk Appetite Categories	
AVERSE	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.
CAUTIOUS	Willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.
MODERATE	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.
OPEN	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.
ADVENTUROUS	Eager to seek original/creative/pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Consequence score (severity levels) and examples of descriptors

Domains	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	• Minimal injury requiring no/minimal intervention or treatment. • No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients
Quality/complaints/audit	• Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• Overall treatment or service suboptimal • Formal complaint (stage 1) • Local resolution • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness • Formal complaint (stage 2) complaint • Local resolution (with potential to go to independent review) • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/service • Gross failure of patient safety if findings not acted on • Inquest/ombudsman inquiry • Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	• Short-term low staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff • Very low staff morale • No staff attending mandatory/ key training	• Non-delivery of key objective/service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	• No or minimal impact or breech of guidance/ statutory duty	• Breech of statutory legislation • Reduced performance rating if unresolved	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action • Multiple breeches in statutory duty • Improvement notices • Low performance rating • Critical report	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Zero performance rating • Severely critical report
Adverse publicity/ reputation	• Rumours • Potential for public concern	• Local media coverage – short-term reduction in public confidence • Elements of public expectation not being met	• Local media coverage – long-term reduction in public confidence	• National media coverage with <3 days service well below reasonable public expectation	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Total loss of public confidence
Business objectives/ projects	• Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Finance including claims	• Small loss Risk of claim remote	• Loss of 0.1–0.25 per cent of budget • Claim less than £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time	• Non-delivery of key objective/ Loss of >1 per cent of budget • Failure to meet specification/ slippage • Loss of contract / payment by results • Claim(s) >£1 million
Service/business interruption Environmental impact	• Loss/interruption of >1 hour • Minimal or no impact on the environment	• Loss/interruption of >8 hours • Minor impact on environment	• Loss/interruption of >1 day • Moderate impact on environment	• Loss/interruption of >1 week • Major impact on environment	• Permanent loss of service or facility • Catastrophic impact on environment

LIKELIHOOD SCORE

Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might Happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

CONSEQUENCES

LIKELIHOOD	Significant	Minor	Moderate	Major	Catastrophic
Almost Certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

DEFINITIONS OF THE TITLE HEADLINES USED WITHIN THE RISK REGISTER DOCUMENT	
ID:	The reference number allocated to the risk automatically by Datix when first logged into system.
Strategic Aim	What the organisation aims to deliver; this is agreed by the Trust Board
Risk	Narrative describing what the risk is and the impact to the organisation.
Likelihood (current)	This is an assessment of the likelihood of the risk occurring taking into consideration the controls which are in place.
Consequence (current)	This is an assessment of severity of the risk if it were to happen taking into consideration the controls which are in place.
Controls	What are we currently doing to control the risks?
Initial rating	The degree of risk prior to the implementation of any controls
Current Rating	The level of risk which is apparent at the time of the review. This is established by calculating the consequence and likelihood as defined in Appendix A.
Target Rating	This is the revised calculated score of the C x L once all treatment plans have been completed and controls are working effective and is the residual risk accepted by the Trust.
Assurance	What evidence do we have to show that the things we are doing are having an impact? E.g. audits, surveys, minutes, external evidence such as CQC Report?
Gaps in controls	Were we are failing to put controls/systems in place?
Gaps in Assurance	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Source of Risk	How the risk was identified/what area of the Trust is the risk coming from?
Executive Owner	The named Executive responsible for the management of the risk assessment.

The Walton Centre NHS Foundation Trust

Report to Trust Board
7th July 2022

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman - Chief Operating Officer
Author (s)	Mark Foy – Head of Information & Business Intelligence
Action Required	To note

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- See summary for performance overview

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Ongoing

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

001 Quality Patient Care	004 Operational Performance	003 System Finance

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Integrated Performance Report

Executive Summary

This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking. The below table highlights indicators by those which are High Performing (achieving target or improvement), Opportunity for Improvement (improving but not hitting target, or underperforming compared to peers, and Underperforming (not hitting target consistently or performance significantly decreasing).

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Referral to Treatment Long Waits
28 Day Emergency Readmissions
% of Patients on a PIFU

Opportunity for improvement
Theatres
Referral to Treatment Waits
Activity Restoration

Underperforming
N/A

Workforce Indicators

High Performing
N/A

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
Complaints
CAUTI
VTE
Hospital Acquired Pressure Ulcers
Risk Adjusted Mortality
Friends and Family Test
Moderate Harm Falls

Opportunity for improvement
Infection Control

Underperforming
N/A

Finance Indicators

High Performing
Income and Expenditure (subject to audit):
- In month - £131k ahead of plan
- YTD - £114k ahead plan

Cash balance £39.1m equivalent to 97 days operating expenses
Capital:
- For the year £629k behind plan

Opportunity for improvement
BPPC (by value) – Target 95%:
- Non-NHS – 85.1%
- NHS – 68.1%
- Total – 81.2%

The content of the IPR has been reviewed to ensure it contains appropriate metrics in line with the single oversight framework and national mandatory key performance indicators. Following this the below metrics have been added to the report.

New Additions

All Staff Group Turnover
% Discharges to usual residence by 5pm
Friends & Family Test
Risk Adjusted Mortality

Conclusion

As listed above the majority of indicators are high performing either against a set target, local improvement or external benchmarking.

Recommendation

To note the compliance against key performance indicators and the assurance or mitigations in place

Author: Mark Foy – Head of Information & Business Intelligence
Date: 27/06/2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Board KPI Report
July 2022

Data for May 2022 unless indicated

Explanation of SPC Charts and Assurance Icons

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

SPC charts are widely used in this report int order to provide increased assurance, insight and an indication of future performance. However SPC charts are not relevant for every indicator. Where there are not enough data points, numbers too small or very unstable, or the indicator is to provide knowledge rather than show an improvement then an alternative visualisation will be used.

To maximise insight the charts will also include any targets and benchmarking where applicable.

All SPC charts will follow the below Key unless indicated

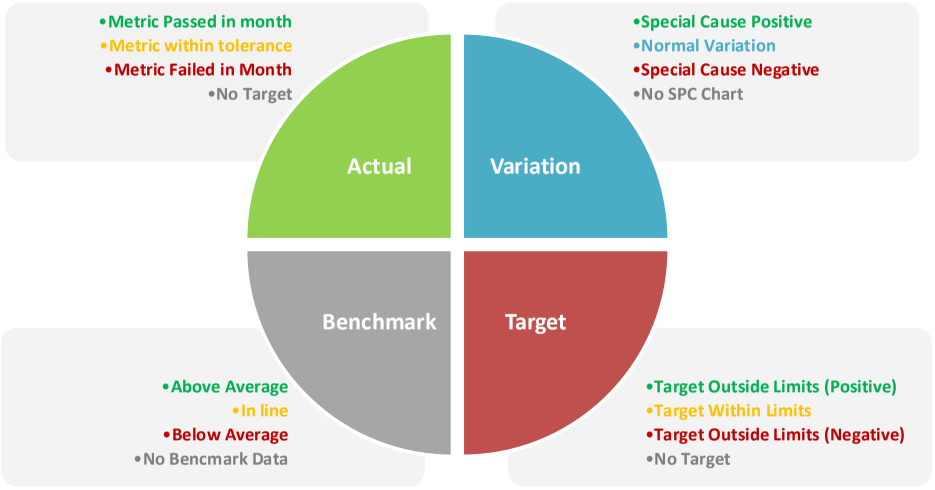
Actual UCL Average LCL National Average Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.



SPC Chart Rules

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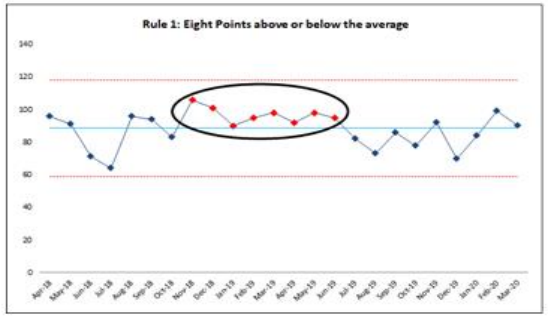
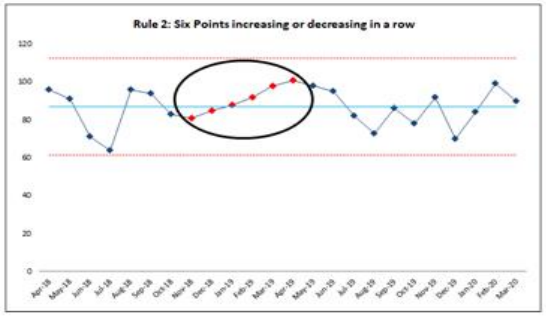
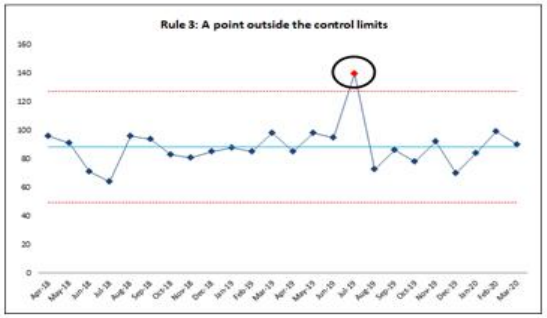
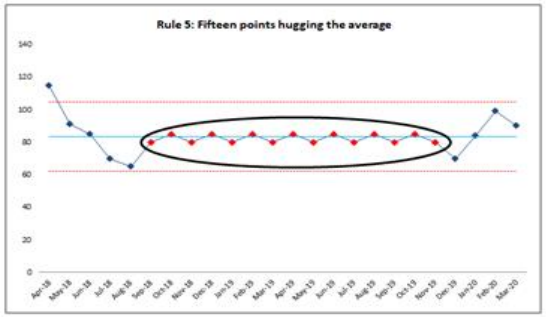
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).









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Operations & Performance Indicators

Operational

Responsive - Cancer Standards

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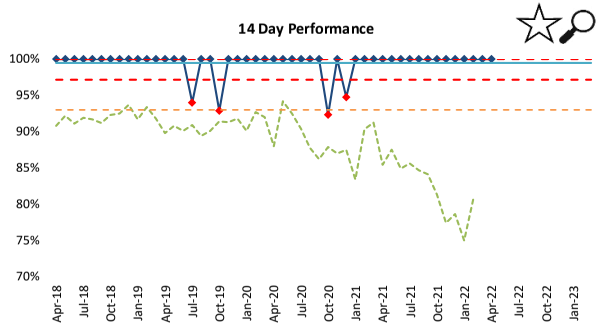
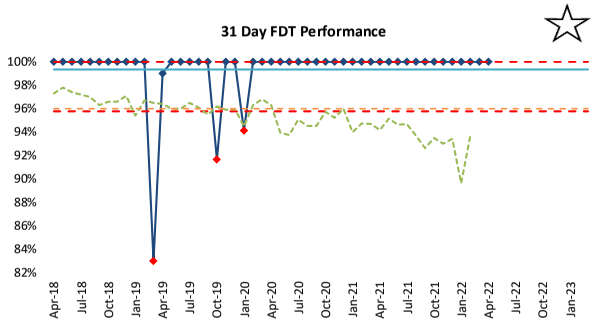
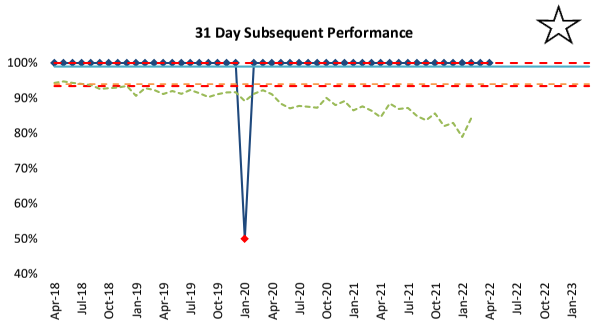
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

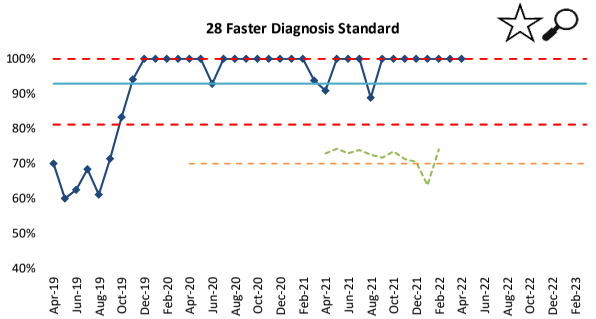
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

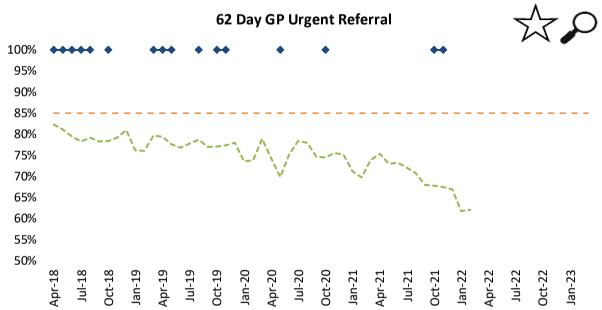
Associated Risks
001 - Covid-19
003 - Performance Standards

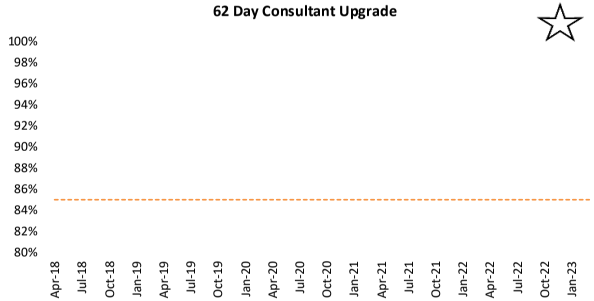












Operational

Responsive - Diagnostics

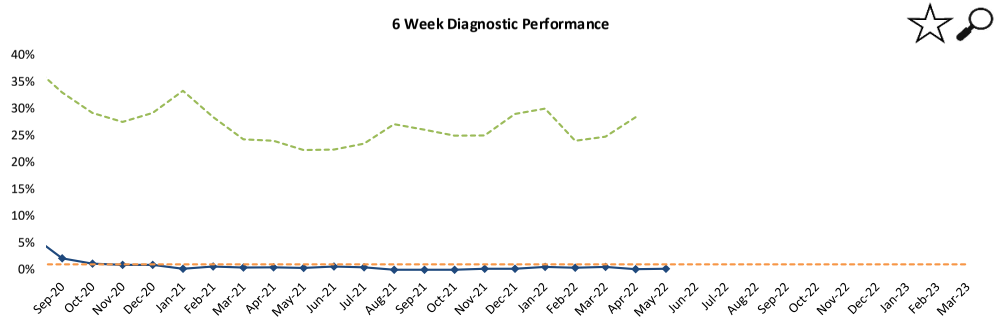
The Walton Centre NHS Foundation Trust

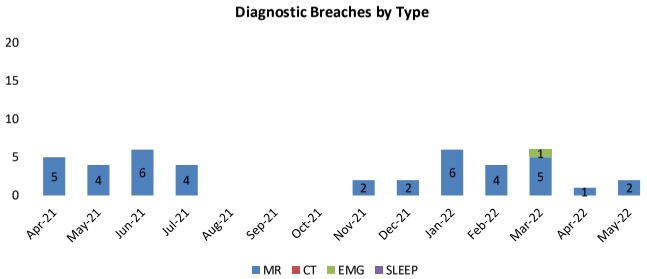
Excellence in Neuroscience

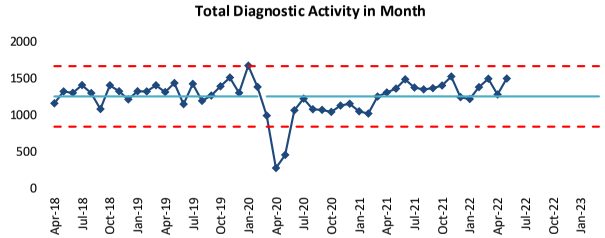
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.19%	

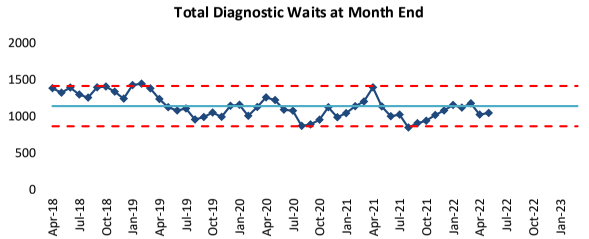
Associated Risks
001 - Covid-19
003 - Performance Standards

Achievement against the Diagnostic 6 week standard has been met in month. There was two 6 week breach in month.









Operational

Effective - Theatres

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

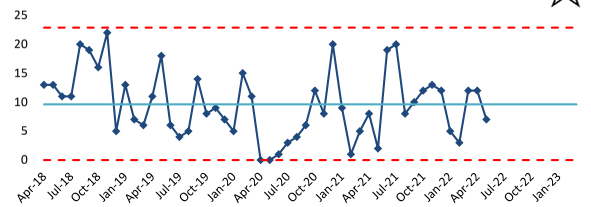
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	7	
% Cancelled operations non clinical on day	0.80%	0.57%	
28 Day Breaches in month	0	1	

Non Clinical Cancellations

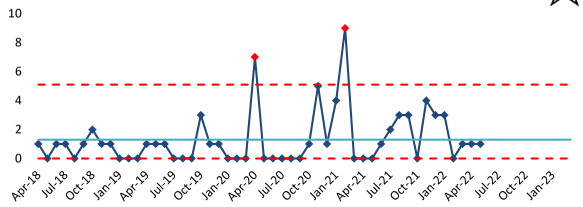
There were 7 patients cancelled at last minute for non-clinical reasons in May 2022, the reasons for the cancellations were replaced by more urgent case (4), Staff unvailable (2) and List overran (1).

The Trust is in line with the national average for the % of non clinical cancelled operations based off latest published data .

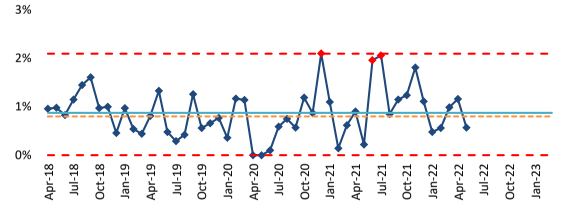
Number of Cancelled operations non clinical (on day)



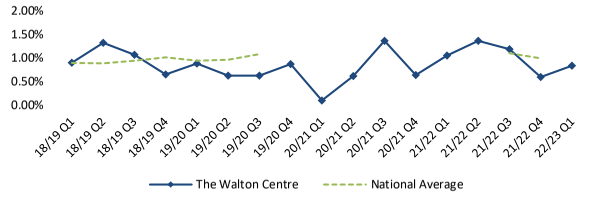
Number of cancelled operations not re-admitted within 28 days



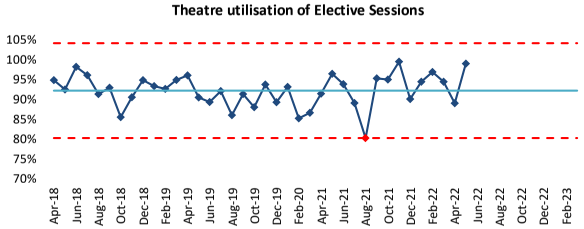
% of Cancelled operations non clinical (on day)



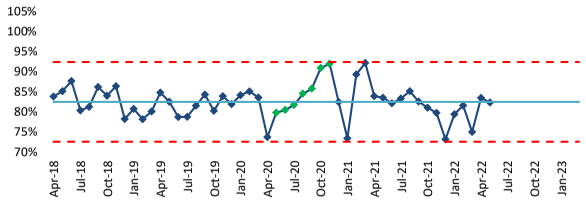
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

May 22 Overall Activity Performance

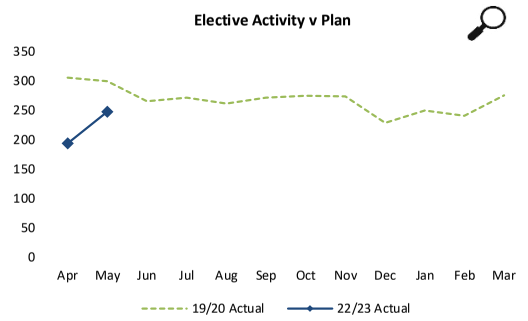
POD	Actual 22/23	Plan 22/23	Actual (% of 19/20)	Target (% of 19/20)
Daycase	977	847	126.9%	104%
Elective	248	312	82.7%	104%
Elective & Daycase Total	**1225**	**1159**	**114.5%**	**104%**
Non Elective	154	-	86.5%	-
New Outpatients	4436	4337	106.4%	104%
Follow Up Outpatients	7879	7556	104.3%	100%

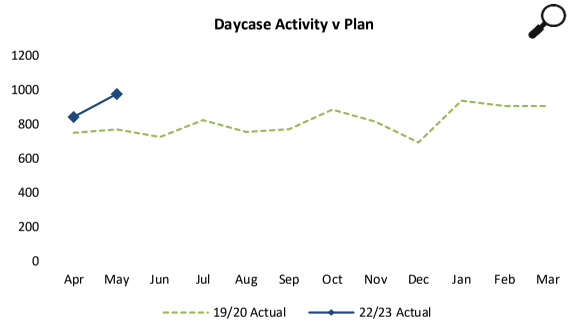
Operational planning for 2022/23 requires trusts to achieve 104% of new outpatient appointments compared to 2019/20 and an am bition for Trusts to deliver 110% of Elective and Daycase activity by March 2023. However ERF levels have been set to 104% of 2019/20.

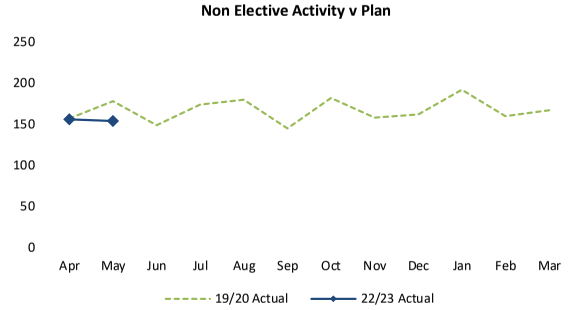
Trusts are also asked to achieve the ambition of reducing follow up outpatient appointments compared to 2019/20.

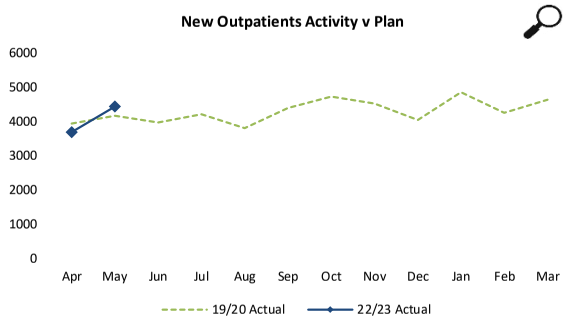
There is no target set against Non Elective activty.

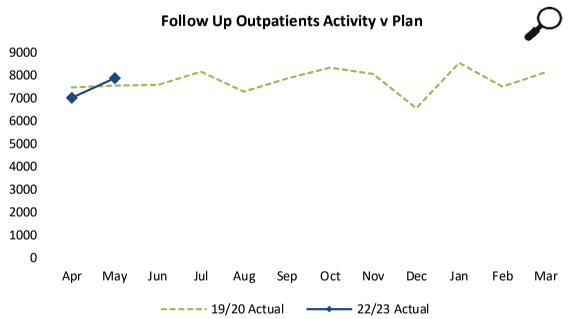
The information on this slide is for all Walton Centre patients.











Operational

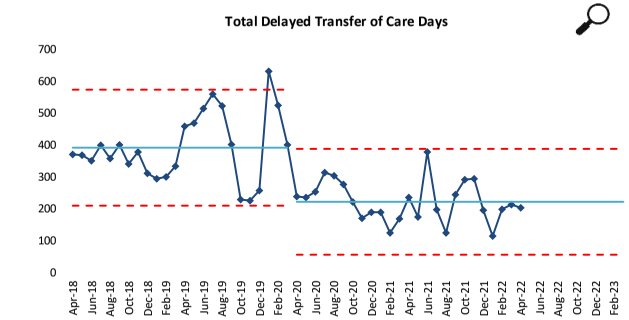
Effective - Flow

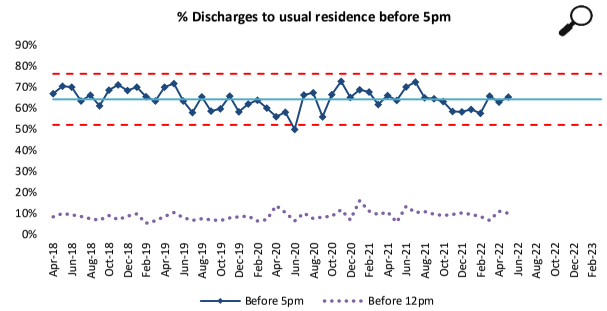
The Walton Centre NHS Foundation Trust

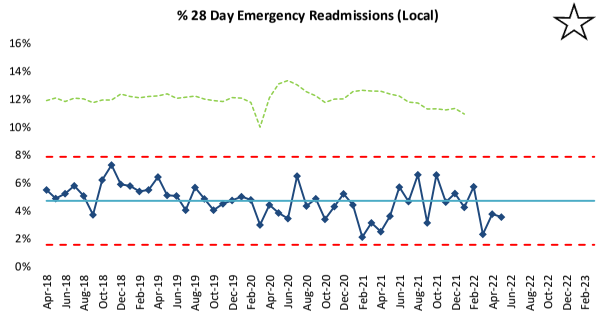
Excellence in Neuroscience

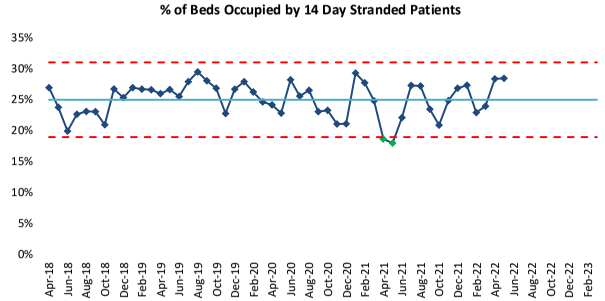
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	3.58%	
Total Delayed Discharge Days	-	204	
% Discharges by 5pm	-	65.32%	
% 14 Day Stranded Patients	-	28.44%	

All indicators are stable and within normal variation. These indicators form part of Patient Flow Transformation and are monitored through that workstream.









Operational

Effective - Outpatient Transformation

The Walton Centre NHS Foundation Trust

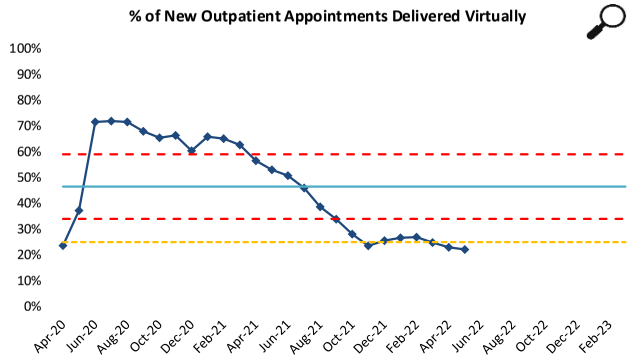
Excellence in Neuroscience

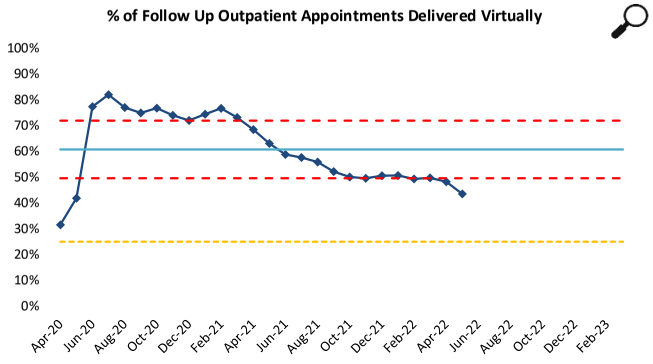
Virtual Appointments

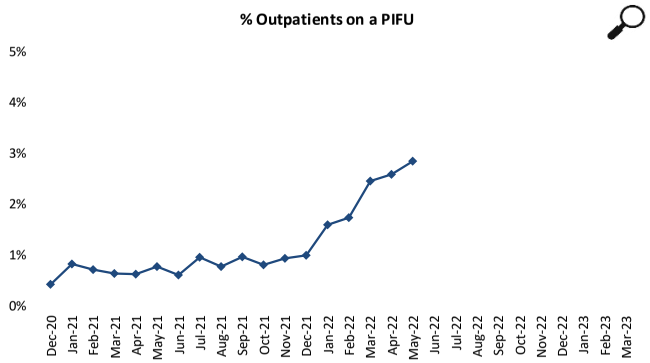
The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. We are currently above this target. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

Patient Initiated Follow Up (PIFU)

As part of national Outpatient Transformation schemes the Trust the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In May 22 2.85% of total outpatients were on a PIFU.







Workforce Indicators

Workforce

Well Led - Workforce KPIs

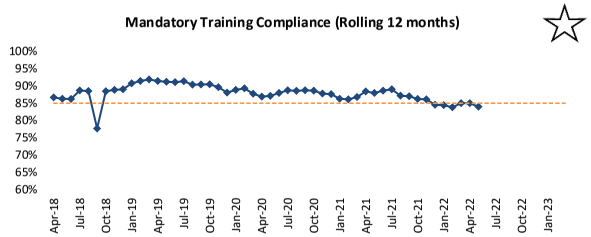
The Walton Centre NHS Foundation Trust

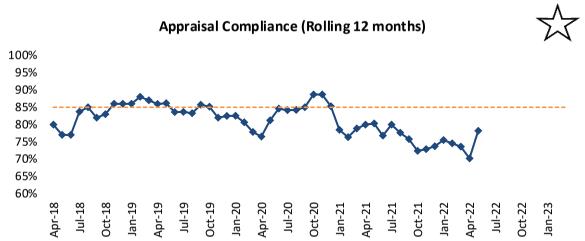
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	78.21%	
Mandatory Training Compliance	85%	84%	

Appraisal Compliance

Training & Development have continued to send monthly reports to Department Heads and separately chase individual departments with low (below 85%) appraisal compliance. Whilst there is understanding of the impact staff sickness has on departments being able to complete mandatory training and appraisals, as a result of the continuous decline in appraisal compliance across the organisation, the Senior Education Manager is in the process od directly contacting all department heads with any out of date PDRs. Any department which does not respond will be escalated to the relevant Executive Director. Assuming appraisals are still below target at the end of June reporting period, a similar process will be followed in July where the Senior Education Manager will directly contact the Department Heads with any out of date appraisals, copying in the relevant Executive Director, and requesting a plan of how they will reach the Trust PDR target by the end of August.





Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	7.16%	
Trust Turnover	-	16.36%	
Nursing Turnover	-	14.03%	
Other Staff Turnover	-	17.52%	

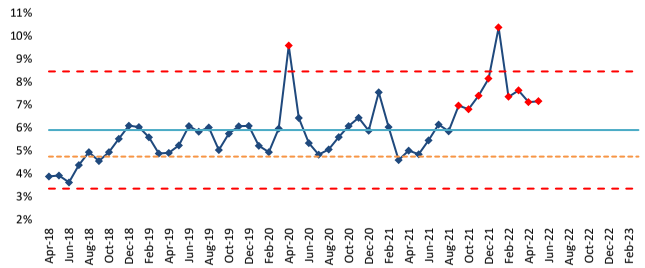
Sickness/Absence

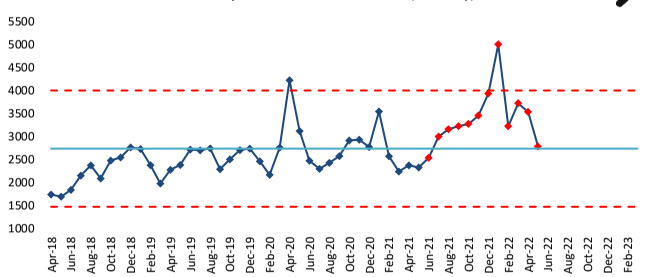
The Trust has seen a significant increase in Sickness/Absence levels which is above the 4.75% target. Sickness continues to be managed and sickness reports are shared monthly with managers and supported is provided by HR advisors. With monthly meeting with ward managers in place. Themes and trends are discussed at People Group with no outlying themes noted.

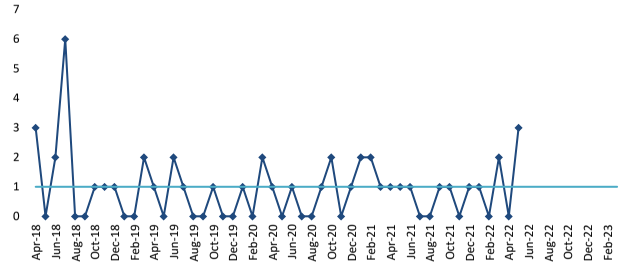
Turnover

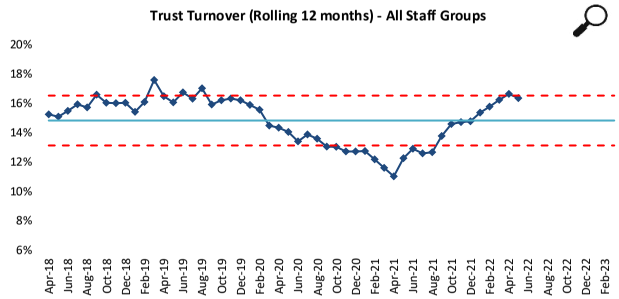
Overall Turnover for the Trust has significantly increased recently, largely driven by Corporate Services and Non Nursing Staff within Divisions. Nursing turnover is within normal variation and the trust is fully established in this area.

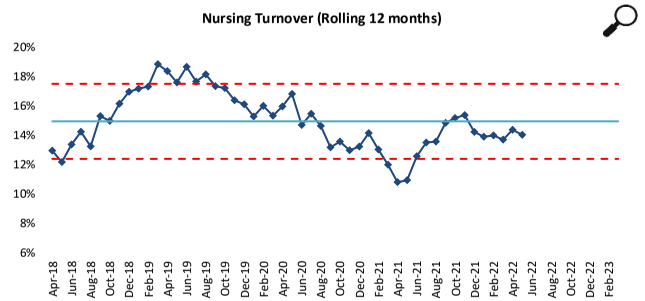
Other staff turnover has increased steadily and reflects the pressures within the wider labour market. This is exacerbated by other NHS providers non adhering to principles of agenda for change.

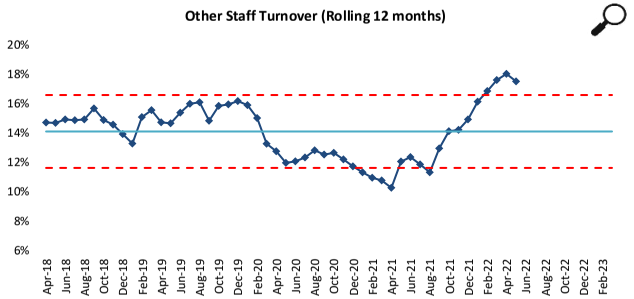












Quality Indicators

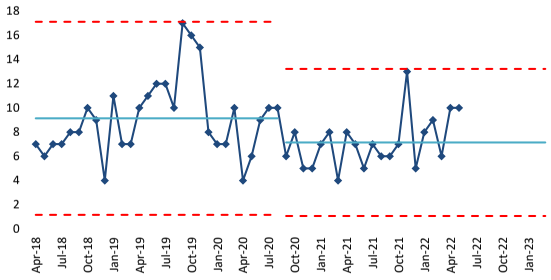
Quality of Care

Caring - Complaints

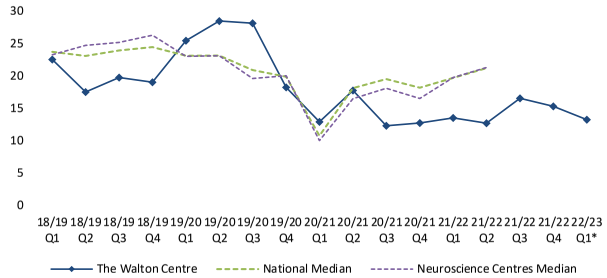
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

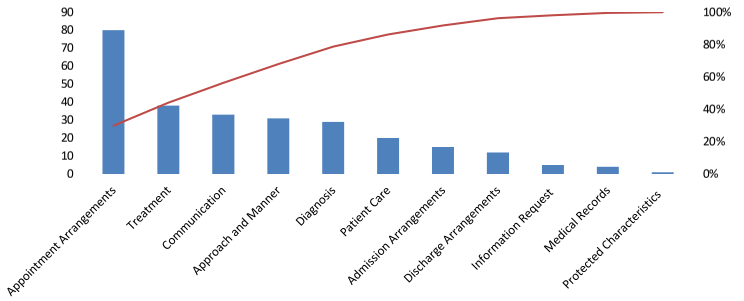
Total New Complaints Received in month



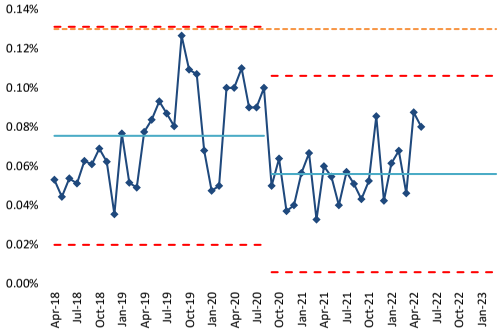
Quarterly Complaints per 1000 WTE



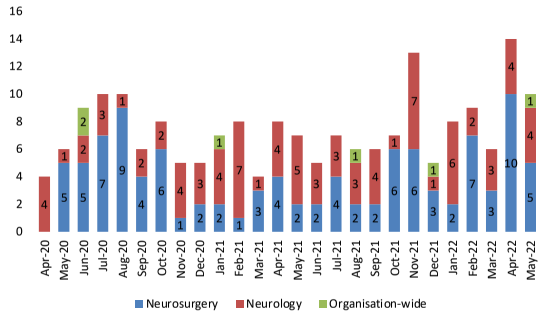
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	46	18	11
22/23	2	2	1

In May 2022 the Trust received 10 new complaints; 4 Neurology and 5 Surgery and 1 Trust Wide. Of the 10 complaints received; 3 related to admission or discharge arrangements and 3 related to treatment or care, 3 related to communcation and 1 to information request.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 0 to 13 at an average of 6 per month. The number of complaints received has significantly dropped during recent months.

Due to the reduction seen the Trust is now below the national average and neuroscience centres average up the latest published period of Q2 2021/22.

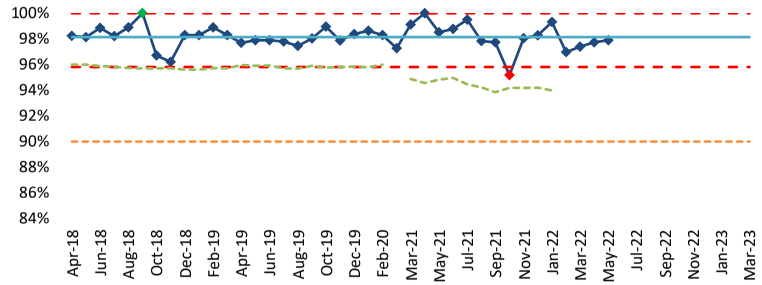
Quality of Care

Caring - Friends & Family Test

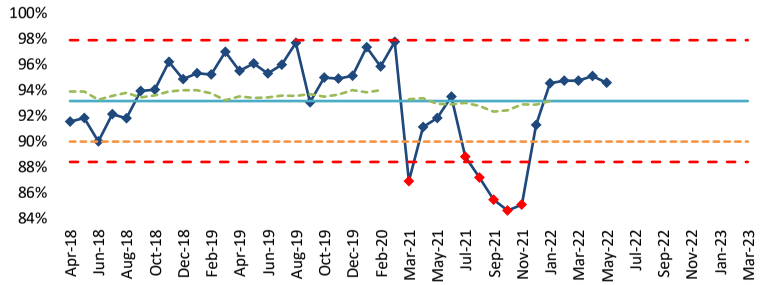
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

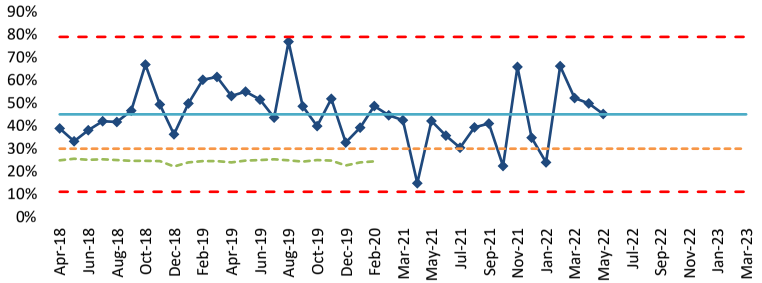
Inpatient FFT % Likely to Recommend



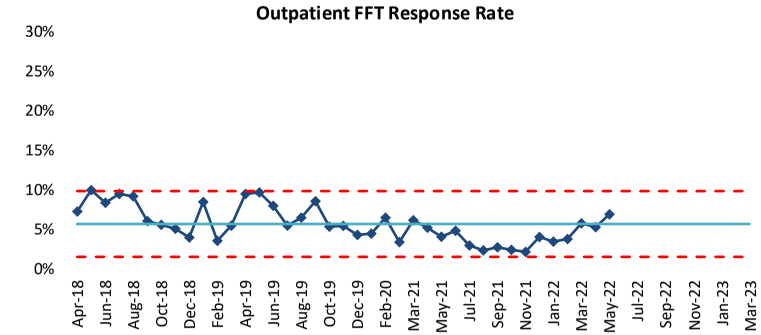
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate



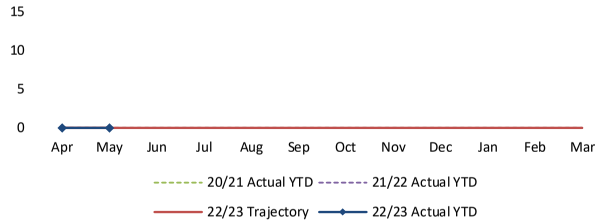
Quality of Care

Safe - Infection Control

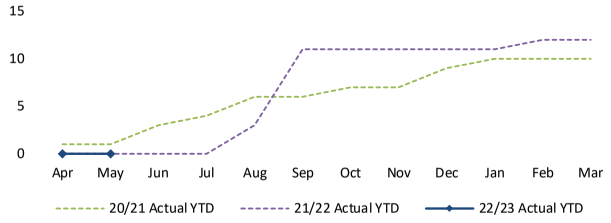
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

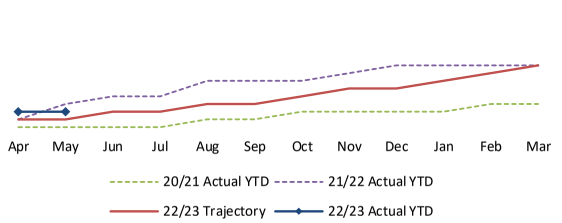
MRSA Bacteraemia



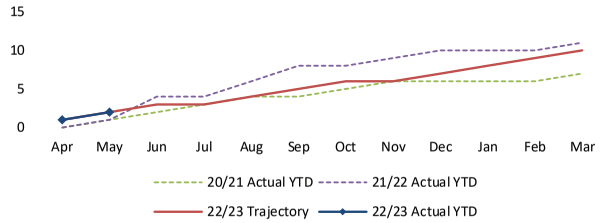
CPE



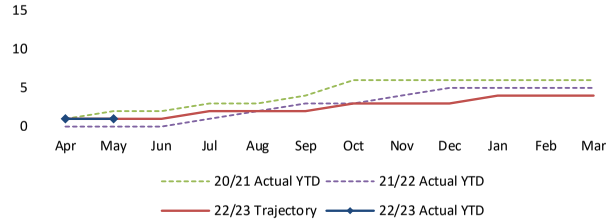
C.Diff



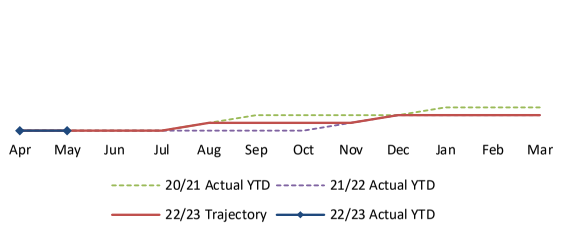
E.Coli



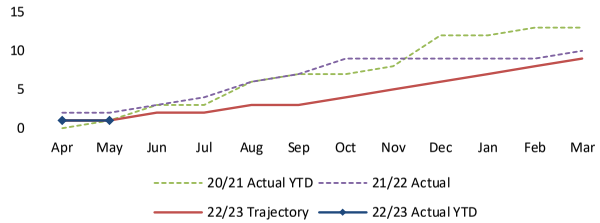
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2022/23

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

May Breakdown by Ward

1x E.Coli - Chavasse

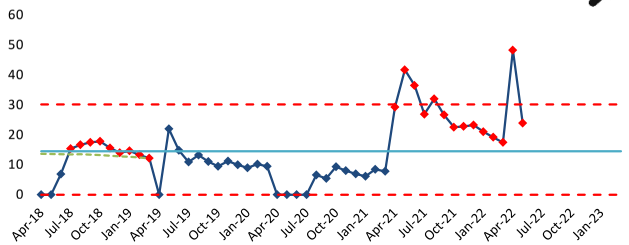
Quality of Care

Safe - Infection Control

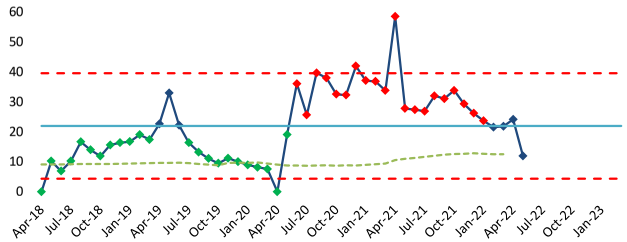
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

C.Diff Rate per 100,000 Bed Days YTD



MSSA Rate per 100,000 Bed Days YTD

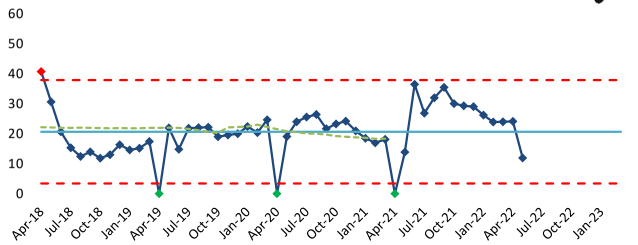


There have been 2 C.Diff cases during 22/23 at a rate of 23.95 per 100,000 bed days.

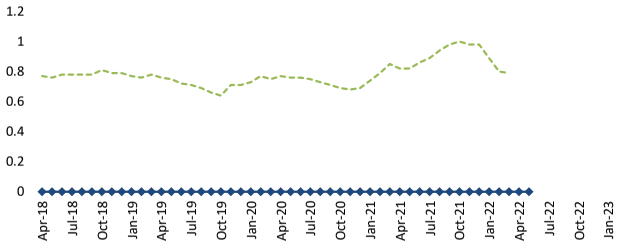
There has been 1 MSSA, 1 E.Coli and 1 Klebsiella YTD . All at a rate of 11.98 per 100,000 bed days. The MSSA rate is in line with the national average for the first time since April 2020.

There was only 1 HCAI in May. A rapid review has been undertaken and the lessons learned has been medication usage.

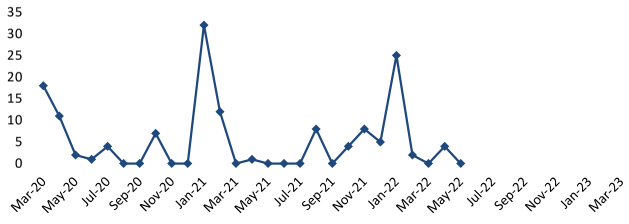
E.Coli Rate per 100,000 Bed Days YTD



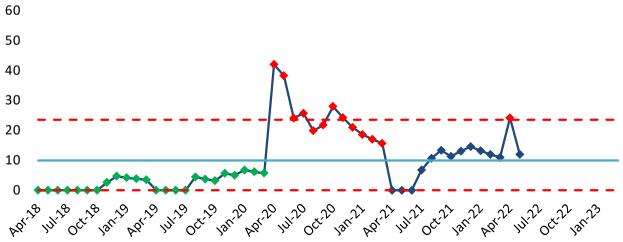
MRSA Rate per 100,000 Bed Days YTD



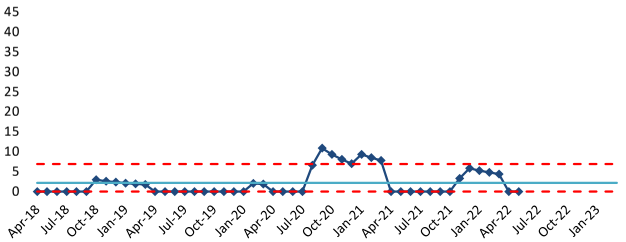
Covid-19 Nosocomial Infections



Klebsiella Rate per 100,000 Bed Days YTD



Pseudomonas Rate per 100,000 Bed Days YTD



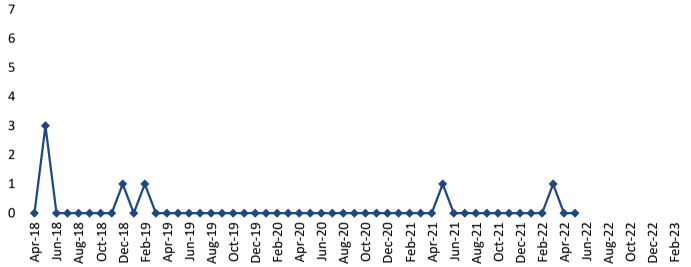
Quality of Care

Safe - Harm Free Care

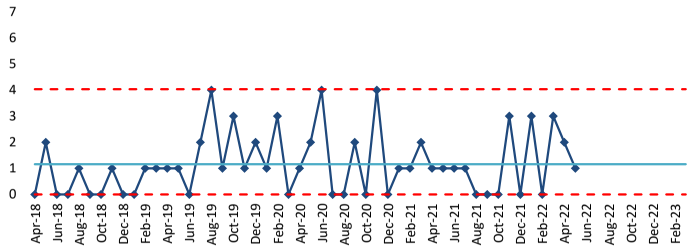
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

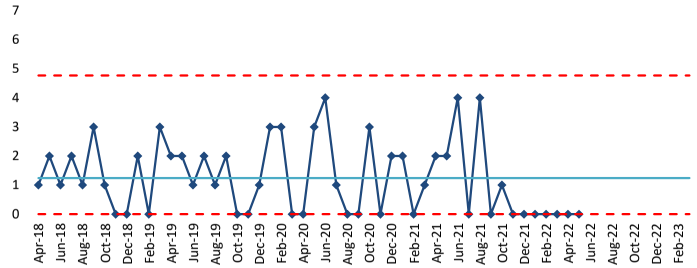
Total Moderate or Above Harm Inpatient Falls



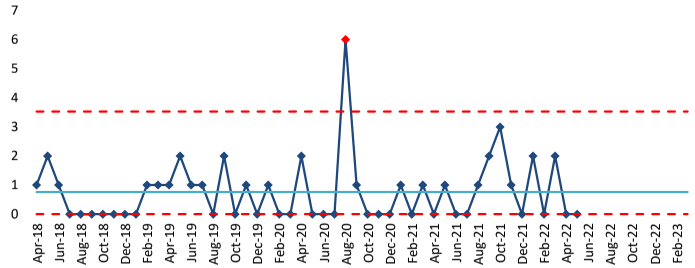
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4, Unstageable & Mucosal)



CAUTI Incidences



VTE Incidences



Falls
There were zero falls which resulted in moderate or above harm in month.

Pressure Ulcers
There was one Hospital Acquired Pressure Ulcers in month

CAUTI
There were zero CAUTI incidence in month

VTE
There were zero VTE incidences in month

All harm measures are within normal variation.

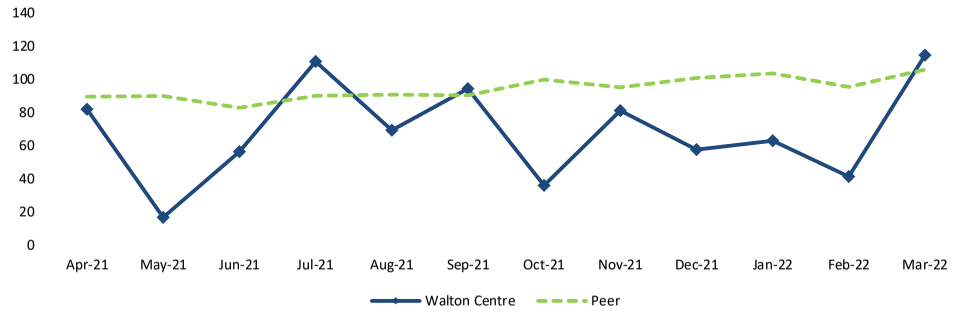
Quality of Care

Safe - Mortality

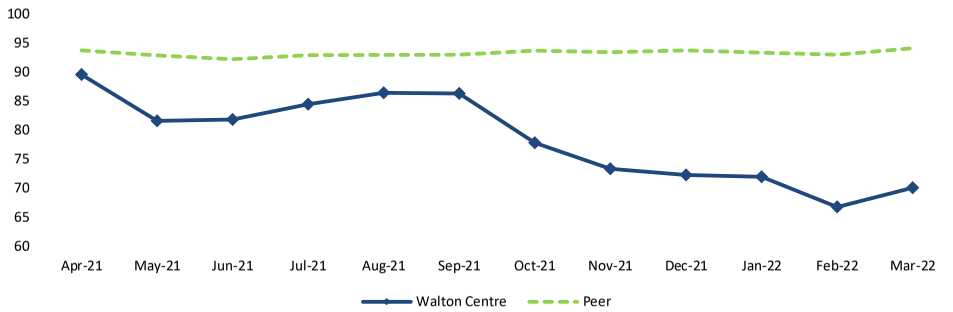
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

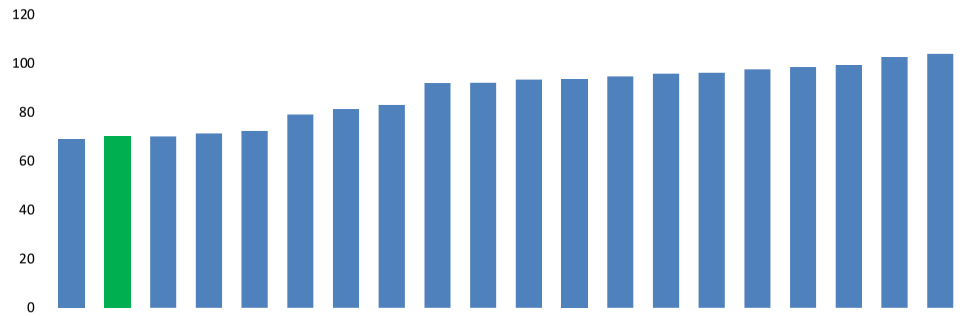
RAMI 2019 by Month



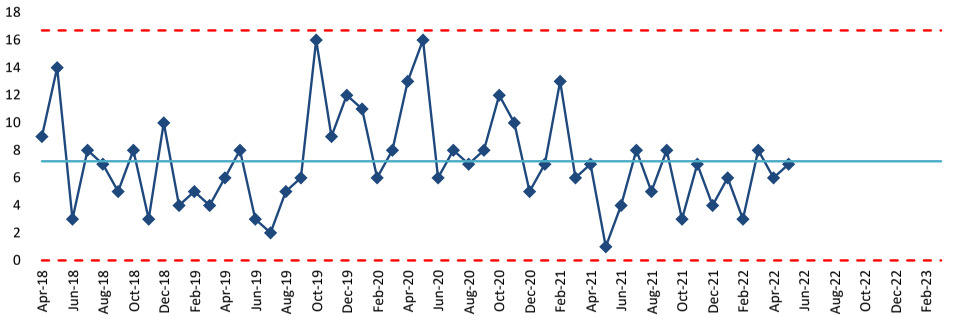
RAMI 2019 Rolling 12 Month



RAMI 2019 Rolling 12 Month Peer Distribution



Crude Mortality



As at March 2022 the rolling 12 month RAMI19 figure is 70.10. During the period there were a total of 62 observed deaths against 88 expected deaths. Compar ed to peers The Walton Centre has performed significantly better during the period.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 3 deaths following a positive covid-19 result. In the most recent two months there has been zero.

Crude mortality is within normal variation

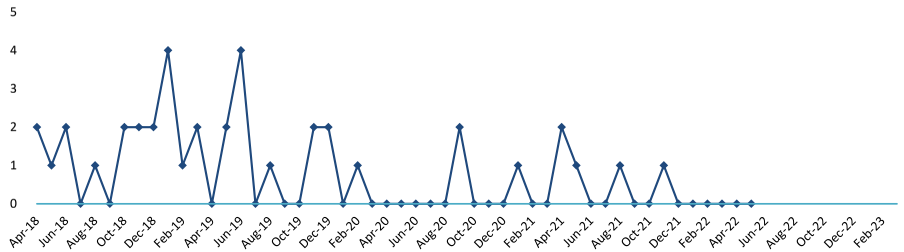
Quality of Care

Safe - Governance

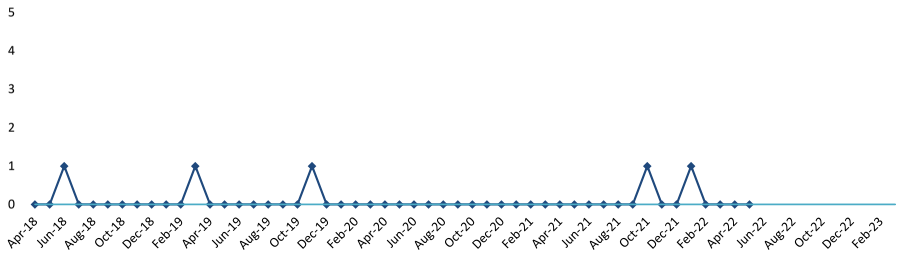
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Total SUIs Reported



Total Never Events Reported



Ward Scorecard

May 2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

	Safe Staffing				Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	100.0%	100.0%	132.3%	135.5%	1	0	0	0	0	0	0	0
Caton	99.2%	100.0%	126.7%	131.2%	0	0	0	0	0	0	0	0
Chavasse	95.3%	97.5%	145.8%	194.4%	0	0	0	0	0	0	1	0
CRU	100.0%	100.0%	100.0%	137.3%	0	0	0	0	0	0	0	0
Dott	99.0%	100.0%	140.9%	137.6%	0	0	0	0	0	0	0	0
Horsley ITU	92.3%	89.1%	100.6%	100.0%	0	0	0	0	0	0	0	0
Lipton	96.8%	100.0%	136.6%	222.6%	0	0	0	0	0	0	0	0
Sherrington	-	-	-	-	0	0	0	0	0	0	0	0

WELL LED

Finance

Trust I&E	In month			Year to Date			Full Year
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Draft Plan £'000
Patient Care Income	10,686	10,342	(344)	21,414	20,449	(965)	128,625
Exclusions	2,430	2,283	(147)	4,860	4,446	(414)	29,160
Private Patients	3	14	11	6	22	16	38
Other Operating Income	643	615	(28)	1,286	1,010	(276)	7,728
Total Operating Income	**13,762**	**13,255**	**(508)**	**27,567**	**25,927**	**(1,639)**	**165,551**
Pay	(7,138)	(6,975)	163	(14,269)	(13,803)	466	(84,722)
Non-Pay	(3,382)	(3,132)	250	(6,775)	(5,940)	835	(47,202)
Exclusions	(2,524)	(2,271)	253	(5,046)	(4,471)	575	(23,988)
Total Operating Expenditure	**(13,044)**	**(12,378)**	**666**	**(26,090)**	**(24,214)**	**1,876**	**(155,912)**
EBITDA	**719**	**877**	**158**	**1,477**	**1,713**	**237**	**9,639**
Depreciation	(525)	(577)	(52)	(1,050)	(1,157)	(107)	(6,300)
Profit / Loss On Disp Of Asset	0	0	0	0	(15)	(15)	0
Interest Receivable	0	23	23	0	41	41	0
Financing Costs	(49)	(42)	7	(97)	(107)	(10)	(583)
Dividends on PDC	(137)	(137)	0	(273)	(300)	(27)	(1,639)
I & E Surplus / (Deficit)	**8**	**144**	**136**	**57**	**175**	**119**	**1,117**
I&E impact capital donations and profit/(loss) on asset disposals	**22**	**17**	**(5)**	**44**	**39**	**(5)**	**264**
I & E Surplus / (Deficit)	**30**	**161**	**131**	**101**	**214**	**114**	**1,381**

The financial regime remains based on block funding for the full financial year and anticipated spend for the same period (based on average spend in H2 of 2021/22 x2). **The current plan for 2022/23 is a £1.381m surplus position** (submitted to Integrated Care System (ICS) and NHS England and Improvement (NHSE/I) in April as part of the 2022/23 planning process).

The current plan includes:

- Elective Recovery Fund (ERF) income and costs for the delivery of activity above the national trajectory targets.
- 'Block' system funding received for Top-up, COVID related costs and growth.
- Recurrent efficiency requirement of at least 3.0% of operating expenses.

It is a requirement that the ICS delivers a balanced financial plan for the financial year. At the present time the ICS financial plan for 22/23 is a deficit position which is not being recognised by NHSE/I. A further planning submission was made to both the ICS and NHSE/I on 20th June, with the Trust planned surplus increasing to £2.86m which will be reflected in the month 3 position.

In month 2, the Trust reported an in month £161k surplus position. This is a £131k favourable variance against the planned position of £30k surplus. The in month overperformance is primarily driven by the YTD impact of 0.7% additional inflationary pressure funding that has been received. This funding has only recently been confirmed and as such will be reflected in the month 3 plan.

Income is £1.6m below planned levels due to reduced elective recovery funding, performance against elective baselines and due to the delayed transfer of Healthcare Procurement Liverpool staffing (offset by reduced expenditure). Although month 2 activity has increased and attracted a level of ERF funding, it has not been sufficient to cover the level of ERF income lost in month 1 (as ERF is delivered on a cumulative basis)

This has been offset by savings within non pay driven by clinical supplies spend being lower than planned levels due to a delay in the spinal transfer from Liverpool University Teaching hospital. There have also been lower than planned levels of activity resulting in an under performance against plan.

STATEMENT OF FINANCIAL POSITION - 2022/23	May-22 Plan	May-22 Actual	Variance
	£'000	£'000	£'000
Intangible Assets	732	984	252
Tangible Assets	94,737	94,171	(566)
Receivables	428	434	6
TOTAL NON CURRENT ASSETS	**95,897**	**95,589**	**(308)**
Inventories	1,841	1,595	(246)
Receivables	6,315	2,770	(3,545)
Cash at bank and in hand	37,583	39,086	1,503
TOTAL CURRENT ASSETS	**45,739**	**43,451**	**(2,288)**
Payables	(29,014)	(26,626)	2,388
Borrowings	(1,677)	(1,678)	(1)
Provisions	(55)	(66)	(11)
TOTAL CURRENT LIABILITIES	**(30,746)**	**(28,370)**	**2,376**
	0	**0**	**0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**110,890**	**110,670**	**(220)**
Borrowings	(22,281)	(22,140)	141
Provisions	(707)	(692)	15
TOTAL ASSETS EMPLOYED	**87,902**	**87,838**	**(64)**
Public Dividend Capital	34,839	34,617	(222)
Revaluation Reserve	7,377	7,377	0
Income and Expenditure Reserve	45,686	45,844	158
TOTAL TAXPAYERS EQUITY AND RESERVES	**87,902**	**87,838**	**(64)**

STATEMENT OF CASH FLOW - 2022/23	May-22 Plan	May-22 Actual	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**427**	**555**	**128**
Non-cash income and expense:	1,050	1,168	118
Working Capital	0	1,971	1,971
Net cash generated from/(used in) operations	**1,477**	**3,694**	**2,217**
Cash flows from investing activities	(4,934)	(5,140)	(206)
Cash flows from financing activities	253	(191)	(444)
Increase/(decrease) in cash and cash equivalents	**(3,204)**	**(1,637)**	**1,567**
OPENING CASH	**39,072**	**40,723**	**1,651**
CLOSING CASH	**35,868**	**39,086**	**3,218**

Capital
In month variance - £314k below plan.

Annual capital funding is now set at an ICS level (rather than using a nationally determined formula). For 2022/23 the allocated capital allocation based on the depreciation calculation was £4.4m.

Bids were made to the ICS for additional capital funding, a number of which were successful and resulted in a further allocation of £1,348k capital.

This means that the overall capital allocation for 22/23 is £5,738k (excluding digital aspirant funding). There is still a shortfall between capital demands and funding allocated and further work is being undertaken to prioritise the schemes.

The Trust has received an allocation of external funding in relation to Digital Aspirant for IM&T innovation of £2.7m.

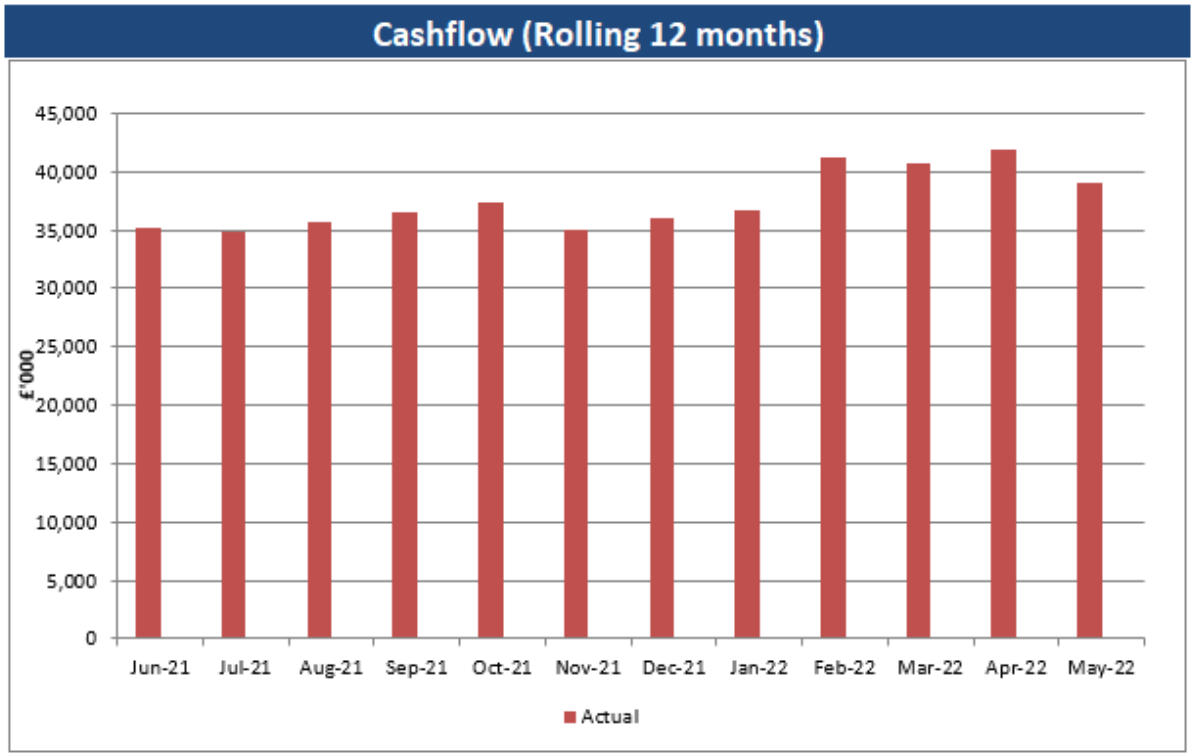
CAPITAL - Subject to prioritisation

	In month			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division						
Heating & Pipework	100	5	95	1,200	1,200	0
Estates	69	0	69	836	836	0
IM&T	0	0	0	593	593	0
Neurology	0	0	0	0	0	0
Neurosurgery	0	0	0	3,109	3,109	0
Corporate	0	0	0	0	0	0
TOTAL (excl. external funding)	**169**	**5**	**164**	**5,738**	**5,738**	**0**
Donated Assets	0	0	0	0	0	0
Digital Aspirant	223	73	150	2,675	2,675	0
TOTAL (incl. external funding)	**223**	**73**	**150**	**2,675**	**2,675**	**0**
TOTAL	**392**	**78**	**314**	**8,413**	**8,413**	**0**

Capital spend in month is £78k.

- **Digital Aspirant (PDC funded):** £73k.
- **Heating and Pipework:** £5k

Work is currently being undertaken with clinical and operational staff to prioritise the capital spend for 22/23 to ensure that it is delivered in line with agreed funding levels.

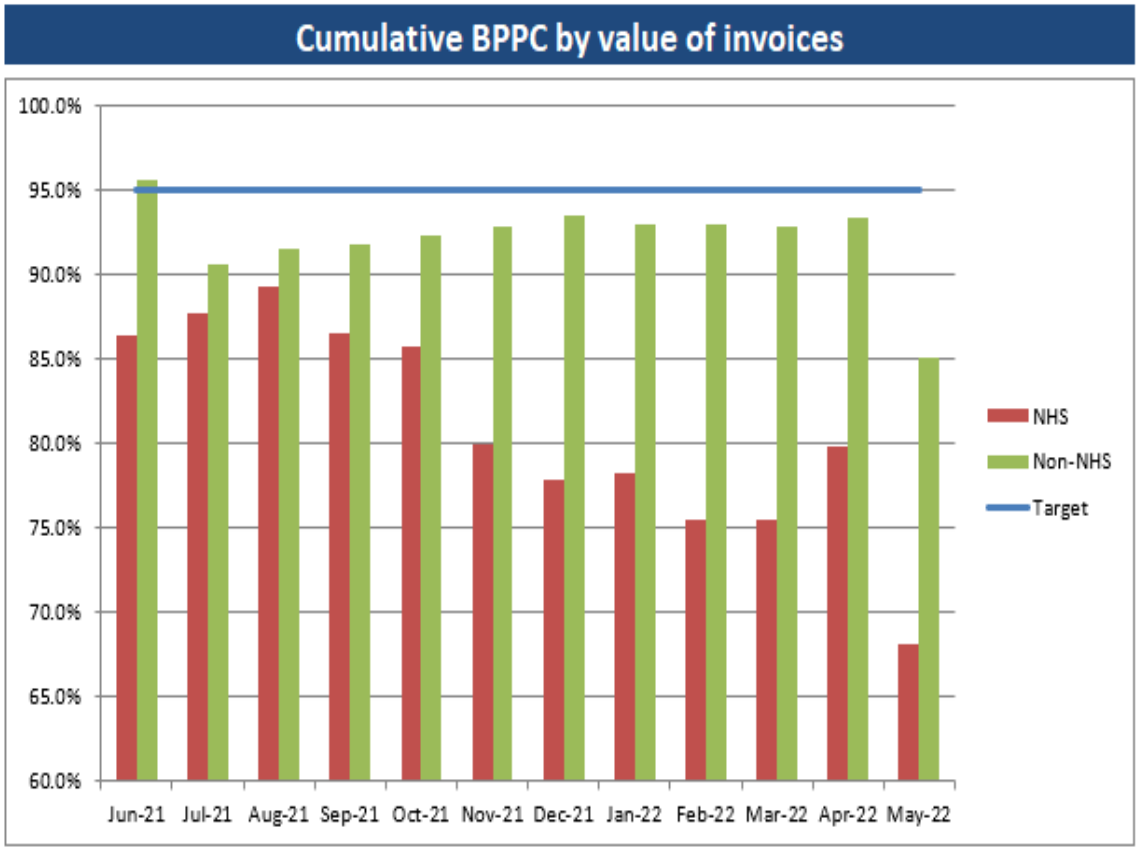
As of the end of April: Actual Cash Balance: £39.1m. Number of days operating expenses = 97 days.		The Trust cash balance at the end of May was £39.1m, £3.2m ahead of the trusts plan of £35.9m. This increase compared plan, is due to: • Higher than planned surplus due to the 0.7% inflationary pressure funding received in M2. • Lower than planned capital payments. • A decrease in trade receivables against plan.

Better Payments Practice Code (BPPC):

There is an increased focus by NHSE/I performance against the better payments practice code standard of settling at least 95% of invoices within 30 days.

The Regional NHSEI team have contacted the CFO about BPPC as the performance has been below the national 95% target for a number of months. They will be closely monitoring the Trusts performance over coming months.

The Deputy Chief Finance Officer is in the process of developing an action plan to improve BPPC performance.



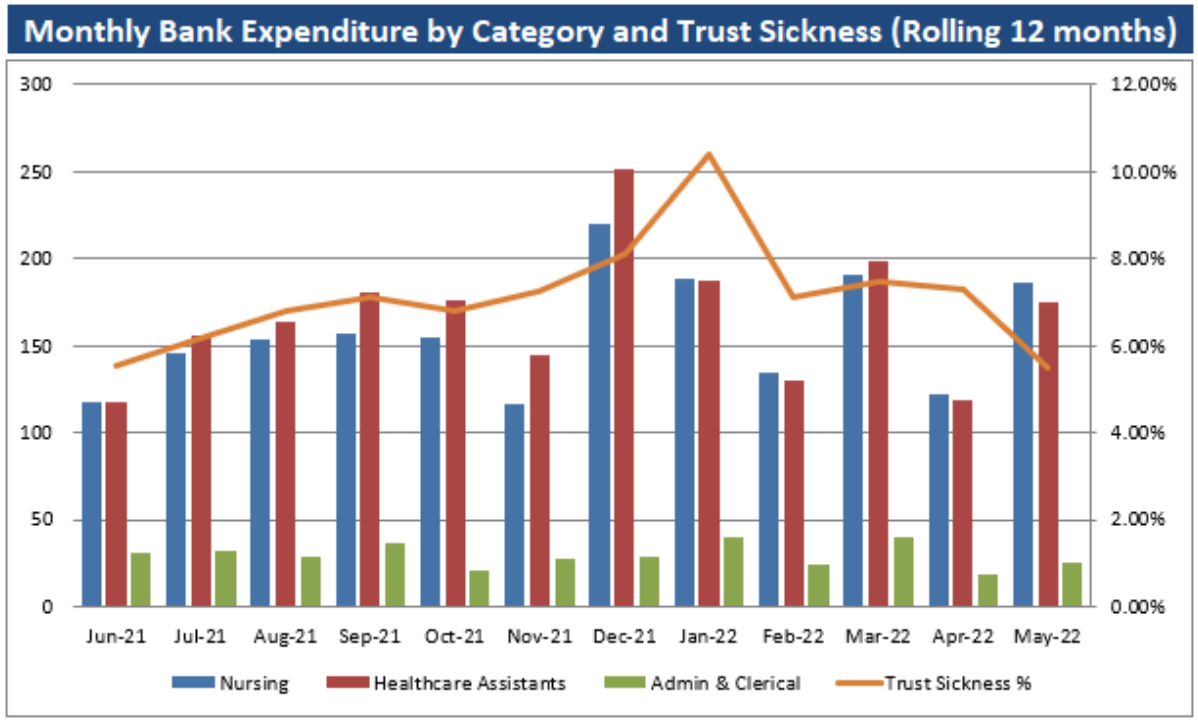
The Trust BPPC percentage (by value) at the end of May against the target of 95.0% was:

- Non-NHS 85.1%.
- NHS 68.1%.
- Total 81.2%.

This has seen Non-NHS payments deteriorate by 8.3% and NHS payments deteriorate by 11.7%, an overall deterioration of 10.4% since the end of April.

The Trust BPPC percentage (by number of invoices paid) at the end of May is 81.2%.

The low % of NHS invoices paid is due to queries being resolved which have already passed the 30-day payment period. This is as the Financial Services team focus on resolving aged payables outstanding on the system. Daily payment runs are now also being processed in order to reduce the time taken to make payments.

Bank Expenditure: In month Actual: £391k.		Bank expenditure incurred in April was £391k, a increase of £128k when compared to April. Work remains ongoing to reduce the level of bank spend utilising the e-rostering system. The trusts overall sickness rate decreased from 7.29% to 5.5% in May.

Key Risks and Actions in 2022/23

- ERF Income:
    - Level of income calculated- whether this will materialise at these values
    - Achievement of activity targets to receive ERF-there is a risk that the Trust might not be able to deliver the required level of activity meaning that ERF funding allocated will be clawed back by commissioners making it difficult to reach a break-even position. The size of the activity underperformance in M1 will also impact upon the Trust's ability to deliver ERF cumulatively.
- Plan delivery – assumptions based on workforce availability and a level of productivity to deliver in 22/23, if this is not possible, the trust will struggle to achieve the activity levels required.
- Delivery of CIP-The 22/23 efficiency requirement of the Trust has currently been set at £4,947k, with £3,500k required to be delivered recurrently. Further work is being undertaken to identify schemes to cover this value, and monthly updates will be provided on the progress of CIP identification and delivery
- Transfer of new services to WCFT – The costing and associated income of services such as the Spinal Transfer has been based upon the latest information available, but this could be different to how it materialises.
- Utility costs – climbing price of energy means that although a 10% increase has already been factored in, the worldwide environment could push prices higher still.
- Block income and exclusions – As these are funded through a combination of block and cost and volume, it means that increased costs will not always be matched by income.
- Still awaiting the outcome of funding of some NICE approved devices-uncertainty whether funding will be available for these.
- ICS partners performance – if other Trusts fail to hit their financial target, this may put pressure on those that can deliver to improve positions to help contribute towards the total system position.
- Capital – reduced level of capital allocation in 22/23 which means trust will have to ration to key priorities.
- Outpatient Follow Up targets – if reductions cannot be made in line with funding, this is a pressure as costs will not be covered above 85% delivery.

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 29/06/22		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 28/06/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Board Assurance Framework Q1 2022/23 • Integrated Performance Report May 2022 • Financial Planning Update • Sustainability Plan • Appraisal Compliance Update • Nursing Turnover Update • Equality, Diversity & Inclusion Annual Report • Intelligence Strategy Update • Freedom of Information Annual Report • Digital Aspirant NHSX Monthly Update • Digital Strategy Update • Cycle of BPC Business • Sub-committee Chair's Reports for 6 sub-committee meetings
2	**Alert**	An additional number of long waiters were identified in early June as part of the transfer of spinal services from Liverpool Universities NHS Foundation Trust (LUFHT). The list includes 11 patients who have been waiting over 104 weeks. The Trust has been working hard to assess, reprioritise and reschedule these patients and return the number of 104 week waiters to zero by the end of July. However, there are challenges due to the availability of the particular supplies that are required. This will impact the recovery trajectory and the Trust is likely to miss its long wait reduction targets which have been set based on prior data.
3	**Assurance**	*Integrated Performance Report* • All cancer wait/treatment and diagnostic targets continue to be achieved • Patient flow and outpatient transformation indicators remain strong • With regards to activity recovery – high levels of day case and outpatients were achieved in May but elective activity remains below target and continues to be a key focus for improvement • Sickness is currently at 7% which is below levels recorded earlier in the year but still above target. Absence due to covid is climbing again, currently at 2% • An action plan, to sustainably return appraisal rates to above target by August, was presented, noting an improvement in the first month of enhanced focus • The report on nursing turnover, which typically averages 15% per annum, provided context that turnover is in line with the long-term trend and is inherent in our nursing recruitment and development model which often involves earlier-career nurses moving

		elsewhere to expand their experience, with many returning later. A mark of the success of the model is that nursing vacancies remain low, so the level of turnover does not equate to 'gaps' in staffing. Benchmarking data shows that turnover is similar or only marginally higher than the average for the region an only around 3% higher than national average. • Staff turnover is highest in non-clinical areas, such that staffing pressures are the highest there, related to skills shortages beyond the NHS. • Income and expenditure outcome was £131k ahead of plan in May (£114K ahead, year to date). This is due to additional funding for inflation being added to allocations but not to the plan at this point. The plan will, however, be adjusted from July onwards pending Board approval of a revised plan in line with system-wide challenges (see Advise section) Elective Recovery income is lagging plan, related to operational performance, which is the biggest current financial concern. • There has been a very slow start to capital spend, partly due the delay in finalising the additional capital allocations at system level • Better Payment Practice Code (BPPC) (paying creditors on time) has deteriorated after starting to improve over the past couple of months; an improvement plan will be presented to Audit Committee • The range of metrics included in the IPR to BPC has been reduced significantly over the last 2 months; the committee requested that some metrics, which provide helpful context and triangulation, be reinstated *Other matters* • 7 of the 12 new BAF principal risks have been assigned to BPC as the lead assurance group. All were reviewed with some minor changes and reported back to Board for endorsement. None are currently deemed 'red risks'. It was recommended to the Board that the risk score for *BAF007 Capital Investment* was reduced from a 12 to a 9 given the improvement in the gap between capital requirements and funding received • The Sustainability Plan will now be finalised following positive feedback, together with recommendations for improvement, from NHS England (NHSE). Prior comments from BPC and recommendations made by NHSE will be acted upon, as part of the implementation of the plan, by the newly appointed Associate Director of Operations • The Informatics Team continue to achieve excellent progress with gaining external qualifications and professional registration. Data quality has increased to be one of the highest in the NHS (98.9% DQMI score). Clinical coding met all mandatory and advisory levels of accuracy in the latest internal audit. The current 3-year action plan is on track for completion, with the intent to reset further strategic objectives for 23/24 onwards • There was an increase in requests under the Freedom of Information (FOI) Act in 2021/22 back towards pre-pandemic levels, but with a tendency for requests to be more complex to address. 100% were responded in the required time, sustaining the record that the trust has never had a breach

4.	**Advise**	• A further revision of the 2022/23 financial budget was submitted on 20 June 2022. An increased surplus of £2.9m is now targeted to contribute to a better system position. This remains a challenge, critically dependent on achieving stretching activity targets (£4.1m elective recovery funding depends on this) and a Cost Improvement Plan (CIP) target of £4.9m. • Capital allocation has increased to £5.7m (plus £2.7m digital aspirant funding) which remains below internal plans. Further internal prioritisation will take place and if significant concern remains regarding residual risk, this will be escalated (and reflected in the BAF). • The Committee noted an increase in spending on bank staff in May despite decreasing sickness and vacancy levels and requested further information into the reasons for this • An updated Digital Strategy is in development and will be presented to BPC in September. • The Equality, Diversity and Inclusion annual report will now be presented to BPC in July prior to coming to Board • 6 Key issues reports from sub-groups were received and noted.		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 7/7/22		**Report of:** **Quality Committee**
Date of last meeting: 16/6/22		**Membership Numbers: 16** **Quorate**
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Integrated Performance Report and KPI Reports • Quality Presentation – Informatics and Business Intelligence • Trust Risk Register • Board Assurance Framework • Medications Management and Controlled Drugs Annual Report • Quarterly Pharmacy KPI Report • National In-patient survey action plan • Clinical Audit and NICE Guidance Updates • External Visits Regarding Quality • Internal Audit Recommendations Update • Sharing & Learning Forum – Terms of Reference • Sub Committee Key Issues / Chair's Reports from 7 sub-committee meetings
2.	**Alert**	SHOT preventing transfusion delays in bleeding and critically anaemic patients was highlighted through the Chair's Report for Clinical Effectiveness and Services Group. The Trust did not have its own transfusion laboratory so would need to wait for LUHFT to update their policies. Plans were in place to update training and assurance had been provided by LUHFT the deadline would be met but the Trust needed to understand if there was a way around this potential issue. Concerns were raised around consultant recruitment. It was noted that interviews for consultants in Epilepsy were currently taking place but due to the small amount of applicants the issue had been added as a risk for both the Epilepsy and Neurophysiology services. A cluster of unusual Pseudomonas infections was highlighted detailing that there were 2 separate issues with the infections arising from water supply and the other from deep seated surgical site infections. The issue had been discussed at regional level and an action plan instituted.
3.	**Assurance**	The Risk Manager presented the Risk Register and the top risks were noted. A review was currently underway in relation to gaps in controls and assurance and a dashboard was being built by the Informatics team targeting gaps. Consideration would be given to having an age profile on some risks. Assurance was provided that a paper would be taken to the Executive Team for approval around risk flows and an update provided to the Committee on this and the ongoing work taking place.

		The Committee received the Q1 Board Assurance Framework from the Corporate Secretary and agreed the new BAF linked into the new strategic ambitions and reflected the risks for the Trust to achieving those. It was noted that BAF would be presented to Board on 7 July 2022 for approval. The Pharmacy and Medicines Management Annual Report 2021-22, presented by the Assistant Clinical Director of Pharmacy and WCFT Lead, was favourably received prior to presentation at Trust Board. The report reflected a challenging year due to significant staff shortages and issues raised by Covid 19 and the international immunoglobulin shortage. It was noted how proud the Assistant CD of Pharmacy was of the WCFT pharmacy staff and the gold standard that was delivered. Despite the challenges faced the Pharmacy department maintained all essential and important services and managed to complete 3 of the 4 CD reports throughout the year. Concern had been escalated by local CCGs and GPs regarding controlled drugs prescribed within the pain clinic. This was discussed by Pharmacy with CCGs who were satisfied that they were assured with the prescribing rationale as clinical documentation was positive. There remained a national shortage of Omnipaque Contrast and supplies were not expected until June 2022. The divisional team had liaised with Pharmacy and a new approach of using vials for more than one patient was considered safe and appropriate by Clinical Effectiveness and Services Group.
4.	**Advise**	The Chief Nurse presented the changes to the IPR following a review to ensure it contained appropriate metrics. The changes would also prevent duplication with Divisional Risk and Governance Committee meetings. Key focus included low CDT levels, however it was noted that many trusts had already reached trajectory on this for the year. Discussion highlighted high staffing levels however both Divisional Chief Nurses were able to explain the additions to the baseline establishment. It was noted that some of the staffing level data was difficult to interpret by some members of the Committee. The Neurology Division had a good monthly performance. There would be a continued focus on improving Friends and Family Test data. The Neurosurgery Division similarly had a positive month. It was noted there had been a transfer of 62 patients from LUHFT under the spinal service and this had been managed well by the Division. The Committee were advised that for 48 hours in May ITU did not meet adequate staffing numbers and the SMART team provided support to meet staffing KPIs and no harm to patients was reported. There continued to be a successful rate of filling nursing vacancies. PDR compliance data was now considered inaccurate with a lot of appraisals having been completed but the necessary uploading on information to the ESR system had not taken place. Divisional Directors were reviewing individuals within each division for more accurate information. Business Performance Committee continued to examine this issue in depth. The Committee received an informative presentation from the Head of Information and Business Intelligence on the core functionality of the team to add value. The presentation highlighted the importance of categorisation in clinical coding; and how data quality was essential for accurate monitoring. The role of the analytics team was

		also explained. The team would continue to strive to obtain professional quality recognition for the work they did. The Head of Patient Experience presented the CQC National Inpatient Survey 2020 action plan and the Committee noted the work completed. It was agreed to close the action plan and add the outstanding action to the 2021 action plan once the current embargoed results were released. The Terms of Reference for Sharing and Learning Forum were approved. Work in progress on clinical audits and NICE guidance assessment activity for both divisions were noted by the Committee. Changes to the next report were suggested to show closed items to recognise work completed and to provide an understanding on the impact on patient care and outcomes.		
5.	Risks Identified	The Pharmacy Report identified the risk that LUFHT were building their own EPMA/EPR system which would have an impact on the Trust if implemented. This issue was now being monitored at the right level through the Chief Operating Officer.		
6.	Report Compiled by	Ray Walker Committee Chair	Minutes available from:	Tracey Eaton Executive PA

The Walton Centre NHS Foundation Trust

Report to Trust Board
Thursday 7th July 2022

Report Title	Major Incident Plan
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Mike Duffy, Head of Risk
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- The trust has a major incident plan in place
- The plan has been approved by the Resilience Planning Group

Next Steps

- Further work to be undertaken following COVID 19 and the Liverpool Women's Incident
- Major Incident Plan exercise to take place

Related Trust Strategic Ambitions	**Impact**		
Leadership	Compliance	Choose an item.	Choose an item.

Strategic Risks

006 Fit for Purpose Estates	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Resilience Planning Group	April 2022	Lindsey Vlasman	Recruit into the EPRR and Health and Safety post to lead the Major Incident Plan

Major Incident Plan

Executive Summary

1. The Major Incident Plan (MIP) has been established to provide an incident response structure, underpinned with documented procedures, supported by management with the authority and necessary competence to manage a disruptive event such as a major emergency, regardless of its cause.

2. This plan has been developed within a context of achieving multi-agency working across Merseyside which includes emergency services, NHS services, local authority departments and voluntary organisations.

3. The NHS service-wide objective for Emergency Preparedness, Resilience and Response (EPRR) is to ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, and minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.

Background and Analysis

4. The plan is owned and developed by the trust EPRR, Health and Safety Lead with executive responsibility of the Chief Operating Officer. All staff on the on call rota and bleep holders will have training and will access to the plan.

5. The plan covers incidents up to and including the following three categories of Major Incident:

    - a Major, Mass or Catastrophic Incident which affects the local community (i.e. within the footprint of the Trust which as a Tertiary Centre Hospital provides services across Merseyside, parts of Cheshire, West Lancashire, North Wales and the Isle of Man)

    - a Major Incident which affects the health services in Merseyside

    - a Major Incident which threatens the continuity of critical Trust services and requires the invocation of the Trust Business Continuity Plans and other Contractors' Business Continuity plans (ISS, Informatics, local NHS providers and NHS Supplies, etc.

Conclusion

6. The plan has been approved by the Resilience Planning group in April 2022 and is not due to be updated until April 2024. However, it has been identified that further work is required following the outcome of COVID 19 and the Liverpool Women's Incident.

7. The EPRR trust lead post has now been recruited into and the candidate is due to commence in post in July 2022 when further review of the Major Incident Plan will be undertaken.

Recommendation

8. The board is asked to note the Major Incident Plan and be assured that further work is due to be undertaken following the recommendations of The Women's Incident and COVID 19.

Author: Lindsey Vlasman
Date: 15/06/2022

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Major Incident Plan

Author and Contact details:	**Head of Governance & Risk** **Tel:** 0151 556 3084 **Email:** michael.duffy@thewaltoncentre.nhs.uk **NHS Net:** Michael.duffy2@nhs.net	
Responsible Director:	**Chief Operating Officer**	
Approved by and date:	**Resilience and Planning Group**	**April 2022**
Document Type:	**POLICY**	**Version 3.1**
Target Audience:	All trust employees.	
Document Approval, History/Changes	**See Appendix 8.** For further information contact the Governance Department	

Think of the environment…Do you have to print this out this document? **You can always view the most up to date version electronically on the Trust intranet.**

If a major incident is taking place and you are unfamiliar with this policy, **do not try and read it now.**

Executive Summary

This Policy is laid out in 2 distinct sections:

Section 1. Major Incident response including an overview for incident Commanders and Action Cards.
Section 2. The underpinning Policy organisation and arrangements for Major Incident Planning.

A high level overview of actions on receipt of a Major Incident message is provided below, read this and go to the respective action card for detailed next steps.

Contents

SECTION 1 - MAJOR INCIDENT OVERVIEW & RESPONSE

1. Major Incident Plan overview

1.1 A major incident can be defined as:

- any emergency that requires the implementation of special arrangements by one or more of the Emergency Services, and the NHS for: the rescue and transport and treatment of a large number of casualties, and/or
- that requires a response over and above the norm - stretches the services - can't be managed within normal routines

Note: This can be either an external or internal incident e.g. fire.

1.2 You are strongly advised to read the Trust's Major Incident Plan. There is a Summary section and it is essential you read the section covering your Department.

The Trust Major Incident response is led by the Director or, if out of hours the Director on call.

The ITU, Theatre and Radiology Departments have specific local plans that outline the main responsibilities of their staff and escalation arrangements.

The remainder of departments and wards have bespoke action cards which describe the key actions for Departmental Managers or Deputies.

The response in Clinical Departments is led by the Clinical Director or, if out of hours the Consultant On call.

1.3 The most likely type of major incident is a Mass Casualty Incident.

A Mass Casualty Incident is defined as a disastrous event where normal Major Incident responses must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response. By definition, such events have the potential to rapidly overwhelm, or threaten to exceed the local capacity available to respond, even with the implementation of major incident plans.
Factors that distinguish a mass casualty are:

- most likely associated with terrorist incidents or transport
- the scale, duration, intensity of the Incident
- loss of infrastructure services
- shortage of supplies or civil dislocation

Normal standards of care provided by the Emergency Services and the NHS may not be achievable. The requirement is to achieve the best possible outcome for the greatest number of people with the available resources.

2. Major Incident Plan Activation

A major incident message will usually be a structured "METHANE" message:

- **M**ajor incident declared or stand-by; time of incident
- **E**xact location of incident
- **T**ype of incident
- **H**azards (e.g. chemicals) involved
- **A**ny problems with access that may impede staff or patient journeys

- **N**umbers of estimated casualties involved
- **E**mergency services involved, any special resources required (e.g. burns/paediatrics), other hospitals involved

2.1 The Major Incident Plan will be triggered by the relevant Director or Executive on Call - Strategic Commander (Gold). There are two stages to the Alert:

- Major Incident Standby - preliminary advice that a Major Incident might be occurring to enable the hospital to anticipate a Major Incident.
- Major Incident Declared - a decision that a Major Incident has occurred and e.g. casualties will arrive requiring implementation of the Plan. A Major Incident Declared can occur without a prior Major Incident Standby notification.

2.2 Major Incident Standby Message

On the receipt of a confirmed Major Incident Standby, the Plan expects:

- the formation of a Major Incident Control Team which will consist of:
  - Strategic Commander (Gold) - Director or Executive On Call
  - Tactical Commander (Silver On call)
  - an administration manager
  - Communication Manager
  - a loggist
- a review of bed capacity and assessment of inpatients for potential discharge
- communication of the Standby message to all departments via email, telephone or via runners
- in a mass casualty the deployment of a Forward Liaison member of the Surgical Department to the Aintree Emergency Department

2.3 Major Incident Declared - External Incident requiring Walton Centre response

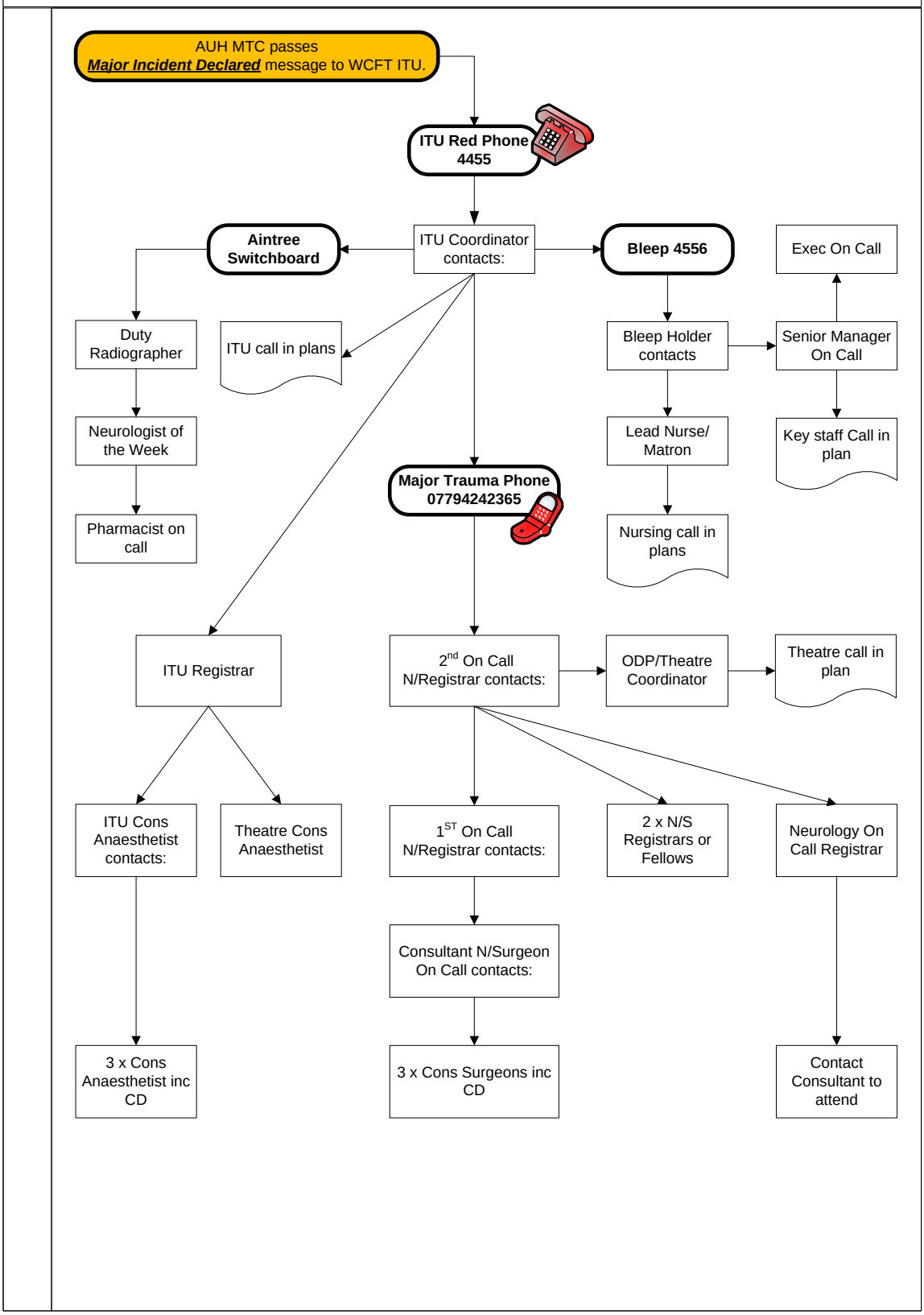
The most likely escalation will be as a result of the Major Trauma Centre (MTC) in Aintree receiving mass casualty trauma patients that require Walton Neurosciences support.

The MTC will contact the ITU Red Phone (4455) and confirm a Major Incident message. The ITU Coordinator escalates message to the Bleep holder (for Senior Manager and Exec On Call) and then notifies:

- the 2nd On Call Neurosurgical Registrar via the Major Trauma Phone who will initiate the Neurosurgical/ Theatres response
- ITU Registrar who will initiate the ITU response
- Divisional Nurse Director/Matron or clinical
- Pharmacy, Radiology and Neurologist of the Week

See algorithm diagram below:

MTC contact – "Major Incident Declared" – WCFT call cascade



3. Walton Centre Response

3.1 Control Room

The Major Incident Control Room will be set up in the Boardroom on the 2nd Floor in The Walton Centre, which acts as the central point for control and communication throughout the Trust and with external agencies.

A secondary room should the Boardroom be unavailable is located in the Lecture Theatre in the Sid Watkins Building on the 2 floor. Access to both of these rooms is via Swipe access and out of hours via Security Reception.

Major Incident Telephone numbers (Boardroom)

There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

a. Major Incident number is (0151) 556 3690 and:
b. Boardroom (0151) 556 3688
c. Theatre Seminar room (0151) 566 3689
d. **NB in the event that the above numbers are not available, use the Red Phone (0151) 529 4245.**

Fax: 0151 529 6434 (Located in Exec office).

3.2 Strategic Commander (Executive Director or Director on call out of hours)

3.2.1 The Strategic Commander controls **ALL** activity throughout the entire Trust. In a confirmed Major Incident - the Director or Executive On call will assume the role of Strategic Commander and declare a Major incident for the Trust. This is done by:

- contacting NWAS Health Control Desk on **0345 113 00 99** (Option 2 for Merseyside & Cheshire) and ask for the ***NHS England 1st on call for Merseyside*** leave a number for a return call (Email eprr.communications@nhs.net)
- and then inform CCG Duty Officers for North Mersey **0845 124 9802** of Major Incident declared and give details
- then inform Spec Comm (England) On Call Manager **0191 266 7733** of Major Incident declared and give details (Email england.spoc@nhs.uk)

The Strategic Commander will communicate with the Tactical Commander and key members of the Incident Control Team via pre-agreed meetings in the Boardroom. The frequency will be determined at the initial meeting dependent on the nature of the incident.

These meetings will establish the severity of the incident, number of likely casualties, patient flow, staffing, and impact on business as usual activity.This information will inform communication with Aintree, NHS England, Critical Care Network and external Situation Reports.

3.3 Situation Reports (SITREP)

NHS England coordinate the NHS response to a Major Incident. They will agree in advance the timings of SITREPs and method of submission, depending on the severity of the incident. This may be done initially via telephone conversation/email and when there is suitable support, via regular teleconferences.

3.4 Tactical Commander

This role in hours will be fulfilled by the Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.

Out of hours the Senior Manager on call (Silver) will escalate the message to the Director on call who will then decide who is to assume the role of Tactical Commander. They will come into the hospital and set up the incident control room and await further direction.

3.5 Bleep Holder (Operational)

If notified of a Major Incident, the Bleep Holder will contact the relevant Director via the Executive Office in hours and if out of hours the Senior Manager and Executive On Call via the Aintree Switchboard.

3.6 Departmental Response

3.6.1 Neurosurgery

The Consultant On Call assumes the role of **Surgical Commander**. He or she calls in the Clinical Director, a Cranial Consultant, a Spinal Consultant and supporting colleagues and allocates roles for them between Theatres, discharge and Aintree. The Surgical Commander based in the theatre complex will:

- provide coordination and prioritisation;
- ensure time limits for futility of intervention;
- be available for second opinion

3.7 Theatres

The Theatre Coordinator/Senior ODP will initiate the local staff call in procedure (algorithm) which is a pre-prepared document which details teams according to skill mix. They initially prepare one theatre for immediate transfer from Aintree followed by a further two theatres once sufficient staffing resources are in place.

3.8 Critical Care

The ITU Registrar calls in the ITU Consultant On call. He or she calls in 3 colleagues (including Clinical Director), liaises with Aintree ITU and Neurosurgery and allocates colleagues on arrival.

The ITU Coordinator/Matron initiates the Escalation Policy to set up extra beds as required, sequentially in SSU, SIM Room, Theatre Recovery and Jefferson Ward infusion bay.

3.9 Wards

The Matron will initiate the local staff call in procedure (algorithm) which is a pre-prepared document which details teams according to skill mix. They will prepare to receive major trauma patients, discharges from ITU and/or potentially other wards due to cohorting requirements. Ward staff will manage patient visitors according to the protocols held within the action card.

The main Outpatients Department will become the Discharge Lounge for in patients that require discharge. The Outpatients Manager will coordinate this role in hours and out of hours by a CST (SHO) and a clinical Pharmacist.

3.10 Radiology

The Radiology Manager or deputy in hours will initiate the local staff call in procedure (algorithm) and if out of hours, the Duty Radiographer. They prepare the radiology response in liaison with the Theatre Coordinator.

3.11 Support Services

Specific information regarding e.g. security, linen, surgical supplies (including instrumentation) and ward consumables, are detailed within specific action cards within the Major Incident Plan.

4. Access & Communication

4.1 Departmental Managers are responsible for assessing staffing requirements and calling in as necessary (or coordinating out of hours).

4.2 Staff report to their normal area. In the event of a Lockdown, they report to the designated staff reporting area. This will be signposted and controlled by ISS Security.

4.3 Families, media and press enquiries, coordination of affected patient families, a pre-prepared social media and website message will be provided by the Communications Team. A standard message will be prepared and disseminated to Heads of Department for onward cascade.

For on site reporters or media press enquiries; the Communications Team will be the first point of contact. Any external messages will require the Executive Director to coordinate with NHS England.

5. Post incident response

5.1 Major Incident Stand Down

The Strategic Commander will issue the Stand Down message throughout the Trust. The incident control room and incident logs will be closed and all relevant documentation (including evidence of decision making) will be collated and stored appropriately.

5.2 Debriefing

A debrief is held after an incident to establish learning points and draw up an action plan to enable the review and revision of emergency plans.

A hot debrief is held immediately after Stand down is declared within the location where responders have been working.

A formal organisational debrief will be held within a week after the event. The Strategic Commander and Head of Risk will prepare an organisational report for the next Executive Team and subsequent Board.

5.3 Staff support

Support of staff welfare and counselling will be a priority throughout the actual incident, stand down and post incident phases. Access to Occupational Health support will be provided by the Trust for all staff, particularly those involved in a major incident, which will include counselling if required.

ACTION CARD 001 - Bleep Holder (Operational) Out of hours

(Will act as Bed Manager until relieved - see Bed Managers Action Card).

Location: **Unit based**

Role Description:

This role will:

1. Manage the immediate local response.
2. Out of Hours refer to the Bed Manager Action Card (**Action Card 022**) until relieved.
3. Contact the Senior Manager on call - Tactical (Silver Command).
4. Co-ordinate the organisations resources onsite by gathering as much information as possible related to:
   - staffing
   - patient flow, transfer from critical care (OOH)
   - discharges of all patients within ward area
   - escalation (utilise support from SMART Team if required)
   - support Silver Commander and provide them with the up to date patient information / updates on care, availability of beds, capacity and infection control status
   - prepare for on site meeting in ITU or Theatre Office
   - liaise with Senior Nursing Team (not on call)

Incident Standby

1. Prepare staffing information for additional staff (to ensure adequate nursing resources are available for level of care required).
2. Consider which patients may be suitable for discharge or transfer.
3. Liaise with ITU Co-ordinator/ Theatre Co-ordinator / Onsite Medical Lead and Infection Control Lead (On call) to ensure that the bed capacity is at full potential.
4. Attend meeting in ITU/Theatre Seminar Room.
5. Liaise with Senior Manager On call - Silver command.

Incident declared

1. Prepare to receive transfers from Critical care as directed. These patients must be accepted immediately on request and a nurse should be sent to assist with transfer.
2. Prepare to receive admissions from Theatres that do not require ITU admission.
3. Arrange to transfer existing in-patients to other wards.
4. Request additional staff as required (consider use of agency staff).
5. Support relevant on-call medical registrar with discharge of identified patients.
6. Keep a record of all actions and decisions taken during the incident.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.

2. Join the Trust hot debrief.

ACTION CARD 002 - ITU Nurse Coordinator

Location: ITU

Role Description:

1. To implement, in conjunction with senior medical staff, the escalation strategies outlined in the Trust Major Incident Plan.
2. To assist in the recruitment and deployment of additional staff according to the likely requirements of the incident (in conjunction with Nurse Manager ITU).
3. To organise the setup of extra ITU bed spaces to take predicted casualties.

Incident Standby

1. The Major Trauma Centre will call on the Emergency Red Telephone (4455) and ask to speak to the coordinator. They will pass the message "Major Incident Stand By or Declared"
2. On receiving the message, the coordinator should inform the following:
    a. Neurosurgery 2nd On Call Registrar via the Major Trauma Phone 07794242365
    b. ITU Nurse Manager.
    c. Duty ITU Registrar.
    d. Radiology On call.
    e. Bleep Holder.
3. And pass the message "***Major Incident Stand By or Major Incident Declared"*** Action cards are kept in the CD cabinet in the bay.
4. Assess bed state and current staffing levels and report these to ITU Nurse Manager.
5. Commence setup of beds 21 & 22 (SSU) to take 2 ventilated patients.
6. If Nurse Manager not on site, attend ad hoc meeting with Theatre Coordinator / Nurse Manager, ITU and Anaesthetic Consultants and Consultant Neurosurgeon in Theatre Seminar Room when senior staff arrive.

Incident declared

1. Complete actions detailed above under standby.
2. Commence calling in nurses to staff extra beds after liaison with Nurse Manager ITU / Duty Consultant ITU following an estimation of likely bed demand.
3. Call in ITU Technician if available.
4. If Escalation 2 procedure seems to be necessary, direct extra staff and ITU technician (if available) to set up Jefferson Infusion bay to take 4 level 2 patients using beds from Jefferson ward bays.
5. If Escalation 2 procedure started, arrange for extra staff to collect reserve monitors and ventilators from storage in Sid Watkins building (**see Appendix 1 "Location of reserve equipment").**
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Matron.
2. Join the Trust hot debrief.

Appendix - Supplementary Action Card: Location of ITU Reserve Equipment.

If it seems necessary to implement the **Escalation 2** plan to increase critical care bed capacity, then it will be necessary to utilise the reserve equipment kept in Sid Watkins Building (SWB) to allow this to happen. Proceed as follows.

1. When extra staff arrive after being called in, form a team of 4 nurses / HCA's and ask them to go over to Sid Watkins with this card.

2. On arrival at SW, inform the security staff of the purpose of your visit and go to the Outpatients department on the first floor. The security staff may need to facilitate entry out of hours.

3. Walk into Outpatients and on reaching the reception desk, turn right and go to the end of that corridor to a door marked "DO NOT ENTER."

4. Go through this door into the unfinished area of the building, the monitors and ventilators are on the left hand side of the room.

5. Carefully move the 4 ventilators across to HDU and the four monitors to the infusion bay on Jefferson Ward.

6. The ventilators should remain in reserve until all other available Evita ventilators are in service. They will need to be set up for use by the ITU technician, or by an ODP.

ACTION CARD 003 - Tactical Commander

Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse or Senior Manager On Call (out of hours).

Location: Based in the Boardroom (in the event the Boardroom is unavailable within the Lecture Theatre in the Sid Watkins Building).

Role Description:

1. Working with the Incident Management Team, you are responsible for:
    a. The Trust's Tactical response to a major incident.
    b. The collection, collation and transmission of information during the incident response
    c. Action tracking.
2. You must establish contact with the emergency services where appropriate, major incident receiving hospitals and other agencies to ensure full operational awareness.
3. Ensure that correct information is made available to the **Strategic Commander** (Executive Director or Director on call out of hours), who will work with the Communications Manager to establish arrangements to brief the media.
4. Work with the Strategic Commander to ensure that a recovery plan is formulated and implemented.

    Major Incident Telephone numbers (Boardroom)

    There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

    a. Major Incident number is (0151) 556 3690 and:
    b. Boardroom (0151) 556 3688
    c. Theatre Seminar room (0151) 566 3689

Incident Standby:

1. Having been alerted you now need to lead the Tactical response until you are stood down or relieved.
2. If appropriate proceed to the Hospital immediately.
3. Inform Strategic Commander who will provide immediate advice on the information you will be required to gather.
4. If appropriate contact Head of Risk/Deputy Head of Risk and instruct to attend the Hospital.
5. Keep an accurate record of messages received from the bleep holder on your personal log sheet within your on call pack until an incident log is running.
6. Consider immediate threat to business as usual (next 24 hours) as follows:
    a. Number of TCI's (both same day admissions and inpatients)
    b. Number of outpatient clinics scheduled
    c. Number of routine radiology investigations scheduled
7. Maintain regular contact with the Strategic Commander throughout the incident.

Incident Declared:

1. Receive **"Incident Declared"** message from Bleep Holder with the likely number of casualties and the nature of the incident declared as well as the number of teams ready to mobilise and the initial potential threat on business as usual.
2. Set up the Major Incident Room in the Trust Boardroom and inform the WCFT reception (if in hours) that the control centre is operational.
3. If our of hours, the Strategic Commander may replace the Senior Manager On Call with a more appropriate Tactical Commander.
4. Key Components of your role:
    - implementation of the actions set by the Strategic Commander
    - allocation of tactical resources including personnel and equipment
    - establish clear communication and location of the operational leads in theatre, Critical care, wards and bed management plus support services and ensure they are fully briefed and command and control hubs set up as appropriate within the trust
    - oversee the response of theatres, ITU, HDU and Radiology appropriate to the incident
    - oversee the discharge process for current inpatients
    - identify and communicate to the Strategic Commander the need for additional support or assistance as required
    - Multi-agency tactical liaison with NWAS, Fire, Police and PHE
    - providing situation reports (SitReps) to the strategic commander and/or NHS England
    - manage the incident support team
5. Start a Major Incident Control Centre log and ensure a robust record (log) is kept of the major incident or emergency to include:
    - date and time
    - major Incident
    - information received – incoming phone calls, emails and faxes
    - request for assistance received and responses
    - instructions received
    - decisions made
    - actions taken
    - ensuring the Strategic Commander signs the log after key decisions and following Major Incident team meetings
    - assign staff tasks as appropriate
6. Briefing / initial meeting of Incident management Team
    - brief on arrival the Incident Management Team; this will include an Administration Manager, a loggist and support from the Division and Governance
7. Chair initial meeting of Incident Management Team
    - assess impact on trust services - if they have been or will be affected by the incident and ensure they are informed of the situation
    - priority is to ensure that services required to respond to the emergency are maintained as well as other essential services

- if deemed necessary ensure that the normal roles of staff working as part of the incident are covered
- provide hand over to appropriate manager if the incident is prolonged
- hand the log to the Control Room Administration Manager once the incident has been closed or you are no longer on-call
- provide handover report to the manager replacing you

8. Support ***For your Information***

a. You will be supported by the Head of Risk or Deputy who have specialist knowledge of the Major Incident Plan and associated Procedures. They will advise you on options available to you, possible courses of action and potential consequences of decisions taken.

b. An Administration Manager will ensure support functions are co-ordinated to provide adequate support to both the Strategic Commander and Tactical Commander.

c. You will work in conjunction with a Loggist to ensure all actions and decisions are captured. All meetings held should also be minuted.

d. The ITU, HDU, Theatres, Radiology and Wards have call in procedures in place.

Public enquiries

2. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. Decide when to stand down in consultation with Strategic Commander and ensure stand down message is communicated.
2. Work with Administration Manager to ensure all information and documentation is collected and safely stored.
3. Agree actions for follow up of staff following the incident and debriefing.

ACTION CARD 004 - Strategic Commander (Director or Executive On Call)

Location: Based in the Boardroom (in the event the Boardroom is unavailable within the Lecture Theatre in the Sid Watkins Building).

Role Description:

1. Provide Strategic leadership to WCFT during a response to a major incident.
2. Provide Support and response as directed/requested by NHS England as part of the health economy response.
3. To direct the Tactical Commander.

Major Incident Standby:

1. You will be contacted via the Executive PA or by the Senior Manager On call out of hours.
2. On being alerted confirm details of current situation:
   - What has happened?
   - Where is the incident?
   - What time did it begin?
   - What are the immediate consequences?
3. Proceed to Incident Control Room (Board Room) and consider the situation with Tactical Commander and other Incident Control Team members.
4. Decide what action is required to prepare the hospital.

Major Incident Declared:

1. The most likely scenario will be providing Neurosurgical support to Aintree Major Trauma Centre with casualties etc.
2. **INTERNALLY** - Declare a **Major Incident** to Trust staff via an all user email message, out of hours do this via a runner to departments and wards.
3. **EXTERNALLY**
   a. Call NWAS Health Control Desk on **0345 113 00 99** and ask for the ***NHS England 1st on call for Merseyside*** leave a number for a return call. Email eprr.communications@nhs.net
   b. Inform CCG Duty Officers for North Mersey **0845 124 9802** of Major Incident declared and give details.
   c. Then inform Spec Comm (England) On Call Manager 0191 430 2498 of Major Incident declared and give details (Email england.spoc@nhs.uk).
4. Report to Incident Control Room and take over from Senior Manager in Charge you are now the Strategic Commander.
5. Commence your incident log.
6. Designate a Tactical Commander; this may be a Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse or Senior Manager On Call (out of hours).
7. You will receive and send intelligence reports, instructions and regular SITREPS to and from NHS Silver Command.

8. Contact ***NHS England Merseyside 1st on call*** to inform them that the Trust Incident Control Room is set up and the contact number and the generic Trust email to use incident@thewaltoncentre.nhs.uk
9. Brief the Command & Control Teams and determine a shift rota as necessary.
10. You will receive and send intelligence reports, instructions and regular Sitreps to and from the incident control room.
11. Strategically direct the **whole** Trust's Major Incident response.
12. Notify other executive directors/non-executives as appropriate and North Mersey CCG on **0845-124-9802** of Major Incident declared and provide details.
13. Monitor response of:
    a. Support services.
    b. Media response with the Communications Team.
    c. Any VIP visits.
14. Call and chair Command meetings every 2 hours.
15. Lead the hospital's liaison with external bodies, e.g. NHSI/CQC etc.
16. Consider use of radio communication between key areas e.g. to cover any blackspots in the Hospital. These can be accessed via the Head of Facilities.

Major Incident Stand Down

1. When the emergency is over declare and cascade to all staff and key stakeholders "Major Incident Stand Down."
2. Inform NHS England Merseyside 1st on call.
3. Conduct a hot debrief in situ in the Boardroom.
4. Arrange and chair a formal Trust wide debrief in a week's time.
5. Compile a formal incident debrief and report with the Head of Risk (including lessons learnt).
6. Send report to the next Trust Board.

ACTION CARD 005 - Communications Manager (In and Out of Hours)

Location: **Incident Control Room**

Role Description:

1. To coordinate communications across the organisation.
2. To coordinate media communications.
3. To support the Strategic Commander in relation to Trusts media response.

Communications resources/equipment:

1. The Communications on-call Lead will have remote access to the Trust's network, to enable them to update the intranet and send all user emails.

Incident Standby/Declared:

Out of hours:

1. The Strategic Commander (Executive on Call) will:
    a. Contact (out of hours/major incident media enquiries or any urgent requirement to inform staff and/or stakeholders) Communications on-call Lead.
    b. Notify the switchboard to direct any media enquiries to the Communications lead.
    c. Establish a protocol with any External Multi-agency/NHS Organisations Communications Lead to ensure that any relevant information/media from The Walton Centre is shared with the Trust's Communications Lead, before circulation (if practicable).

In hours:

1. The Communications Lead will take all necessary steps to prepare for internal and external enquiries, including any or all of the actions below:
    - set up a message on the intranet providing information and assurances
    - send an all-users email providing information, stating when more information will be sent, and directing staff to the intranet
    - liaise with Multi Agency/NHS Gold Communications Lead (e.g. Merseyside Police press office) to agree who will be the first point of contact, which will depend on the scale of the incident
    - consider using web updates for key media messages - e.g. linking to the Merseyside Resilience Forum webpage
    - identify key stakeholders to be notified and circulate a message to all relevant stakeholders
    - erect signs in and around the hospital site
2. Maintain communication and report any issues to the Strategic/Tactical (Silver) Control Team.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Incident stand down

1. Gradually reduce the frequency of briefings (internal and external).
2. Continue to liaise with communications leads at key partner organisations about key messages and media protocol.

3. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the TACTICAL (Silver) COMMANDER.
4. Join the Trust hot debrief.

ACTION CARD 006 - Administration Manager

Location: **Incident Control Room**

Role Description:

1. To set up Incident Control Centre.
2. To provide administrative and clerical support.
3. To collect, collate and display information.
4. To establish and maintain liaison with internal and external services.

Incident Standby

1. Agree roles and immediate action with Director.
2. Agree on operating base either Boardroom or, if not available 2nd Floor Lecture Theatre SWB.

Incident declared

1. Alert relevant staff as instructed (including Loggists) - ask them to report to Incident Control Centre.
2. Set up the Incident Control Centre.
3. With the Director / Divisional Director, Divisional Manager or Deputy Director of Nursing/Lead Nurse confirm room layout, set out communications system, log sheets, incident status boards.
4. Layout three telephones for team members, contact details are as follows:

   Major Incident Telephone numbers

   There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

   a. Major Incident number is (0151) 556 3690 and:
   b. Boardroom (0151) 556 3688
   c. Theatre Seminar room (0151) 566 3689
   d. **NB in the event that the above numbers are not available, use the Red Phone (0151) 529 4245.**

5. Use mobile telephones for outgoing calls if necessary. Supply of log sheets to be available.
6. Set up an incoming fax, and an outgoing fax if required.
7. Set up incident status boards and record initial details, incident location, brief statement of situation, names, organisations and contact numbers of responders.
8. Display any relevant maps where necessary.
9. Create a file directory and give it the name of the incident. Use this directory for all the documents relating to the incident.
10. Ensure all communication is documented.
11. Tasks:

    - Confirm the dedicated telephone numbers for calls to be received / made, dedicated fax line.
    - Make list of the Incident Control Centre staff and their telephone numbers (include direct incoming lines and extension numbers)

- Refer to a list of internal and external contacts. Add these as they call in or as reported by incident managers

12. Incoming call taking:

- Record caller's details and time of call on your log sheet or on the standard message sheet.
- Record name, organisation and contact numbers. Check spelling of unfamiliar names with caller. As well as their landline number, ask for their mobile phone and pager numbers
- Ask if email contact is possible. Take email details.
- Answer queries or divert calls to appropriate person as necessary

13. Other tasks:

- Where requested, provide secretarial support to Strategic/Tactical Commander.
- Where requested, arrange telephone and incident briefings
- Delegate a colleague to reschedule the appointments and commitments of the Executive Director
- Provide stationery / materials

14. Staffing considerations (with Strategic/Tactical Commander)

- Consider staffing requirements to allow critical functions to continue
- Arrange and maintain rota for the staff in the Incident Control Centre
- Ensure there are catering arrangements and refreshments
- Make arrangements for the support of staff in the short or long term

15. At the end of your shift

- Hand over this action card to your replacement.
- Brief them on the current situation on Incident Control Centre procedures and on liaison needs.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical/Strategic Commander.
2. Join the Trust hot debrief.

ACTION CARD 007 - Loggist

Location: Incident Control Room

Role Description:

1. To maintain an accurate combined log of messages received in the Incident Control Room.
2. To maintain an accurate combined log of decisions and actions taken by Tactical/Strategic Commander.

Incident Standby

1. Agree roles and immediate action with the Administration Manager.
2. Confirm room layout, communications system, log sheets to be used and collection system.
3. Issue a log book for the Incident Control Room (held in the Major Incident Cupboard).

Incident declared

1. At the initial meeting:
    - Confirm your role and that of others, staff locations, communications system, log keeping system.
    - Ensure that all members of team are keeping an accurate individual log.
    - Ensure that all details are being entered on the log - Messages details - time of call, name of caller (check spelling), their contact number, spelling of technical names, spelling of locations and company names.
    - Actions taken
    - Challenge anything you are unsure about.
2. Compile a combined log of messages sent and received and actions taken.
    - Collect, collate and store individual log sheets - via updating status board.
    - Record chronologically all information in the incident log.
3. At the end of your shift:
    - Hand over this action card to your replacement. Brief them on the current situation on incident room procedures and on liaison needs.
    - Ensure all communication is documented.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Strategic Commander.
2. Collect all log books.
3. Complete the combined log for the Incident Control Centre and ensure passed on to the Administration Manager or Director.
4. Join the Trust hot debrief.

ACTION CARD 008 - 1st on-call Neurosurgical Registrar (on-site)

Location: Theatre reception

Role Description:

1. Support clinical teams as directed by Surgical Commander.
2. Inform appropriate colleagues as detailed below.
3. Prepare to attend theatre.

Incident declared

1. Attend Major Incident Control Room (theatres) and meet ITU Coordinator.
2. Call two other Registrars/Fellows (see attached) and inform “Major incident declared – you must attend Theatre Incident Room (Theatre Seminar Room).”
3. Assist in the preparation of three Neurosurgical theatres, ensuring appropriate equipment available.
4. On arrival of Discharge Consultant assist in the discharge ward round in conjunction with Discharge Consultant, Bleep holder and Senior Nurse, CST
5. Return to Major incident control room and await further instructions from SURGICAL COMMANDER.
6. Be prepared to attend theatres in Aintree if required with theatre team and necessary equipment.
7. Be prepared to scrub in theatres at Walton to assist or operate as directed by SURGICAL COMMANDER.
8. Ensure all communication is documented.
9. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 009 - 2nd on-call Neurosurgical Registrar (on-site)

Location: Theatre reception

Role Description:

1. Receive call on Major Trauma Phone (07794 242365) from ITU Coordinator. Who should indicate that **"this is not an exercise."**
2. Support clinical teams as directed by Surgical Commander.
3. Inform appropriate colleagues as detailed below.
4. Prepare to work across sites (Aintree).
5. Act as Forward Liaison between Aintree and Walton.

Incident Standby

1. Attend Theatre Incident Room (Theatre Seminar Room) and meet ITU Coordinator, Senior ODP, Bleepholder to assess the current incident state based on information received from MTC.

Incident declared

1. In the event of an escalation to Major Incident Declared call:
    a. Consultant Neurosurgeon on call.
    b. 1st on call Neurosurgical Registrar.
    c. Neurology On call Registrar (BLEEP 5573).
    d. Radiographer on call (contacted via Aintree Switchboard).
2. Attend Aintree Resusc in the Emergency Department as forward liaison (assist TRIAGE CONSULTANT on arrival).
3. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
4. Liaise with ED Commander to assess scale of events and number of expected casualties and update **Surgical Commander** on Theatre Major Incident Room phone - 5790.
5. Log-on to PACs.
6. Remain insitu and await attendance of TRIAGE CONSULTANT.
7. Be prepared to attend theatre as TRIAGE CONSULTANT sees fit.
8. Await further instructions and respond flexibly as required.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Confirm this with the Surgical Commander in ED.
3. Join the Trust hot debrief.

ACTION CARD 010 - Surgical Commander - Consultant On Call Neurosurgeon (on-site)

Location: Theatre reception

Role Description:

1. Receive call from 2nd on-call Neurosurgical Registrar to inform “Major Incident Declared - attendance required immediately.”
2. Assume role of Surgical Commander – to direct the surgical teams in response to the incident as required.
3. To remain within Incident Command Room (theatres) and receive casualty information from Forward Liaison (2nd on-call Reg / allocated Triage Consultant).
4. To ensure surgical personnel are allocated appropriately and responsively.
5. Liaise with Theatre Co-ordinator, Lead Anaesthetic Consultant, ITU Co-ordinator, Senior Nurse, on-site bleep holder and regularly debrief with the clinical teams.
6. Ensure operations are proceeding in a timely manner and adequate support is available to all surgical teams.

Incident Declared

1. Attend Major Theatre Incident Room (Theatre Seminar Room).
2. Assume role as SURGICAL COMMANDER.
3. Conduct on site major incident planning meeting with Theatre Co-ordinator, ITU Co-ordinator and Lead Anaesthetic Consultant, Senior Nurse, on-site bleep holder in attendance.
4. Ensure you are in possession of designated wireless surgical command phone (5790) in order to receive information from Forward Liaison team (2nd on-call Reg & Consultant).
5. Contact the following people within own team immediately (see below):
    a. Clinical Director for Neurosurgery (if available, if not, any other Team Consultant).
    b. 1x team Cranial Consultant Neurosurgeon.
    c. 1x team Spinal Consultant Neurosurgeon.
6. Be prepared to receive calls from Forward Liaison (2nd on-call Reg) with expected number of casualties.
7. Allocate responsibilities and duties as follows:
    a. On arrival of first Consultant
        i. Present with action card for Consultant 1 – Discharge Consultant.
        ii. Duties to assess and identify discharges from wards.
    b. On arrival of second Consultant
        i. Present with action card for Consultant 2 – ED Forward Liaison Consultant.
        ii. Duties to attend Aintree ED as Forward Liaison Consultant.
    c. On arrival of third Consultant
        i. Present with action card for Consultant 3 – Theatre Consultant.
        ii. Ensure Consultant 3 is ready and prepared to operate on Aintree or Walton sites as required.
8. Monitor theatre activity regularly and update surgical teams on the scale of incident and expected casualties.

9. Ensure all Surgeons have adequate support particularly to make decisions regarding futility of surgery (aim to keep surgical time less than 1 hour).
10. Continually assess in conjunction with forward liaison Consultant, Theatre Co-ordinator and Lead Anaesthetic Consultant, the need for expansion in theatre availability and staffing requirements.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of incident stand down from Forward Liaison team at Aintree ED.
2. Prepare to stand your team down.
3. Join the Trust hot debrief.

ACTION CARD 011 - Consultant 1 - Discharge Consultant (on-site)

Location: Theatre Seminar Room

Role Description:

1. Assume role as Discharge Consultant.
2. To assess the discharge requirements of current inpatients in conjunction with the designated discharge team.
3. Liaising with Surgical Commander at WCFT and attend Trust Incident Control Room (Boardroom).
4. Flexibly undertake duties which may include operating on Walton or Aintree sites as instructed by Surgical Commander.

Incident declared

1. Call received from Surgical Commander (Consultant Neurosurgeon on-call) to inform "Major Incident declared – attendance required immediately."
2. Attend Theatre Incident Room (Theatre Seminar Room) and liaise with Surgical Commander.
3. Undertake ward round with Bleep holder (Bed manager in hours), Senior Nurse and SHO to identify potential discharges.
    a. Be aware of emergency discharge arrangements for current inpatients
    b. A discharge lounge will be set up
    c. An SHO will be available in the discharge lounge to ensure appropriate discharge paperwork completed.
    d. A clinical pharmacist will be allocated to the discharge lounge to ensure prescriptions are available for patients.
    e. Arrangements will be made for ANP's to conduct telephone follow up within 24-48 hours to ensure no problems have arisen.
4. Liaise with on-site bleep holder to confirm that patients assessed as fit for discharge can be transferred to discharge lounge (Main Outpatients Department).
5. Return to Theatre Seminar Room.
6. Prepare to undertake surgery at Aintree or Walton site as instructed by Surgical Commander in conjunction with theatre teams.
7. Ensure all communication is documented.
8. Attend Operational debriefing in the Boardroom.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 012 - Consultant 2 - Forward Liaison Consultant (on-site)

Location: Theatre Seminar Room

Role Description:

1. Assume role as Neurosurgical Triage Consultant.
2. Triaging major incident patients at Aintree ED.
3. Liaising with Surgical Commander at WCFT.
4. Operative duties may be necessary as instructed by Surgical Commander.

Incident declared

1. Call received from 2nd on-call Neurosurgical Registrar to inform “Major Incident has been declared – attendance required immediately.”
2. Attend Theatre Incident Room (Theatre Seminar Room) for briefing from Surgical Commander.
3. Attend Aintree Resusc in the Emergency Department, joining the Forward Liaison (2nd on-call Reg).
4. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
5. Report to ED Command and locate Neurosurgical triage station note the following will be available:
    a. Dedicated telephone (or hand held radio).
    b. Dedicated computer with PACS access.
    c. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
6. Triage incoming casualties as required and in communication with ED Commander.
7. Instruct Forward Liaison regarding information to be relayed to Surgical Commander at WCFT – 5790.
8. Ensure all communication is documented.
9. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ED Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 013 - Consultant 3 (and additional incoming Consultants)

Location: Theatre Seminar Room

Role Description:

1. Flexibly undertake duties which may include operating on Aintree or Walton sites as instructed by Surgical Commander.
2. Liaising with Surgical Commander at WCFT.

Incident declared

1. Attend Theatre Incident Room (Theatre Seminar Room) for briefing from Surgical Commander.
2. Obtain login details for Aintree PACS system (if required).
3. Identify Theatre team in liaison with Theatre Co-ordinator.
4. Ensure preparedness of theatre to receive surgical casualties.
5. Adapt role as communicated by Surgical Commander.
6. Conduct WHO team brief with complete theatre and anaesthetic team.
7. Clarify appropriate equipment, sterile and available.
8. Ensure PACS access and imaging available.
9. Operate on emergency cases as requested by surgical commander.
10. Communicate operative progress when required by surgical commander, constantly evaluating futility of treatment.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander
2. Join the Trust hot debrief.

ACTION CARD 014 - Theatre Co-ordinator (In-Hours)

(If out of hours – Refer to Theatre Action Card 015).

Location: Operating Theatre

Role Description:

1. Co-ordinate Theatre Major Incident Plan **(See: "Theatre: Major Incident Folder" in Recovery CD Cupboard).**
2. Co-ordinate with "surgeon of the week" to cancel/ postpone elective & non-life threatening surgery.
3. Activate "Theatre Team Algorithm" if extra staffing required.
4. Facilitate the safe opening of 3 Major Incident operating Theatres.
5. Facilitate standby staff.

Incident Standby

1. Receive call from ITU Registrar **(Log time and name of person relaying message).**
2. Contact Band 7 immediately.
3. Liaise with "Surgeon of the week" & "Anaesthetist of the day."
4. Liaise with Recovery Co-ordinator, prepare for safe discharge of patients.
5. Review theatre staffing numbers so as to allow the opening of 3 Theatres **(See: "MIP Algorithm/ MIP Team Algorithm).**
6. **Do not** send for any further elective/ non-life threatening surgery.
7. Begin planning for standby/ relief staff **(See: "MIP Team Algorithm").**
8. Consider sending staff home if viable to accommodate 3 shift plan **(See: "MIP Team Algorithm").**
9. Await Major Incident declaration.

Incident declared

1. Cancel all elective/ non-life-threatening surgery.
2. Facilitate the safe discharge of patients from Recovery unit **(Liaise with Bed manager Bleep: 2009).**
3. Open 3 Theatres ASAP **(See: "MIP Algorithm: Appendix 1)**
4. Once 3 Theatres are open Liaise with Silver Command
5. Once 3 Theatres are ready prepare transfer teams **(See: "MIP Algorithm: Appendix 2)**
6. Prepare staff for initial response.
7. Activate "Standby" staff for following shifts.
8. Maintain communication and report any issues to the Tactical (Silver) Control Team regarding Theatre availability.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 015 - Theatre Co-Ordinator (Out of Hours)

(If in hours – Refer to Theatre Action Card 014).

Location: Operating Theatre

Role Description:

1. Co-ordinate Theatre Major Incident Plan **(See: "Theatre: Major Incident Folder" in Recovery CD Cupboard).**
2. Co-ordinate with "on-call surgeon/ anaesthetist" & "on-call consultant" to cancel/ postpone non-life threatening surgery.
3. If Major Incident is declared activate **"MIP Algorithm."**
4. Facilitate the safe opening of 3 Major Incident operating Theatres **(See: MIP Algorithm Appendix 1).**
5. Facilitate standby staff **(See: MIP Algorithm/ MIP Team Algorithm).**

Incident Standby

1. Receive call from ITU Registrar **(Log time and name of person relaying message).**
2. Contact Band 7 immediately.
3. Liaise with "On-Call Surgeon & Anaesthetist."
4. If a patient is already in theatre liaise with hospital bleep holder stating.

   "Patient in theatre we will require assistance initiating "MIP Algorithm" (Bleep: 2009).
5. If a patient is in Recovery liaise with Hospital Bleep Holder **(Bleep: 2009**) to facilitate safe discharge of patients ASAP.
6. Review theatre staffing numbers and plan to open of 3 Theatres **(See: "MIP Algorithm/ MIP Team Algorithm).**
7. **Do not** send for any further non-life threatening surgery.
8. Begin planning for standby/ relief staff **(See: "MIP Team Algorithm").**
9. Await Major Incident declaration.

Incident declared

1. Cancel all non-life-threatening surgery.
2. If a patient is already in theatre liaise with hospital bleep holder stating:

   "Patient in theatre we will require assistance initiating "MIP Algorithm" (Bleep: 2009)."
3. Facilitate the safe discharge of patients from Theatre/ Recovery unit **(Liaise with "Hospital Bleep Holder" Bleep: 2009).**
4. Activate **"MIP Algorithm."**
5. Open 3 Theatres ASAP **(See: "MIP Algorithm: Appendix 1).**
6. Once 3 Theatres are open Liaise with Silver Command.
7. Once 3 Theatres are ready prepare transfer teams **(See: "MIP Algorithm: Appendix 2).**
8. Prepare staff for initial response **(Continued on next page).**
9. Activate "Standby" staff for following shifts **(See: MIP Team Algorithm).**

10. Maintain communication and report any issues to the Tactical (Silver) Control Team regarding bed availability.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 016 - Duty Anaesthetic Fellow / SpR

Location: ITU

Role Description:

4. To initiate the call protocol for the Duty Consultant Anaesthetist.
5. To assist the Duty Consultant Anaesthetist in responding to the likely workload from a major incident.

Incident Standby

1. On receiving a call from the ITU SpR, collect action cards from the CD cupboard in Recovery.
2. Call the Duty Consultant Anaesthetist. If they are off site, read the contents of their card to them and **advise them to attend the hospital.**

Incident declared

1. Call in one extra fellow from the rota.
2. If current workload permits, assist theatre coordinator and duty ODP in setting up extra theatres.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ITU Consultant.
2. Join the Trust hot debrief.

ACTION CARD 017 - Duty Consultant Anaesthetist

Location: ITU

Role Description:

1. To coordinate, in conjunction with the Duty Consultant Neurosurgeon / Surgical Commander and Nurse Manager Theatres, the anaesthesia response to a major incident.
2. To liaise with Critical Care to ensure adequate resources are in place to cope with expected workload.

Incident Standby

1. On receiving a call from the duty theatre anaesthetist, attend the hospital immediately if off-site.
2. Liaise with neurosurgery and critical care to ascertain possible oncoming workload.
3. Call the Clinical Director (or acting Clinical Director) to inform them of the situation.

Incident declared

1. Call in two colleagues from the Theatre Rota.
2. Attend meeting in theatre seminar room with duty consultant neurosurgeon, duty consultant ITU, nurse coordinator theatres, ITU nurse manager/ coordinator and Bronze and Silver control if available. Ascertain workload, plan any possible discharges.
3. Liaise with duty ODP and Critical Care, and assist in setting up two stabilisation and retrieval teams to attend the MTC and retrieve patients for surgery if necessary.
   Team composition is:
   a. Team 1: Consultant anaesthetist, consultant neurosurgeon, ODP.
   b. Team 2: Consultant Intensivist, consultant neurosurgeon, ACCP/ ITU nurse.
4. Despatch first team as soon as possible to act as on-site liaison in the MTC. Use them to ascertain likely nature and extent of workload.
   As casualties arrive, allocate theatre resources in conjunction with Theatre Nurse Coordinator / Nurse Manager. Liaise with Duty ITU consultant over requirement for critical care beds.
5. As the incident progresses, liaise with Nurse Manager Theatres, Senior Management and Clinical Director to ensure that sufficient staffing and resources are available to provide ongoing higher level of service.
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgeon Commander.
2. Join the Trust hot debrief.

ACTION CARD 018 - Duty ITU Consultant

Location: ITU

Role Description:

1. To implement the escalation strategies outlined in the Major Incident Procedure to allow the unit to receive casualties in excess of normal capacity.
2. To liaise with colleagues from Neurosurgery and from the Major Trauma Centre (MTC) to provide a coordinated response to the incident.
3. To provide Mutual Support to Critical Care at Aintree Hospitals.

Incident Standby

On receiving a call from the ITU registrar or Nurse Coordinator:

3. Call the Clinical Director (or acting Clinical Director) to inform them of the situation.
4. **Attend the hospital immediately** if off site.
5. (On Arrival) Ensure that all elements of the Call Protocol have been initiated.
6. Liaise with the MTC and Aintree Critical Care to try and ascertain potential oncoming workload.

Incident declared

8. Call in **two** consultants from ITU rota. Call in more *if potential workload seems very large.*
9. Attend meeting in theatre seminar room with duty consultant neurosurgeon, duty consultant anaesthetist, nurse coordinator theatres, ITU nurse manager/ coordinator and Bronze and Silver control if available. Ascertain workload, plan any possible discharges. Decide, on the basis of information available, whether to implement **Escalation 1 or Escalation 2** plan to increase bed numbers. Update Aintree ITU on potential bed state.
10. When consultant colleagues arrive, one stays on ITU, one goes to a stabilisation & retrieval team.
11. Assist ITU Nurse Coordinator / ITU Matron with setup of extra bed spaces and commissioning of reserve equipment.
12. As patients arrive, liaise with Surgical Commander and Duty Consultant Anaesthetist over admissions to ITU.
13. As the incident progresses, liaise with ITU Matron, Senior Management and Clinical Director to ensure that sufficient staffing and resources are available to provide ongoing higher level of service.
14. Ensure all communication is documented.
15. Attend Operational debriefing.

Public enquiries

3. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

3. You will be informed of the stand down from the Major Incident by the Surgeon Commander.
4. Join the Trust hot debrief.

ACTION CARD 019 - Duty ITU SpR

Location: ITU

Role Description:

1. To coordinate the response to a Major Incident Standby or Declared call in conjunction with the ITU Nurse Coordinator pending the arrival of senior staff.
2. To oversee the start of the Call protocol which initiates the start of the Major Incident Procedure, in conjunction with the ITU Nurse Coordinator.
3. To assist in the preparation of the ITU to receive casualties.

Incident Standby

On receiving a message “Major incident Standby” from the Nurse Coordinator, obtain the action card set from the CD cupboard and proceed as follows:

1. Call the Duty Theatre Anaesthetist, inform them and advise them to follow the actions on their card.
2. Call the duty ITU consultant. Read the actions on their card to them, and **instruct them to attend the hospital immediately** if they are off site.
3. Assist the Nurse Coordinator to set up 2 extra bed spaces in SSU.
4. Make a list of any potential ward discharges and liaise with the Bleep Holder about moving these patients, if an incident is declared.

Incident declared

1. Act as directed by the Duty ITU Consultant to help prepare the unit to receive potential casualties.
2. If the consultant has not yet arrived, liaise with the 2nd-on Neurosurgeon and Duty ITU Consultant, Aintree to try and get an idea of likely incoming workload.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ITU Consultant.
2. Join the Trust hot debrief.

ACTION CARD 020 - Neurosurgical CST (SHO)

Location: Theatre reception

Role Description:

1. Support clinical teams as directed by Surgical Commander.
2. To assess the discharge requirements of current inpatients in conjunction with the designated discharge team.
3. Liaise with Discharge Consultant and/or Surgical Commander at WCFT to update as required.

Incident declared

1. Attend theatre incident room and receive instructions from Surgical Commander and/or Discharge Consultant
2. Undertake ward round with Discharge Consultant, Bleepholder and Senior Nurse, Neurosurgical Registrar to identify potential discharges.
    a. Be aware of emergency discharge arrangements for current inpatients
    b. Assist in the set-up of a temporary discharge lounge (Main Outpatients Department).
    c. A clinical pharmacist will be allocated to the discharge lounge to ensure prescriptions are available for patients
    d. Arrangements will be made for ANP's to conduct telephone follow up within 24-48 hours to ensure no problems have arisen.
3. Liaise with on-site bleep holder to confirm that patients assessed as fit for discharge can be transferred to discharge lounge (Main Outpatients Department).
4. On completion of ward round be available in discharge lounge to ensure appropriate discharge paperwork is completed.
5. Communicate effectively and reassure patients of discharge plan and follow up arrangements.
6. Report back to Discharge Consultant as necessary
7. Ensure all communication is documented.
8. Attend Operational debriefing in major incident control room (theatres seminar).

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 021 - Consultant Neurologist (Neurologist of the Week)

(Onsite Monday 09:00 - 19:00 - If out of hours – contact via Aintree Switchboard).

Location: **Own base & Wards**

Role Description:

1. To assist the bed management team in maximising the number of available beds for incoming casualties.
2. To support the front line Surgical, Anaesthetic and Critical Care responses to an incident by coordinating available medical staff resources from Neurology.

Incident Standby

1. On receiving a call from Switchboard via the Bleep holder or Bed Manager.
2. Depending on the local situation call the Clinical Director (or acting Clinical Director) to inform them of the situation.
3. Attend the hospital immediately if off site.

Incident declared

1. Make yourself known to the Surgical Commander (Duty Consultant Neurosurgeon), who will be in the Theatre Suite.
2. Discuss the likely need for beds, then conduct a “Board round” of the neurology patients with the duty neurology registrar and identify any patients who can be reviewed and potentially discharged.
3. As the incident progresses, liaise with Neurosurgery and Critical Care over the need to provide extra medical staff support from Neurology for ward duties in Neurosurgery or Critical Care.
4. Ensure all communication is documented.
5. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander or Neurology Clinical Director.
2. Join the Trust hot debrief.

ACTION CARD 022 - Bed Manager - In hours

(If out of hours - Bleep Holder #2009).

Location: **Chavasse Ward**

Role Description:

1. Provide up to date bed capacity information to the **Tactical Commander** - this role will be fulfilled by the Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.
2. Have an oversight of patient flow in regard to delayed discharge or potential discharge.
3. Ensure adequate bed management cover is available to continue with the Trust's return to normal function.
4. Co-ordinate the organisations resources onsite by gathering as much information as possible related to:
    - ITU capacity - discharges to ward
    - staffing
    - potential discharges of all patients within ward area
    - liaise with ITU Co-ordinator regarding Critical Care beds/network capacity

Incident Standby

1. Inform Tactical Commander of potential situation.
2. Prepare current bed state to inform Tactical Commander.
3. Assess current staffing levels and potential requirements for the initial 24 hours.
4. Co-ordinate support from the Matrons, Discharge Co-ordinator and Rehab team to consider which patients may be suitable for immediate transfer to maximise bed capacity.
5. Await further instructions from ITU co-ordinator regarding incident stand-down / declared.

Incident declared

1. Inform Tactical Commander "Major Incident declared."
2. Attend Boardroom and receive full briefing of incident.
3. Undertake ward round with Discharge Consultant(s), Matrons, Discharge co-ordinator and Neurosurgical SHO, Bed Management Administrator.
4. Ensure B6 Bed Management staff are available to assist with patient flow across all wards.
5. Identify numbers of potential discharges and inform Tactical Commander.
6. Maintain communication and report any issues to the Tactical Commander regarding bed availability/flow.
7. Ensure all communication is clear for the logging Administrator.

Support ***for information only***

1. A discharge lounge will be set up in Main outpatients.
2. An SHO will be available in the Discharge lounge to ensure appropriate discharge paperwork is completed.

3. A clinical Pharmacist will be available in the Discharge Lounge to ensure prescriptions are available to patients.
4. Arrangements will be made for ANP's to conduct a telephone follow-up with 48 hours to advise further.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the Silver Commander.
2. Join the Trust hot debrief in the Boardroom.

ACTION CARD 023 - Matron (out of hours)

(This person may not be on call - but may be contacted in the event of a Major incident).

Location: **Boardroom or the Theatre Seminar Room**

Role Description:

1. To support the Senior Manager / Executive On Call, until a Tactical Commander is appointed by the Executive On Call (Strategic Commander).
    a. NB the Tactical Commander will be one of the following roles; Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.
2. To support the Trust's Tactical incident response.
3. Support the Surgical Command Teams.

Incident Standby

1. To be contacted by the Bleep Holder.
2. If appropriate proceed to the Hospital immediately and report to the Boardroom or Theatre Seminar Room.
3. In conjunction with the Surgical Commander, ITU Lead Nurse, Theatre Co-ordinator and Bleep Holder decide what action is required to prepare the hospital.

Incident declared

1. Report to Boardroom/Theatre Seminar Room.
2. Assume role as Senior Nurse within the discharge team, which consists of the following:
    a. Discharge Consultant (Surgeon)
    b. Consultant Neurologist
    c. Bleep holder.
    d. Neurosurgical Registrar
    e. SHO
3. Instruct Ward Managers (if in hours) to identify number of visitors and their locations.
4. With assistance from Bleep Holder, ensure staffing has been identified, appropriate to the incident and its likely longevity.
5. Maintain contact with Tactical Commander and report any issues or requirements.
6. Support Ward Managers/Nursing teams.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident via the Tactical Commander.
2. Ensure all relevant staff attend operational debriefing.
3. Join the Trust hot debrief.

ACTION CARD 024 - Outpatients Manager

In and Out of Hours

Location: Outpatients Department in the Walton Centre main building

Role Description:

1. To facilitate the rapid discharge of the Outpatient Department in order to receive discharges from the wards.
2. Ensure that follow up arrangements are made for patients in conjunction with the Neurosurgical SHO and Clinical Pharmacist.

Incident Standby

1. Alert all staff in Outpatients Department.
2. Undertake an assessment of current patients/visitors within the department.

Incident declared

Out of Hours

1. Report to Outpatients Department in the Main Building for further instructions.

In working hours

1. Alert all staff in Outpatients department.
2. Inform current patients/visitors that Trust has invoked its Major Incident Plan.
3. Commence clearing the department and provide follow up appointment advice.
4. Prepare all relevant areas/suites to receive discharges from wards.
5. Ensure whole area is prepared.
6. Allocate staff to appropriate tasks and duties as instructed by the Neurosurgical SHO and Clinical Pharmacist.
7. Reception staff to ensure all inpatient discharges are provided with standardised letter (see appendix), and this information is returned to the appropriate Divisional Management Team for follow arrangements.
8. Inform the Matron of any transport requirements for existing outpatients who arrived by Patient transport Services (PTS).
9. Report any issues and maintain communication with the Matron.
10. Ensure all communication is documented.
11. Attend Operational debriefing as instructed.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Matron.
2. Join the Trust hot debrief.

ACTION CARD 025 - Radiology Manager (Out of hours – refer to Action Card 26).

(Or in their absence MR Superintendent radiographer/ Principal Radiographer receiving the call in-hours).

Location: RADIOLOGY

Role Description:

1. Co-ordinate Radiology Major Incident plan.
2. Co-ordinate with “Radiologist of the day”/ Principal radiographers to cancel/ postpone elective & non-urgent Imaging.

Incident Standby

1. Receive call from ITU Registrar (Log time and name of person relaying message).
2. Contact Principal radiographers.
3. Liaise with “Radiologist of the day.”
4. Liaise with PAC Diagnostic, to cancel elective outpatients.
5. Review rota, allocate staff according to outpatient lists.
6. **Do not** send for any further elective patients.
7. Begin planning for standby/ relief staff (contact staff on shift days off and part time staff as required).

Incident declared

1. Cancel all elective / outpatient imaging.
2. Facilitate the cancellation of outpatients from Radiology.
3. Prepare staff for initial response.
4. Activate “Standby” staff for following shifts.
5. Maintain communication and report any issues to the Tactical (Silver) Control Team
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the (Tactical) Silver Commander.
2. Join the Trust hot debrief.

ACTION CARD 026 - Radiographer On Call (Out of Hours)

Location: Radiology Department

Role Description:

1. Receive Major incident message and initiate the Radiology Department response.
2. Co-ordinate Radiology Incident response with Radiologist On-Call and Radiology Manager/ MR Superintendent Radiographer.
3. Radiology Manager / MR Superintendent Radiographer will activate “Radiology Call Cascade” if extra staffing required.
4. Switch on all imaging equipment.

Incident Standby/Declared

1. Call to activate a Major Incident will come to Radiographer on-call.
2. Ask how many patients expected and approximate timescale.
3. Radiographer On Call phones:
    a. Radiologist On Call.
    b. Radiology Manager or if not available phone MR Superintendent and confirm that they are **FIRST** call).
4. Radiographer On-call heads for hospital and switches on ALL equipment.
5. Radiology Manager (or MR Superintendent) will start call cascade.
6. Principals will be advised to start their cascade depending on incident type and number of casualties expected.
7. If you are not called through the night, please attend for your normal shift.
8. Remember to bring your hospital pass with you (depending on incident type you may need it to get through police cordons).
9. On arrival Radiology Manager or Principal Radiographer will allocate work areas (2 Radiographers per area). Anyone arriving after staffing is allocated will be asked to wait in the tearoom. This means that if the incident goes on over several hours we can rotate and have some rest breaks.
10. Activate “Standby” staff for following shifts.
11. Maintain communication and report any issues to the Tactical (Silver) Control Team.
12. Ensure all communication is documented.
13. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the Silver Commander.
2. Join the Trust hot debrief.

ACTION CARD 027 - IT

(If out of hours contact 0151 556 3017).

Location: **IT Department/Wards**

Role Description:

1. 1st line support to staff (Accounts / Passwords / Software issues).
2. 2nd line support of IT Equipment (Desktops / Laptops / Printers / iPads).
3. 3rd line support of IT Infrastructure (Servers / Networks).
4. 2nd & 3rd line support of Telephony (Mitel VOIP System).

Incident Standby

1. Call the IT Service desk (24hr) on 0151 556 3017.

Incident declared

1. Report to the incident Control Room in the Boardroom for further instructions.
2. Provide technical support to Tactical Commander.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 028 - Head of Facilities (In and Out of hours).

Location: Facilities Office

Role Description:

1. Provide service support to the Major Incident Response.
2. Working with the Tactical Commander and Strategic Commander to provide Facilities support to the Hospital.

Incident Standby

1. Support the Tactical Commander to estimate potential number of patients.
2. Work with the ISS General Manager to establish rotas call in of staff.
3. Review current holdings of stock, catering supplies etc.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area - Outpatients.
2. Obtain briefing from Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Liaise with:
    a. Bed Manager - identify estimated number of patients
    b. Estates Manager
    c. ISS General Manager
    d. ISS Logistic Manager for:
        i. Security
        ii. Portering
        iii. Laundry
        iv. Car parking
    e. ISS Domestic Manager for:
        i. Catering
        ii. Cleaning
    f. Head of Procurement/Team.
    g. Key contacts within AUH Facilities
    h. Mortuary and Funeral Directors
5. Site Security liaise with the:
    a. LSMS/ISS Logistics Manager in relation to Lock Down.
    b. Police regarding traffic control on the approach routes to the hospital. Inform the Hospital Major Incident (Silver) Control Team of any decisions made.
6. Ensure rooms are opened/closed as applicable.
7. Provide rooms for briefings as requested.
8. Have access to the Trusts Credit card for emergency purchases

9. Work collaboratively with other members of the Incident Control Team.
10. Ensure all communication is documented.
11. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 029 - ISS General Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Provide ISS Managerial support to the Head of Facilities/Tactical Commander.
2. Co-ordination of the provision of the ISS response.

Incident Standby

1. Work with the Head of Facilities to estimate potential number of patients, incident duration, staffing and resource requirements.
2. Brief the ISS Logistics Manager and ISS Domestic Services Manager on the incident intent. Establish incident roster and prepare to evoke staff call in arrangements.
3. Brief ISS Divisional Director on incident intent.
4. Review food and non-food stock holdings and liaise with suppliers.
5. Provide incident continuity plan to sustain the response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from Head of Facilities or Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Establish the following ISS managerial posts and brief each on their responsibilities:
    a. ISS Logistic Manager for:
        i. Security and Security Reception.
        ii. Portering.
        iii. Laundry - including off site linen at Ormskirk.
        iv. Medical gas supply.
        v. Car parking and external cordons.
    b. ISS Domestic Manager for:
        i. Catering – Patient Catering. Courtyard Bistro restaurant, briefing/holding rooms catering as required.
        ii. Cleaning – Wards and public areas. Improvised treatment areas as required.
5. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
6. Implement shift rosters for efficient utilisation of staff labour.
7. Liaise with:
    a. The ISS Divisional Director.
    b. Key suppliers/agency.
8. Report any difficulty in maintaining services in any areas to the Head of Facilities.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 030 - ISS Logistics Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Support the Head of Facilities/ISS General Manager.
2. Co-ordination of the ISS Logistics incident response.

Incident Standby

1. Work with the ISS General Manager to estimate potential number of patients and additional staffing and resource requirements.
2. Establish logistics staff roster and prepare to evoke staff call in arrangements.
3. Review current logistics stock holdings.
4. Provide a logistics continuity plan to sustain the service response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from Head of Facilities or Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Ensure that the following posts are filled and that they are aware of their tasks:
    a. Security and Security Reception.
    b. Portering.
    c. Laundry - including off site linen at Ormskirk.
    d. Medical gas supply.
    e. Car parking and cordon control.
5. If not, appoint suitably senior members of staff as necessary until key personnel arrive.
6. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
7. Ensure that shift systems are instituted as soon as possible to enable staff to get maximum rest.
8. Report any difficulty in maintaining services in any areas to the ISS General Manager/Head of Facilities.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 031 - ISS Security Supervisor/Officer (In and Out of hours).

Location: Security Reception

Role Description:

1. Support the ISS Logistics Manager/ISS General Manager.
2. Co-ordination of the Security response.

Incident Standby

1. Work with the Head of Facilities/Incident Commander to estimate security response and additional security and service staff call in.
2. Work with the ISS Logistics Manager/ ISS General Manager to establish rotas and call in arrangements for staff.
3. Prepare reception to accept incident response.
4. Prepare to setup and maintain car parking and cordon areas
5. Locate and check Major Incident equipment box and check communication radios.

Incident declared

1. Alert ISS Logistic Manager/ISS General Manager of the Major Incident activation.
2. Ensure high visibility ISS Security vest are worn by all staff at all times
3. Evoke 'lock-down' of The Walton Centre Main Building and Sid Watkins Building and ensure
4. Evoke incident immediate staff call-in.
5. Deploy radios and relevant keys to Outpatients and meet Bleep Holder.
6. If Out of Hours, open the staff rear entrance and Link Bridge.
7. Cordon and secure car parking for arriving emergency vehicles.
8. Assess traffic problems within the hospital and take any necessary action.
9. Liaise with the Police regarding traffic control on the approach routes to the hospital.
10. Assess the parking situation within the hospital and in the visitors' car park, and take any necessary action.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Guards

1. Ensure full uniform with jacket is worn at all times.
2. Assume traffic duty at main road entrance.
3. Admit only essential staff with Identity Badges (in the event staff cannot be verified escalate to Logistics Manager).
4. Advise security control of parking availability.
5. Advise On-Call staff on arrival of parking availability.
6. Staff arriving without identification badges must not be allowed access.
7. Keep Radio traffic to a minimum.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 032 - ISS Domestic Services Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Provide ISS Managerial support to the ISS General Manager/Head of Facilities.
2. Co-ordinate the ISS Catering and domestic cleaning response.

Incident Standby

1. Work with the ISS General Manager to estimate potential number of patients and additional staffing and resource requirements.
2. Establish catering staff roster and prepare to evoke staff call in arrangements.
3. Review current catering and non-food stock holdings and liaise with suppliers to sustain catering throughout.
4. Provide a catering and cleaning continuity plan to support the response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from the ISS General Manager or Head of Facilities.
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Ensure that the following posts are filled and that they are aware of their tasks:
    a. Housekeepers/cleaning staff.
    b. Catering.
5. If not, appoint suitably senior members of staff as necessary until key personnel arrive.
6. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
7. Ensure that shift systems are instituted as soon as possible to enable staff to get maximum rest.

Cleaning (Supervisor)

1. Obtain briefing from ISS Domestic Manager/ISS General Manager following Incident activation on catering requirements.
2. Evoke staff call in.
3. Prepare incident period catering rosters.
4. Check stock holding and plan contingency feeding for the advised period.
5. Liaise with suppliers for food non-food resources
6. Coordinate the service of meals for patients and staff and adhoc requirements for briefing holding rooms.
7. Attend operational briefings with ISS Domestic Services Manager.

Catering

1. Assess the likely initial catering requirements and the current capabilities.

2. Liaise with the Senior Nurse/Manager regarding any immediate catering requirements.
3. Liaise with the Volunteer Co-ordinator regarding the use of Volunteers to assist in the Catering department.
4. If necessary institute a shift system to provide 24 hour staffing at the required level.
5. Prepare drinks and snacks for the following areas:
    a. Discharge area.
    b. Outpatients.
    c. Briefing/holding rooms as required
6. Catering requirements of staff involved in the Major Incident Response e.g. consider open catering if required.
7. Catering requirements as dictated by the Head of Facilities/ISS General Manager.
8. Maintenance of the catering for non-major Incident patients.
9. Ensure all communication is documented.
10. Attend Operational debriefing from ISS General Manager.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the ISS General Manager.
2. Join the Trust hot debrief.

ACTION CARD 033 - Records Manager

Location: **Records Department**

Role Description:

1. To provide case notes for incoming major incident patients.
2. To support wards and departments.

Incident Standby

1. Report to the incident Control Room in the Boardroom for further instructions

Incident declared

1. Alert all staff to Major Incident.
2. Work with divisions to support the evacuation of the whole of the OPD.
3. Allocate staff from medical records to support Wards.
4. Assist with re location of existing in patients and relatives from Wards to the Outpatients department.
5. Ensure that all Clinic lists are taken to major incident room.
6. Work with PAC/division to cancel clinics if appropriate either via telephone or posting out cancellation letters.
7. Allocate appropriate staff to all other tasks and duties working with division.
8. Work with ward clerks and IT to initiate colour coding system on PAS to identify major incident patients if deemed necessary.
9. In the event of system outage, emergency packs located in Medical Records office (above TCI shelf) would be used.
10. Report any issues to Tactical Commander.
11. Ensure all communication is documented.
12. Attend Operational debriefing.
13. Ensure all case notes are returned to the Health Records department.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 034 - Pharmacy

Job Title: **Pharmacist - out of hours**

Location: **Pharmacy Office or within Aintree Pharmacy**

NOTE:

Pharmacy services are provided to the Walton Centre by a Service Level Agreement by Aintree University Hospital (AUH). If a mass casualty incident occurs, it is likely that there will be pharmacy needs for both Hospitals (Pharmacy have a bespoke Major Civilian Disaster Procedure).

The Tactical Commander/Surgical Commander will liaise with Aintree's incident Control Room to discuss the immediate requirements until sufficient numbers of pharmacy staff can be deployed.

Role Description:

1. To support discharge rounds with Consultant Neurosurgeon or Neurologist.
2. To prepare TTOs for discharge patients.

Incident Standby

1. If the incident affects Aintree, Pharmacy will already have been alerted via AUH major incident pathways.
2. If not, bleep the on call pharmacist via Aintree switchboard.
3. Liaise with the on call or senior pharmacist regarding the Walton Centre's needs, this may include extra stocks, dispensing of discharge prescription or clinical advice

Incident declared

1. The senior pharmacist on duty will determine what services can be offered or personnel made available depending on the local situation and staffing available.
2. Pharmacist to attend the Theatre Seminar Room and assist the Discharge Consultant and team.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 035 - Local Security Management Specialist

Role Description:

1. To provide advice to the Tactical and Strategic Commanders in relation to security management and lock down arrangements.

Incident Standby

1. Report to the incident Control Room in the Boardroom for further instructions.

Incident declared

1. To provide competent security management advice to:
    a. Incident commanders;
    b. Head of Facilities;
    c. ISS General Manager.
2. Liaise with Aintree Hospital LSMS in the event of a major trauma incident or site incident e.g. bomb threat etc.
3. In the event of a Lock Down, the LSMS has devised a Lockdown Procedure based on locking down key areas e.g. Main entrances or individual specific e.g. departmental access & egress. See **ACTION CARDS 036 and 037 below**.

1. Liaise with Police, Counter Terrorism Support Agency (CTSA) or Explosive Ordnance Disposal (Army Bomb Disposal).
2. Report any issues to Tactical Commander.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

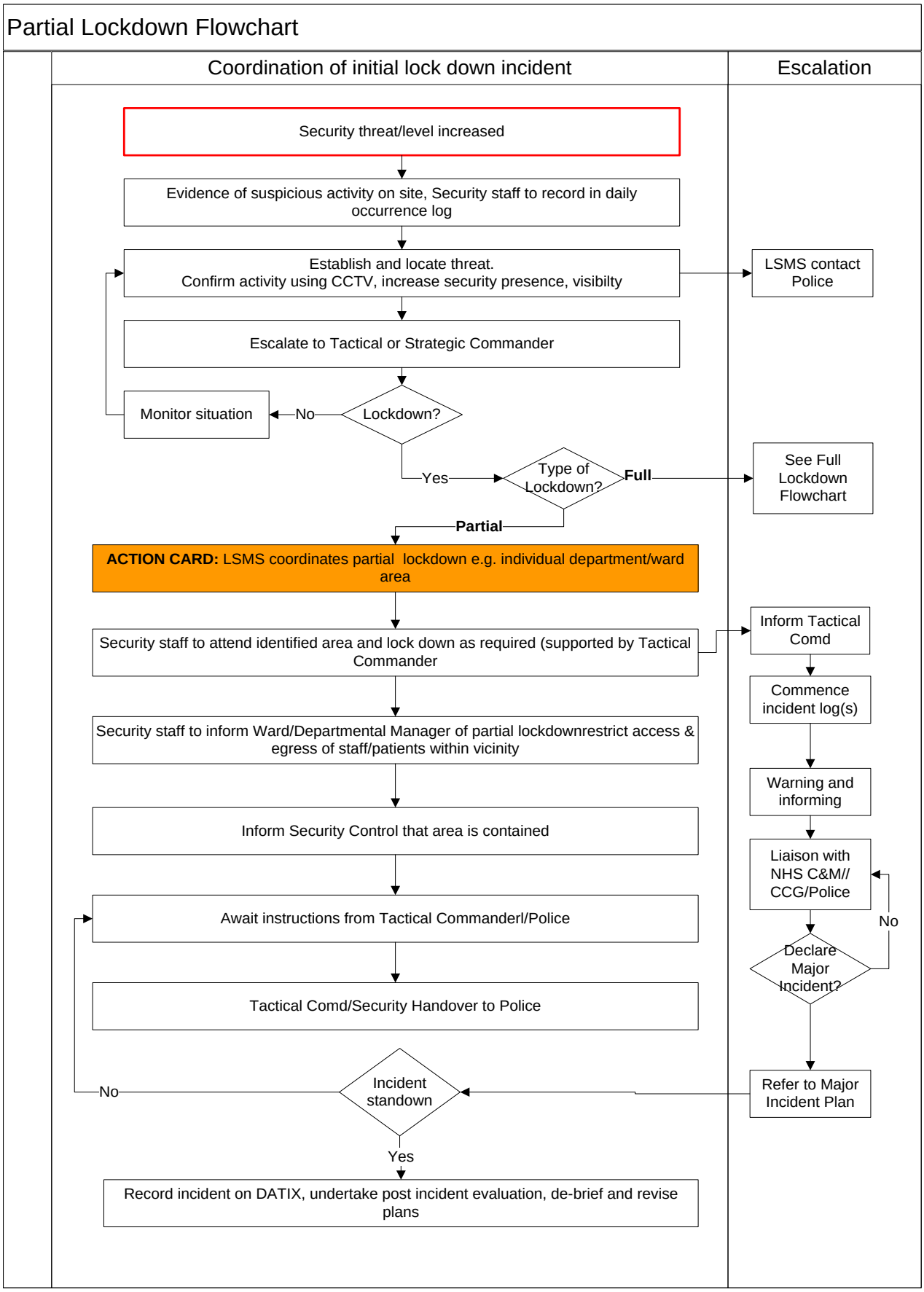
Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

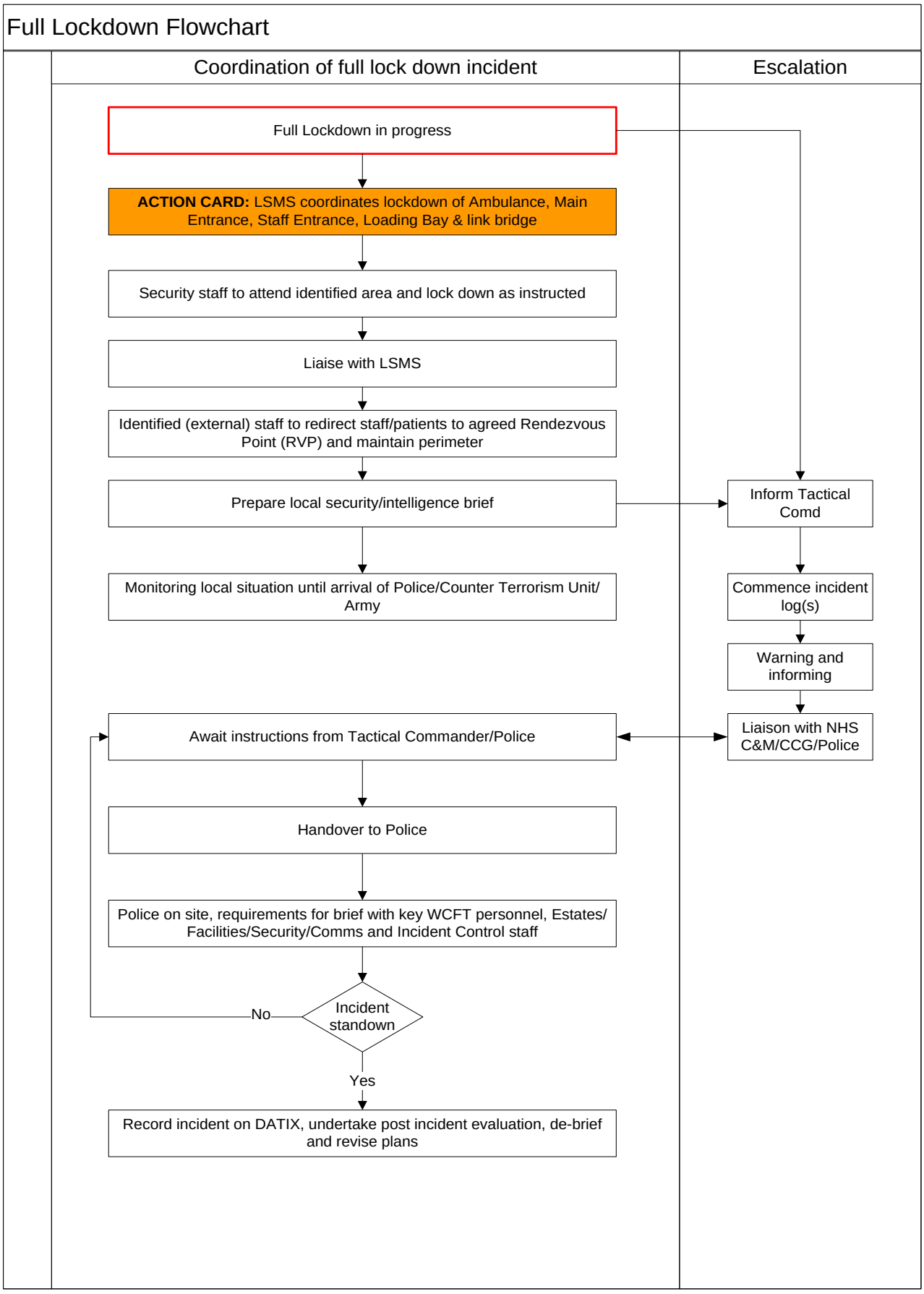
Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 036 - Lockdown procedure (partial)



ACTION CARD 037 - Lockdown procedure (Full)



ACTION CARD 038 - List of Red Phones (Resilient Network)

Walton Centre Main Building:

All phones are standard analogue.

Sid Watkins Building (SWB):

All phones in the SWB are MITEL VOIP.

The following phone numbers in the table below are analogue emergency phones. All numbers have the prefix 529

No:		Ext no:	Department:	Site:	Floor:	Notes:
1	4245	5385	Boardroom	W	2	Diverted to Outcomes Office
2		4245	Executive Offices	W	2	No dial tone
3		8292	Main Reception	W	G	No phone in place
4		6236	Main Reception SWB	SWB	G	
5		8261	Cairns	W	1	
6		8321	Caton	W	1	
7		8262	Chavasse (Left)	W	1	
8		4241	Chavasse (Right)	W	1	
9		6207	CRU Nurse station (Green)	SWB	G	
10		6208	CRU Nurse station (Purple)	SWB	G	
11		5380	Dott	W	1	No phone in place
12		5946	Estates Plantroom	W	3	
13		5010	IT Copy Room	SWB	2	Requires labelling
14		4455	ITU Nurse base	W	G	
15		8301	ITU Modular	W	1	
17		5382	Jefferson	W	G	Requires labelling
19		5381	Lipton	W	1	
20		5236	Mersey Care Nurse Base	SWB	1	
21	8276	8274	N/Physiology	W	1	
22	5404	8293	OPD Main	W	G	
23		6259	OPD SWB	SWB	G	
24		6352	PMP Meeting Room	SWB	1	No ringer
25		5383	Radiology MR	W	G	
26		5538	Radiology Reception	W	G	
27		5941	Radiology Room 2			
28		6236	Reception Desk	SWB	G	
30		6257	Security Office	SWB	G	
31		5388	Secretaries Kitchen	W	2	
32		8276	Sherrington	W	1	
33		8268	Sutcliffe Kerr	W	2	
34		6383	T&D Copy Room	SWB	2	Requires labelling
35		6407	T&D Lecture Theatre	SWB	2	No ringer/requires labelling
36		8295	Theatre reception	W	G	Not working, needs labelling

SECTION 2 - MAJOR INCIDENT PLAN

1. Introduction

The Walton Centre is unique to the NHS in that it is the only specialist Neurosciences Trust in the UK. The catchment population is over 3.5 million and is drawn from Merseyside Cheshire, part of Lancashire and Greater Manchester, the Isle of Man and North Wales. The Trust treats patients with trauma, spinal tumours, spontaneous intracranial haemorrhage, epilepsy, multiple sclerosis, brain tumours, Parkinson's disease, stroke, cancer, chronic pain and other neurological diseases.

This Major Incident Plan (MIP) has been established to provide an incident response structure, underpinned with documented procedures, supported by management with the authority and necessary competence to manage a disruptive event such as a major emergency, regardless of its cause.

The Walton Centre NHS Foundation Trust (WCFT) is classed as a **Category 1 Responder** under the Civil Contingencies Act 2004 (CCA) and has a duty to produce and review its emergency and business continuity plans in the light of emerging local, regional and national guidance.

This plan has been developed within a context of achieving multi-agency working across Merseyside which includes emergency services, NHS services, local authority departments and voluntary organisations.

The NHS service-wide objective for Emergency Preparedness, Resilience and Response (EPRR) is to ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, and minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.

1.1. Core standards

1.1.1 The minimum core standards, which NHS organisations and providers of NHS funded care must meet, are set out in the NHS England Core Standards for EPRR. These standards are in accordance with the Civil Contingencies Act 2004, the Health and Social Care Act 2012, the NHS England planning framework ('Everyone Counts: Planning for Patients') and the NHS standard contract.

1.1.2 NHS organisations and providers of NHS funded care must:

- nominate an accountable emergency officer who will be responsible for EPRR;
- contribute to area planning for EPRR through local health resilience partnerships;
- contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents
- reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys, they must be made through the organisations' formal reporting structures;
- have suitable, up to date incident response plans which set out how they plan for, respond to and recover from significant incidents and emergencies, the plans should fulfil the testing schedule as detailed in the CCA 2004;
- have suitably trained, competent staff and the right facilities (incident coordination centres) available round the clock to effectively manage a major incident or emergency;

- share their resources as required to respond to a major incident or emergency

1.2. Business Continuity

1.2.1 The CCA 2004 places a statutory duty on organisations to develop a comprehensive approach to business continuity.

1.2.2 The aim of business continuity planning is to enable planning and reaction in a coordinated manner to ensure that services can be maintained at the highest level for as long as possible whatever might happen to the infrastructure. There is a range of problems that might affect services, for example loss of water or power, flooding or criminal activity. A business continuity event is any incident requiring the implementation of special arrangements to maintain or restore services.

1.2.3 It is the role of the Chief Executive, or nominated deputy, to ensure business continuity is maintained wherever possible during a declared major incident, and to return to normal working as soon as possible after the event. This will form part of the collective tasks of the Major Incident Team. Business continuity planning enhances the Trust's ability to withstand the effects of potential widespread disruption as a result of an unpredictable event(s).

1.3. Purpose

This policy is part of a suite of emergency plans which provide a framework to enable effective and co-ordinated planning and response to any incident *up to and including* a Major or Catastrophic Incident as defined by the Civil Contingencies Act 2004 and follows the NHS Emergency Planning Resilience & Response Framework 2013 and other relevant guidance (see bibliography). All Major Incident planning is carried out in consultation, coordination and cooperation with partner agencies such as:

- Other hospital trusts
- ISS, Health Informatics Systems, Contractors and suppliers, e.g. Synergy
- The NHS England Merseyside Area Team
- Cheshire & Merseyside Commissioning Support Unit
- Public Health England Cheshire & Merseyside Team
- NHS North of England
- Department of Health (DH)
- North West Ambulance Service (NWAS)
- Liverpool & Sefton Clinical Commissioning Group
- other Merseyside community health providers
- other acute hospitals,
- Mersey Care NHS Trust & local Specialist Trusts
- Merseyside Police
- Merseyside Fire & Rescue Service (MFRS)
- Voluntary agencies under the **UNITY Protocol**
- Utilities companies (United Utilities, Scottish Power, National Grid Gas)

2. Scope

This plan covers incidents up to and including the following three categories of Major Incident:

- a Major, Mass or Catastrophic Incident which affects the local community (i.e. within the footprint of the Trust which as a Tertiary Centre Hospital provides services across Merseyside, parts of Cheshire, West Lancashire, North Wales and the Isle of Man)
- a Major Incident which affects the health services in Merseyside
- a Major Incident which threatens the continuity of critical Trust services and requires the invocation of the Trust Business Continuity Plans and other Contractors'

Business Continuity plans (ISS, Informatics, local NHS providers and NHS Supplies, etc.

This plan should be read in conjunction with Departmental/ Ward Business Continuity Plans which cover the risk assessment process, identification of critical functions, alerting arrangements, activation of staff and resources and incident management of an internal Major Incident.

3. Definitions

3.1. Emergency - The Civil Contingencies Act 2004 defines an emergency as - 'An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, all war or terrorism which threatens serious damage to the security of the UK.' For the NHS, *'major incident'* is the term commonly used. With the implementation of the Civil Contingencies Act, the term 'emergency' may be used by other organisations instead of 'incident'. However, the NHS continues to use the term 'major incident' to avoid confusion with other elements of the services provided.

3.2. Major Incident - NHS definition is 'Any occurrence, which presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or Clinical Commissioning Groups (CCG).'

3.3. Major Incident standard messages - the four categorisations will be used for all major or potential major incidents whether multi-agency or internal within the Trust are:

- **Major incident - standby -** This alerts the NHS that a major incident may need to be declared. Major incident standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang' or 'rising tide'.
- **Major incident declared -** activate plan - this alerts the NHS of the need to activate its plans and mobilise additional resources
- **Major Incident cancelled -** this message cancels either of the first two messages at any time.
- **Major Incident Stand Down -** all receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route.

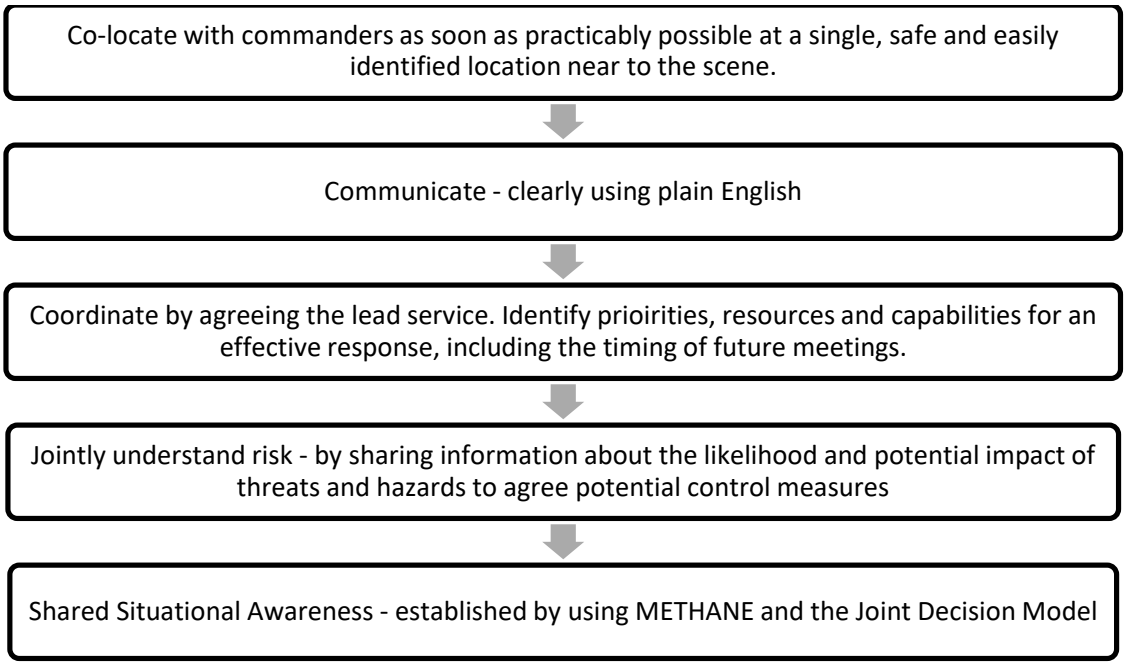
3.3.1 While ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each NHS organisation to assess their own organisation's appropriateness to stand down.

3.4. The Joint Emergency Services Interoperability Programme (JESIP)

3.4.1 JESIP was established in 2012 to address the recommendations and findings from a number of major incident reports.

3.4.2 Principles for joint working. Commanders arriving at the scene take too long or don't make contact with commanders from the others services. This leads to poor information sharing, lack of communication and no joint understanding of the unfolding emergency

3.4.3 The Five Principles of JESIP are:



3.4.4 If the principles are followed then the result should be a jointly agreed working strategy where all parties understand what is going to happen when and by who, this strategy should include:

- What are the aims and objectives to be achieved?
- Who by – police, fire, ambulance and partner organisations?
- When – timescales, deadlines and milestones
- Where – what locations?
- Why – what is the rationale? Is this consistent with the overall strategic aims and objectives?
- How are these tasks going to be achieved?
- For the Joint Decision Model see http://www.jesip.org.uk/joint-decision-model

3.5. The Scale of a Major Incident in the NHS

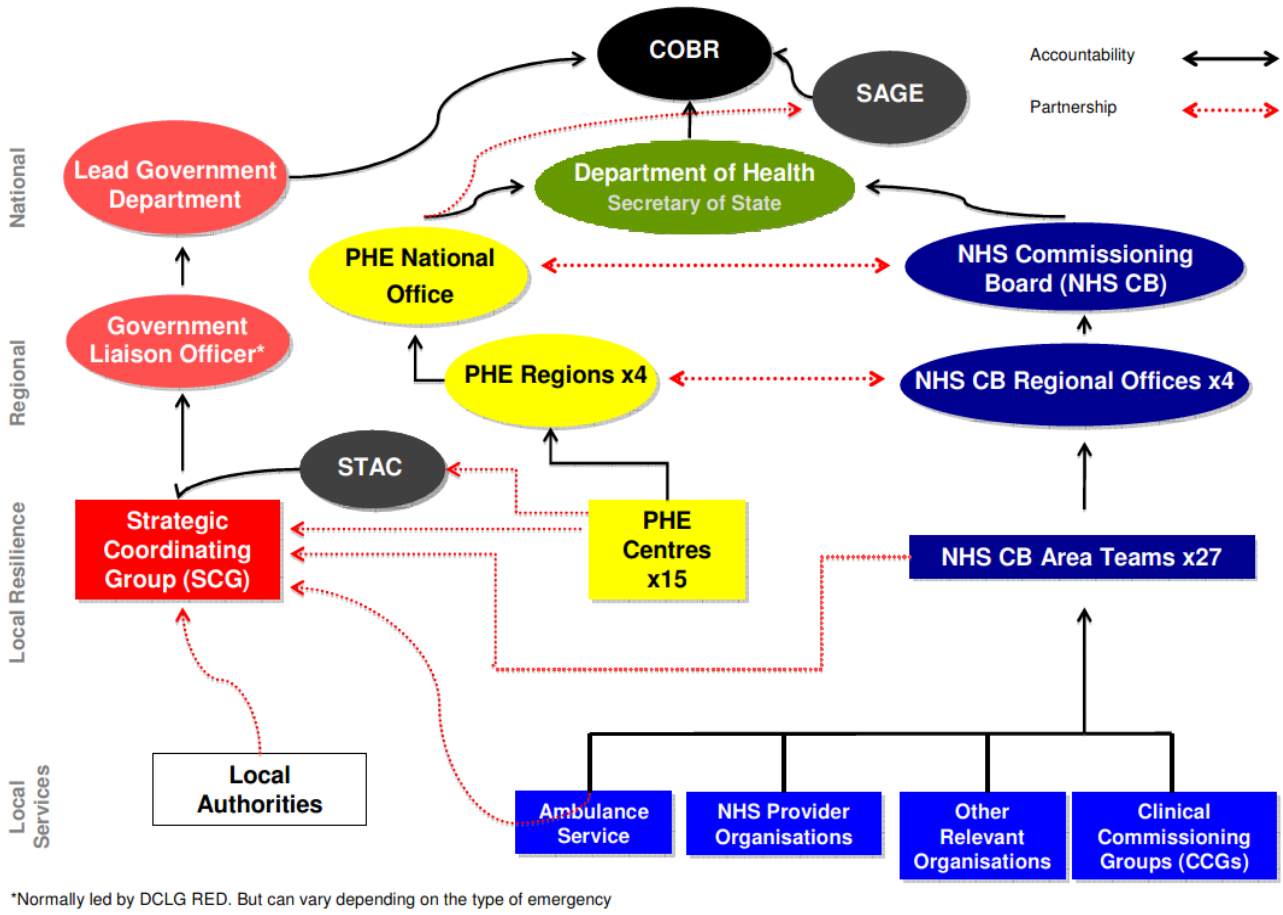
NHS organisations are accustomed to normal fluctuations in daily demand for services. Whist at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation policies. The levels of incident for which NHS organisations are required to develop emergency preparedness arrangements are:

- **Major** – individual ambulance trusts and acute trusts are well versed in handling incidents such as multi-vehicle motorway crashes within the long established major incident plans. More patients will be dealt with, probably faster and with fewer resources than usual but it is possible to maintain the usual levels of service.
- **Mass** – much larger-scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility (for example, because of fire or contamination) or persistent disruption over many days. These will require a collective response by several or many neighbouring trusts.
- **Catastrophic** – events of potentially catastrophic proportions that severely disrupt health and social care and other functions (for example, mass casualties, power, water, etc) and that exceed even collective local capability within the NHS.

In addition, there are pre-planned major events that require planning for. Although not formally described, there may be events occurring on a national scale, for example fuel

strikes, pandemic or multiple events that require the collective capability of the NHS nationally.

3.6. Overview of National Emergency Structure



*Normally led by DCLG RED. But can vary depending on the type of emergency

3.7. MERM - Merseyside Emergency Response Manual

3.7.1 The aim of this Merseyside Resilience Forum (MRF) Manual is to set out the response arrangements of agencies who are Category 1 and 2 Responders, as defined in the Civil Contingencies Act 2004 (CCA), to an emergency or other incident that requires multi-agency co-ordination at any one or any combination of Operational, Tactical and Strategic levels.

4. Duties

4.1. The Trust

The Trust is a specialist Neurosciences Trust and has a specific role as a partner within the Merseyside Trauma Network to:

- fulfil the requirements as ***a Category 1 Responder*** under the Civil Contingencies Act
- implement national policy and guidance in the local context
- ensure that the Trust's own escalation plans for dealing with pressures recognises the higher-level requirements of a Major Incident including suspension of non-emergency work
- demonstrate a high level of preparedness and plan in conjunction with local NHS partners, local partners in the independent healthcare and staffing sector and external multi-agency partners (including the emergency services, local authorities and voluntary agencies)

- establish and maintain working relationships with other NHS partners, emergency services, local authorities, local major organisations and other key stakeholders
- train and exercise as an organisation with all partners to an agreed schedule in agreement with the Local Resilience Forum (LRF)
- develop a command and control structure that allows appropriate linkages to local resilience arrangements including operational (NHS Bronze) command
- participate in Merseyside, North West emergency planning forums
- be accountable to NHS North of England (NHS NE) via NHS Merseyside Resilience
- implement national policy and guidance in the local context
- develop contingency plans for business continuity in the event of a protracted incident or failure of utilities and supplies
- take into account the needs of vulnerable groups of patients whose treatment may need to continue despite a major incident being in progress. This is particularly important in the event of a sustained major incident (see Trust Business Continuity Plan)

4.2. Resilience Planning Group is responsible for:

- ensuring the major incident plan remains appropriate for the currently identified risks to the organisation, that appropriate training is provided for relevant staff, and for reviewing and updating the policy and procedure on a bi-annual basis
- ensuring that the annual work programme is developed and reviewed in the light both emerging internal and external risks linked to the Community Risk Register (See 5.1 below)
- reviewing, testing and updating the Trust's Major Incident and Business Continuity plans. This includes development of a training programme that meets national requirements, ensuring that lessons are learnt from exercises and incidents, and that appropriate major incident reports are produced for the Board
- ensuring divisions and services are represented at this forum
- providing the Business & Performance Committee with regular assurances that Emergency Planning and Business Continuity Management (BCM) is embedded within the trust

4.3. Chief Executive is responsible for ensuring:

- that the Trust has a Major Incident Plan that is built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing
- this plan has been tested in accordance with Department of Health Guidance and reviewed regularly
- the Board receives regular reports, at least annually, regarding emergency preparedness including reports on exercises, training and testing undertaken by the Trust, and that appropriate resources are made available to allow discharge of these responsibilities
- the declaration of a major incident, and stand down. The Chief Executive will determine the most appropriate members of the Major Incident Team, which will be based at a pre-determined location (i.e. Trust Boardroom or at a more appropriate venue depending on the circumstances of the incident)

4.4. Director of Strategy & Planning

This director is the Trust Accountable Emergency Officer (AEO) and has been designated to:

- take responsibility for emergency preparedness as the designated Accountable Emergency Officer; this includes attendance at the Merseyside Local Health Resilience Partnership (LHRP)

- ensure that the trust has identified funding streams in advance in order to support an incident response e.g. for additional staffing, call off orders, equipment suppliers
- ensure that there are arrangements for timely legal advice, in the event of a business disruption or the requirement for interpretation of specific statute e.g. HSWA 1974, CCA 2004 etc
- ensure that an Annual Resilience Report has been completed and reported to the Board/Committee of the Board and interested parties e.g. governors, commissioners etc
- establish and maintain:
  - an on-call rota for Executives and Senior Managers
  - a 24 hour switchboard facility (maintained via AUH)
  - a bleep system that responds to the switchboard
  - a key contact list for Execs & senior managers On-call
  - ensure there is an internal communications test between operation and strategic by way of a twice yearly test

4.5. Finance Director

4.5.1 Finances - if warranted when responding to an emergency situation, a separate cost centre will be set up in agreement with the Director of Finance.

4.6. Executive Directors

It is recognized that there are a number of scenarios that will require leadership to be delegated to any specific Executive Director e.g. for Clinical Incidents the Director of Operations and Nursing etc.

4.7. Head of Risk

The Accountable Emergency Officer is supported by the Head of Risk who will:

- provide advice for emergency and business continuity planning
- deputise in the absence of the AEO at the LHRP Strategic and Trust Resilience Planning Group meetings
- fulfil the role of competent lead for Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity within the Trust
- is the point of contact with other health and social care partners and attends Merseyside Health Resilience Group meetings in the capacity of WCFT Emergency Planning Lead
- will liaise with partner organisations (including the Trauma Collaborative Network) to share planning information in order to ensure that documentation is accurate
- will review the contents of EPRR documentation in order to ensure this plan is reflective of strategic partners

4.8. On Call system

The Trust has an established on-call system mirroring the command and control structure. Clinical, non-clinical managers and Directors are included in a weekly rota covering both in hours and out of hours. In the event of a significant disruption these arrangements will be reviewed to ensure effectiveness. The on-call system is reviewed at least annually or in the event of a significant organisational change.

4.9. External Emergency Planning forums:

4.9.1 Merseyside NHS Emergency Planning Forums

- Merseyside Local Health Resilience Partnership (LHRP) Secretariat hosts, chairs and administrates the Merseyside LHRP at the NHS England Area Team offices in Regatta Place, Liverpool. This forum comprises the emergency planning Executive

leads from all local NHS bodies including commissioners, Public Health England and other agencies (e.g., emergency services, local authorities and voluntary agencies)
- the LHRP ensures that key priorities from joint working with the MRF are reviewed, discussed and agreed

4.9.2 Merseyside NHS Health Resilience sub groups

- the Merseyside Local Health Resilience Partnership Practitioners (LHRPP) is the NHS emergency planning practitioners' forum, this forum is chaired by the Cheshire & Merseyside Commissioning Support Unit (CSU) and hosted and administered by the LHRP Secretariat
- the Trusts RSM attends Merseyside Local Health Resilience Partnership (LHRP) Practitioners (LHRP-P) meetings and other sub groups and working groups under the LHRPP and the Merseyside Local Resilience Forum, as required

4.9.3 Merseyside (Local) Resilience Forum (MRF)

- the NHS England Area Team Exec Lead for emergency planning represents the local NHS economy at the Merseyside Resilience Forum (strategic multi agency forum chaired by Merseyside Police)
- NHS England Resilience Officer represents the NHS economy at the MRF General Working Group which is the joint tactical forum of the MRF
- other NHS Emergency Planning officers take on NHS representation at Merseyside Resilience Forum sub groups also and report back to the HRG with any issues

4.9.4 Informal Emergency Planning Network and Liaison Meetings

- The Civil Contingencies Act and regulations specify that emergency planning practitioners must interact, liaise and network regularly both formally and informally. They must share information and good practice and support all partner agencies (not just NHS) and take part in training and exercising in each other's organisations to ensure properly integrated and consistent, coordinated emergency management and planning and effective mutual aid

5. Inputs into Major Incident Planning

5.1. Community Risk Register (external)

The ***Merseyside Resilience Forum (MRF)*** has a number of multi agency sub groups including the Risk Assessment Group (chaired by the Fire & Rescue Service) which meets regularly and has drawn up the ***Community Risk Register*** for the County. This is based on hazard mapping of the County area and potential risks that may require a coordinated major incident response. The model of risk assessment used is the Australian Emergency Management model and is heavily weighted by the impact analysis of each risk. Disasters, thankfully, do not occur very often but their impact can be catastrophic, so the likelihood criteria used by most insurance companies is less applicable to emergency management risk assessment. To see the Local Community Risk Register click here.

5.2. External Incidents potentially affecting the Trust[1]

Transport Hazards

- Loss of cover due to industrial action by workers providing a service critical to the preservation of life (such as emergency service workers)

[1] Source Merseyside Community Risk Register

- Emergency services: loss of emergency fire and rescue cover because of industrial action
- Significant or perceived significant constraint on the supply of fuel at filling stations e.g. industrial action by contract drivers for fuel, refinery staff, or effective fuel blockades at key refineries / terminals by protestors, due to the price of fuel
- Unofficial strike action by prison officers
- Industrial action by key Rail workers

5.3. Human Health

The following risks have the potential for a severe to catastrophic impact in terms of disruption, damage to the built and natural environment, large scale numbers of casualties and deaths:

- Influenza type disease (pandemic)
- Major outbreak of a new or emerging infectious disease
- Localised legionella / meningitis outbreak

5.4. Industrial Technical Failure

- Technical failure of a critical upstream oil/gas facility, gas import pipeline terminal, or Liquefied Natural Gas (LNG) import reception facility leading to a disruption in upstream oil and gas production
- Failure of water infrastructure or loss of drinking water
- No notice loss of significant telecommunications infrastructure in a localised incident such as a fire, flood or gas incident
- Technical failure of national electricity network
- Technical failure of electricity network due to operational error or bad weather causing damage to the system

5.5. Risk Assessment & Hazard Mapping (internal)

Risk issues will be managed in the first instance via Incident Logs and then transposed onto DATIX Risk Register at the first available time post incident.

5.6. Planning for risks

Emergency plans are prepared on the foundation of risk assessment including hazard mapping and coordinated multi agency response required for expected impacts of an event. Risks identified (internal and external) during the planning process, exercise, or incident debriefs and are placed on the risk register for the affected ward/ department.

5.7. Trust Risk Register

Trust wide risks can be recorded on the Trust Risk register using the Datix System and will be managed in line with the Trusts Risk Management Policy and underpinning Departmental Risk Protocols.

Emergency Planning and Business Continuity risks are identified on departmental and ward risk registers which are scrutinised as part of the overall Trust governance arrangements, which then gives assurance to the Board and the Quality Committee (board sub-committee) regarding the management of the risks.

5.8. Business Continuity Risks (identified from Business Impact Analysis [BIA])

Every department in the Trust has specific business continuity plans and has carried out a Business Impact Analysis. BIAs are entered on the Datix system and Ward and Department managers are be responsible for managing and Directorate Managers being accountable for them.

6. Activation Emergency Roles

The following roles are identified within the action cards above:

- Chief Executive/Director in Charge - Strategic Commander
- Staff supporting the Tactical Commander,
- Operational Command Team
- Switchboard staff and Control Room staff (including loggists)

Note: These documents contain sensitive information so are only distributed to the staff undertaking these emergency roles but can be requested from the Head of Risk by email to tom.fitzpatrick@thewaltoncentre.nhs.uk

6.1. Major Incident Board

A Major Incident white board is now available for use in the Board Room which allows for ease of writing changing bed states and number of casualties expected. The board can be used to document changing events as the incident progresses but should not be used to replace a timed, hand written log.

6.2. Major Incident Log Book

During the major incident and immediately afterwards it is essential that a suitably trained “loggist” is allocated to record all agreed major decisions taken within the Incident Control Room in the ‘official log book’ which will need to be established and maintained by the loggist.

The designated Senior Manager in charge of the incident room will be required to collate incident logs after the event. These in turn will be submitted to the Resilience & Safety Manager who will prepare and submit a report to the next available RPG.

7. External Declaration

A Major Incident can be declared externally by either NWAS or via the Major Incident Command Structure by NHS England Area Team NHS Tactical (Silver) Command or NHS Strategic (Gold) Command.

The NHS England Merseyside Area Team will support these commanders by establishing an NHS Silver/ Gold Command in their headquarters. Trusts and other providers will report to and obtain instructions and intelligence from this Command Centre when reacting to a Major Incident. An external declaration is most likely in a Mass Casualty event involving a number of Receiving Hospitals (and all other partner agencies) or an event that affects a number of agencies (not necessarily NHS).

8. Mutual Aid/Support & Capacity Management

8.1.1 Mutual Aid can be defined as an arrangement between Category one and two responders, other organisations not covered by the CCA 2004, within the same sector or across sectors and across boundaries, to provide assistance with additional resource during any incident that may overwhelm the resources of a single organisation. The NHS England (Merseyside) will be responsible for the co-ordination and implementation of mutual aid requests during a major incident, significant incident or emergency.

8.1.2 Events involving Trauma may involve support from/to the Trauma Network and Critical Care Network. (Trauma and critical care leads use these contact details frequently and will activate the arrangements for their services). Mutual aid can be arranged by:

- The local Public Health Departments will provide advice and support on public health and epidemiological issues. The Scientific & Technical Advisory Cell provides advice to NHS Gold command but can be accessed via the command structure once in place
- ***Public Health England (PHE)*** Cheshire & Mersey Unit on call Duty Officer can access and provide advice on hazardous material ***(HAZMAT)*** and ***CBRNe*** issues.
- Assistance from Local Authority Social Care Departments with accelerated and early discharge.
- Inform the ***NHS Bronze Command*** of any safe, secured or protected routes for staff called in, as advised by fire, police or military.
- Request assistance from the voluntary agencies under the ***UNITY Protocol*** (***primacy*** agency British Red Cross) for help with general humanitarian assistance.
- NHS Gold Command co-ordinate the Merseyside NHS strategic response to major incidents for the County and can provide county and regional resources (via NHS England North of England) as required.

8.2. Mass Casualties

8.2.1 NHS Merseyside has in place a (interim) Mass Casualties Plan which describes the arrangements agreed by Merseyside LHRP as part of a multi-agency response to a mass casualty incident arising from a sudden, focal, time-limited event - such as a rail / plane crash, an explosion or a terrorist attack - which overwhelms normal local response capabilities.

8.2.2 The incident may occur outside of Merseyside, but may still require Merseyside's resources to be utilised.

8.2.3 The objectives of this plan are to:

- provide an overview of the mechanisms available to deliver the local response in the event of a mass casualty incident
- explain how these mechanisms can be activated
- describe command and control within across NHS organisations and other co-ordination arrangements within Merseyside for a mass casualty incident, and;
- provide an overview of the roles and responsibilities of individual agencies involved in a response to a mass casualty incident

NHS NW Criitical Care Contingency pla

9. Communications & sharing information

9.1. Staff Communications

The Communications Team will ensure that staff and managers are made aware of progress in a major incident and issue urgent global emails and leaflets, posters etc as appropriate.

9.2. Major Incident Communications (NHS Bronze Command)

The Communications Team will be present in the Bronze Control Room and the Head of the Team will be part of the Command Team.

9.3. Media Communications

The Trust Communications Team will provide a point of contact for the media and will provide bulletins and press statements for issues affecting the Trust after first discussing the matter with the NHS Gold Communications team if it has been set up,

according to the ***Merseyside Press & Media Protocol***. This process will also be used for messages on health advice to the general public.

The Communications Team will brief the Trust's spokespersons before interviews and deal with the press on behalf of the Trust. Trust spokespersons will be media trained Execs (usually the Medical Director) or appropriately trained Senior Managers.

They will work together with Health Informatics to produce global emails and 'ticker tape' news on the intranet, update the Trust website, and manage the Trust social networking accounts on e.g., Facebook and Twitter.

The designated ***Media Liaison Point*** for press and media interviews and briefings will be determined at the time by the Communications team.

9.4. Regional & National Incidents

In the event that the incident is regional or national level media messages will be available via NHS Gold Communications to ensure consistent messages.

9.5. Public /Local Community Communications

The Communications Team will notify the local community and the public of major events occurring or due to occur at the Trust (like live exercises) and issue leaflets, press releases, posters and letters as appropriate.

9.6. Telecommunications Plans

There are numerous means of communications that can be used in the alert and later stand down, these include:

- Bleep/pagers
- landlines
- trust mobile phones that can be used in a major Incident
- major Incident radios (via Security Staff)
- mobile phones
- satellite telephones in the Major Incident Rooms (when installed can be used by the Bronze Command Team as a fall back communications system when other methods have failed)
- runners
- email

9.7. Sharing information

9.7.1 Under the CCA 2004 local responders have a duty to share information and this is seen as a crucial element of civil protection work, underpinning all forms of co-operation.

9.7.2 The sharing of information will include, if required for the response, details of vulnerable people. The general definition of a vulnerable person is a person:

- "present or resident within an area known to local responders who, because of dependency or disability, need particular attention during incidents"

9.7.3 Sensitive data not in this plan will be made available to key Trust personnel by confidential email to relevant groups or individuals. Partner agencies and members of the public may request a sanitized copy by email from the Resilience & Safety Manager. The Trust is signed up to the Merseyside Major Incident Information Sharing Protocol.

10. Considerations during, or in the aftermath of an incident

10.1. Surge and demand - See Escalation Policy.

10.2. Counselling:

10.2.1 Staff

Access to Occupational Health support will be provided by the Trust for all staff, particularly those involved in a major incident, which will include counselling if required

10.2.2 Patients & Relatives

Those who have been involved in an incident either as victims or responders may be traumatised and suffering from shock intense anxiety and grief. Some may also need social support such as contacting family and friends, transport, finding temporary accommodation and financial assistance.

The incidence of Post-Traumatic Stress Syndrome in survivors and responders has been recognised from past experiences such as Hillsborough and the London Bombings.

Liverpool City Council is responsible for coordinating both professional and voluntary sector welfare response, particularly when people have been evacuated from their homes.

Patients and visitors may require support in the event of an incident occurring on the Trust site. Trust Chaplains, trained staff and volunteers will be able to assist but also, advice should be sought from your local GP, Mental Health Services, CCG and Liverpool City Council.

Independent support organisations and their services include:

- Local 111 provider can provide further advice and information: Tel: 111
- The Samaritans offer a 24 hour helpline for those in crisis: Tel: 08457 909090
- Disaster Action provides both support and guidance: Tel: 01483 799066
- Assist Trauma Care offer telephone counselling and support to individuals and families: Tel: 01788 560800

10.3. Staff

Responding to incidents puts staff under more pressure than normal. It is therefore vital that staff welfare issues are given a high priority. In order to achieve this, those staff with management responsibility will ensure that the following issues are continually addressed:

- the availability of food and other refreshments
- working hours (consideration will be given to extended shifts)
- rest breaks
- travel arrangements
- consideration of personal circumstances
- emotional support during and after the incident
- sleeping arrangements e.g. impacts to travel caused by adverse weather

To assist staff in the response to an incident, regular briefings will be given by senior staff, particularly at the start of a shift, or at shift changes and handovers.

10.4. Visits by VIPS

During the response to an incident or during the recovery stage, visits by VIPs can be anticipated. A Government minister may make an early visit to the scene or areas affected to mark public concern and to report to Parliament on the current situation.

Depending upon the scale of the incident, visits by members of the Royal Family and Prime Minister may take place. Local VIP visitors may include religious leaders, local MPs, mayors and local authority leaders. If foreign nationals are involved, their country's Ambassador, High Commissioner or other dignitaries may visit.

Visiting ministers and other VIPs will require comprehensive briefing before the visit and will require briefing before any meetings with the media. VIPs are likely to want to meet patients who are well enough and prepared to see them. This will be dependent upon medical advice and respect for the wishes of individual patients and their relatives.
In the case of such visits to hospitals it is common for VIP interviews to take place at the hospital entrance to cover how patients and medical staff are coping.

Merseyside Police are experienced in handling VIP visits and are likely to be involved and would be the main contact point so far as the arrangements are concerned.

The relevant Communications Manager in consultation with the Chief Executive and Medical Director is responsible for managing VIP visits.

10.5. Vulnerable People

The guidance relating to the Civil Contingencies Act 2004, Emergency Preparedness sets out the responsibilities placed on Category 1 responders to plan for and meet the needs of those who may be vulnerable in emergency situations.

The section concerning making and maintaining plans for reducing, controlling or mitigating the effects of an emergency specifically covers the vulnerable as 'people who are less able to help themselves in the circumstances of an emergency.'

The section concerning warning and informing outlines how the needs of vulnerable persons, including those who may have difficulty understanding warning and informing messages, need to be taken into consideration by those Category 1 responders responsible for communicating both pre-event and during an emergency.

Other legislation may interact with the Trust responsibilities under the Civil Contingencies Act, in particular the Disability Discrimination Act 1995 and 2005 and the Human Rights Act 2000.

The Civil Contingencies Act allows the sharing of certain information for emergency planning purposes, although sensitive information (which would include some personal data within the meaning of the Data Protection Act and patient records) needs to be subject to controls on the way it is handled, and the purposes to which it is put. The restrictions that need to be placed on sharing information at the planning stage are different from those applying in an emergency. For instance: it can be necessary to provide partner agencies like the police documentation teams with details like the name, address, age, gender and description of casualties for the good of the patient so that they can be reunited with their families from whom they have been separated by the event.

10.6. Patients

Most patients either in-patients or attending the Trust, outpatients etc in a hospital are vulnerable and their care and support in conjunction with other agencies is normal daily business.

10.7. Health & Safety

During a major incident the Trust's Health and Safety Policy will apply.

Staff will not be expected to undertake any task for which they are not trained or skilled for. All staff have the right to decline, remembering they have a duty of care for themselves and to that others.

During any response to a major incident, members of staff involved **must wear their identity badges throughout**, and those with Trust mobile phones and laptops should ensure that this equipment is available for use.

10.8. Switchboard Failure

In the event of a switchboard failure staff will utilise the designated trust issued mobile phones to ensure continuity of communications.

10.9. Pandemic Flu Planning

See Trust Pandemic Flu Plan. The Pandemic Influenza Plan is enhanced by multi agency element specific plans and 'Managing the H1N1 Flu Pandemic September 2009'. (See DoH website) and is consistent with Merseyside Pandemic Influenza Plan 2013 and the National Pandemic Influenza Plan and should be read in conjunction with the Trust's Infection Control policies (see intranet under infection control policies).

10.10. Lockdown

The LSMS has devised a Lockdown Procedure based on locking down key areas e.g., Radiology, Theatres, ICU, secure side-rooms (police incidents) or a rolling lockdown according to the exigencies of the incident concerned. See **ACTION CARDS 036 and 037 above**.

10.11. Recovery

The Trust recovery and restoration arrangements from an incident will form a vital component of the overall response. Whilst the Exec in charge is dealing with the immediate issues affecting the Trust or its partner agencies, the Chief Executive will consider the establishment of a Recovery and Restoration Team.

The Team responsibilities would involve the consequence management of the incident including the identification of issues that could continue to disrupt the services provided by the Trust.

The effective management of these consequences should provide a successful recovery and restoration process. The team would identify a strategy for the recovery and restoration stages by considering the consequences and the impact of the incident on the Trust in the immediate and longer term.

The team will consider the following issues:

- managing the return to normal service delivery
- managing the restoration of any structural damage
- consider the priority of elective services including the impact on targets

- communication with patients affected by the incident including the rebooking of cancelled appointments
- staffing levels in the immediate future
- identifying patients who require further surgical intervention
- management arrangements of beds occupied by patients decanted from other hospitals
- support of staff welfare and counselling
- re-stocking of supplies and equipment & audit issues

11. Training

11.1.1 In order to identify or maintain competencies and awareness, this is included within the Personal Development Review (PDR) process.

11.1.2 Training is provided for key staff that may be required to carry out essential tasks in response to a major incident. Staff are provided with training that ensures they understand the role they are to fulfil in the event of an incident and have the necessary competencies to fulfil that role e.g. national Occupational Standards for Civil Contingencies.

11.1.3 Training is provided on induction for all staff on general principles of EPRR and BCM. On Call managers and executive have 1:1 sessions.

11.1.4 Staff members that are likely to follow an Action Card are sent an annual reminder that cards should be reviewed if there are internal changes to process or staff structures. Staff are also be given the opportunity to participate in NHS and multi-agency exercises.

12. Monitoring

12.1. Audit

The Trust undertakes an EPRR self-assessment annually, with a statement of compliance against the self-assessment to Board for sign off. This is then returned to NHS England C&M.

12.2. Exercising (internal)

All of the Trust's Major Incident plans are exercised by at least a table top style exercise annually and a live exercise every 3 years (or more frequently) as per the requirements of the Civil Contingencies Act 2004 in order to:

- continually refresh key staff in its use and equip them with the skills to use the plan
- ensure the contingency plan continues to be updated and meets the needs of the trust
- familiarise new staff with the plan and its function
- it will be the responsibility of the Director of Strategy & Planning or nominated deputy to ensure the MIP is tested every 12 months
- the test should take the form of a mock emergency and be division/trust wide

An objective observer will be invited to each test to help evaluate the process. The outside evaluator should have some experience in emergency planning.

Some exercises are internal e.g., Exercise First Responder and others are conducted in cooperation with partner agencies e.g., with AUH and may include communication via the Major Incident Command Structure to report upwards and access expert advice, resources and assistance from partner agencies that are part of that structure.

The Trust is working collaboratively with partners since it became a Category 1 responder, and will actively support and take part in testing the plans of partner agencies exercises including those conducted by the NHS England Area Team.

13. Consultation

This plan has been developed in accordance with the Trusts Document Control Policy, which in the first instance will seek comments from the Resilience Planning Group, and Business & Performance Committee. For external partners this will seek comments from colleagues from the StH & K, RLUH & AUH as part of the Trauma Collaborative. This document will also be shared with Commissioners and other interested parties on request.

14. Review

This document will be reviewed in two years (this is applicable to new or revised documents on approval of this policy revision), or sooner in the light of organisational, legislative or other changes e.g. changes in risks or in the event of significant findings from internal or external incidents/reviews.

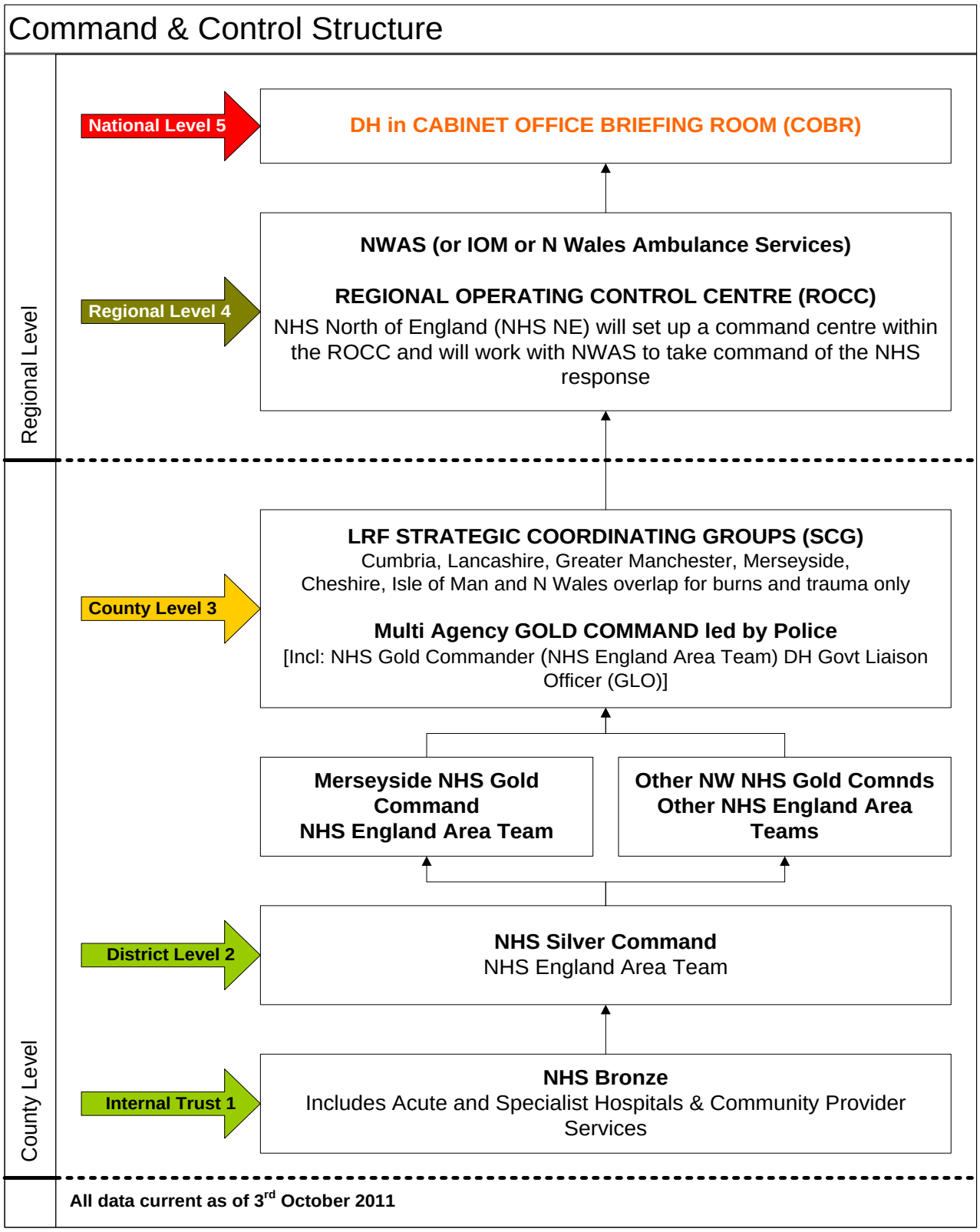
15. References

- Civil Contingencies Act 2005.
- NHS Standard Contract;
- Everyone counts: Planning for Patients 2013/14;
- Arrangements for health emergency preparedness, resilience and response from April 2013 (to be read to support NHS Emergency Planning Guidance 2005);
- NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies;
- NHS Commissioning Board Business Continuity Management Framework;
- NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response;
- Memorandum of Understanding for Emergency Preparedness, Resilience & Response between NHS CB Local Area Teams and providers of NHS-funded care;
- The NHS England Business Continuity Framework http://www.England.nhs.uk/ourwork/gov/eprr
- Role of the Accountable Emergency Officer https://www.england.nhs.uk/wp-content/uploads/2012/12/eprr-officer-role.pdf
- Role of EPO (including competencies)
- JEIP Joint Doctrine http://www.jesip.org.uk/uploads/resources/JESIP-Joint-Doctrine.pdf
- Merseyside Infectious Diseases Management Plan 2014
- MRF Merseyside Emergency Response Manual (MERM) 2013[1]
- Merseyside Mass Fatalities Plan – Interim Excess Deaths Protocol
- http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063393.pdf
- NW Critical Care Network Pandemic Influenza: Critical Care Plan
- NHS Shelter and guidance information https://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf
- MRF Community Risk Register 2017 http://www.merseysideprepared.org.uk/media/1406/2017-merseyside-crr-v1-0-17.pdf

15.1. Supporting policies/documents

- Health & Safety Policy
- Trust Business Continuity Plan
- Departmental Business Continuity Plans
- Pandemic Influenza Plan
- Fire Policy
- Security Policy
- Risk Management Strategy
- NHS NW Critical Care Contingency Plan
- Incident Reporting Policy
- Partner trust/agency Emergency Plans
- Trust Emergency Plans (i.e. Pandemic Flu, Fuel Shortage)
- Infection Prevention Policies
- Data Sharing Policy
- Escalation Policy
- Winter Plan
- Transfer of patients into WCFT due to Major Incident Situation by AUH (Internal document)

Appendix 1 - Command & Control Structure



National Level

The Prime Minister will convene the Cabinet including a rep from the DH and specialist advisors in Cabinet Office Briefing Room (A) supported by staff officers from the Civil Contingencies Secretariat to develop and deliver policy and a national response to catastrophic events (e.g. Foot & Mouth epidemic, London Bombings, major flooding events, large scale civil unrest, etc).

Regional Level

The NHS in the North West has a Command and Control Structure that will be operated to coordinate Mass and Catastrophic Level Incidents.

NHS North of England (NHS NE) will take overall Command and Control of any Major/Significant Incidents that affect more than one county or if the incident is believed to be caused by a terrorist event.

Depending on the time or day of the incident the NHS NE will exercise its Command and Control functions from various places across the North of England. In the North West they will operate from ***North West Ambulance Service (NWAS) Regional Operational Control (ROCC)*** room at Broughton, Preston or from their offices in central Manchester or Leeds.

The NHS NE will brief the DH as required.

Depending on the type of incident the team will consist of:

- On Call Director
- On call Communications Lead
- Regional Director of Public Health (if appropriate)
- A member of the Critical Care Networks (to oversee Critical Care issues)
- Administration support

This NHS Regional team will communicate throughout the incident with:

- Local Adult & Paediatric Critical Care Networks
- Northern Burn Care Network
- National Burn Bed Bureau and
- Trauma Networks.

Merseyside County Multi Agency Gold Command

Where the incident is contained within the county the Local NHS Gold Commander from NHS England Area Team will have strategic responsibility for Merseyside NHS economy. In addition an NHS North of England Government Liaison Officer (GLO) *may* attend the ***Strategic Coordinating Group (Gold Command)*** of the county affected.

The term 'Gold' refers to the person in overall executive command of each service (health, fire, police, etc.) and is responsible for formulating the strategy for the incident response. Each strategic command (Gold) has overall command of the resources of their own organisation, but delegate tactical decisions to their respective tactical commanders (Silver(s)).

The ***Merseyside Gold Command*** or ***Strategic Co-ordinating Group (SCG)*** is a multi agency group that meets at ***Merseyside Gold Control Centre*** in
Merseyside Police HQ, Liverpool. This is usually chaired by the Chief Constable as the Police normally have ***'primacy'*** over all other agencies in a Major Incident. It will be attended by the ***NHS Merseyside Gold Commander***. Please note the health economy represented by the Merseyside NHS Gold Commander extends beyond Merseyside boundaries.

The primacy agency and chair of the LRF may change to the Local Authority or NHS Gold Commander if appropriate.

NHS Gold Command (Greater Merseyside)

The Chief Executive (or nominee) of NHS England Area Team is the NHS Gold Commander. S/He will strategically lead the NHS response in the County from an ***NHS Gold Command***

Centre at Regatta House, Brunswick Business Park, Liverpool set up and staffed by ***NHS Merseyside Resilience Team***.

The NHS Gold Commander will attend the Strategic Coordinating Group when it meets and will represent the entire Greater Merseyside NHS economy including Wirral, Warrington and Halton.

NHS Tactical (Silver) Command

In Merseyside the NHS command structure reflects the multi-agency structure as follows:

The term 'Silver' refers to those who are responsible for formulating the tactics to be adopted by their service (NHS economy in this case) to achieve the strategic direction set by strategic command. Tactical command will oversee but not be directly involved in managing the operational response to the incident.

NHS England Area Team will also provide a rota of Silver Commanders who may operate from Regatta House or a control centre.

NHS Operational (Bronze) Command

The term 'Bronze' refers to those who provide the frontline operational response and/or direct service provision, and control the resources of their respective service within a specific area of the incident. They implement the tactics defined by the NHS Silver Command Team.

In Merseyside the executive/ strategic command within Hospital Trusts (Acutes and specialist) and Community Health Provider Services are the NHS Bronze Command. These teams are chaired by a Trust Executive. In the Trust the Exec in Charge becomes the Bronze Commander once the Command & Control Centre is up and running.

The Exec in Charge for the Trust is:

Office hours	Operational Director (or executive nominee)
Out of hours	Exec on Call

Appendix 2 - UK Roles of Partner Agencies

Introduction

Pre-planning, training and exercising on a multi-agency basis enables plans and procedures to complement each other and enables agencies to have an understanding of each others roles, responsibilities and capabilities.

All Major incident plans for Category One Responders are peer reviewed with partner agencies before full publication.

NHS agencies play an important role in this multi-agency approach to emergency planning. The roles of the Trust's partner agencies are as follows:

NHS North of England (NHS NE)

NHS North of England (NHS NE) may convene meetings of incident leads from the NHS organisations (which may use telephone or video-conferencing).
The role of the NHS NE is to:

- activate North of England and sub regional (e.g., North West Ambulance Service footprint area) Major Incident Plans
- give priority to the incident, relative to meeting of targets and achievement of standards that would otherwise be imperative
- assume that resource adjustments would flow to recognise extraordinary expenses incurred in responding to the incident
- stand down their emergency response.
- at the recovery stage ensure that any commitments made during the incident are honoured.

Local NHS Community Health Care Providers

(E.g. Mersey Care and Community Health Care Provider Services)

Local NHS Community health care providers will provide community health care service to casualties and to displaced persons. They may provide healthcare input to people with minor injuries, and to persons at (Local Authority managed) Rest Centres and will support acute hospitals by diverting minor injuries away from Emergency Departments and into walk in centres, provide an integrated specialised emergency response for e.g., therapy services. Provide more hours and different working practices in community health care to reduce admissions.

NHS England Area Team (NHE AT) Merseyside

NHSE AT is responsible for an NHS countywide response and provides strategic and tactical (borough wide) decisions; command and control for the entire NHS economy in Greater Merseyside and arranges mutual aid on behalf of NHS North of England.

It provides an NHS Gold Control Room and staff to support the Gold Commander in a Major incident. NHSE AT Resilience Officer in conjunction with the Commissioning Support Unit Resilience Officer coordinates Multi agency emergency plans for the NHS in Merseyside, support Trusts with emergency planning, exercises and training, provide a conduit /is a filter for information/ instruction from DH and provides help and advice to Trusts.

When a major incident is declared, NHSE AT Silver/Gold Team will:

- set up and staff the NHS Gold Control Room in Regatta House
- initiate and support the public health response to the incident if this is appropriate

- mobilise CCGs, primary care and community resources in response to the incident
- support Acute Trusts by taking steps to relieve pressure on them
- communicate with the media and public
- assess the impact on health and health services of the incident
- provide the health service input to the strategic and borough wide tactical management of the incident (may be in conjunction with the Public health England Cheshire & Merseyside Health Protection Unit)
- arrange follow-up if needed of persons affected or exposed to risk during incident
- activate the major incident procedure including the setting up of the major incident room
- ensure that the Merseyside Local Health Resilience Partnership Major Incident plans are co-ordinated with those of other relevant organisations.

In the event of the Trust requiring access to secure transport routes and accommodation facilities in a Major Incident, the consultation will take place with the Silver/ Gold NHS Team.

Scientific & Technical Advice Cell (STAC)

A Scientific and Technical Advice Cell may be established during an incident to bring together technical experts from those agencies involved in the response to provide advice to the Gold Command where there may be wider health and /or environmental consequences. It is chaired by a Director of Public health and can be staffed by the HPA, local authority Environmental Health Officers, NWAS, representatives from other emergency services, and experts from other government agencies and the military. Local experts like the Nuclear Physicist at the Royal may also be required.

The Trust may be requested to send a representative to meetings of the STAC particularly if the Trust is experiencing a Major Incident.

Public Health England (PHE)/ Cheshire & Merseyside Health Protection Unit (HPU)

The HPU provides HAZMAT, CBRN(e) and poisons advice to Category One Responders like Acutes via a Duty Officer system. This can be accessed in an emergency via Ambulance Control.

North West Ambulance Service NHS Trust (NWAS)

NWAS attend the scene, provide on-site healthcare, decontaminates casualties where necessary (the Fire and Rescue services would assist by decontaminating affected individuals who are not ill or injured), and transport patients to hospital.

They also provide a Hospital Ambulance Liaison officer (HALO) at the ED to provide a link to the scene and inform the Coordinators about the numbers and types of casualties en route and their estimated time of arrival. This facility may be requested when the Trust is dealing with a mass casualty or CBRN(e) or HAZMAT incident.

Merseyside Police

In a disaster or serious Major Incident involving casualties/ hospital premises, the police have ‘primacy’ i.e. control and a coordination role over all other agencies involved including the Trust.

The primary areas of response are:

- the saving of life in conjunction with other emergency responders
- coordination and communication between the emergency responders and other agencies acting in support at the scene of the incident or elsewhere during the response phase
- secure, protect and preserve the scene through the use of cordons

- investigation of the incident and obtaining and securing evidence
- collation and dissemination of casualty information
- identification of the dead on behalf of HM Coroner
- short term measures to restore normality
- provision of advice and guidance from the local ***Counter Terrorist Advisory Office (CTSO).***

Merseyside Fire & Rescue Service

The primary areas of support are:

- Fire fighting, fire prevention and Search and Rescue (SAR)
- decontamination and mass decontamination of uninjured people
- provision of specialist advice and assistance where hazardous materials are involved (especially the Detection Identification and Monitoring or DIM teams operating at the scene)
- provision of specialist equipment (pumps, rescue equipment and lighting)
- safety management within the *Inner Cordon* of an incident

Liverpool City Council (LCC)

The primary areas of response are:

- support the emergency services and those engaged in the response to an incident
- use resources to mitigate and relieve the effects on people, property and infrastructure
- resource Reception Centres for the temporary accommodation of survivors/ evacuees
- provide humanitarian assistance
- activate and coordinate voluntary sector support
- arrange emergency mortuaries
- maintain the provision of essential services

As the emphasis moves from response to recovery, take the lead role to facilitate recovery and the restoration of the environment

Government Decontamination Service

The Government Decontamination Service has been established to help agencies prepare for and recover from CBRNe (chemical, biological, radiological, nuclear or explosive) or significant HAZMAT (hazardous materials) incidents by providing advice, guidance, management support and contractual arrangements.

In response to an incident requiring decontamination equipment, the Government Decontamination Service can provide expert advice on the capability and capacity of its framework of contractors, their services and where relevant, the different remediation or decontamination methodologies available.

Contact Details: The Government Decontamination Service, MoD Stafford, Beaconside, Stafford, ST18 OAQ
Tel: 08458 501323, Fax: 01785 216363, Email: gds@gds.gsi.gov.uk

Military Aid to the Civil Community

The Military is authorised to provide assistance in the response to an incident if there is a threat to life. The immediate assistance the Military is able to provide will depend upon the resources available at the time. Requests for assistance will normally be made by via the Command Structure.

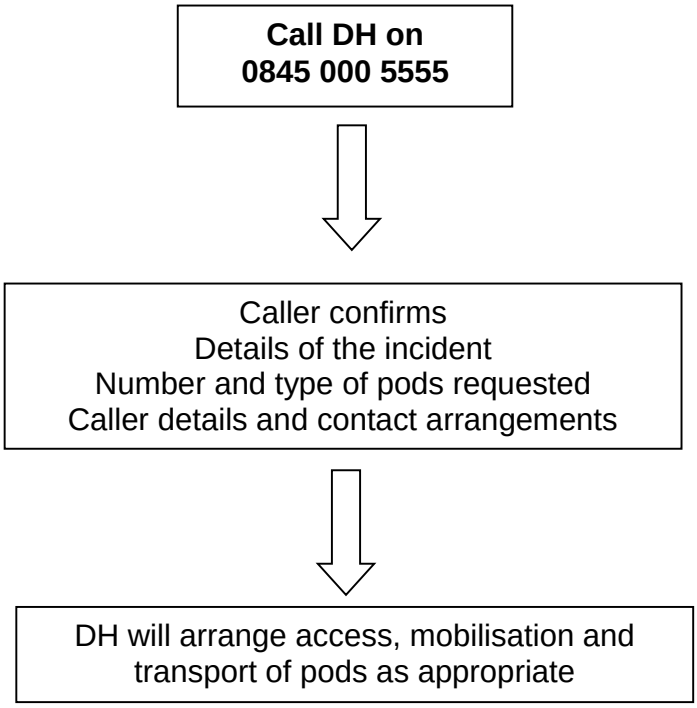
Merseyside Integrated Voluntary Agencies under the UNITY Protocol

The British Red Cross (Merseyside District Branch Offices in Bradbury house, Brunswick Dock Estate, Liverpool) have 'primacy' over other voluntary agencies and faith and community organisations with a stated emergency response role and will coordinate and manage the integrated voluntary agencies response in any humanitarian crisis and provide specific services and support to the Trust and other NHS providers in such events. They can be activated via a call from NHS Bronze to Knowsley Council to request assistance.

A British Red Cross 'Unity' Coordinator will attend Silver &/or Gold Command (Strategic Coordinating Group) to coordinate voluntary humanitarian assistance across the entire County/ Borough.

Appendix 3 - UK Reserve of National Stock for Major Incidents

Items Accessed Centrally (Summary)



The decision to deploy these medical supplies will normally be taken by the local Consultant in Communicable Disease Control, Director of Public Health or Consultant in Public Health Medicine.

The Regional Director of Public Health must be informed of all decisions to use/access centrally managed countermeasures.

Customer Procedure

Case of emergency during normal working hours

Monday to Friday between the hours 8.30am and 5.00pm contact your local Supplies Manager who will respond to your emergency in the most appropriate way and in line with local procedures.

Case of emergency out of hours

Outside of normal working hours as indicated above the Customer must obtain the appropriate permission from budget holder, Manager in charge etc. Once permission has been obtained you should contact the local Distribution Centre by telephone not by facsimile (see overleaf)

All such demands will be charged to the local emergency GL code to be apportioned according to local procedures. As a necessity, the emergency procedures are designed to allow authorised personnel to obtain their emergency issues without the encumbrance of normal requisitioning.

Procedure for case of emergency during office hours

Before pursuing an emergency delivery from the NHS Logistics Distribution Centre, consider the following:

- Are the goods needed urgently?
- Could the goods be obtained quickly from another department?

Procedure to be followed by Supplies Manager/ Officers for an emergency during office hours

Investigate the request and ascertain if the goods required can be obtained more quickly from another Ward/Department or Hospital.

Use the enquiry facility on LOL (Logistics Online) or local legacy system to determine where any delivery of the items required has been made recently.

Once it is apparent that a delivery is required from the Distribution Centre, obtain the following:

- Authorising Officer's name
- location name and telephone number
- requisition point
- NSV code for each commodity required
- description of product with issue pack size
- quantity required
- delivery if different from normal delivery location
- precisely when the item/s are needed

The procedure to be followed by customers depends upon the time of day the emergency arises. An emergency is defined as a Major Incident or an unforeseen circumstance where delivery is required the same day or within 5 hours. There is no charge for genuine emergencies.

Appendix 4 - National Emergency Purchasing Scheme

NHS Supply Chain Emergency Procedure

Contact the Distribution Centre and your usual Customer Service advisor.
You must clearly state that it is an emergency situation and that you require an urgent delivery from the Distribution Centre.

Your Customer Service advisor will then ask the questions listed above and read back the answers to you, to confirm the request.

The Customer Service advisor will confirm the warehouse pick of the goods by telephoning either the customer or the Receipts and Distribution point and give details of the transport to be used and the estimated time of arrival at the delivery location.

Upon receipt the customer will be asked to sign the delivery note, printing their full name, job title and normal telephone number - a copy of which will be given to the customer.

An emergency is defined as a major incident or an unforeseen circumstance. This is usually a same day delivery.

Procedure to be followed by the ***customer*** for an emergency outside of 'normal' hours - security manned site.

Authorisation must be obtained for any emergency request.
Obtain the following information ***before*** contacting the Distribution Centre:

- Authorising officer's name
- location name and telephone number
- requisition point and requisition code
- NSV code for each commodity required
- Description of product with issue pack size
- quantity required
- delivery if different from normal delivery location
- precisely when the item/s are needed

Contact the Distribution Centre. (Facsimile messages are not acceptable)
Security Manned Distribution Centres – Alfreton, Maidstone, Normanton, Runcorn, Bury and Bridgwater. Once the facts are confirmed, the Security Gatehouse Officer/depot on call officer will ring the number given by the caller to confirm that the call is genuine; having first checked that the telephone number given is in the directory of Hospital numbers. Whenever the afternoon shift is in work, contact the Shift Manager or Charge-hand.

Contact Telephone Numbers for Distribution Centres - Out of Hours

Manned Sites

Alfreton	01773 724000	Normanton	01924 328700
Runcorn	01928 858500	Bury	01284 355923
Maidstone	01622 402600	Bridgewater	01278 464000

Operations to provide Security with a detailed list of contacts for each Distribution Centre.

Appendix 5 - Multiple incidents Emergency Response summary

Code Name Alert

Multiple site incidents like the London Bombings in 2005 will require a coordinated multi agency regional response from all standing agencies. The alert to the Trust from either NWAS or the NHS Silver or Gold Commander will contain **a code name known only to key officers of the Trust**.

Upon hearing this code name the Exec in Charge will ensure that the Trust is immediately fully prepared to respond to a large scale Major Incident or series of incidents.

Possible Required Responses to Multiple Incidents

If the incident occurs within a 20 mile radius it is fairly certain that the Trust will be required to receive a potentially large number of the most serious casualties, the ***Priority or P1s*** requiring emergency care, surgery and ITU.

However, there are a number of possible responses required from the Trust dependent upon whether it is a ***Receiving Hospital*** for the casualties or not.

Actions by the Trust on Declaration of Multiple Incidents by NWAS

If it is anticipated that the Trust will be receiving large numbers of casualties the Exec in Charge will activate the full range of the Major Incident Plans including:

- Establish a Bronze Command Team supported by a Control Support Team in the Major Incident Suite.
- Establish lines of communication with the NHS Merseyside Resilience Gold and Silver Command Centres to receive intelligence about the incidents and set up situation reporting up the command structure.
- Obtain as full a picture of the incidents as possible from Silver Command including traffic conditions, any hazards and safe or clear routes recommended by the emergency services.
- Alert staff to a Major Incident by instructing the Switchboard to issue a Major Incident alert (Majax alert)
- Apprise all Tactical Managers of the situation.
- Instruct all managers to:
- Brief staff and be prepared to ensure that they are issued with Major Incident action cards, tabards, relevant PPE and other equipment,
- Create capacity (being careful to coordinate and not adversely impact on other departments and services – e.g., ITU, Theatres)
- Cease and cancel non-essential services to free up key staff for redeployment.
- Allocate staff to deal with the emergency whilst others continue treating patients already in the progress.
- Ensure access to current essential stocks and initiate plans in place to obtain more supplies quickly in consultation with the Materials Management Team.
- Call in extra staff.
- Liaise with other providers for a coordinated response.
- Take business continuity measures like charging electrical equipment and having paper documentation systems handy.
- Convert the Outpatient's Dept into a Major Incident Discharge Lounge
- Liaise with the emergency services and other responding agencies

Emergency Communications

Alerts and global emergency messages can be transmitted via Switchboard to all Trust mobile telephones.

The Trust has 1 Mobile Telephone Preference Access Scheme (MTPAS) enabled mobile phones kept in the Major incident Cupboard in the Major Incident Room (Boardroom).

MTPAS (formerly ACCOLC) can be invoked by police to cut off mobile phone signals of all phones except those with SIM cards registered by responding agencies. However, Vodaphone mobiles can still be used if accessed via a computer.

Debriefs

After Stand Down has been declared by the Bronze Commander all areas/departments Managers/Coordinators, including the Bronze Command Team, will conduct a 'Hot Debrief' in their location. These hot debriefs will include other agencies present.

As a result of these debriefs all Tactical Managers will send a brief and concise report to the Resilience & Safety Manager highlighting what happened, what went well, areas for concern and actions to be taken to rectify these, by whom and when.

The Bronze Commander will call a formal debrief of all Tactical Managers/Coordinators and key staff within a week of the Stand Down.

The Bronze Commander and Resilience & Safety Manager will attend the formal NHS Merseyside Debrief.

The NHS Gold Commander will attend the Merseyside Multi Agency Debrief on behalf of the NHS Merseyside economy and regional debriefs.

Appendix 6 - Glossary of Emergency Planning Terms

Emergency planning terms are highlighted in ***bold and italic*** throughout the plan. Some of these terms are used in supporting plans

BASICS Doctors

Immediate care doctors are specialists, trained in pre-hospital care and to provide medical support at the scene of an accident or major medical emergency, or while patients are transit to hospital. They also provide medical support at mass gatherings.

Category One Responder

Emergency Services, Local Authorities, CCG's and Acutes plus the Environment Agency and Marine & Coastguard Agency are all Category One responders under the Civil Contingencies Act and must plan and work together to provide a coordinated response to emergencies.

Category Two Responder

The NHS NE, Utilities companies, Telecoms companies, some government departments and Transport executives are Category Two agencies that must work with, support and inform Category One Responders and each other to provide a coordinated response to emergencies.

CBRN(E)/ HAZMAT

These are Chemical, Biological, Radiological, Nuclear and Explosion incidents caused by deliberate criminal or terrorist acts. As opposed to HAZMAT incidents which may have the same hazards, characteristics and response but are accidents.

Civil Contingencies Act 2004 (CCA)

The act that determines which agencies are Category One and Two Responders to emergencies and how they should work together to provide a coordinated response with each other and other partners like the voluntary sector and private contractors.

Cloudburst (Operation Cloudburst)

A multi agency major incident response to incidents involving a release of toxic HAZMAT substances. Declaring Operation Cloudburst unlocks resources and sets in motion a formalised response in regard to sites where this has occurred (e.g., see below COMAH sites). There are currently Cloudburst sites on Merseyside and a further 36 in Cheshire.

Command & Control

The Command & Control Structure during a Major Incident has 3 levels:

- Bronze - Operational
- Silver - Tactical
- Gold - Strategic.

Bronze Command

These are the teams that manage the operational response to a Major Incident. At the scene it is fire crews attending the fire, police staffing the cordons, paramedics dealing with casualties, Environmental Health Officers and other local authority responders etc providing advice and finding resources for clean up, etc.

NHS Bronze Command

In the NHS command structure NHS Bronze Command is the exec team of the Acutes, specialist hospitals and community health service providers that manage their own

organisation's strategic response to an incident. They report to NHS Merseyside Resilience who provides both the NHS Silver and NHS Gold Command Teams.

NHS Gold Command

The Chief Exec of NHS Merseyside (or nominee) is the NHS Gold Commander. They will operate from an NHS Gold Control Room (supported by admin staff), which is the NHS Merseyside Resilience for emergency planning in Merseyside. They will attend the Strategic Coordination Group (SCG) to represent the NHS economy in Merseyside.

NHS Silver Command

The NHS Silver Commander and Control Room will be provided by NHS Merseyside Resilience but may operate from a control room within the local authority district where the incident occurred (unless it is a regional or national event like pandemic flu).

Hospital Incident Control Team (NHS Bronze Command)

This consists of the Exec in Charge, Medical Director, Exec Nurse, Ops Director and other Execs.

Control Room (Bronze) Support Team

Call Takers

Trained call takers who complete Major Incident enquiry forms with a précis of telephone, fax and email messages and pass these to the Log Keeper for numbering, noting and passing on to the Bronze Command Team (see above).

Control Support Team (Manager)

The Manager of the admin support team for Bronze Command.

Loggist

Trained loggist for the Bronze Command team who takes down all decisions and actions and key information at Bronze meetings.

Log Keeper (General)

Member of Bronze Control staff who numbers and notes all communications into the Bronze from outside.

Situation Board Writer

Admin officer trained to keep the situation board up to date in the Bronze Command room.

Welfare Officer

Officers of the Trust in each area of activity who arrange refreshments and catering for staff and ensure that breaks are taken and monitor staff for stress.

Control of Major Accident Hazards Regulations 1999 (COMAH)

Top tier COMAH site

A top tier COMAH site, as defined by the Health & Safety Executive, is an industrial or storage premises that holds substantial quantities of hazardous materials that if released have the potential to cause a catastrophic off site effect.

Lower tier COMAH site

A lower tier COMAH site, as defined by the Health & Safety Executive, is an industrial or storage premises that holds substantial quantities of hazardous materials that if released have the potential to cause a serious on site effect.

Community Risk Register

A register of risks and hazards in the County devised by a Risk Assessment Sub Group of all the responding agencies that make up the Local Resilience Forum.

Debrief

A debrief is held after an incident or an exercise to establish learning points and draw up an action plan to enable the review and revision of emergency plans. A hot debrief (see hot debrief) is held immediately after Stand down is declared within the location where responders have been working and a formal organisational debrief will be held within a week after the event. A multi-agency debrief will be held within a month and chaired by a senior officer of the Strategic Coordinating Group.

Exec in Charge

The Chair of the strategic Hospital Bronze Command Team and the officer of the Trust who takes ultimate responsibility for declaring a Major Incident for the Trust and the strategic response to the incident.

Emergency Centres (Established/ run by Local Authorities)

Emergency Rest/ Reception Centre

This is a designated centre to accommodate displaced persons staffed by local authority and voluntary agencies. A place of safety and shelter where people can be accommodated and care for from a few hours to days, weeks or months, dependant upon the incident.

Survivor Reception Centre

This is any initial place of safety near the incident scene that survivors have reached themselves or the emergency services have directed them to, e.g., a church hall, a car park, a supermarket café, etc. It is not necessarily a shelter.

Humanitarian Assistance Centre

This is a drop in centre for anyone affected by the incident that can be an advice centre plus a combination of other centres.

Family & Friends Reception Centre

A centre (usually a hotel or conference centre) where the victim's families are interviewed by police supported by the local authority/voluntary agency crisis support teams, to ascertain the identity of the dead and injured and where they can receive information and emotional and practical support.

Emergency Mortuary

The mortuary at Liverpool Royal Hospital is the designated primary Emergency Mortuary for Merseyside (and in some circumstance North West England). Whiston Mortuary has an Alternative Emergency Mortuary Plan under development for the event that Royal Liverpool is unable to take on this role because it is part of or within the zone of the incident or due to the exigencies of the rebuild of the new hospital. The mortuary can also carry out this function for Cheshire if requested. Being the largest mortuary in the North West, Whiston can also support

the Royal Liverpool with extra cold storage and viewing and Family & Friends Reception and pastoral care.

Emergency Services

North West Ambulance Service (NWAS)

Ambulance Incident Commander (AIC)

This is the officer in charge of the operational response for the ambulance service at the scene.

Hospital Ambulance Liaison Officer (HALO)

This officer will be dispatched to the ED of a receiving hospital where s/he will liaise with the ED Coordinator and other staff and keep them informed of the number, severity and type of incoming casualties and other vital information from the scene.

Hazardous Area Response Teams (HART)

The teams are specialist trained and equipped to work in conjunction with Search and Rescue Teams to triage and treat casualties within the 'hot zone' (on a fire ground) or inside the 'inner cordon' (see the Scene below) in incidents involving hazardous materials or in hazardous places needing special rescue equipment and training.

Casualty Clearing Point/ Area

This is an area that can be on the edge of either the 'inner' or 'outer cordons' where casualties can be brought away from the danger to be treated and transported away to hospital.

Casualty Clearing Centre (Advance)

A building near the scene that provides shelter for casualties awaiting distribution to the most appropriate health care facility and were MERIT teams can stabilise and treat Priority 1 casualties who can't be moved far.

Medical Incident Commander

The MIC will take command of and coordinate all non-ambulance clinical staff at the scene and all casualty points and centres.

National Capability Mass Casualty Vehicles (NCMCV)

These are available to Ambulance Trusts and Hospital Trusts in the event of a mass casualty incident. The following is a brief overview of the capability.

"The NCMCV are part of the governments capabilities programme. Each vehicle contains enough medical equipment to provide emergency treatment for: 100 x either P1/ P2 Casualties and 250 x P3 Casualties

Merseyside Fire & Rescue Service (MFRS)

Detection Identification and Monitoring Team (DIM)

Merseyside Fire & Rescue Service (MFRS) DIM team is a specialist team of HAZMAT officers, deployed to the scene of any incident, which specially equipped and trained to detect, identify and monitor suspected hazardous substances potentially found at the scene. They may have a communications link to the Health Protection Unit Duty Officer direct or via the STAC (see below).

Decontamination (Mass)

The fire service is responsible for mass decontamination at the scene of an incident. They can use the 'New Dimensions' specialist demountable units (2 in Merseyside, stored at the Fire Service Training Academy in Storrington Road, Liverpool) or a system using 2 fire engines, a ladder, a hose and modesty screens. Decontamination of casualties is undertaken at scene by the Ambulance Service and self presenters by the Receiving Hospital.

Merseyside Police

Casualty Bureau

The Police Casualty Bureau is designed to gather information from the public phone calls from concerned family and friends of people who are missing and whom they believe may be affected or caught up in a Major Incident and registration documentation from emergency centres (see above).

For incidents in the NW, the Police Casualty Bureau will be convened near Manchester, supported initially by officers from the affected force area and later by CASWEB which is a national arrangement for receiving calls - when a Major Incident involving a large number of people occurs. A number for the Bureau will be broadcast on radio and TV once it is set up.

Counter Terrorist Security Advisors (CTSA)

The local police Counter Terrorist Security Advisor works with all emergency responders and local communities, etc to advise, inform and train people in how to be vigilant with regards to terrorism and security issues. S/he also advises on ways of responding/ managing your working area/ neighbourhood after an incident has occurred. They run Project Argus sessions to this end.

Documentation Teams

Merseyside Police may send documentation teams to the hospital when a mass casualty incident occurs.

Family Liaison Officers

These are police officers normally allocated to the families of homicide or road traffic collision victims. They are a single point of contact for that family and part of the investigative team. They are supported in Major Incidents by Local Authority/Voluntary Agency Core Crisis Teams. These officers may be part of the response at the hospital.

Force Incident Manager (FIM)

A police inspector in a separate control room to the area control rooms who coordinates the response to a Major Incident as Silver Commander in the initial stages until senior officers are in place.

Health Protection Agency (HPA)

This is a government agency that provides expert assistance and advice in all chemical, biological, radiological and nuclear incidents. The HPA has a useful website that can be used by clinical staff dealing with HAZMAT incidents.

Health Protection Unit (HPU)

This is the local operational version of the above which has a Duty Officer on call who can be accessed via Ambulance Control for advice and assistance.

Hot Debrief

A hot debrief is a short meeting of responders within the location they have been working immediately after the Stand Down, convened to capture learning points while they're still fresh in the mind and to thank the responders.

Local Resilience Forum (LRF)

This is a group of generally high ranking officers from each type of the Category One Responders in a police force area (county) that meets quarterly to discuss emergency planning on a countywide basis and has multi agency sub groups.

Major Incident

This is any incident that requires an emergency response by a number of agencies that will stretch resources and requires special arrangements and procedures to be enacted.

Major Incident Command & Control Structure

See UK National Resilience Structure at Appendix 4.

Medical Coordinator

A Senior Clinician who supports the Exec in Charge/ Bronze Commander on behalf of the Medical Director if the Medical Director his/her deputy or assistant Medical Directors are not available.

S/He will activate and strategically coordinate the medical teams and clinical response to a Major Incident until the Medical Director arrives to take over.

Mobile Telephone Preference Scheme (MTPAS)

Mobile Telephone Preference Scheme can be invoked by police to cut off mobile phone signals of all phones except those registered by responding agencies.

Meteorological Office (Met Office) (see also Weather)

The Met office issues to all Category One responders as required: Severe weather warnings, Extreme rainfall warnings, Flood warnings and Heatwave warnings

Police Link Officer

A member of ED admin team, designated by the ED Coordinator who will liaise with and facilitate police officers in the ED, gather the police pink copies of the casualty Major Incident casualty documentation and supply it to the police documentation team.

Scene (of the incident)

Advance Casualty Centre (ACC)

Any suitable public building near the scene that can be set up to accommodate casualties that require immediate triage, stabilisation and treatment and which due to the grid lock or destruction of the local infrastructure and/or sheer scale of casualty numbers, may take some time to transport to acute hospitals. They can be kept safe and receive vital immediate treatment and be dispersed to the most appropriate hospitals, etc from this centre, in a more coordinated manner.

Casualty Clearing Point

A point on the edge of the Inner Cordon (see below) where NWAS will set up an initial casualty triage, first aid and dispersion point (usually a specialist vehicle or initially regular ambulances).

Cordon (Inner and Outer)

The Inner Cordon is a line around the Hot Zone (see below) where the impact of the event is most apparent. Access through this cordon is controlled by the Fire & Rescue Service and the Fire Incident Commander is the authority within this cordon.

The Outer Cordon is determined by the police at some distance from the Inner Cordon and access points will be controlled by the police who may be supported by local authority officers or highways contractors under contract.

If the police are present at the scene, the most senior police office on site will become the Police Silver Commander and is the overall Commander of all agencies operating from the scene within the Outer Cordon. S/He works in close liaison with the Fire Incident Commander and the Ambulance Incident Commander (if present).

Hot Zone

The area within the Inner Cordon (see above) controlled by the Fire & Rescue Service where the main impact of the event has or is occurring, e.g. a major fire, chemical release, transport crash, explosion.

Incident Control Point (ICP)

A point set up near the outer cordon at the scene where the Silver Commander or Incident Commander operates from to tactically manage the scene.

Rendevous Point (RVP)

A safe or convenient point that responders report to for a briefing before responding to their location of operation.

Stand Down

Stand Down is declared when the response to the incident is no longer required.

UNITY Protocol (see Voluntary Agencies)

The Unity Protocol is a Merseyside plan which provides access to voluntary agencies with an emergency response under the primacy of the British Red Cross. The UNITY Protocol can be activated by the local authority via Silver Command. (Hard copy held in the Major Incident Cupboard in the Bronze Control Room).

Voluntary Agencies

See UNITY Protocol

Appendix 7 - Bibliography

Civil Contingencies Act 2004. Great Britain. London: HMSO

Department of Health (2005) **NHS emergency planning guidance 2005** [online] Available at http://webarchive.nationalarchives.gov.uk/20130124041821/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081303.pdf [Accessed 13 December 2017]

http://www.england.nhs.uk/ourwork/gov/eprr/

NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

https://www.england.nhs.uk/?s=eprr%20core%20standards

Merseyside Community Risk Register

http://www.merseysideprepared.org.uk/media/1406/2017-merseyside-crr-v1-0-17.pdf

Major Accident Hazards (COMAH) Regulations 1999

Response and Recovery Guidance

http://www.cabinetoffice.gov.uk/sites/default/files/resources/recovery-plan-guidance-template.doc

NHS Commissioning Board Emergency Preparedness Framework

Emergency Response and Recovery, Non statutory guidance accompanying the Civil Contingencies Act 2004

https://www.gov.uk/government/publications/emergency-response-and-recovery

Annex 7 A: Communicating with the public: News Co-ordination Centre

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61041/Chapter-7-Annex-7Av2_amends_18042012.pdf

Annex 7 C: Checklist of suggested protocols

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61043/Chapter-7-Annex-7C_amends_18042012.pdf

Annex 7 D: Duty to communicate with the public – The Ten Step Cycle
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61044/Chapter-7-Annex-7D-amends_18042012_0.pdf

Glossary - Revision to Emergency Preparedness

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Appendix 8 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
1.0	Whole document	Full document review in the light of: • changing NHS Landscape and C&C arrangements • lessons from Exercise Jubilee	14/10/13	T. Fitzpatrick/ I. Neill
1.1	Review of Appendix 1 & 2	Review of internal and external reporting, discussion at executive management team and subsequent meeting with Medical Director.	11/06/14	T. Fitzpatrick
1.2	Review of Appendix 3	Review action cards to take into account review at Executive Team meeting.	30/06/14	T. Fitzpatrick
1.3	Review of Appendices 1 & 3	Change to NWAS Helpdesk telephone number to 0345-1130099	07/07/14	T. Fitzpatrick
1.3	Appendix 1	Update flowchart with NWAS revised helpdesk number.	07/07/14	T. Fitzpatrick
1.3	Appendix 3	Update with NWAS revised helpdesk number.	07/07/14	T. Fitzpatrick
1.3	Appendix 3	Update AC011 - Action Card Communications Manager, after update from Communications group update.	07/07/14	T. Fitzpatrick
2.0	Cover	Update contacts change of role for Resilience & Safety Manager and contact details. Update of references throughout.	25/06/15	T. Fitzpatrick
2.1	Appendix 4	Update of Lockdown flowcharts		
2.2	Cover	Update contacts change of role from Director of Governance & Risk to Director of Operations & Performance and throughout document.	28/09/15	T. Fitzpatrick
2.3	AC011 - Action Card Comms Manager	Update Senior Communications Officers contact details	19/10/15	T. Fitzpatrick
3.0	ALL	Full review of content following learning from national mass casualty incidents	June 17 - Dec 17	T. Fitzpatrick
3.1	3.2.1	then inform Spec Comm (England) On Call Manager **0191 430 2498** of Major Incident declared and give details (Email england.spoc@nhs.uk)	Nov 18	T. Fitzpatrick
	3.2.1	Spec Comm number		

Translation Service

If you require this leaflet in any other language or format, please contact the Patient Experience Team on 0151 556 3088 or email patientexperienceteam@thewaltoncentre.nhs.uk stating the leaflet name, code and format you require.

Arabic	اذا كنت بحاجة إلى هذه النشرة بأي لغة أو تنسيق آخر، فيرجى الاتصال بفريق متابعة تجارب المرضى على الرقم 0151 525 3091 أو 3093، أو إرسال بريد إلكتروني إلى patientexperienceteam@thewaltoncentre.nhs.uk موضحاً اسم النشرة، والرمز، والشكل الذي تطلبه.
Chinese	如果你想索取本传单的任何其他语言或格式版本，请致电0151 525 3091或3093联络「病人经历组」，或发电邮至patientexperienceteam@thewaltoncentre.nhs.uk，说明所需要的传单名称、代码和格式。
Farsi	در صورت نیاز به این بروشور به هرفرم یا زبان دیگری,لطفا با تیم تجربه بیمار با شماره ۰۱۵۱۵۲۵۳۰۹۱ یا۳۰۹۳ یا با ایمیل زیرتماس بگیرید patientexperienceteam@thewaltoncentre.nhs.uk با ذکر نام بروشور ، کد و قالب مورد نیاز خود
French	Si vous avez besoin de ce dépliant dans une autre langue ou un autre format, veuillez contacter Patient Experience Team (équipe de l'expérience des patients) au 0151 525 3091 ou 3093, ou envoyez un e-mail à patientexperienceteam@thewaltoncentre.nhs.uk en indiquant le nom du dépliant, le code et le format que vous désirez.
Polish	Jeśli niniejsza ulotka potrzebna jest w innym języku lub formacie, należy skontaktować się z zespołem ds. opieki nad pacjentem (Patient Experience Team) pod numerem telefonu 0151 525 3091 lub 3093, lub wysłać wiadomość e-mail na adres patientexperienceteam@thewaltoncentre.nhs.uk, podając nazwę ulotki, jej kod i wymagany format.
Punjabi	ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਕਿਤਾਬਚਾ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਪੇਸ਼ੇਂਟ ਐਕਸਪੀਰਿਅੰਸ ਟੀਮ ਨਾਲ 0151 525 3091 ਜਾਂ 3093 'ਤੇ ਸੰਪਰਕ ਕਰੋ, ਜਾਂ patientexperienceteam@thewaltoncentre.nhs.uk 'ਤੇ ਈਮੇਲ ਕਰੋ ਅਤੇ ਪਰਚੇ ਦਾ ਨਾਮ, ਕੋਡ ਅਤੇ ਆਪਣਾ ਲੋੜੀਂਦਾ ਫਾਰਮੈਟ ਦੱਸੋ।
Somali	Haddii aad u baahan tahay buug-yarahan oo luqad kale ku qoran ama isaga oo qaab kale ah, fadlan Kooxda Waayo-arragnimada Bukaanka kala soo xiriir 0151 525 3091 ama 3093, ama email-ka patientexperienceteam@thewaltoncentre.nhs.uk oo sheeg magaca iyo summadda buug-yaraha iyo qaabka aad u rabtid.
Urdu	اگر آپ کو یہ کتابچہ کسی دیگر زبان یا شکل میں درکار ہو تو، براہ کرم پیشنٹ ایکسپیرینس ٹیم سے 0151 525 3091 یا 3093 پر رابطہ کریں، یا کتابچے کا نام، کوڈ اور اپنی مطلوبہ شکل کا ذکر کرتے ہوئے patientexperienceteam@thewaltoncentre.nhs.uk پر ای میل کریں۔
Welsh	Pe byddech angen y daflen hon mewn unrhyw iaith neu fformat arall, byddwch cystal â chysylltu gyda'r Tîm Profiadau Cleifion ar 0151 525 3091 neu 3093, neu ebostiwch patientexperienceteam@thewaltoncentre.nhs.uk gan nodi enw'r daflen, y cod a'r fformat sydd ei angen arnoch.

The Walton Centre NHS Foundation Trust

Report to Trust Board
7 July 2022

Report Title	**Covid-19 Emergency Powers**
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Approval required to end all Covid related emergency powers

Next Steps

- Revert to agreed Standing Financial Instructions and Scheme of Reservation and Delegation

Related Trust Strategic Ambitions and Themes	**Impact**		
Not Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Board of Directors	30 April 2020	J Hindle, Corporate Secretary	Agreed revised governance arrangements for management of the Covid-19 pandemic
Board of Directors	4 March 2021	P Buckingham Interim Corporate Secretary	Reviewed use of powers and NHS Improvement Reducing the Burden letter
Board of Directors	3 February 2022	K Dowson Corporate Secretary	Reviewed use of powers and agreed an extension to July 2022 and updated NHS Improvement Reducing the Burden letter and checklist

Covid-19 Emergency Powers

Executive Summary

1. Emergency spending powers outside of the Scheme of Reservation and Delegation (SORD) are no longer justified by the Covid-19 pandemic and consideration given to the ending of the emergency powers.

Background and Analysis

2. The response to the coronavirus (COVID-19) emergency situation required NHS organisations to operate differently to normal business as usual practice. As part of this, NHS England and NHS Improvement (NHSIE) recommended that Trust's considered the governance arrangements in place for decision-making and spending to reduce the burden on staff.

3. The Trust now considers that it has restored services to pre-COVID-19 arrangements, except where it has chosen to retain processes or systems such as virtual and hybrid meetings due to the advantages that they bring.

COVID-19 Spending

4. The Trust put into place emergency spending arrangements to enable fast and responsive decision-making for COVID-19 spending as below.

Table 1

Financial Limit	Authority
Up to £5,000	Bronze Command
£5,001 to £20,000	Silver Command
£20,001 to £25,000	Deputy Director of Finance
£25,001 to £40,000	Gold on Call
£40,001 to £50,000	Executive Directors
£50,001 to £100,000	Director of Finance
£100,001 to £250,000	Chief Executive

5. The Bronze, Silver and Gold Command structure has now been stepped down and COVID-19 specific funding is no longer in place. Therefore, it is proposed that these spending arrangements are formally revoked and the Trust's SORD is used as the criteria for all decisions on spending.

General Spending

6. At the meeting held on 30 April 2020, the Board of Directors agreed Emergency Powers for general commitment of expenditure. The relevant entry in the Trust's Scheme of Reservation & Delegation (SoRD) relates to items of pay and non-pay expenditure including software, IT equipment, maintenance contracts, goods and services contracts and management consultants. The continuation of these emergency arrangements were agreed at Board on 4 March 2021 and 3 February 2022 as per Table 2.

Table 2

Value	Standard Delegation	Emergency Powers
Up to £25,000	Divisional Directors/ Deputy DON/	Director of Operations & Strategy or Director of Nursing & Governance
£25,001 to £35,000	Deputy Chief Finance Officer	Director of Finance
£35,001 to £60,000	Other Executive Directors	Chief Executive **or** two Executive Directors jointly
£60,001 to £100,000	Chief Finance Officer	Chief Executive or 2 x voting Executive Directors
£100,001 to £150,000	Chief Executive (Executive Team)	Chief Executive or 2 x voting Executive Directors
£150,001 to £500,000	Business Performance Committee	As per Standing Order 5.2 Emergency Powers - Chief Exec or 2 Executive Directors and Chair acting jointly and after having consulted with at least 2 Non-Executive Directors. The exercise of such powers shall be reported to the next formal meeting of the Board for ratification.
£500,001 and above	Board of Directors	

7. It is now proposed that the standard delegation is reinstated. The Constitution (Standing Order 5.2 Emergency Powers) still allows for emergency powers:

'Chief Exec or 2 Executive Directors and Chair acting jointly and after having consulted with at least 2 Non-Executive Directors. The exercise of such powers shall be reported to the next formal meeting of the Board for ratification.'

Conclusion

8. The requirement for the retention of emergency spending powers is no longer justified and therefore should be formally ended.

Recommendation

To approve

Author: K Dowson
Date: June 2022

The Walton Centre NHS Foundation Trust

Trust Board
7 July 2022

Report Title	Non-Executive Director Champion Roles
Executive Lead	Max Steinberg, Chair
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Review of Non-Executive Director roles against NHS England and NHS Improvement guidance has taken place to ensure the right approach is being taken
- No changes are proposed to the current NED Champion roles as a result

Next Steps

- Add assurance on Resuscitation to the Quality Committee cycle of business

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Leadership	Not Applicable	Not Applicable	Not Applicable

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Non-Executive Director Champion Roles

Executive Summary

1. Following the publication of guidance by NHS England in December 2021, the role of Non-Executive Director (NED) champion roles was reviewed by the Trust as part of the review of NED roles by the new Chair following taking up the post on 1 April 2022. The guidance was taken into account when reviewing the roles that were required. This paper provides the assurance that the considerations were made appropriately and the Board has sufficient oversight. The full guidance is available here: https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf

2. 18 roles were assessed as part of this review. Guidance recommends retaining five of these due to the current importance of the role or statutory requirement. These are:
   - Wellbeing Guardian
   - Freedom to Speak up Guardian
   - Maternity Board Safety Champion
   - Doctor's Disciplinary
   - Security Management

3. This is guidance only, the Trust can appoint NEDs to alternative champion roles to provide assurance on specific issues if they feel it necessary. The guidance recommended that all Trusts should review their current roles and agree an approach.

4. The Trust has considered this guidance and proposed to follow the guidance, largely as summarised in the table below. There is no requirement to appoint a Maternity Champion at the Trust and the security management will be overseen by Quality Committee through its agreed cycle of business as the statutory requirement does not extend to Foundation Trusts.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

Background and Analysis

5. Over time a number of NED champion roles have been proposed nationally, through system reviews and investigations, or when additional Board-level focus was required on issues related to leadership and lack of oversight in the NHS. There is no formal definition of what a NED Champion is. It is a role which through guidance or statute has been created to have a specific NED responsible for promoting and championing a particular area or issue. Sometimes these have been called 'NED leads' or 'named NEDs' and all these roles have been considered for this report.

6. The number of these roles being proposed meant that at times it has been challenging for Trusts to discharge the role effectively, due to the number of NEDs available and the limited support or information available about the role. Therefore, the impact of assigning a NED champion has been difficult to measure. There is also a danger of responsibility for a particular issue being focused on one NED when all Board members should have oversight

Retained Director Champion Roles

Wellbeing Guardian

7. This role originated from the Health Education England Pearson Report in 2019 and was adopted through the People Plan 2020-21. The NED appointed should challenge their Trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every direction. It is anticipated that this role will reduce as the approach becomes more embedded.

Freedom to Speak up Champion

8. The Francis 'Speak Up' Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the Board.

9. All NEDs are expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation.

Doctors Disciplinary Champion/ Independent Member

10. This is an advisory role for Foundation Trusts, statutory for other NHS Trusts. There is a requirement for Chairs to designate a NED member to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED each time and the Trust has taken the approach that this is assigned on a case-by-case basis.

Security Management Champion

11. This is statutory for NHS Trusts but not for Foundation Trusts, as set out in the Directions to NHS Bodies on Security Management Issues (2004). This requires a designated member to promote security management work at Board level, including counter fraud, violence and aggression and security management of assets and estates. Counter Fraud now sits with

the Audit Committee as part of Counter Fraud work and Quality Committee oversee violence and aggression. This role has been retained in the guidance as it is a statutory requirement for NHS Trusts but it is acceptable for this to be overseen by committee assurance and this is the recommended approach.

Maternity Board Safety Champion

12. This is only required by Trusts providing maternity services and therefore one has not been appointed at the Trust.

Areas Overseen by Committee Structures

13. The remaining areas are already covered through existing Board Committee structures, as recommended in the guidance, with the exception of assurance that a Resuscitation policy is agreed and implemented. It is recommended that this is added to the cycle of business for the Quality Committee.

14. Where a single point of contact for an area is required, ie during a Care Quality Commission inspection, it would be anticipated that the Chair of the appropriate Committee would be identified as the most appropriate NED.

Conclusion

15. The growth of NED Champion roles was creating some confusion and disparity between how competing priorities and areas of focus were being managed. There was a danger of other areas/ issues being seen as less important as a champion had not been identified. The Trust is able to make its own decision about the extent to which it implements this guidance from NHS England and NHS Improvement. Ultimately the Board should collectively hold the responsibility across all areas.

16. The reduction of champion roles to two assigned roles, and one role that moves on a case-by-case basis, will keep the focus on the two areas identified. The approach should be reconsidered periodically.

Recommendation

To note the guidance and agree the Trust's proposed approach.

Author: Katharine Dowson, Corporate Secretary
Date: June 2022

Appendix 1

NED Champion Roles Review

	Assurance to	Legal Basis	Comments on management of area
Recommended for Retention			
Maternity Board Safety Champion	n/a	Recommended	Not required if maternity services not offered
Wellbeing Guardian	BPC	Recommended	NED in post
Freedom to Speak Up	Board	Recommended	NED in Post
Doctors Disciplinary	BPC	Advisory	Assigned on a case-by-case basis by the Chair as required
Security Management:		Not FTs	
Counter Fraud	Audit		Managed under Committee responsibilities
Violence and Aggression	Quality		Managed under Committee responsibilities
Recommended for Overview through Committee Structures			
Hip fractures, falls and dementia	Quality	Recommended	Executive Lead is sufficient if overseen by Committee and data is provided (through Integrated Performance Report)
Palliative and End of Life Care	Quality	Role for all NEDs	End of Life Care is on the cycle of business (Quality Committee) to provide assurance
Resuscitation	Quality	Recommended	Guidance recommends this is through committee processes rather than an individual. **Assurance regarding policy to be added to Quality Committee cycle of business**
Learning from Deaths	Quality	Role for all NEDs	No specific requirement for an individual NED, collective responsibility for all NEDS regarding mortality, particularly in regard to patients with learning disabilities
Health and Safety	Quality	Statutory	All NEDs have a statutory responsibility for Health and Safety
Safeguarding	Quality	Recommended	Can be discharged through a committee - all NED members to have at least Level 1 core competencies
Safety and Risk	Quality	Role for all NEDs	Reference to a NED for safety and risk is generally to the NED with oversight ie Chair of Quality Committee
Lead for Children and Young People	Board	Role for all NEDs	Limited services provided for Children & Young People - responsibility is across all Board members

Counter Fraud	Audit	No longer required	Statutory requirement revoked; Audit Committee Chair would fulfil any requirements
Emergency Preparedness	BPC	Role for all NEDs	Board oversight required
Procurement	BPC	Role for all NEDs	No requirement for a NED Champion, fulfilled through Committee processes.
Cyber Security	BPC	Role for all NEDs	All Board members require oversight. Senior Information Risk Owner is the Chief Finance Officer

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 30/06/22		**Report of:** Audit Committee		
Date of last meeting: 20/06/22		**Membership Numbers:** Quorate		
1.	**Agenda**	The Committee considered an agenda which included the following: • Audit Findings Report for the Year Ending 31st March 2022 (including Auditors Letter of Representation) • Auditors Annual Value for Money Report 2021/22 • Accounts for the Year Ending 31st March 2022 • Draft Annual Report and Accounts 2021/22 • Compliance with Provider License – Self Certification		
2.	**Alert**			
3.	**Assurance**	• It was anticipated that the audit opinion would be unqualified. • There were some outstanding matters to be resolved before the audit findings report could be approved for sign off and no issues were anticipated. This included a slight change required in remuneration reporting relating to some staff recorded in incorrect bandings • The Committee noted that the audit findings report, letter of representation and auditors annual value for money report were all on track to be signed off on 22nd June. • Auditors confirmed that information to be published within the financial statements was consistent with their knowledge of the Trust and the financial statement that had been audited.		
4.	**Advise**	• All items were recommended for Board approval.		
5.	Risks Identified	• None		
6.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
7 July 2022

Report Title	2022/23 Financial Planning update
Executive Lead	Mike Burns – Chief Finance Officer
Author (s)	Helen Wells – Deputy Chief Finance Officer
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance**	☐ **Partial assurance**	☐ **Low assurance**
Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	Evidence indicates poor effectiveness of system of controls

Key Messages

- Integrated Care System (ICS) financial plans submitted to NHS England and NHS Improvement (NHSEI) in April 2022 were rejected due to the outstanding deficit that remained, meaning that all organisational financial plans were rejected, and that revised plans were required to be submitted at the end of June.
- 2022/23 financial plan reported to NHSEI in April was a £1.381m surplus. Following the allocation of additional income to cover inflationary pressures and the allocation of a proportion of some of the ICS deficit the Trust planned surplus increased to £2.868m in the June 2022 submission.
- Additional capital funding has been allocated by the ICS to the Trust, meaning the overall 22/23 allocation is £5.738m, leaving a gap of £0.7m between funding and capital demand.

Next Steps

- Further prioritisation work on the capital plan.
- Continued identification and development of CIP plans for 22/23.
- Monitoring of financial risks identified within the paper.

Related Trust Strategic Ambitions and Themes	**Impact**		
Value for Money	Finance	Not Applicable	Not Applicable

Strategic Risks

003 System Finance	007 Captial Investment	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
BPC	21st Feb 2022	Mike Burns – Chief Finance Officer	Initial financial plan submitted to HCP on 17th Feb of £13.3m deficit presented (assuming £2.8m CIP but no ERF income) Was agreed that further work was required to review and update the plan ahead of next system submission

Execs	9th March 2022	Mike Burns – Chief Finance Officer	Latest 22/23 plan position presented (submitted to HCP on 9/3/22) showing a £4.9m deficit with description of key changes between plan submissions. Position included £4m CIP but no ERF income. Agreed work would continue on understanding and validating the plan.
BPC	22nd March 2022	Mike Burns – Chief Finance Officer	Latest 22/23 financial plan submitted to HCP and NHSE/I on 17th Feb presented showing a breakeven position with description of key changes between plan submissions. Agreed that work would continue on understanding and validating the plan.
BPC	April	Mike Burns – Chief Finance Officer	Update on planning where it was proposed that a surplus of £1.382m for 2022/23 be submitted (to help with the ICS financial position). It was also identified that there remained a significant shortfall between capital demand and capital allocation but that the outcome of business cases submitted for additional capital was awaited.
Trust Board	9th June 2022	Mike Burns – Chief Finance Officer	Verbal update provided on business planning and possible adjustments required to help improve the system wide financial plan (although final values were still to be agreed). These adjustments resulted in a proposed £2.868m surplus plan. It was also noted about the additional capital allocation from the ICS.
BPC	28th June 2022	Mike Burns – Chief Finance Officer	Updated Final Plan paper submitted for review to BPC. This had been previously verbally discussed at Board prior to final NHSEI submission but final paper details I&E, Balance Sheet, Cash-Flow, Capital and risks and potential mitigations. BPC recommended to Trust Board for approval.

2022/23 Business Planning

Executive Summary

1. The requirements for preparing the financial plan for 2022/23 were set out in draft guidance issued by NHSEI on 24th December 2021. The guidance lays down the over-arching principles to be applied in the financial planning with the key items being the move to 12-month financial planning (instead of 6 monthly which has been the case for the last 2 years) and the continued requirement for system level planning to be undertaken. There is a requirement for systems to deliver a balanced financial position in 2022/23.

2. Financial planning has been an iterative process with a number of submissions required to be made to the Integrated Care System (ICS) (shown in the paper). The Trust has also had to submit a number of plans to NSHEI with the final submission being made on 22 April 2022, in which the Trust posted a planned year end surplus of £1.381m.

3. Based on the plans submitted in April, the ICS were anticipated to deliver a year end deficit in excess of £140m. This was rejected by NHSEI, meaning that all organisational plans were also rejected, resulting in a requirement for updated plans to be submitted at the end of June 2022 in which the system position was expected to be breakeven.

4. Due to the need for the ICS to report a breakeven position, the deficit has been allocated to all organisations using a methodology across several areas. This resulted in The Walton Centre being required to deliver a surplus of £2.868m at the end of 2022/23.

5. The paper provides a breakdown of the key assumptions applied in the 2022/23 business plan, main movements between the reported 2021/22 year end position and plan, analysis of the balance sheet and cashflow, main financial risks and associated mitigations, efficiency requirements and capital update.

Background and Analysis

6. The financial planning process has required a number of submissions to be made to the ICS, prior to the first draft detailed plan submission to NHSE/I on 17th February 2022. The final detailed financial plan submission was required to be made to NHSEI on 22nd April 2022, which resulted in a number of additional submissions to the ICS (which are shown in Appendix 1 of the paper). The Trust reported a planned surplus of £1.381m in the April submission.

7. Due to the size of the planned ICS deficit following the April submission to NHSEI, the plans were rejected meaning that all organisations financial plans were also rejected. This resulted in a requirement to submit an additional plan to NHSEI at the end of June, with the expectation that the ICS would breakeven.

8. In order to enable the ICS to report a breakeven position, all organisations have been allocated a proportion of the deficit (meaning they have to improve their positions) based on several different apportionment methods. This resulted in the surplus requirement of the Trust increasing to £2.868m, which was proposed through an additional income allocation (to reflect above inflationary increases not anticipated in initial planning assumptions) as well as a reduction to planned expenditure to reflect the Trusts proportion of the ICS deficit.

9. A number of assumptions have been applied to the financial plans which have been refined throughout the process. The latest formal submission is breakeven which assumes £4.9m CIP will be delivered to achieve this. It also assumes that £4.1m ERF income will be received for successful delivery of activity targets.

10. There are a number of changes in both income and expenditure between the 2021/22 year end position and the 2022/23 plan, which are described in the report, but include:

    a. Additional ERF income (over and above 21/22 levels);
    b. Transfer of services (spinal and Health Procurement Liverpool);
    c. Commissioning of new services (transcranial guided ultrasound);
    d. Pay award costs.

11. There are a number of risks associated with the delivery of a balanced financial plan, which are described in the paper (along with mitigations) but include:

    a. ERF – achievement of activity targets to receive ERF;
    b. Achievement of planned activity targets – the plan is based on workforce availability and a level of productivity;
    c. Delivery of CIP;
    d. Utility costs – a 10% increase has been applied to already increased costs but the worldwide environment could push prices higher;
    e. Limits on workforce availability may impact on ability to deliver planned levels of activity and productivity.

12. Capital allocations for 2022/23 also present a pressure for the organisation. System wide capital allocations remain in place with the 2022/23 allocation being £175.6m compared to demand of £247m. The Trust was initially allocated £4.4m capital funding based on the depreciation generated calculation, which resulted in a gap of approx. £2m between Trust capital demand and funding. Bids were submitted to the ICS for additional funding, against which a further £1.3m was awarded to the Trust. This takes the overall capital allocation for 22/23 to £5.7m (excluding digital aspirant funding), which still results in a shortfall of approximately £0.7m. Further work is being undertaken to prioritise requested capital spend for 22/23. A number of people are involved in the capital prioritisation (Chief Finance Officer, Chief Operating Officer, Deputy Medical Director and Deputy Chief Nurse) to ensure that all issues (e.g. patient safety, performance, regulatory compliance etc.) is considered.

13. Further work continues on validating the plan and identifying CIP schemes. Quality Impact Assessments are in the process of being prepared which will then be reviewed and signed off by the Chief Nurse, Medical Director and Chief Finance Officer.

14. Based on the current plans, the Trust's cash balance is planned to be £34.8m at the end of March 2023. This is a reduction of nearly £5.5m from the March 2022 cash balance and is primarily due to increased payable PDC dividends as well as payment for capital items purchased at the end of 2021/22.

Conclusion

15. The financial plan submitted to NHSEI on 20th June shows a planned year end surplus of £2.868m. This plan is based on a number of assumptions and there are risks associated with the delivery of this plan.

Recommendation

16. To approve the financial plan for 2022/23.

17. To note the associated risks and mitigations within the financial plan.

Author: Helen Wells – Deputy Chief Finance Officer
Date: 17th June 2022

The Walton Centre
NHS Foundation Trust

2022/23 Financial Planning

Purpose of the report

The purpose of the report is to provide an update on financial plans for the 2022/23 financial year. The paper will describe the financial planning process, key assumptions that have been applied and risks within the plan, alongside potential mitigations and opportunities (e.g. additional ESRF income).

Background

Operational and financial planning guidance was issued in late December 2021. This laid out the principles for 22/23 planning which included the requirement to submit 12-month plans (rather than 6-month plans which have been required for the last 2 years). There is also a requirement to continue to work at a system level (Cheshire & Merseyside Integrated Care System (ICS). There is a national expectation that the ICS, and partners within the ICS, will deliver a breakeven plan for the 2022/23 financial year.

Systems are asked to develop fully triangulated plans across activity, workforce and finances for the 2022/23 financial year.

There have been a number of submissions made to both the ICS and NHSEI during the planning process, with the financial plan position changing as further clarification was received around national and system wide assumptions as well as internal validation of financial plans. Appendix 1 provides a summary of the submission timetable as well as the Trust financial positions that were submitted (all of which have been shared with BPC and Board).

At the time of writing, system and organisational financial plans have been rejected nationally by NHSEI, with a requirement for the system to deliver breakeven by the end of the financial year. There was an approximate £85m deficit position in the Cheshire & Merseyside ICS which needed addressing and therefore further stretch targets were set by the ICS to specific providers to deliver an improved financial position. This means that improved financial plans need to be submitted to NHSEI at the end of June. Following discussions with the ICS, there have been some improvements to organisational plans to reduce the overall system deficit. This has included allocation of additional inflationary income and distribution of the system gap across all organisations, based on several factors.

Key assumptions applied

The 2022/23 financial plan is based on a number of assumptions (national, system and internal):

- Block contract values carried forward from 2019/20, adjusted for inflation and agreed service developments, plus non-recurrent allocations for COVID and provider sustainability support (albeit at a reduced level);
- 2% system CIP applied (1.1% national efficiency target plus 0.9% ICS nationally mandated convergence target to move towards fair share allocations);
- Additional inflationary income of 0.7% to reflect above inflationary cost increases that have been incurred as a result of national and international circumstances;
- The Trust recurrent efficiency requirement is 3% of turnover (equivalent to 3.6% when removing excluded drugs and devices from turnover). This is higher than the system target of 3% CIP requirement given the gap;
- 3% pay award assumed (as per national guidance);
- 1.8% net inflation applied to income;

- Full year impact of agreed internal business cases included;
- Finance costs increased to reflect increased capital spend;
- Utility costs increased by 10% (in addition to a significant increase in costs assumed in 2021/22 costs) given the current political environment;
- Non-recurrent CIP built back into plans;
- All COVID costs removed as per national guidance;
- CNST costs adjusted to predicted 2022/23 levels;
- Income and costs for new transcranial ultrasound assumed;
- Non-recurrent income removed;
- Welsh income assumed at block plus inflation;
- Clinical pay budgets calculated to reflect agreed WTE establishments;
- Admin and other pay budgets based on H2 run rates;
- No adjustments to nurse bank run rates (from H2);
- Additional non-pay costs assumed for 22/23 activity plan;
- Income and costs assumed to reflect the transfer of spinal services from LUFHT;
- Costs have been reduced to reflect the allocation of system wide deficit to all organisations;
- Elective System Recovery Funds (ESRF) are included within the plan, with the assumption that the Trust will exceed 104% of the value of 2019/20 activity. The value of this income is £4.1m;
- The annual leave accrual built in the 2021/22 financial position is assumed to be released in 2022/23. This was a request by ICS to ensure all organisations were being consistent in their approach to planning. It is assumed that additional annual leave accrued by staff as a result of COVID will be utilised in 2022/23, removing the requirement for the annual leave accrual moving forward;
- The expenditure plan includes a non-recurrent contingency reserve to cover unplanned expenditure that will be incurred during the year as well as a minor equipment reserve (for items under £5,000).

Plan submissions

The plan submitted on 22nd April showed a surplus of £1.38m, as shown below:

	TOTAL PLAN
Income	
Patient Care Income	**128,625**
Exclusions	**29,160**
Private Patients	**38**
Other Operating Income	**7,727**
Donated Income	**0**
Total Operating Income	**165,551**
Expenditure	
Pay	**(84,722)**
Non-Pay	**(47,202)**
Exclusions	**(30,288)**
COVID	**0**
Total Operating Expenditure	**(162,212)**
Total Operating Surplus/(Deficit)	**3,339**
Gains/(losses) including disposal of assets	**0**
Finance Income	**0**
Finance Expense	**(583)**
PDC Dividends Payable	**(1,639)**
I & E Surplus / (Deficit)	**1,117**
Impact Charitable Funds Income	**0**
Impact Donations Depreciation	**264**
Impact gains/(losses) including disposal of assets	**0**
Adjusted I & E Surplus / (Deficit)	**1,381**

System position and changes to organisational plans

At the end of May 2022, Cheshire & Mersey ICS reported a 2022/23 planned deficit of £85.2m. This was after additional national funding had been allocated for inflationary and COVID pressures. There is an expectation from the national NHSEI team that the system delivers a breakeven position by the end of the financial year. This means that the existing deficit will need to be distributed to organisations utilising an agreed methodology, with a requirement for revised plans to be submitted to NHSEI on 20th June 2022.

0.7% additional tariff inflation has been allocated to Trusts, with the expectation that it will improve the Trusts financial position. For The Walton Centre, this equates to £0.8m additional income that will be received. In addition to this, a further reduction to expenditure is assumed as an allocation of an element of the system wide deficit. This equates to £0.7m for The Walton Centre.

Even after the implementation of these changes, there would still be a system wide deficit in excess of £40m. Discussions have taken place with those organisations in deficit to agree stretch targets to bring the deficit down further. CEO's were included in these discussions given the risks to organisations on further improving their financial positions.

This distribution of the initial system deficit to The Walton Centre results in a revised 2022/23 surplus of £2.9m, which is the plan submitted on 20th June (shown in the table below). This equates to 1.7% of turnover, which is the largest percentage surplus of provider organisations in Cheshire & Mersey ICS (and likely to be one of the highest in the Northwest).

	TOTAL PLAN V6 - 22/06/22
Income	
Patient Care Income	129,413
Exclusions	29,160
Private Patients	38
Other Operating Income	7,727
Donated Income	0
Total Operating Income	**166,338**
Expenditure	
Pay	(84,721)
Non-Pay	(46,743)
Exclusions	(30,288)
COVID	0
Total Operating Expenditure	**(161,752)**
Total Operating Surplus/(Deficit)	**4,586**
Gains/(losses) including disposal of assets	0
Finance Income	239
Finance Expense	(583)
PDC Dividends Payable	(1,639)
I & E Surplus / (Deficit)	**2,604**
Impact Charitable Funds Income	0
Impact Donations Depreciation	264
Impact gains/(losses) including disposal of assets	0
Adjusted I & E Surplus / (Deficit)	**2,868**

Explanation of key movements between forecast and plans

The table below shows the movement between the 2021/22 reported position (subject to audit) and the 2022/23 financial plan (submitted on 20th June).

	M12 (subject to audit)	TOTAL PLAN V6 - 22/06/22	Movement
Income			
Patient Care Income	119,475	129,413	9,938
Exclusions	25,590	29,160	3,570
Private Patients	33	38	5
Other Operating Income	10,900	7,727	(3,173)
Donated Income	0	0	0
Total Operating Income	**155,998**	**166,338**	**10,340**
Expenditure			
Pay	(82,059)	(84,721)	(2,662)
Non-Pay	(35,066)	(46,743)	(11,677)
Exclusions	(29,836)	(30,288)	(452)
COVID	(1,000)	0	1,000
Total Operating Expenditure	**(147,961)**	**(161,752)**	**(13,791)**
Total Operating Surplus/(Deficit)	**8,037**	**4,586**	**(3,451)**
Gains/(losses) including disposal of assets	19	0	(19)
Finance Income	21	239	218
Finance Expense	(6,668)	(583)	6,085
PDC Dividends Payable	(1,503)	(1,639)	(136)
I & E Surplus / (Deficit)	**(94)**	**2,604**	**2,698**
Impact Charitable Funds Income		0	0
Impact Donations Depreciation		264	264
Impact gains/(losses) including disposal of assets	94	0	(94)
Adjusted I & E Surplus / (Deficit)	**0**	**2,868**	**2,868**

The table above shows that there is a planned increase in income of £10.3m primarily due to:

- ESRF income in addition to 21/22 outturn (£1.1m);
- Transfer of spinal services from LUFHT (matched by additional costs);
- Commissioning of transcranial guided ultrasound services by NHS England;
- Inflation (including additional inflationary allocation awarded in June);
- Growth funding from commissioners;
- Transfer of procurement staff as part of the Health Procurement Liverpool collaboration with Alder Hey, Heart and Chest and Clatterbridge (matched by additional costs).

There is also a planned increase of £13.8m in operating costs from 2021/22 primarily due to:

- Transfer of spinal services (and associated TUPE of staff) – both pay and non-pay costs;
- Transfer of staff as part of Health Procurement Liverpool collaborative;
- Pay award costs (£3.5m);
- Additional costs assumed for anticipated activity increase;
- Additional costs related to transcranial guided ultrasound service;
- Reduced expenditure assumed in relation to the allocation of a share of the ICS deficit in June 2022;
- Additional utility costs;
- Depreciation (moved from the finance expense line);
- Internally agreed developments.

Efficiency requirements

The financial plan shown includes an assumed 3% CIP target, equating to £4.9m.

The Trusts assumed CIP target of 3% consists of:

- 1.1% national efficiency assumption;
- 0.9% ICS convergence adjustment (replaces pre-COVID Financial Improvement Trajectory regime to being organisations and system underlying deficits back to balance);
- 1.3% to cover internal Trust developments and non-recurrent CIP from prior years.

The 2022/23 CIP consists of a recurrent (£4.1m) and non-recurrent (£0.9m) element. The overall requirement is 3% of turnover but this increases to 3.6% once the impact of excluded drugs and devices is removed from turnover figures (as these are 'pass through' costs which the Trust cannot generate savings from).

2022/23 CIP schemes in development are:

	Recurrent	Non-Recurrent	Total
CIP TARGET	**4,092**	**855**	**4,947**
Possible CIP schemes			
Bed repurposing	646	321	**966**
Procurement	238	292	**530**
E-roster	250	0	**250**
Wireless	22	0	**22**
Non-recurrent slippage from vacancies	0	1,000	**1,000**
Neurovascular	375	0	**375**
Warrington consultant savings	260	0	**260**
Anticipated non-pay savings	500	0	**500**
TOTAL CIP SCHEMES	**2,291**	**1,612**	**3,904**
To be identified	**1,801**	**(757)**	**1,043**

All schemes identified will require a quality impact assessment to be undertaken and approved by the Chief Nurse and Medical Director before budgets are adjusted.

To support the delivery of the CIP programme, the Trust will utilise the skills and expertise of the Service Transformation team. Reporting of CIP delivery and progress will take place through Business Performance Committee (BPC) on a monthly basis (through the Integrated Performance Report).

Statement of Financial Position (SOFP/ Balance sheet) and cashflow

Appendix 2 shows the planned balance sheet and cashflow for 2022/23. Based on the current financial plan, the Trust's cash balance is planned to be £34.8m at the end of March 2023. This is a reduction of nearly £5.5m from the cash balance at the end of March 2022. This is primarily due to increased PDC dividends that are payable, as well as payment for capital items purchased at the end of 2021/22 (on site by the end of the year but invoices not necessarily paid).

The impact of the new lease standard (International Financial Reporting Standard – IFRS16) is included within the 2022/23 plan. The impact is not expected to be significant, and the current message from the Department of Health and Social Care (DHSC) is that the impact of IFRS16 in 2022/23 will be excluded from performance targets, however the exact treatment of this is yet to be determined.

Interest, tax, depreciation and amortisation

Planned depreciation (excluding IFRS 16 leased assets) has increased by £205k, reflecting the increase in capital spend over the last two years.

PDC Dividend payments have increased by £101k, reflecting the increased capital base and reduction in cash, which impacts directly on the calculation.

Capital

The national system allocation for capital for 2022/23 is £4 billion, of which the C&M ICS share is £175.7m. The ICS are responsible for the allocation of capital funding to organisations for 2022/23, following the principles set in 2021/22. This removes autonomy that Foundation Trusts have previously had to utilise cash reserves for capital items.

The allocation of capital allocations from the ICS is based on a hybrid model of allocation and prioritisation, with capital funding being divided into 4 areas:

- Depreciation generated (£113.3m) – apportion to providers based upon relative 2020/21 depreciation figures;
- Backlog maintenance generated (£16.7m) – a bidding process will be developed to prioritise schemes based upon risk and need. Externally validated data will be used wherever possible. This process will include input from clinical and estates teams;
- Prior year surpluses generated (£16.4m) – a bid process to prioritise schemes where pre-commitments have been made to utilise prior year surpluses. This will also include input from Clinical and Estates teams;
- Contingency – gross assets generated allocated (£29.3m) – create a strategic contingency to address larger issues and support strategic priorities of the ICS.

Appendix 3 shows the Trust's current capital submission for the years 2022/23 to 2024/25, compared to the depreciation generated calculation of £4.4m. Current capital submissions from departments total £6.4m for 2022/23, which is significantly in excess of the Trust's allocated capital funding.

Bids were made to the ICS for additional capital funding (through the backlog maintenance and contingency funds). A number of bids were successful, which resulted in an additional capital allocation of £1.3m, meaning that the overall capital allocation for 2022/23 is £5.7m. However there still remains a shortfall between the capital allocation and Trust capital demands of approximately £0.7m. Appendix 4 shows the current 2022/23 capital position, taking account of the increased ICS capital allocation. It should be noted that this does not take account of planned digital aspirant expenditure which is separately funded.

Initial prioritisation work has taken place which reduced divisional capital submissions from £9.5m (for 2022/23) but further work is required on this given there remains a gap in funding. As such a prioritisation process will be undertaken using a risk-based approach. The Trusts risk register will be reviewed to ensure the capital plan addresses the most pressing risks. A prioritisation panel has been established and comprises the Chief Finance Officer, Chief Operating Officer, Deputy Medical Director and Deputy Chief Nurse.

The Trust's capital budget must be agreed within the Cheshire & Mersey ICS, and the overall ICS capital plan must be deemed affordable and approved by NHSEI.

The approach to capital planning will be managed by the Trust's Capital Management Group (chaired by the Chief Finance Officer) with updates and progress against the capital plan provided to Business Performance Committee on a regular basis.

Risks and Mitigations

The most significant risks to delivery of the draft Financial Plan for 2022/23 are as follows:

- Actual activity below levels required to attract Elective Recovery Funding, resulting in lower than anticipated income (£4.1m), or clawback of base contract income as no floor exists on ERF clawback.

Mitigation: Performance monitoring through weekly performance meetings with corrective action taken as needed. Fortnightly meetings are being held between finance and operational teams to aid understanding of the potential ERF position and to agree corrective action to be taken. Monitoring of activity performance will be undertaken by Business Performance Committee.

- Delivery of CIP programme – level of maturity impacts on ability to deliver recurrent savings required in year.

Mitigation: weekly CIP meetings held with Chief Operating Officer, Chief Finance Officer and senior managers of clinical and corporate areas to discuss progress on schemes as well as identification of new schemes. Finance and transformation teams working in collaboration with Divisions on scheme identification and delivery.

- Additional costs pressures arising during the year for emerging issues.

Mitigation: Small contingency fund held in reserves. Budget monitoring, forecasting and reporting in place.

- Delegated ICS Capital Resource Limit insufficient to meet investment requirements.

Mitigation: Risk based approach to capital prioritisation to take place. Work with ICS to identify potential slippage for diversion where possible. Identification of potential capital schemes that could be mobilised at short notice if additional ICS capital funding made available. Pursue alternative funding sources from outside the system envelope where opportunities exist (e.g. TIF).

- Costs/ income assumed in relation to service transfers differ from current assumptions.

Mitigation: Closely monitor services that transfer to understand cost with budget monitoring, forecasting and reporting.

- Levels of inflation incurred are greater than assumed within plan. Due to national and international events inflationary increases have been greater than levels assumed within national planning guidance.

Mitigation: Some additional inflationary funding has been allocated to the ICS, which will be allocated to individual organisations, although this is expected to help improve the overall organisational position. Monitoring of costs with budget monitoring, forecasting and reporting.

- NICE funded drugs may not be funded by Commissioners creating cost pressures.

Mitigation: Monitoring of spend (including forecasting) and raising potential issues with commissioners through regular contract meetings. Also raise cost pressures with ICS.

- ICS partners performance – may put pressure on organisations that can deliver to improve positions to help towards those that can't.

Mitigation: Regular meetings with senior ICS leaders. Discussion at a CEO and Chair level to discuss potential impact of this on Trust performance.

- Limits on workforce availability may impact on ability to deliver planned levels of activity and productivity.

Mitigation: Recruitment, retention, turnover and sickness monitoring through Business Performance Committee with use of international nurses to address known gaps.

- Outpatient Follow Up targets – if reductions cannot be made in line with funding, costs will be incurred for which funding will not be received (as no funding will be received for any follow-up activity over 85% of 2019/20 levels).

Mitigation: Weekly monitoring of activity performance. Discussion with commissioners and ICS about the nature of some long-term conditions that will require a higher level of follow-up appointments.

Next steps

As has been stated, there is a requirement from the ICS for organisations to improve their financial positions to enable the system to deliver a breakeven financial position. The impact of this on the Trust is not known at the present time but will be discussed with the Executive Team once the information is available.

A challenge and review process is being undertaken by the ICS for any organisations showing a deficit for 2022/23. There is also a requirement for all organisations to undertake a financial sustainability assessment. This comprises a self-assessment but will also require organisations to commission an independent external assessment by auditors. A separate paper will be prepared explaining this process further.

Recommendations

The Board is asked to note the current Financial Plan for 2022/23, noting that the position may still vary depending on discussions with the ICS around the overall financial position.

Appendix 1: Summary of financial positions and dates submitted

	Version 1 17th Feb 22	Version 2 23rd Feb 22	Version 3 9th Mar 22	Version 4 17th Mar 22	Version 5 22nd April 22	Version 6 20th June 22
Income						
Patient Care Income	118,202	121,804	122,787	127,554	128,626	129,413
Exclusions	28,728	28,728	29,160	29,160	29,160	29,160
Private Patients	38	38	38	38	38	38
Other Operating Income	7,577	7,577	7,727	7,727	7,727	7,727
Total Operating Income	**154,545**	**158,147**	**159,712**	**164,479**	**165,551**	**166,338**
Expenditure						
Pay	(89,352)	(89,352)	(87,161)	(86,125)	(84,722)	(84,721)
Non-Pay	(45,816)	(45,816)	(45,228)	(46,109)	(47,202)	(46,743)
Exclusions	(30,768)	(30,768)	(30,288)	(30,287)	(30,288)	(30,288)
COVID						0
Total Operating Expenditure	**(165,936)**	**(165,936)**	**(162,677)**	**(162,521)**	**(162,212)**	**(161,752)**
Total Operating Surplus/(Deficit)	**(11,391)**	**(7,789)**	**(2,965)**	**1,958**	**3,339**	**4,586**
Gains/(losses) including disposal of assets	0	0	0	0	0	0
Finance Income	0	0	0	0	0	239
Finance Expense	(583)	(583)	(583)	(583)	(583)	(583)
PDC Dividends Payable	(1,639)	(1,639)	(1,639)	(1,639)	(1,639)	(1,639)
I & E Surplus / (Deficit)	**(13,613)**	**(10,011)**	**(5,187)**	**(264)**	**1,117**	**2,604**
Impact Charitable Funds Income	0	0	0	0	0	0
Impact Donations Depreciation	264	264	264	264	264	264
Impact gains/(losses) including disposal of assets	0	0	0	0	0	0
Adjusted I & E Surplus / (Deficit)	**(13,349)**	**(9,747)**	**(4,923)**	**0**	**1,381**	**2,868**

Appendix 2 – Balance sheet and cash flow (based on £2.868m surplus)

SoFP - 21/22 ACTUAL	MAR - 22	Mar-23
	£'000	£'000
Non-current assets		
Intangible Assets	**747**	567
Other property, plant and equipment	**94,678**	96,119
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	**101**	43
Receivables: due from non-NHS/DHSC Group bodies - non current	**428**	428
Total non-current assets	**95,954**	**97,157**
Current assets		
Inventories	**1,841**	1,841
Receivables: due from NHS and DHSC group bodies - current	**4,296**	4,296
Receivables: due from non-NHS/DHSC Group bodies - current	**2,019**	2,019
Cash and cash equivalents: GBS/NLF	**38,871**	**34,617**
Cash and cash equivalents: commercial/in hand/other	**201**	201
Total current assets	**47,228**	**42,973**
Current liabilities		
Trade and other payables: capital	**(6,888)**	(1,500)
Trade and other payables: non-capital	**(22,790)**	(21,305)
Borrowings - current	**(1,630)**	(1,605)
Provisions - current	**(55)**	(55)
Other liabilities: deferred income including contract liabilities	**(1,198)**	(1,198)
Total current liabilities	**(32,560)**	**(25,662)**
Total assets less current liabilities	**110,621**	**114,468**
Non-current liabilities		
Borrowings - non current	**(22,284)**	(20,852)
Provisions - non current	**(707)**	(707)
Total non-current liabilities	**(22,991)**	**(21,559)**
Total net assets employed	**87,630**	**92,909**
Financed by		
Public dividend capital	**34,616**	37,291
Revaluation reserve	**7,377**	7,377
Income and expenditure reserve	**45,637**	48,241
	87,630	**92,909**

STATEMENT OF CASH FLOW - 2022/23 ACTUAL	MAR-23
	£'000
Cash flows from operating activities	
Operating surplus/(deficit)	**4,586**
Non-cash income and expense:	
Depreciation and amortisation	**7,210**
Impairments and reversals	**0**
Income recognised in respect of capital donations (cash and non-cash)	**0**
(Increase)/decrease in receivables	**0**
(Increase)/decrease in inventories	**0**
Increase/(decrease) in trade and other payables	**(1,381)**
Increase/(decrease) in other liabilities	**0**
Increase/(decrease) in provisions	**0**
All other movements in operating cash flows (including working capital movements)	**0**
Net cash generated from/(used in) operations	**10,415**
Cash flows from investing activities	
Interest received	**240**
Purchase of property, plant and equipment and investment property	**(13,801)**
Proceeds from sales of property, plant and equipment and investment property	**0**
Initial direct costs, up-front payments and (lease incentives) in respect of new right of use assets	**0**
Receipt of cash donations to purchase capital assets	**0**
Net cash generated from/(used in) investing activities	**(13,561)**
Cash flows from financing activities	
Public dividend capital received	**2,675**
Loans from Department of Health and Social Care - repaid	**(1,396)**
Capital element of lease payments	**(61)**
Interest paid	**(559)**
Interest element of lease payments	**(24)**
PDC dividend (paid)/refunded	**(1,743)**
Net cash generated from/(used in) financing activities	**(1,108)**
Increase/(decrease) in cash and cash equivalents	**(4,254)**
Cash and cash equivalents at start of period	**39,072**
Cash and cash equivalents at end of period	**34,818**
Cash balance per SOFP	**34,818**

Appendix 3: Trust 3-year capital requests compared to ICS funding

CAPITAL	2022/23	2023/24	2024/25
Division	**£'000**	**£'000**	**£'000**
Estates - Pipeworks	1,200	1,100	1,600
Estates - Other	2,764	2,315	1,545
IM&T	593	1,373	522
Neurology	50	2,934	3,814
Neurosurgery	1,676	1,856	792
Corporate	165	0	0
Total	**6,448**	**9,578**	**8,273**
ICS Capital allocation as at 31st May 2022	4,400	4,400	4,400
Difference	**(2,048)**	**(5,178)**	**(3,873)**

Appendix 4: Trust 2022/23 capital requests compared to revised ICS funding

	22/23 requests (after initial prioritisation)	Initial ICS allocation	ICS additional approvals (tranche 1)	TOTAL ICS allocation	Shortfall
Estates - Pipeworks	1,200	1,200		**1,200**	0
Estates - Other	2,764	2,635		**2,635**	(129)
IM&T	593		593	**593**	0
Neurology	50			**0**	(50)
Neurosurgery	1,676	555	755	**1,310**	(366)
Corporate	165			**0**	(165)
TOTAL	**6,448**	**4,390**	**1,348**	**5,738**	**(710)**

The Walton Centre
NHS Foundation Trust

Report to Trust Board

7th July 2022

Report Title	Pharmacy and Medicines Management Annual Report 2021-22
Executive Lead	Dr A Nicolson, Medical Director
Author (s)	Dave Thornton, Jenny Sparrow and the Walton Senior Pharmacist team.
Action Required	To note

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

✓ **Acceptable assurance**	☐ **Partial assurance**	☐ **Low assurance**
Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- The report describes the pharmacy services delivered by LUHFT to Walton and developments in Walton's Medicines Management processes during 2021-22.
- It was a challenging year due to significant staff shortages both within the Walton team and pharmacy in general, plus issues raised by Covid 19 pandemic and the international immunoglobulin shortage.
- Throughout the year review of needs and prioritisation of services was undertaken, and all essential and important services were maintained to a good standard. Most other work was also continued along with new or one-off tasks as appropriate, but some lower priority work had to be postponed.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Presentation to Trust Board

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Quality of Care	Quality	Workforce	Compliance

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

001 Quality Patient Care	004 Operational Performance	003 System Finance

Equality Impact Assessment Completed *(must accompany the following submissions)* N/A

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	16th June 2022	Dr A Nicolson, Medical Director	

Executive Summary

- It was a challenging year due to significant staff shortages both within the Walton team and pharmacy in general, plus issues raised by the Covid 19 pandemic and the international immunoglobulin shortage. All key services were maintained, and other demands for pharmacy time and resources were assessed and prioritised, in agreement with Walton senior managers.
- All inpatients were reviewed by ward pharmacists daily on weekdays, and all same day admission patients for surgery were reviewed and had their medicines prescribed by pharmacist prescribers. There was continued provision of specialist neuroscience pharmacist advice, antimicrobial stewardship and input into education and training of Trust staff.
- Support was provided to key Trust committees and groups and participation continued in the Pan Mersey Area Prescribing Committee subgroups and the North Wales Neuroscience medicines network.
- Pharmacy responded to the evolving needs of the Covid 19 pandemic, including producing and maintaining Walton clinical guidelines for treatment of patients with Covid, with frequent updates in response to changes in the evidence base and national recommendations.
- The international immunoglobulin shortage had major implications for Walton's neurology service. All appropriate steps were taken to manage the situation and plan ahead as far as possible to minimise the impact on patients. Most longterm patients had to have their dose interval increased and their usual brand switched, often more than once.
- There was increasing use of homecare medicines services, with various new medicines and a large rise in patient numbers.
- Business cases were presented and approved for senior pharmacist time to focus on medicines safety, and extra pharmacy assistant resource for administrative support for homecare medicines.
- There were national shortages of many medicines; Pharmacy communicated the issues to wards and departments and sourced alternatives where possible.

Key areas for further development

- Recruitment and development of the newly funded medicines safety pharmacist role.
- Scoping exercise for use of pre-filled syringes prepared in an Aseptic unit to improve safety and efficiency of the intrathecal pump service by using ready prepared prefilled syringes. A business case will be presented when scoping is complete.
- A continued increase is anticipated in patient numbers requiring medicines via homecare services, which is likely to require extra pharmacist resource in future.
- Upgrade of the electronic prescribing and medicines administration system is planned.

Conclusion

Despite the challenges faced during the year, Pharmacy maintained all essential and important services to a good standard, and responded flexibly as situations evolved. Most other routine work was also continued, and new or one-off tasks completed where appropriate, but some lower priority work had to be postponed. Staffing was expected to improve from April 2022.

Recommendation

To note.

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

Appendix 1

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

Pharmacy and Medicines Management Annual Report 2021-22

Our Mission:

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

Report prepared by:
Dave Thornton, Assistant Clinical Director of Pharmacy, WCFT Lead
Jenny Sparrow, Lead Neurosciences Pharmacist
Ruth Bennett, Advanced Clinical Pharmacist, Neurosciences
Sian Davison, Advanced Clinical Pharmacist, Neurosciences
Elizabeth Akinsanya, Advanced Clinical Pharmacist, Neurosciences
Elaine Ho, Advanced Clinical Pharmacist, Neurosciences
Tas Rahman, Advanced Neurocritical Care Pharmacist
Ellen Wightman, Senior Clinical Rotational Pharmacist
Olivia Court, Senior Clinical Rotational Pharmacist

Context

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

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

1. Core Pharmacy Services

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

1.1 General information

Aintree Pharmacy employs 139 members of staff, comprising pharmacists, pharmacy technicians, assistant technical officers (ATOs) and administrative staff. In April 2021, compliance with mandatory training was 98%, and in February 2022 sickness absence was at 5% (these figures relate to the whole department).

Aintree Pharmacy is a Registered Pharmacy with the General Pharmaceutical Council (GPhC), and has a wholesale dealer's license which enables supply of medicines to the Walton Centre, which was granted in November 2020 and valid up to date. It also has a license to supply controlled drugs to the Walton Centre and is inspected by The Home Office for renewal of this license to supply. The current license is valid until March 2023 and is reviewed annually. The Clinical Director of Pharmacy is the Controlled Drugs Accountable Officer for both LUHFT and Walton.

1.2 Dispensary services - medication supply

Figure 1. The automated dispensing robot. When medicine labels are requested, or ward stock orders scanned by barcode, one of the robot 'arms' moves along to the required row & column and selects the correct medicine, and outputs it to a conveyer belt system which delivers it to the appropriate output chute. Most medicines are processed into the robot automatically via a 'hopper' that conveys them into the robot for bar code scanning and storage.

During 2021-22, a total of 39,212 items were dispensed for individual Walton inpatients, discharge prescriptions and outpatients, and 19,402 stock items were issued. 3,444 items were returned to stock and credited to The Walton Centre. These figures have increased from the previous year due to the resumption of elective procedures that had previously been cancelled/delayed in 2020-21 secondary to the COVID-19 pandemic.
The average turnaround time for Walton discharge prescriptions was 61 minutes; consistently under the target time of 2 hours. The average number of Walton discharge prescriptions clinically checked by the ward pharmacist was 70%.

The EPMA portal is a web-based system designed by Aintree Pharmacy, which reads information from the electronic prescribing and medicines administration (EPMA) system. It has many benefits and is frequently updated with extra features.

Key benefits include:

- Nurses can place orders for individual inpatient medicines electronically using the portal at any time of the day, including out of hours. The 'out of hours' orders are dispensed when Pharmacy is next open. Nurses can generate a medication order by simply selecting the item(s) required for the patient and submitting the request. There is an option to mark the item as urgent. Pharmacists view all requests and authorise them before they are dispensed. Stock medicines can also be ordered on the portal.
- The portal displays recent medication supplies made by Pharmacy for each patient and indicates the ward the medicines were sent to. This reduces duplicate ordering, medication wastage and unnecessary expenditure.
- The portal is directly linked to automatic labelling systems in pharmacy. Once a medication supply order has been authorised by a pharmacist, the labels are automatically generated in pharmacy within minutes and thus dispensed in a timely manner. The automatic labelling systems use information pulled from the electronic prescription, avoiding the need for manual input of medicine details. Most medicines are stored in the 'robot' (see Figure 1), which identifies medicines by bar codes, and automatically delivers the medicinal product selected during the labelling process. When used together, the automatic labelling system and robot abolish the potential for dispensing errors due to incorrect manual entry of medicine details, manual selection of medicine or incorrect entry of patient details or dosage instructions. Those risks remain for the small minority of medicines not stored in the robot or where medicine and labelling details cannot be automatically pulled from the prescription. All dispensed items routinely undergo a final check by a senior accredited checking pharmacy technician or a pharmacist, mitigating these risks, so very few dispensing errors leave Pharmacy.
- Ordering of controlled drugs (CDs) is also performed electronically. This removes the need for porters to take CD order books to Pharmacy from Walton. As well as being linked to the automatic labelling systems the EPMA system is linked to the Omnicell electronic CD cabinet. This improves the safety and security of CDs and automates the completion of the mandatory CD records. It also ensures that CDs not routinely used by wards have to be ordered against an individual patient, allowing a pharmacist safety check of the prescription.

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

In addition to the ordering features already described, the web portal has a nurse dashboard for each ward which includes a discharge prescription tracker, indicating when these have been received and completed in Pharmacy. The portal highlights patients on certain medicines such as intravenous (IV) medicines or CDs. Nurses can view where to locate supplies of each patient's medicines out of hours, and there are links to medicine information

resources online. As an in-house system the web portal is subject to continuous development to improve safety and efficiency in labelling and dispensing of medicines.

New functionality was introduced to the web portal to allow recording of temperatures of ward medication stock rooms and fridges, and use of this was implemented at Walton in 2021-22. If a temperature is recorded which is out of range, it alerts the Medicines Information unit during opening hours. The ward pharmacist would then be asked to review the temperature logs and medication and take any appropriate action.

Since November 2019 an outsourced Lloyds pharmacy has been open in Aintree Hospital to dispense outpatient prescriptions for both Aintree and Walton. This dedicated outpatient service was implemented to help reduce outpatient waiting times and reduce medicines expenditure by avoiding VAT. (Hospital pharmacies have to pay VAT on medicines but community pharmacies do not.) It also allows the hospital pharmacy team to focus solely on inpatient care and the processing of inpatient and discharge medication. Lloyds is able to sell over the counter medicines to both patients and staff.

1.3 Pharmacy stores - procurement, stock distribution and medicine recalls

Pharmacy stores provided a stock top up service to all wards and departments, including refills and checks of used or expired resuscitation medicine boxes and intubation kits. Ward stock lists were reviewed regularly by ward pharmacists in conjunction with ward managers. Pharmacy assistants use tablet devices to conduct stock top-ups electronically. Formal checks of expiry dates of medication in stock cupboards were implemented in 2021. The software prompts the assistant to check expiry dates of all medicines within different cupboard(s) on each visit, on an 8 to 12 week cycle, so that in any given 2 to 3 month period the expiry date of all stock medicines on each ward will have been checked.

National shortages of specific medicines have been an increasing problem in recent years. Pharmacy stores play a key role in managing stocks and sourcing alternative products where possible. They disseminate information to pharmacists who in turn can inform and/or liaise with other clinical staff to ensure everything possible is done to maintain optimal patient care and safety.

Approximately 75 drug alerts and supply disruption notices were received during the year, and appropriate action taken. Significant shortages included: human normal immunoglobulin (see section 2.15), Plasmalyte infusion fluid, lorazepam injection, digoxin injection, parecoxib injection, phosphate polyfusor, Phyllocontin (aminophylline SR) tablets, lithium carbonate MR tablets, histoacryl glue, sterile water for irrigation and metformin 500mg/5ml oral solution. Lorazepam injection ongoing shortage required regular monitoring of ward stock levels, and digoxin stocks were restricted to prioritised areas only such as Horsley ITU.

Morphine MR Sachets (MST sachets) were discontinued in 2021. Pharmacy implemented a trust wide switch to Zomorph MR Capsules as an alternative. As sachets were mainly used in patients with enteral routes or swallowing difficulties, pharmacy identified a safe alternative and educated Trust staff that Zomorph capsules may be opened and the contents dispersed while still maintaining modified release properties. Pharmacy staff recalled the

remaining MST sachet stock from wards. In addition to this, other MST brand preparations (tablets) were removed to avoid administration errors. Stock lists were amended appropriately and information on safe prescribing and administration of Zomorph in this manner was disseminated through verbal and email communication and written informative bulletins displayed on wards.

During shortage of Plasmalyte, additional stock of Hartmann's solution and sodium chloride 0.9% were supplied to wards and stock lists amended by pharmacy to facilitate this. Trust information about this supply issue was raised to the Clinical Director of Anaesthetics in order to send Trust wide information.

In 2021 the UK licensed product of type B botulinum toxin (Neurobloc) was discontinued. The procurement team sourced European and US products which were suitable to be imported. This switch resulted in longer gaps between ordering and receipt, and increased costs. Senior pharmacists liaised with the relevant clinical teams to ensure that appropriate stock levels were ordered to fulfil patient needs, while not purchasing more than necessary, and ensure that staff and patients were made aware of the unlicensed status of the imported products and the implications of this. Consideration was given to any patients who could potentially have licensed type A toxin instead. Physiotherapist independent prescribers are not legally authorised to prescribe unlicensed products, so the specialist botulinum toxin physiotherapist had to change practice and arrange for prescriptions to be written by a doctor for her patients requiring type B toxin.

The procurement team's work also included:

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

1.4 Aseptic Unit

Aseptic preparation refers to "operating in conditions and in facilities designed to prevent microbial and chemical contamination." It is a complex activity which requires skilled staff and appropriate facilities with close monitoring and control.
As a licensed unit all activity complies with the principles and guidelines of good manufacturing practice (GMP). Sterile, high quality products such as chemotherapy and parenteral nutrition were produced in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements.
The Aseptic unit facility consists of four clean rooms, one of which is designated to the production of cytotoxic agents such as chemotherapy. This isolator is ducted externally to restrict any recirculation of contaminated air back into the clean room. The use of this isolator prevents risk of ward staff exposure to those harmful agents. The environmental conditions in the clean rooms are continuously monitored, including pressure and temperature checks. A particle counter is present to detect contamination. Manipulations and checking of volumes are completed using CCTV.
Preparation of injectable medicines by the Aseptic unit provides a greater assurance of asepsis than is possible at ward level. Preparation within such a controlled environment minimises the risk of calculation errors and incorrect preparation of medicines. The ability to provide ready-to-use medicines as batches also saves time for nursing staff. In addition, aseptic production can achieve resources and cost efficiencies by allowing multiple doses to be prepared from one vial.

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

In 2021/2022 the licensed Pharmacy Aseptic unit prepared for Walton approximately:

- 1040 batches of ready-to-use injectable medicines for Walton for stock on wards e.g. intrathecal vancomycin and prefilled syringes of ketamine
- 411 ready-to-use medicines prepared specifically for individual patients including cytotoxic (chemotherapy) medicines such as cyclophosphamide, and monoclonal antibodies including alemtuzumab, rituximab and ocrelizumab
- 30 bags of total parenteral nutrition (TPN) made to specific daily formulation for individual patients
- 16 ready-to-use medicines for clinical trials

1.5 Medicines Information service

The Medicines Information team answered 112 queries regarding medicines during the year, using a wide variety of specialist reference sources and/or comprehensive literature searches. 85% of these were complex (level 2 and 3) enquiries taking on average 2 hours to complete. Enquiries included alternatives to medicines with supply problems, complex drug interactions with monoclonal antibodies, pharmacokinetics and pharmacodynamics advice and information regarding adverse effects with various medicines.

Medication related queries from patients were received via the patient hotline, a service advertised to all patients discharged from Walton via an insert in their discharge prescriptions. The Medicines Information team also took over 30 informal miscellaneous queries regarding Walton patients from a wide variety of internal and external staff. For example, information for community healthcare workers regarding discharge prescriptions.

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

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

1.6 Drug expenditure information and analysis and cost improvements

Medicines expenditure for the year was £10.9 million with a further £10.2 million spent on homecare medicines. The expenditure for homecare medications has increased by 67% in the past financial year, mainly due to new therapies becoming available e.g. monoclonal antibodies for prophylaxis of migraine. All of the homecare expenditure and much of the other medicines expenditure was on high-cost medicines excluded from tariff and therefore rechargeable to commissioners.

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

In order to reduce waste, the pharmacy department returned and credited unused high-cost items from ward areas, so they could be reused. To maximise the efficiency of this process, high-cost medicines were coded on the dispensing label. £539,835 of stock was re-credited to Walton this year.

Senior neurosciences pharmacists would usually undertake analysis of medicines expenditure to identify any potential cost improvements as part of the annual pharmacy quality/cost improvement programme (QIP/CIP), however due to the pandemic and staff shortages this work had to be put on hold, with plans to resume in Summer 2022. The top 200 drugs by expenditure and the top medicines issued by Lloyds for Walton were still reviewed each month in order to identify potential charging errors (medicines charged in error to Walton consultants instead of LUFHT consultants). Any errors identified were rectified, with re-crediting of the cost to Walton.

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

1.7 Clinical trials

In 2021-22, pharmacy staff dispensed and checked 74 clinical trial medicines at the Walton trials dispensary. Pharmacy staff took responsibility for the safe and appropriate storage of all trial medicines, delivery receipt, temperature monitoring and management of temperature excursions. They also maintained and held a code break list for all studies to allow ease of access and support out of hours. Subsequent 'returns' of leftover trials medicines were managed as per protocols. Seven new studies were opened, with pharmacy staff meeting with sponsor representatives (often remotely due to Covid-19). A senior trials pharmacist was involved in the initiation process of all new studies to ensure that all legal and good practice requirements were satisfied and appropriate documentation was in place. In total, 36 different trials were in progress (some of which were on hold), and 20 monitoring visits were undertaken to oversee the progress of certain trials.

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

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

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

Liverpool University Hospital Foundation Trust (LUHFT) is in the process of upgrading to the latest version of the WellSky EPMA system (formerly JAC). The pharmacy stock control system was upgraded to WellSky in March 2022, as the first step in this process.

The Walton Centre will not be able to continue on the previous version and will need to transition to the newer version along with LUHFT. It is important to note that the newer versions of the WellSky EPMA solution are web-based applications and will require extensive staff training due to differences between the versions.

Senior neurosciences pharmacists will attend and contribute to meetings with the EPMA team at LUHFT in the coming year to ensure that the Trust's requirements for EPMA are taken into account.

1.9 On-call pharmacist

An on-call pharmacist service was available at all times outside of pharmacy opening hours, for advice and supply of urgent medicines, and was regularly accessed by Walton staff. In 2021-22 the on-call pharmacist service was utilised 238 times by staff from the Walton Centre.

1.10 Clinical service

1.10.1 Ward pharmacy service

Ward pharmacists visited all wards daily Monday to Friday, and reviewed patients and their prescriptions, considering safety, efficacy and optimum individualised treatment for each patient. They ensured appropriate monitoring of bloods/observations were undertaken for specific medicines and were vigilant for side effects. They discussed medicines with patients, providing information and answering questions. Reviews were sometimes carried out remotely for patients where this was more appropriate or necessary, such as patients with Covid-19, or where the ward pharmacist / covering pharmacist was working from home due to self-isolation or medical reasons such as late pregnancy. However a pharmacist would attend the ward where it was necessary to speak to specific patients.

Medicines verification is the process whereby the pharmacist 'verifies' a medicine on the electronic prescribing system when they are satisfied that the medicine is safe and appropriate for that patient and correctly prescribed. The medicine changes from blue to white once it has been verified (see figure 2). The pharmacist also ensures compliance with the Pan Mersey formulary and local policies/guidelines where appropriate. A check is made each month of the proportion of current prescribed medicines which have been verified. For 21-22, a mean of 99.7% medicines were verified at the time of the monthly checks.

It is a recognised problem that when patients are admitted to hospital there is a risk of miscommunication and unintended changes to patients' medication. As such, the pharmacy team undertook medicines reconciliation for all inpatients within the constraints of the ward pharmacy service operational hours. Medicines reconciliation involves confirming the patient's usual medication regimen from a combination of sources, then reconciling this

against the hospital inpatient prescription to ensure all usual medicines are continued correctly, unless it is appropriate to stop or amend them. Medicines reconciliation was completed within the national target of 24 hours for an average of 83.1% of patients each month (target 75%).

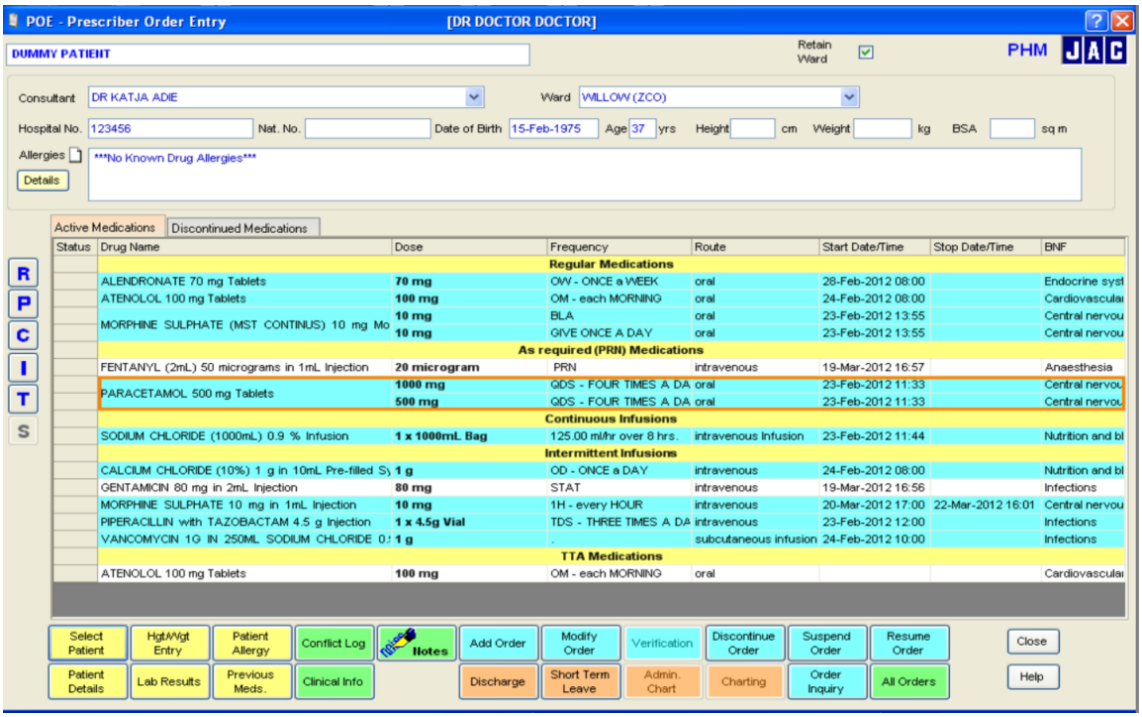


Figure 2: An example of an electronic JAC prescription illustrating a mix of unverified medicines (shaded in blue) and verified medicines (shaded in white)

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

The EPMA web portal (as discussed under dispensary services) also pulls information from EPMA to produce a pharmacy dashboard for each ward, showing key information at a glance to aid the ward pharmacists in prioritising patients for review that day. For example, it highlights newly admitted patients, those with outstanding medicines reconciliation, those on high risk medicines and those with nurse requests for supply of medicines. It displays certain notes written on EPMA, allowing it to be used as a handover tool for priority patients/issues, and enabling a list to be printed of issues highlighted by the ward pharmacist which require attention by a prescriber or doctor. The dashboard also highlights when a discharge prescription (TTO) has been written and if it has been sent to pharmacy.

Wherever possible, TTOs were verified by the ward pharmacist, rather than by the duty pharmacist in the dispensary. This had multiple benefits:

1. The ability to discuss medicines with the patient;
2. Familiarity with the patient's history;
3. Access to case notes;
4. Easier access to nursing and medical staff in case of queries.

In 2021-22 60.3% of TTOs were verified by the ward pharmacist rather than the duty pharmacist in the dispensary. This is a reduction from 2020/21 due to staff shortages.

1.10.2 Ward rounds and multidisciplinary team meetings (MDTs)

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

- Daily surgical registrar-led ward rounds. These are predominantly attended by senior prescribing pharmacists. In addition to reviewing medication, observations and test results during the ward round, pharmacist prescribers can initiate new therapies and modify prescriptions as required (within the remit of their agreed prescribing formulary).
- The daily neurology 'board round'
- The daily critical care ward rounds
- The daily critical care antimicrobial ward round (as often as possible)
- The weekly antimicrobial collaborative ward round
- Weekly critical care MDT
- A senior pharmacist attended the weekly Multiple Sclerosis (MS) Disease Modifying Therapy MDT (as often as possible)
- The antimicrobial pharmacist attended the weekly outpatient antibiotic therapy (OPAT) clinic

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

Benefits of a pharmacist on the ward round include:

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

Participation at ward rounds is monitored as part of the monthly key performance indicators (KPIs). In 2021-22 pharmacists participated in 823 ward/board rounds or MDTs, an average of 69 per month (excluding the ITU antimicrobial ward round and DMT MDT for which attendance figures are not available). This figure is significantly reduced from 2020-21, which reflects staff shortages during the year.

1.10.3 Pharmacist independent prescribers

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

The pharmacists prescribe in three types of situation:

- Newly admitted patients admitted on the morning of elective surgery (also known as 'same day admissions'). The pharmacists check appropriate instructions about

medicines in relation to surgery have been given in clinic and followed by the patient. They review and prescribe the patient's usual medicines, highlighting any potential problems in relation to surgery and making any appropriate amendments for the peri-operative period.

- On wards day to day, adding or amending prescriptions as necessary, within an agreed prescribing formulary. In most cases this takes place as part of the plan from daily ward round.
- Prescribing short-term leave and discharge medicines and completing a summary of the admission on the discharge prescription document. This ensures prompt production of the prescription, saves junior doctor time, and audit data shows much lower risk of prescribing errors than medical colleagues.

Since same day admission started in May 2017, the pharmacists have reviewed and prescribed all appropriate medicines for every weekday same day admission patient. In 2021-22, this was an average of 125 patients per month. This is a similar figure to the number of patients seen as same day admissions prior to the pandemic. All band 8 Walton pharmacist prescribers contributed to this service, with two required on most mornings to ensure all patients were reviewed and appropriate medicines prescribed in a timely manner pre-theatre.

Pharmacists prescribed approximately 12% of all discharge prescriptions, producing discharge prescriptions for an average of 27 patients per month. These figures are significantly lower than last year because of reduced staffing within the team.

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

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

1.10.4 Pharmacy Technician service to pre-operative assessment outpatient clinics

Pharmacy technician involvement in pre-operative assessment clinics started in early 2017, redeploying some of the pharmacy technician time previously assigned to inpatients. The technician uses a variety of sources to obtain a complete and accurate medication history, including GP records, discussion with the patient and/or carer, and where available, the patient's own medicines. Since the start of the pandemic there have had to be some adjustments to the way of working, with some discussions with the patient and/or carer being undertaken via the telephone rather than in person. Pre-operative clinic practice also changed during the year, with all patients completing an online questionnaire and only selected patients attending a pre-operative clinic in person, which further increased the proportion of patients where discussions with the pharmacy technician took place over the phone. For patients who completed the online questionnaire, the pharmacy technician noted on the same system any extra or different information on medication history compared to that entered by the patient. The information was also recorded on EPMA and eP^2.

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

Data collection from November 2021 to March 2022 showed that the pharmacy technician obtained drug histories for 97% of patients in this period. The main reason for pharmacy omission was that patients did not attend their appointment.

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

1.11 Pharmacy service level agreement

Monthly Pharmacy review meetings took place between the Walton Divisional Director for Neurology, the Assistant Clinical Director of Pharmacy and the Lead Pharmacist for Neurosciences. During most of the year there were significant staffing shortages (due to maternity leave, vacancies, Covid-related absence and non Covid related sickness). Walton managers were kept up to date, and priorities discussed and agreed. Roles and responsibilities within the team were reviewed and reallocated as appropriate to optimise delivery of services.

The agreed pharmacy KPIs were submitted monthly and presented quarterly at the Quality Committee. Two pharmacy indicators (medicines reconciliation within 24 hours and discharge prescription turnaround time in the dispensary) were also reported as part of the monthly neurology divisional dashboard.

The format of KPIs is to be reviewed during 2022-23, with a view to switching to the Trust's preferred SPC (Statistical Process Control) format as far as possible, with the aid of the Informatics department. This was not feasible during 2021-22 due to staff shortages.

1.12 Homecare medicines: administration and governance

Homecare medicine services deliver ongoing medicine supplies and, where necessary, associated care, initiated by a hospital prescriber, direct to patients' homes (with their consent). These treatments are often specialist therapies for chronic health conditions. The homecare medicines service improves convenience for patients by avoiding the need for them to travel to Walton frequently to collect medicines. It also benefits the health economy by saving VAT on the cost of the medication delivered by the externally registered pharmacy (since hospital pharmacies are required to pay VAT). A pharmacist with designated time for homecare was appointed in February 2020 following a successful business case. Roles of this pharmacist included:

- Ensuring valid service level agreements (SLA) were in place with all homecare providers, both for new providers or where existing contracts were due to expire.
- Attending regional homecare meetings with other trust homecare leads to share good practice.
- Attending quarterly service review meetings with the individual homecare providers, where monthly KPIs were discussed.
- Implementing new homecare services.
- Dealing with day to day homecare related queries and incidents from clinical teams and homecare providers.
- Maintaining SOPs and guidance on homecare processes

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

- patients were prescribed the correct medication dose and (where appropriate) device
- prescriptions met all the legal requirements for dispensing

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

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

All these processes are in keeping with national standards.

The workload associated with homecare increased significantly during the year. 1872 patients were receiving medicines prescribed by Walton via homecare in March 2022 compared with 1123 patients in March 2021. In addition to the day to day prescription processing, there were various significant homecare-related projects undertaken during the year including:

- In July 2021, Biogen announced that they were ceasing the pharmaceutical funding of homecare service for dimethyl fumarate with the homecare provider Alcura from August 2021 for new patients and October 2021 for existing patients. This meant that the approximately 200 existing Walton patients on dimethyl fumarate at Walton had to be transitioned to a different homecare provider. The homecare pharmacist worked closely with the MS team as well as both the new and old homecare provider to ensure a seamless transition for all patients.
- New neurology medicines approved by NICE were made available to Walton patients via the homecare service; ofatumumab and risdiplam. The level of homecare service ranged from low to mid-tech.
- The homecare pharmacist worked closely with the MS and headache teams to develop new Trust guidelines and update existing ones at expiry and/or in line with national drug safety alerts regarding further monitoring requirements.
- A self-assessment audit of homecare processes was conducted in September 2021 by the homecare pharmacist, using a national tool. The audit shows performance against the Professional Standard for Homecare services published by the Royal Pharmaceutical Society in three domains: patient experience, implementation and delivery of safe and effective homecare services and the governance of homecare services. In this audit, the Walton Centre had an overall score of 74% which is similar to the results of the last audit of 74.9% in 2019. The audit was postponed in 2020 due to the pandemic.

A business case was approved in early 2022 for additional pharmacy administrative support (1 WTE band 3) in light of the increasing homecare patient numbers. A review of pharmacist time spent on homecare duties was conducted in late 2021, and was within the funded resource at this stage. It is anticipated however that patient numbers and numbers of medicines via homecare will continue to rise. This is particularly due to increasing patient numbers on newer migraine therapies, and new medicines for progressive multiple sclerosis.

Increased pharmacist time is likely to be needed in future, for clinical checking of prescriptions and governance of homecare. This will be reviewed in late 2022.

It has been acknowledged by the Walton Executive team that commissioning for high cost medicines does not include funding for the processes involved in their repeat prescribing by Walton; these processes require time from clinicians, pharmacy, finance and clerical staff. This is an ongoing issue, especially as new medicines are launched and commissioned and patient numbers rise.

2. Medicines Management and Clinical Governance at Walton

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

The Walton pharmacist team establishment in 2021-22 consisted of:

- six permanent senior pharmacists (band 8);
    - the lead pharmacist for neurosciences
    - four neurosciences specialist pharmacists (including a homecare and antimicrobial lead);
    - one neuro ITU specialist
- two annual rotational senior pharmacists (one to specialise in ITU; band 7)
- three junior pharmacists (band 6) at a time assigned to Walton on four monthly rotations.

This team of pharmacists provided the daily ward pharmacy service (with occasional cover from other pharmacists during times of severe staff shortage within the Walton team), plus all the prescribing services already described.

During most of 2021-22 there was not a full team in place due to maternity leave and vacancies, which along with Covid-related absences and non-Covid related sickness, made it very challenging at times to deliver the service. In addition, the immunoglobulin shortage and Covid – related tasks required a significant amount of pharmacist time to manage. Clinical work was prioritised, and some of the team's usual roles had to be suspended, in agreement with Walton.

From April 2022 staffing was expected to improve. In March 2022, extra funding was agreed which will bring the Walton pharmacist team up to 11.4WTE. Recruitment will take place as early as possible in 2022-23.

2.1 Medicines safety and learning from medication incidents at Walton

278 medication incidents were reported in 2021-22, making them one of the most common incident types reported within Walton. It is well established nationally that medication errors and incidents are common and often under-reported. The incidents reported mostly involved little or no actual patient harm, but many had potential for more serious harm if not identified and corrected promptly.
There were two medication related never events at Walton during the year. A patient was given oral morphine solution intravenously, resulting in no harm. Another patient was administered botulinum toxin to a muscle on the wrong side of the neck, and experienced some adverse effects as a result. Both were reported and fully investigated, with actions agreed to improve practice and reduce the risk of recurrence.

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

MHRA continued to issue safety alerts for specific medicines affecting the Trust in its regular safety bulletins or warning letters to healthcare staff. Pharmacists ensured this information was disseminated to the appropriate staff. For examples, information on increased risks of hepatic side effects with cladribine than previously known.

The Pharmacy risk register was partially reviewed and updated, and other medicines-related risks monitored and some risks updated as appropriate, in liaison with other relevant staff. A full review of these risks will be undertaken in 2022-23, when pharmacy staffing has improved.

Automated daily notification emails were sent to ward managers detailing omitted doses of critical medicines for patients on their wards within the last 24 hours (except ITU which does not use EPMA). Ward managers carried out a formal audit of omitted doses when nurse staffing allowed. Reports from these audits were submitted to SMG, allowing ongoing monitoring and assurance of improvements in missed doses.

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

There remained a significant gap in the medicines safety related work and the funded resource within the SLA. Much further work, particularly more proactive work, which could be undertaken on an ongoing basis in relation to medicines safety if the MSO role was fully resourced, in terms of a dedicated medicines safety pharmacist.

A business case was written and submitted for 0.36WTE of band 8 pharmacist time for a designated medicines safety role, and approved in March 2022. The funding will be combined with funding from other members of the team having reduced their hours, to allow appointment of a new full time band 8a pharmacist with approximately half of their time dedicated to medicines safety roles. The priorities for this role will be agreed with senior nursing leaders and other relevant Walton staff.

A senior pharmacist attended the Trust's daily Safety Huddle (subject to other commitments) to respond to any medication incidents or pharmacy/medicines-related safety issues in a timely manner and cascade to other members of the pharmacy team.

Healthcare practitioners are encouraged to report suspected adverse drug reactions (ADRs) to the Medicines and Healthcare products Regulatory Agency, as part of pharmacovigilance for all medicines, especially newer medicines. This is called the Yellow Card Scheme.

Staff at Walton were encouraged to submit brief details of suspected adverse events to the Trust ADR mailbox. The pharmacy team then completed the formal report on their behalf, thereby reducing the barrier to adverse effect reporting for busy clinicians. As a result of this work by the pharmacy team, The Walton Centre came top of the North West for secondary/tertiary care centres in terms of yellow card reports per hospital episode during Q4 in 2021-22.

Pharmacy have worked with IT to plan an electronic ADR reporting form on eP^2, to increase awareness of ADR reporting and make reporting easier for clinicians. This will be implemented during 2022.

2.2 Specialist neuroscience pharmacist advice

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

- advice on commissioning issues or individual funding requests
- advice on formulary status and whether GPs could prescribe medicines
- advice on amendments to NMP formularies
- queries over the transitioning of patients from Alder Hey and continuation of care
- availability of unlicensed medicines or different formulations
- queries over apparent shortages of specific medicines in primary care
- medicine interactions, cautions and contra-indications, alternative routes of administration
- prices of medicines
- payment by results exclusions
- suitability of medicines formulations for intrathecal administration
- advice on unlicensed administration of medicines by Interventional Radiologists
- information regarding unusual or unlicensed medicines recommended by neurologists at satellite hospitals
- advice and data for audits
- giving advice to patients on their medicines pre-operatively, on admission and discharge.

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

2.3 Delivery of education and training

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

- Trust induction (monthly)
- Trainee doctor induction (five times per year)
- Consultant/registrar medical health and safety mandatory training days (up to seven times per year)
- IV medicines study day
- Nurse preceptorship programme, including:
    - General medicines management sessions
    - Catheter associated infections
- ITU nurse induction on medicines management
- ITU ACCP teaching sessions
- Pharmacology study day for Liverpool John Moores University Neuro Masters Module and contribution of examination questions
- Medical student teaching on a monthly basis as part of the third year prescribing module

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

- Being shadowed by nurses and pharmacists undertaking the non-medical prescribing course.
- Pharmacy EPMA web portal training for ward staff.

The Walton senior pharmacist team were also involved in training Aintree pre-registration pharmacists, as well as tutoring junior pharmacists undertaking clinical pharmacy postgraduate diplomas. They provided induction, formal training sessions and supervision for junior pharmacists on rotation to Walton.

2.4 Non-Medical Prescribing governance

Walton has long encouraged and supported appropriate clinical staff to become non-medical prescribers, but in recent years numbers have steadily increased. By March 2022, over 90 staff were either already registered independent prescribers or undertaking the training. These include nurses, pharmacists and physiotherapists, who prescribe and/or give advice on medicines in inpatient and/or outpatient settings.

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

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

All existing NMPs were encouraged to review their practice and formularies, and asked to submit annual declaration forms in line with the NMP policy. Clarification was made around situations in which the Trust supports a single practitioner to prescribe and administer medicines and all NMPS were asked to undertake a risk assessment.

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

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

Meetings of the non medical prescribing forum were organised but mostly cancelled due to Covid-related staffing issues within clinical teams. Quarterly meetings will be resumed in 2022-23.

2.5 Patient Group Directions (PGDs)

PGDs are formal legal documents which authorise named individuals in specified staff groups to administer named medicines to patients without a prescription. During the year senior pharmacists worked with physiotherapists and nurses to update existing documents due for expiry. A senior pharmacist worked with the Walton SMART team to prepare PGDs for their use; these will be finalised and approved in 2022-23.

2.6 Policies, guidelines and patient information

The senior pharmacist team continue to play a large role in maintaining the Trust's wide range of medication related documents. During 2021-2022 the team collaborated with colleagues from various disciplines and departments to update policies, clinical guidelines and drug monographs. New documents were also created to reflect new practices and address gaps in the Trust's guidance. As of March 2022 there were approximately 120 documents either written by or contributed to by pharmacists, and this number continues to increase.

Senior pharmacists routinely attended meetings of the Drugs and Therapeutics Committee (see section 2.10) and Clinical Effectiveness and Services Group. As part of this membership, presented documents were reviewed and comments submitted where appropriate.

Pharmacy maintained the Trust's Medicines policies page on Sharepoint: uploading newly approved documents, archiving expired documents and sending notification to authors as their documents approach expiry. Pharmacy also kept the department's intranet pages up to date with practical information about the pharmacy service, and links to relevant external sites for information about medicines.

Keeping up to date with documents due for review proved challenging due to staff shortages during the year. Consideration was given to which documents were highest priority to update or produce, such as local Covid-19 treatment guidance in response to changes in national recommendations, administration guidance for new immunoglobulin brands bought in due to the international shortage, and other medicines/conditions where there were important changes. Approval was sought for extensions to some documents where little or nothing had changed but an update was due. Sufficient time will be allocated in 2022-23 when staffing improves to ensure that all documents for which Pharmacy are responsible are fully reviewed and brought up to date.

2.7 Freedom of information requests and complaints

Senior pharmacists, with support from the Pharmacy Computer Services Manager, responded wholly or partly to 22 freedom of information (FOI) requests during the year. Requests were varied, but the most common type was for information about usage of, or expenditure on, specified medicines or groups of medicines, particularly high cost medicines such as disease modifying therapies for MS, and monoclonal antibodies/botulinum toxin for migraine.
In addition senior pharmacists were involved in investigating and responding to a number of complaints from patients/relatives where medicines or Pharmacy were involved.

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

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

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

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

- Addition of Dacepton® (alternative brand/device of apomorphine) to formulary
- Addition of cenobamate (new antiepileptic) to formulary
- Addition of ticagrelor for post intracranial stenting to formulary
- Addition of erenumab, fremanezumab and galcanezumab to formulary with update to the headache pathway
- Update to the prescribing statement for fremanezumab in line with NICE
- Update of shared care guideline for riluzole
- Update to the valproate safety statement
- Participation in the annual horizon scanning exercise to identify upcoming new medicines and plan reviews.

A senior neuroscience pharmacist attended meetings of the North Wales Neuroscience medicines network, via MS Teams.

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

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

2.9 Compliance with standards and targets from commissioners

The Quality Contract requirements relating to medicines management were suspended for the first part of 21-22. The Lead Pharmacist worked with the Quality Manager to prepare and submit data as required for the latter half of the year, including quarterly reviews of medicines related incidents.

There were no medication related CQUINs for Walton in 2021-22.

2.10 Drugs and Therapeutics Committee

Senior pharmacists collated agenda items for and at least two senior neuroscience pharmacists attended each Drugs and Therapeutics committee meeting and presented numerous documents to the committee.

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

- Medication related clinical guidelines, policies, patient information leaflets & PGDs
- Applications to add new medicines to the formulary
- Use of manufacturer's free of charge schemes for medicines, including official Early Access to Medicines Schemes.
- Medicines related audits including regular controlled drug audits.
- Medicines expenditure and potential cost improvements or cost pressures
- Non-Medical Prescriber formularies
- Reports from subcommittees: Safer Medication group, Antimicrobial Stewardship group, Immunoglobulin Advisory Panel and Non medical prescribing forum.
- Immunoglobulin database dashboard submissions
- Relevant current workstreams within the Pan Mersey Area Prescribing Committee subgroups
- New national guidance on medicines including safety alerts
- Significant miscellaneous issues arising relating to medicines, such as the immunoglobulin shortage.

Changes were agreed whereby the consultants on the committee discussed agenda items/documents related to their speciality with the authors prior to committee, and this has improved the quality of discussions within the meeting.

Pharmacist committee members assisted in the feedback of comments to authors and publication on the intranet of approved documents.

In 2022-23 formal feedback to clinicians following each meeting will be implemented by the senior pharmacists, to improve communication about changes in guidelines and policies.

2.11 Contribution to Walton committees and groups

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

- ITU operational group
- Neurology Divisional Assurance Group
- Safer Medication group
- Infection Prevention Control Committee
- Immunoglobulin Advisory Panel
- Antimicrobial Stewardship group
- Team Brief
- LUFHT Medication Safety Group (as the representative for Walton)
- Trust Sponsorship Oversight Board (for clinical trials)
- Clinical Systems Safety Group
- Quality Committee (quarterly attendance to present papers)
- Quarterly homecare provider service review meetings
- Clinical Effectiveness and Services Group
- Quality and Patient Safety Group
- Hospital Management Board
- Clinical Audit group

Pharmacist attendance at some of these meetings was less regular than usual due to staff shortages; in some cases meeting attendance was a lower priority than other competing demands, particularly clinical work.

In addition, pharmacists were asked to join various short term working groups for transformation workstreams. They attended meetings and undertook any work necessary:

- Same day discharge
- Bed repurposing
- Discharge medicines process
- Ward round review
- Patient flow/discharge planning

2.12 Audit & Service Evaluation

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

- Controlled drug audit - the usual quarterly cycle was not possible due to staffing but three were undertaken during the year
- Antimicrobial prescribing point prevalence audit
- Audits currently ongoing in ITU include rates of ventilator-associated pneumonia, and use of dexmedetomidine in neurocritical care
- Findings from the audit of omission and delay of critical medicines in ITU were disseminated to nursing staff

Results were reported and discussed at the most relevant forum.

A senior pharmacist attended the monthly clinical audit group meeting when possible.

2.13 Antimicrobial stewardship

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

During 2021-22, the antimicrobial pharmacist along with the wider clinical pharmacist team at Walton were actively involved with microbiology and infection control teams and engaged with medical and nursing staff to maintain and improve antimicrobial prescribing.

Maternity leave of the substantive antimicrobial pharmacist, and subsequent resignation of the pharmacist covering, along with ongoing staffing shortages, made it challenging to maintain the service over the year, but key activities were maintained, including:

- Attendance at the weekly collaborative antimicrobial ward rounds; reviewing every patient prescribed antibiotics alongside a consultant medical microbiologist, medical teams and infection prevention and control (IPC) nurse specialists. Any identified themes were raised by the antimicrobial pharmacist at the Infection Control Committee and with the IPC lead neurosurgeon. Patients potentially suitable for outpatient antimicrobial therapy (OPAT) were identified by the pharmacist at the weekly ward round and highlighted to the OPAT team for weekly discussion.
- Senior pharmacist attending ITU microbiology ward rounds, aiming for twice weekly attendance.
- Attendance at weekly OPAT outpatient MDT clinics, producing clinic letters, reviewing new OPAT referrals, submitting Datix reports and yellow ADR cards on behalf of patients.

- Attendance at the quarterly AMS meetings; producing agenda, writing minutes and co-chairing the meetings.
- Monitoring of automated daily reports of restricted high-risk antimicrobials and drugs that require TDM generated from the electronic prescribing system. Patients identified were reviewed by a senior pharmacist and flagged to ward pharmacists to discuss with the parent teams and microbiology.
  Attendance at the IPC Committee (where possible) and quarterly presentation of the point prevalence audits.
- Monthly PP audit data collection. All antibiotic prescriptions on a chosen day were reviewed against the Trust formulary and prescribing standards to establish if the appropriate medicine, dose, route, duration for the indication were prescribed. Data were compared between audits to identify any trends in prescribing within the Trust..
- The antimicrobial pharmacist commented on root cause analyses relating to infection as part of the IPC Committee. These included patients that developed C. difficile, MRSA, MSSA and E. coli infections.
- The Trust antimicrobial formulary was reviewed and rewritten by the antimicrobial pharmacist. Antimicrobial choice was streamlined and benchmarked against other specialist neuro centres. The layout of the formulary was changed to make it more user friendly and has received good feedback so far from users.
- Contributions to the flu campaign as required

2.14 CQC compliance

A CQC pharmacist visited Walton in June 2021 for an engagement visit with the Assistant Clinical Director of Pharmacy and Lead Pharmacist for Neurosciences, regarding medicines optimisation during the pandemic. The CQC pharmacist was generally satisfied with the information shared, but expressed concern about the lack of dedicated time for the Medicines Safety Officer role. This will be corrected in 2022-23 following the successful business case for senior pharmacist resource for medicines safety.
No proactive work on CQC compliance regarding medicines was undertaken during the year, due to staffing issues within Pharmacy and in the wider Trust. This work will resume in the coming year.

2.15 Immunoglobulin stewardship

Routine work on immunoglobulin stewardship includes a senior pharmacist working with neurology managers, neurologists, the neuromuscular specialist nurse and the Trust Immunoglobulin Advisory Panel throughout the year. They ensure compliance with national guidelines for immunoglobulin, ensure prescribing is safe and appropriate, that documentation is correctly completed, and all data is entered on the national database. Failure to comply risks the Trust not being reimbursed for this frequently used and high-cost medicine.
From April 2021 onwards the international shortage of immunoglobulin worsened significantly. The pandemic resulted in reduced donations of plasma, the key raw material for immunoglobulin production, and this caused an acute exacerbation of an existing chronic shortage. Allocations for Walton from NHS England started to be greatly reduced. This resulted in an enormous amount of work for Walton staff, in particular the senior pharmacist team and specialist neurovascular nurse. They worked closely with the neurology division and lead neuromuscular consultant to manage the situation and minimise the impact on patient care.
Where possible patients should be maintained on the same brand, but the brands and quantities allocated to Walton were changed frequently, meaning many patients had to have their brand changed more than once. In addition it was necessary to reduce usage for most patients by increasing their dose interval and/or reducing their dose. This did have a detrimental clinical impact on some patients, and where this was significant, dosing was reverted back to normal.

Actions taken by the senior pharmacist team (with other staff as appropriate) included:

- Creation and maintenance of a spreadsheet detailing all longterm patients, their usual dose and dose frequency, and factors which might impact on choice of brand such as previous adverse reactions.
- Initial review of all longterm patients with the specialist nurse/consultant to risk assess the potential for increasing their dosage interval and/or changing brand.
- Monthly reviews comparing quantity of each brand available for the coming month, against quantity needed for the patients expected for treatment, and deciding on actions to manage shortfalls, such as further delays to treatment or switching of brands. Ongoing review of plans depending how patients responded to the reduced doses and new brands. Proposed new patients were reviewed to assess urgency or latner
- Review of any proposed new patients to assess priority and/or alternative treatments. Switch to use of ideal body weight for dosing for new patients to conserve stocks.
- Communication with patients, via a general information letter from the division and individual discussions with each patient before or at the time of their appointments.
- Liaison/negotiation with the subregional immunoglobulin panel leads, who had a partial role in managing allocations and were also facilitating mutual aid between local hospitals. Liaison with other local hospitals to order their unneeded stocks or supply specific brands to them where necessary.
- Escalation within Walton regarding the shortage and the severity of its impact on patients, including revision of the existing risk on the risk register.
- Escalation to NHS England that Walton's allocation appeared to have been reduced proportionally more than many other Trusts, resulting in Walton having to make greater reductions in use which impacted patients. Formal letters were sent to NHS England, and the lead pharmacist was subsequently involved in discussions and analysis of various data sources to identify the problems and cause. After this NHSE agreed that Walton's needs had been underestimated and provided some extra stock to ease the impact on patients.
- Work associated with multiple new brands and suppliers of IVIg, such as setting up suppliers and brands on ordering, dispensing and prescribing software, producing specific prescription/administration charts, guidelines for safe usage and communication with relevant staff and patients.
- Negotiating for increased volumes of subcutaneous products to be allocated, allowing some patients to switch to self-administration of immunoglobulin at home (after appropriate training and review). This was preferred by some patients and reduced the demand for IV immunoglobulin which was in shorter supply.

By quarters 3 and 4 the situation had improved somewhat, and patients were able to receive their optimum doses once again. Some switches of brand were still necessary but much less so than earlier in the year. Allocations were made for longer periods and communicated well in advance, so the monthly review of need versus supply continued but was more straightforward.

2.16 ITU – related work

The specialist service to Horsley ITU was provided by 2 senior pharmacists, following a successful business case for the second pharmacist in 2020. They provided day to day (Monday to Friday) clinical review of all patients, including attendance on ITU ward rounds. Other work included:

- Supported delivery of training ITU staff regarding elements of A2F Bundle (e.g. choice of sedation and analgesia), and participation in A2F Bundle Steering group
- Updated drug monographs and guidelines, including a specific ITU antimicrobial formulary.

- Developed and circulated Pharmacy bulletins, such as timely administration of critical medicines; morphine modified-release preparations; updates to management of patients with Covid-19
- Developed signage regarding locations and controlled drug register requirements for all strengths of midazolam stored on ITU
- Support for clinical trials on ITU (e.g. SOS, SCIL trial, Enceph Ig)
- Circulated findings from audit of omission and delay of critical medicines in ITU, and implemented plan for re-auditing annually
- Data collection for audit of prescribing antibiotics for patients with suspected ventilator-associated pneumonia on ITU
- Training on critical care pharmacy for the band 7 pharmacists who rotate each year.
- Teaching sessions to junior pharmacists for managing patients stepped-down from ITU
- Teaching sessions for ACCPs (e.g. pharmacological management of hypertension)
- Quick reference guide for prescribers circulated (designed to minimise prescribing errors when admitting and discharging patients to/from ITU)
- Attendance at Cheshire and Mersey Adult Critical Care Network / North West Critical Care Network pharmacists' meetings

2.17 COVID-19

In March 2020, COVID-19 was declared a national pandemic by the World Health Organisation. To plan and prepare for the resultant changes in service delivery at the Trust many changes were made during 2020-21, as reported last year. In 2021-22, pharmacy and the Walton pharmacist team continued to respond to the evolving situation nationally and locally, as infection rates rose and fell, regulations and NHS guidelines changed, and different issues arose.

- In response to regular updates of national advice for the management of patients with confirmed or suspected Covid-19, pharmacists regularly updated Walton-specific guidelines. This included both overall treatment guidelines for management for confirmed or suspected Covid-19, monographs/guidelines for specific therapies such as steroids, remdesivir and interleukin-6 inhibitors, plus guidelines for VTE prophylaxis and management of anticoagulation in Covid positive patients. Changes to national advice occurred frequently and it proved challenging to keep Walton guidance current. In most cases, LUFHT produced in house guidance and this was then adapted for Walton. The Drugs and Therapeutics Committee discussed the process and agreed that having Walton-specific guidance was preferable, so guidance was adapted for Walton by a senior pharmacist, checked by a second senior pharmacist, and Chair's action sought to enable prompt publication on the intranet of updates. These processes required a significant amount of senior pharmacist time throughout the year.
- Systems put in place the previous year were continued to facilitate staff working from home where necessary due to self-isolation; for example pharmacists could still review inpatients' prescriptions, case notes, blood results etc from home but would be paired with a pharmacist on site to allow any appropriate follow up in person on the ward.
- Pharmacy continued to support and advise on the vaccination programmes for staff, inpatients and the public, including use of PGDs, and highlighted inpatients eligible for vaccination.
- Office relocations to enable social distancing and ensure pharmacists had suitable working space, and as part of the Trust accommodation review.
- Same day admission patients were mostly admitted to ward areas rather than Jefferson, which introduced various practical issues for the pharmacist prescribers seeing them before theatre. Discussions were held with bed managers and systems put in place to ensure all patients were identified and reviewed in good time.

- Compliance with staff lateral flow and lamp testing, with statutory reporting of results.

2.18 Other projects and developments

Some of the projects listed below are ongoing.

- The NHS North West Quality Control laboratory undertook stability testing on colistimethate solutions to enable preparation of solution for intrathecal use out of hours (currently due to lack of stability data the solution would have to be reconstituted by neurosurgical doctor if the treatment is needed out of hours). This work will be completed in 2022-23.
- A review of midazolam strengths stocked and stored in ward areas was undertaken in liaison with Aintree.
- Implementation of Sativex prescribing for spasticity in MS patients, utilising the first month's supply free of charge scheme from the pharmaceutical company
- Production and circulation of SGLT2 inhibitor medicine safety bulletin following multiple incidents
- Review of stocks and storage of fluids on wards, particularly those containing potassium.
- The IVIg dose calculator Microsoft Excel programme written by a pharmacist was formally approved for use and uploaded to intranet for use by all Walton staff.
- Preparatory work for Pharmacy managing the supply and refill of seizure kits for wards and departments.
- Liaison with other clinical staff and IT regarding digitisation workstreams, including scanning of paper prescriptions for specific medicines, and planning for switch from a paper orange alert chart to a digital version.
- Scoping of potential for Walton to become a clozapine prescribing centre, in liaison with the neuropsychiatry team.
- Participation in the external audit by HiMMS which assessed the Trust's digital maturity.

3. Future plans and areas for development

Some of the work described in this report is ongoing. Specific areas of focus for 2022-23 include:

- Full resumption of tasks postponed due to the staffing issues in 2021-22.
- Upgrade to Wellsky EPMA system at LUFHT and Walton. It is not yet known whether the Walton upgrade will be possible within the coming year. Walton IT will review whether any integration of the Wellsky EPMA system into eP^2 is possible.
- In the longer term, LUHFT are considering a switch to a new EPR system with integrated EPMA. This will have implications for Walton; if Walton do not switch to the same EPMA then extra resource will be needed in the SLA to maintain Walton's EPMA as standalone work for Walton only.
- Recruitment of a new pharmacist and implementation of increased medicines safety work following the successful business case to enable development of a specific medicines safety pharmacist role.
- Recruitment of the extra band 3 homecare pharmacist assistant post following the successful business case.
- Review in late 2022 of the senior pharmacist time required for homecare (for both governance and day to day prescription checking) and consideration of a business case submission if the homecare patient numbers continue to increase as expected.
- Senior neuropharmacist to attend weekly neuropsychiatry ward round to provide input on medicines
- Systematic review of medicines expenditure to identify potential cost improvements.
- Scoping of options and feasibility of provision of ready prepared syringes for medicines to fill/refill implanted intrathecal pumps. This is a complex area but Aseptic preparation

(either by LUHFT or purchased from an external company) would reduce risk of microbial contamination, preparation errors and save time for specialist nurses. There would likely be a cost implication for this, and a business case will be presented in due course.

- Implementation of actions of the National Emergency Steroid Card alert.
- Change in reporting of Pharmacy KPIs to the Trust's preferred SPC format where possible.
- Implementation of the adverse drug reaction reporting form on eP[2].
- Implementation of patient specific directions for botulinum toxin for migraine integrated into the electronic approval form, to remove the need for use of patient group directions for the administration of toxin to patients by non prescribers.
- Pharmacy to start providing sealed seizure kits to wards, and manage the refill process. (This was delayed in 2021-22 due to difficulties obtaining the appropriate bags and staffing issues within the SMART team.)
- Further development of antimicrobial stewardship within the Trust, including scoping extensions to the role of the antimicrobial pharmacist.
- Ongoing involvement with transformation workstreams including discharge planning, same day discharge, and bed repurposing.
- Contribution to the Trust's digitisation project.
- Implementation of the switch from IV ketamine to esketamine for most indications, with associated measures to reduce risks of confusion/error given the different dosing.
- Review of processes and governance for repeat prescribing of non-homecare red (hospital only) longterm medicines within neurology, following issues highlighted by audit and incident reports.

The Walton Centre
NHS Foundation Trust

Report to Board of Directors
7 July 2022

Report Title	Controlled Drugs Accountable Officer Report 2021/22
Executive Lead	Andrew Nicholson, Medical Director
Author (s)	Dave Thornton, Associate Clinical Director, Pharmacy
Action Required	To approve

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- Following the Shipman Report all Trusts were mandated to appoint an Accountable Officer for controlled drugs (CDAO) who monitors all CD incidents within the Trust. At The Walton Centre NHS Foundation Trust, the CDAO is the Clinical Director of Pharmacy, Alison Ewing.
- Controlled drug assurance audits continue to be undertaken by the pharmacy department to identify compliance with Trust standards however Covid-19 and staffing issues have impacted on the frequency of the audits. Three Audits were undertaken in 2021/22. No areas for concern have been highlighted.
- Monthly CD incident reports were submitted to the CDLIN. No areas of concern have been highlighted.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- None

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Quality of Care	Not Applicable	Not Applicable	Not Applicable

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

001 Quality Patient Care	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Controlled Drugs Accountable Officer Report 2021/22

Executive Summary

1. This report provides the Trust Board with an overview of controlled drug (CD) activity during 2021/22. The following are the key issues of note from the report:
   - Following the Shipman Report all Trusts were mandated to appoint an Accountable Officer for controlled drugs (CDAO) who monitors all CD incidents within the Trust. At The Walton Centre NHS Foundation Trust, the CDAO is the Clinical Director of Pharmacy, Alison Ewing.
   - Controlled drug assurance audits continue to be undertaken by the pharmacy department to identify compliance with Trust standards however Covid-19 and staffing issues have impacted on the frequency of the audits. Three audits were carried out in 21/22. No areas for concern have been highlighted.
   - Following discussions at Drugs and Therapeutics Committee (DTC), it was agreed to undertake the controlled drug assurance audits on a six monthly basis, in line with current practice at other NHS Trusts.
   - Concerns were raised by local CCGs and GPs, via the Regional CDAO, regarding CD prescribing in the Pain Clinic at The Walton Centre. Following further investigation by the lead pharmacists and the Regional CDAO these concerns were found not to be an issue.

Background

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

Introduction

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

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

   - *CD policy and supporting standard operating procedures*

   The Accountable Officer must ensure adequate and up-to-date standard operating procedures are in place within their organisation. The Medicines Policy and supporting CD Standard Operating Procedures are available to all staff through the hospital intranet. The Trust CD Standard Operating Procedures (SOPs) are updated as required to ensure that they reflect requested clarifications, following learning from incidents, internal audit recommendations or published changes in legislation.

- *Routine Monitoring and Audit*

The Accountable Officer must ensure that the use of Controlled Drugs is monitored through routine processes. This report provides details of the monitoring and assurance obtained about the management of CDs at The Walton Centre (TWC).
Within TWC there are 12 wards and departments holding controlled drugs. Regular audits are undertaken by the pharmacists to ensure all controlled drugs are stored correctly, that the stationery for ordering and recording controlled drugs is held securely and that there are no discrepancies in the stock balances. The ward managers have been tasked to ensure regular balance monitoring is taking place. The results of the audits support this being the case.

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

This report demonstrates compliance with all elements of the CD Accountable Officer and organisational responsibilities and summarises the evidence to support assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12; Safe care and treatment, section (g) the proper and safe management of medicines

- *Collaboration and Local Intelligence Networks*

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

Key Issues

Monitoring of CD Incidents

5. There were 62 incidents that involved CDs reported at The Walton Centre between April 2021 and March 2022 compared with 79 in 20/21 and 87 in 19/20. The majority of these issues continue to be low risk and related to balance discrepancies and do not raise any issues of concern.

6. CD incidents are monitored regularly by the Lead Pharmacist (via SMG) and incidents are escalated to the Controlled Drug Accountable Officer as necessary.

Incidents by Category

	21/22	20/21	19/20
Administration-includes omitted doses, wrong dose, wrong patient	8	5	3
Dispensing	0	0	1
Governance-includes storage and security	6	5	3
Patients/public of concern	2	5	2
Prescribing	2	1	6
Record keeping	10	8	16
Accounted for losses-includes spillages, breakages	5	4	6
Unaccounted for losses*	29	51	50

*Includes all balance discrepancies. Comprises predominantly low volume liquid discrepancies.

7. There were no issues of concern raised and all unaccounted for losses were within acceptable tolerance limits (set as <5% of actual recorded volume by NHSE CDAO). No high risk incidents (using the NHSE risk matrix) were reported. Eight moderate incidents were reported. Two related to the illicit use of CDs by patients; four related to administration errors where the patient had taken the drug (all of which resulted in no or low harm); one related to an omitted CD resulting in low harm and one related to CDs not being prescribed on admission resulting

in no harm. One of the moderate risk incidents was due to out of date administration charts still being in circulation at ward level. The review of the incident resulted in all out of date documents being removed from all ward areas demonstrating a strong improvement culture following an incident.

8. Concerns were raised by local CCGs and GPs, via the Regional CDAO, regarding CD prescribing in the Pain Clinic at The Walton Centre. Following further investigation by the lead pharmacists and the Regional CDAO these concerns were found not to be an issue. In all the cases, the pattern of CD use had sound and evidence based clinical rationale.

Quarterly Ward/Department CD Stock Checks by Pharmacy Staff

9. It is a requirement of the Department of Health Safer Management of CD's Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. Three assurance audits were undertaken in this reporting period. In line with other local Trusts and following agreement at DTC, the CD assurance audits will take place every 6 months in future.

10. In every audit all cupboards were locked and controlled drugs were stored correctly. Controlled drug stationery was stored securely in the majority of areas. Ward Nurse Managers are informed when stationary is not securely stored and remedial action to rectify this is undertaken. Inappropriate amendment of records has also been highlighted as a continuing area for improvement. All ward managers undertook regular controlled drug checks; daily stock checks were carried out on the majority of wards. The results of the audits are shared with the Trust's Director of Nursing, the Medical Director and the ward managers. Following the latest audit, an action plan for improvement has been approved at DTC and this is in the process of being implemented.

11. Naloxone and Flumazenil should be available on all areas where CDs are administered as they can be used to reverse the effects of the drug in the event of an overdose. Stocks were supplied to all areas that did not have them.

Pharmacy Department Stock Checks

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

Controlled Drug Destruction

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

Local Information Network Activity (LIN)

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

15. The Trust's Controlled Drug Accountable Officer has a duty to submit occurrence reports within 28 days of the incident occurring to the LIN with information about any issues identified

regarding prescribing or abuse of CDs. Monthly reports were submitted but due to Covid-19 and how the incidents are reviewed within The Walton Centre, this was not always within 28 days of the incident occurring. Alternatively, advice from the LIN was to report incidents or concerns that you consider are **"extremely serious"** or have had a **"catastrophic"** outcome. To the end of this reporting period, no such incidents were reported to the LIN.

Conclusion

16. The management of controlled drugs continues to be monitored by the Trust's Controlled Drug Accountable Officer and reported via the Trust incident reporting system. The programme of audit demonstrates that robust systems are in place to ensure the safe handling of controlled drugs. There were no areas of concern raised during the reporting period.

Recommendation

To approve

Alison Ewing, Controlled Drugs Accountable Officer
June 2022
Prepared by: Dave Thornton, Assistant Clinical Director, Pharmacy

The Walton Centre
NHS Foundation Trust

Report to Trust Board
7th July 2022

Report Title	Risk, Governance and Patient Experience Annual Report (including Q4 statistics)
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Katie Bailey, Risk Manager Lisa Judge, Head of Patient & Family Experience Mike Duffy, Head of Risk & Governance
Action Required	To note

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

Acceptable assurance Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- To note 3 new themes and trends contained within the Governance Assurance Framework identified within Quarter 4.
- To approve closure of 3 Governance Assurance Framework entries due to sufficient controls and assurance now in place.
- 5 serious incidents were reported in 2021/22 compared with 3 in 2020/21
- 76 moderate harm incidents relating to patient safety incidents, with 100% compliance with DOC statutory requirements in 2021/22
- 100% of Trust KPIs for acknowledging and responding to complaints in 2021/22
- June 2021 - Mersey Internal Audit Agency (MIAA) carried out an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance

Next Step

- Continue to monitor the identified themes and trends contained within the Governance Assurance Framework via the Quality Committee work plan.

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Not Applicable	Choose an item.	Choose an item.	Choose an item.

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*		
Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*		
Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	Document amended on 11th April 2022	Head of Risk & Head of Patient Experience	The report has been amended to reflect the new Trust format.
Quality Committee	19th May 2022	Head of Risk & Head of Patient Experience	Noted.

Risk, Governance & Patient Experience Report Annual Report (including Q4 statistics)

Executive Summary

1. This report provides a summary of the Governance & Risk and Patient Experience teams' activity, outcomes and actions across the Trust for 2021/22. Providing the Quality Committee with assurance that themes and trends identified from incidents, complaints, concerns and claims are being managed appropriately.

2. Following review of incidents, complaints, concerns and claims at the Trusts Thematic Review Group, 3 new entries have been added to the governance assurance framework (see appendix 2). These are:

    - Ref 315 - Nutrition and Hydration - opened 24th March 2022
    - Ref 293 - Increase in Patient Falls - reopened 24th March 2022
    - Ref 316 - Unsafe staffing levels - opened 25th April 2022

3. There are 3 governance assurance framework entries requested for closure by the Quality Committee. This is due to sufficient controls and assurance now in place (see appendix 4).
    - Ref 311 - Carbapenemase Producing Enterobacteriaceae (CPE) - opened 22nd September 2021
    - Ref 312 - Outstanding Recommendations - opened 20th December 2021
    - Ref 313 - Covid 19 – opened 20th December 2021

4. There were 5 serious incidents were reported in 2021/22 compared with 3 in 2020/21

5. 76 moderate harm incidents relating to patient safety incidents, with 100% compliance with DOC statutory requirements in 2021/22

6. 10 incidents were reported in 2021/22 to the HSE via RIDDOR compared with 8 in 2020/21

7. 100% of Trust KPIs for acknowledging and responding to complaints in 2021/22

8. June 2021 - Mersey Internal Audit Agency (MIAA) carried out an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance

Background and Analysis

9. Themes, trends and lessons learned identified are reviewed quarterly by the Thematic Review Group. The group includes representation from Nursing, Human Resources, Quality and Divisional Management teams.

10. Lessons learned are shared via the divisional governance meetings on a monthly basis and quarterly through the Quality Committee. Moving forward Governance Assurance Framework (GAF) entries will be presented to the relevant divisional governance meetings information, monitoring and assurance purposes.

11. The Governance Assurance Framework entries and SPC charts have been added to the report as appendices for information, as requested previously by the committee.

Conclusion

12. The Risk & Governance Team and Patient Experience Team will continue to monitor the identified themes and trends contained within the Governance Assurance Framework via Trusts Thematic Review Group and the Quality Committee work plan.

Recommendation

- To note report
- To approve amendments to the GAF (new and closed)
- To recognise the process of lessons learned
- To have separate reports for Governance & Risk and one for Patient Experience Teams moving forward

Authors: Katie Bailey, Mike Duffy & Lisa Judge
Date: 5th May 2022

Appendix 1 - Risk, Governance & Patient Experience Report Annual Report

1. Introduction

The purpose of the report is to:

- Provide a quarterly report and annual summary of Governance activity, outcomes and actions across the Trust for 2021/22.
- Provide assurance to the Quality Committee that identified themes and trends are being managed affectively, robust actions are taken to mitigate risk and reduce harm and we learn lessons from incidents, complaints, concerns, and claims.

1. Throughout 2021/22, the Risk and Governance Team have:

- delivered additional mandatory training sessions (including evening sessions)
- delivered risk, incident and investigation training
- significantly reduced the number of policies, procedures, and guidelines past the identified review dates, from 169 to 46. Of which there are 20 policies, 6 standard operating procedures, 10 guidelines and 10 procedures. All are currently under review with a plan for ratification at the appropriate committee/group in the coming months. All outstanding documents are monitored by the Quality & Patient Safety Group and Corporate Governance & Risk group
- developed a governance dashboard on Minerva which provides an overview of overdue incidents within the Datix system. This has supported the substantial reduction in incidents awaiting review and improved the process for incident management across the Trust
- supported with the reduction in incident investigation recommendations, from 188 to 91
- supported the management of patient who are violent and aggressive
- completed the Emergency Planning Resilience Response (EPRR) national returns and bank holidays plans
- Introduced a new template for business continuity plans and updated existing plans for the wards
- completion of a hot and cold debrief process following the Liverpool Women's Hospital vehicle explosion incident, supporting the regional EPRR team with their debrief process and feedback
- created a Trust Cold Weather Plan establishing a new process for Met Office weather warnings
- re-established the Resilience Planning Group and Violence and Aggression working group.
- developed the violence, prevention and reduction strategy, in line with the new national standards
- completed an EBME competencies refresh
- supported the covid vaccination programme for in-patients, including the development of training and competencies for vaccinators
- supported fit testing throughout the Trust and maintained compliance with required guidance

Throughout 2021/22, the Patient Experience Team have:

- proactively listened to patients, carers and families thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided additional support to families unable to visit their loved-ones due to visiting restrictions
- safely reintroduced the volunteer service on site
- continually strive to improve the complaints management process in line with Trust targets
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meetings prior to discharge
- delivered bespoke training sessions to teams including Therapies and Council of Governors

- developed and implemented a new project to focus on a 7-day service of Patient Support Assistant role across wards, to bridge the gap between the ward and Patient Experience Team providing support to patients and families during visiting restrictions
- improved the delivery and compliance of Friends & Family Test (FFT)
- review the mortality process and learning from deaths process in line with the introduction of the Medical Examiner

2. Governance Assurance Framework (GAF)

Three new themes have been added to the GAF (see Appendix 2) following review of Q4 statistics, at the quarterly Thematic Review Group :

- Ref 315 - Nutrition and Hydration - opened 24th March 2022
- Ref 293 - Increase in Patient Falls - reopened 24th March 2022
- Ref 316 - Unsafe staffing levels - opened 25th April 2022

Three GAF themes are requested for closure by Quality Committee. This is due to sufficient controls and assurance now in place.

- Ref 311 - Carbapenemase Producing Enterobacteriaceae (CPE) - opened 22nd September 2021
- Ref 312 - Outstanding Recommendations - opened 20th December 2021 - to be monitored via risk register entry 885
- Ref 313 - Covid 19 – opened 20th December 2021

3. Incidents

- 831 incidents were reported in Q4 compared with 868 in Q3
- 3328 incidents were reported in 2021/22 compared with 3139 in 2020/21

Serious Incidents (SI):

- 0 serious incidents were reported in Q4 compared with 2 in Q3
- 5 serious incidents were reported in 2021/22 compared with 3 in 2020/21
- Please see breakdown below of those reported in 2021/22 by incident category and date reported to Commissioner:
    - Patient fall - Fractured humerus – reported: 25th May 2021
    - Missed scan finding – reported: 27th August 2021
    - Never Event Wrong route administration of medication - reported: 19th October 2021
    - Unexpected death – reported: 26th November 2021
    - Never event- wrong site surgery (Botulin injection) – reported: 13th January 2022

All investigations are now complete, with review and approval at the Serious Incident Review Group (SIRG). Any identified recommendations will be monitored via the appropriate Divisional Governance and Risk meetings.

Duty of Candour (DOC):

- 79 moderate harm & above incidents reported in 2021/22, including 12 within Q4, compared with 68 in 2020/21
- 76 of the moderate harm incidents relate to patient safety incidents, with 100% compliance with DOC statutory requirements in 2021/22
- This equates to 1.66 moderate harm patient safety incidents per 1000 occupied bed days in 2021/22

4. Incident overview

Incidents by category

Patient Care:

- 452 incidents were reported in 2021/22 compared with 339 in 2020/21

Incidents relating to unsafe staffing accounts for the main area of increase, increasing from 5 in 2020//21 to 44 2021/22. Please refer to GAF entry ref 316.

All staffing incidents reviewed by matrons and discussed with ward managers. All areas have remained safe following redeployment of staff across the Trust to reduce the risk to staff and patient safety. All areas have additional staff to support 1-1 specials, ward managers and matrons work clinically where required to ensure safety. There have been no reported red flags.

An increase in incidents relating to tissue viability (including moisture lesions and friction damage) can also be seen on review of Patient Care Incidents. Please refer to GAF entry ref 310.

Communication (GAF entry 304):

- 102 incidents were reported in Q4 compared with 102 in Q3
- 445 incidents were reported in 2021/22 compared with 385 in 2020/21

Accident:

- 425 incidents were reported in 2021/22 compared with 344 in 2020/21

An identified increase in incidents relating to patient falls accounts for the main area of increase, with 243 reported in 2021/22 compared to 198 in 2020/21. It was also noted that 2 of the incidents reported in 2021/22, resulted in patients sustaining moderate harm. Please refer to GAF entry 293.

Violence & Aggression:

- 74 incidents were reported in Q4 compared with 73 in Q3
- 316 incidents were reported in 2021/22 compared with 342 in 2020/21

The Trust has developed a Violence Prevention and Reduction Strategy, which has been approved and endorsed by the Trust Board. A work plan will be developed to underpin the strategy in line with the national Violence Prevention and Reduction Standards. The risk of violence or aggression is on both the Trust wide risk register and the GAF, ref 287.

Medication:

- 84 incidents were reported in Q4 compared with 82 in Q3
- 304 incidents were reported in 2021/22 compared with 284 in 2020/21

The highest reported subcategory of the 304 incidents recorded for 2021/22 was stock discrepancies, with 50 incidents noted.

Safeguarding:

- 74 incidents were reported in Q4 compared with 72 in Q3
- 253 incidents were reported in 2021/22 compared with 277 in 2020/21

The highest reported subcategory of the 253 incidents recorded in 2021/22 was a breach of Deprivation of Liberty (DOLs) applications, with 143 incidents noted.

This is due to the lack of timely assessment by the Local Authority due to a shortage of resources; this is a national issue. It is expected that the Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS) will be implemented in 2023, introducing revised governance arrangements and processes which will improve the current situation regarding legal breaches.

Infection control:

- 53 incidents were reported in Q4 compared with 41 in Q3
- 186 incidents were reported in 2021/22 compared with 185 in 2020/21

The highest reported subcategory of the 186 incidents reported for 2021/22 was covid 19 – WCFT acquired, with 53 incidents noted. The Trust has a COVID-19 Assurance Framework that is reviewed quarterly by Trust Board. COVID-19 is on the Trust risk register and is reviewed monthly at the Infection Prevention Control Committee. IPC reports are submitted quarterly to Quality Committee which provide further information regarding cases, themes and trends.

Information Governance:

- 33 incidents were reported in Q4 compared with 23 in Q3
- 114 incidents were reported in 2021/22 compared with 122 in 2020/21

The highest reported subcategory of the 114 incidents reported for 2021/22 was confidentiality, with 46 incidents noted.

All incidents are reviewed by IG Team, investigated and immediate steps taken to resolve and contain incidents. Reviewed monthly at the Information Governance and Security forum. Actions taken include incidents being brought to Daily safety huddle and Team Brief. Top tips newsletter distributed around the Trust both virtually and in paper format which includes themes of incidents and how to prevent them.

RIDDOR:

- 0 Incidents were reported during Q4 to the HSE via RIDDOR compared with 3 in Q3
- 10 incidents were reported in 2021/22 to the HSE via RIDDOR compared with 8 in 2020/21
- Please see breakdown below of those reported in 2021/22 by incident category and injury noted:

Injury preventing staff member from working for more than 7 days x 10

- Physical assault x 2
- Lifting and handling injures x 4
- Collision with a fixed object
- Staff slip, trip, fall same level – fractured wrist
- Staff slip, trip fall same level – fractured wrist

NB the above incident occurred on Liverpool University Teaching Trust site.

Incident involving member of the public

- Member of the public slip, trip, fall same level - fractured elbow

5. Risks

During Q4 the Trust wide risk register received scrutiny at Quality Committee.

A review of the Corporate, Neurology and Neurosurgery divisional risk registers was completed by the Executive Team in Q4.

The rotational review of divisional risk registers continues via the divisional governance and Quality & Patient Safety Group meetings. This provides assurance to the Trust Quality Committee that risks are being scrutinised and reviewed accordingly, including new and closed risks.

6. **Fire, Health & Safety and EPPR (Emergency Planning, Preparedness & Response**)

Fire:

- During Q4 the Trust experienced 6 unwanted fire signals. Merseyside Fire and Rescue Service (MFRS) were not called to attend the Trust, as all fire signals occurred during core hours. As per protocol agreed with MFRS

- The use of cooking/toasting equipment in Chavasse Ward staff room is currently under review due to 2 unwanted fire signals occurring within this location in Q4
- Mandatory training compliance currently stands at 80%. Additional sessions, including evening sessions currently being provided to increase the compliance rate.
- A review of the Fire Risk Assessment process is currently underway; this is to ensure the system is accessible to all stakeholders
- The Fire Safety Advisor has been working alongside the Estates Manager with regards to a new work plan and an upgrade of works, to ensure continued compliance

Health & Safety and EPPR:

The Risk & Governance Team are currently recruiting a Health & Safety Manager, to support the following items:

- business continuity plans
- policies and processes under the Health, Safety and EPPR remit
- bank holiday planning, highlighting department working patterns and contact details
- review and development of the current medical device competencies and guidance
- table top exercises to test the Major Incident Plan
- review and development of the risk assessment process
- supporting with DSE assessments

7. Complaints & Concerns

Quarter 4

- 100% of Trust KPIs for acknowledging and responding to complaints were met in Q4
- **Complaints** 22 received in Q4, and 3 complaints were re-opened as further clarity was sought. A deep dive undertaken by PET concluded this is not as a result of the quality of the investigation or response but a difference of opinion in relation to the factual/clinical information provided.
- Of the 25 complaints closed, 2 were upheld (*appointment arrangements/2nd opinion request, incorrectly removed from waiting list)*, 5 partially upheld *(issues regarding communication, delay in results, approach/manner, content of clinic letter)* and 17 not upheld as investigations revealed they did not require any action/learning. 1 complaint was retracted.
- The divisional split of complaints remains static with Neurology receiving 11 (including 1 re-opened) in Q4, compared to 12 (including 2 re-opened) in Q3. Neurosurgery 13 (including 2 re-opened) in Q4, compared to 11 in Q3. There was also 1 cross-divisional complaint and 0 corporate complaints
- A decrease in the number of concerns noted with 188 received compared to 224 in Q3. This is more in line with numbers received in previous quarters (Q1 159, Q2 161).
- **Concerns** are graded by level of involvement – level 1 being resolved within a couple of days and level 2 requiring multiple contacts with both patient/relative and staff and may require a written response. For Q4, there were 88 level 1 concerns and 100 level 2 concerns.
- 85 enquiries/requests for support were received in comparison to 67 received in Q3; themes relate to the referral process, general hospital enquiries and PET support in clinic appointments.
- **Protected Characteristics:** 5 concerns raised in relation to *Disability* (2) deaf & visual impairment, *Gender* (2) all patients asked if they could be pregnant, trans status referred to in clinic letter, *Religion* (1) recorded incorrectly – All appropriately actioned. As a result, Disability Working Group to be implemented from May 2022 and E, D & I training to be reviewed across the Trust.
- **New Service:** the introduction of a 7-day Patient Support Assistant roles introduced in March 2022 has demonstrated a positive impact for patients with over 70 contacts in the first two weeks, in addition to documenting more than 25 Trust wide compliments and successfully resolving concerns at the earliest opportunity and providing support for patients and families.

Annual Complaints/Concerns Data

- In June 2021 the Mersey Internal Audit Agency (MIAA) carried out an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance demonstrating there is a strong system of internal control which has been effectively designed to meet the system objectives, and controls were consistently applied in all areas.
- 100% of Trust KPIs were met for 2021/22, as complaints were acknowledged and responded to within the negotiated timeframe with an average response time at 23 working days. An excellent outcome below the 25-working day target, breakdown below:

Average Response – working days	**Q1**	**Q2**	**Q3**	**Q4**
Overall Levels 1 & 2	20	27	25	22
Level 1	13	23	22	17
Level 2	33	44	44	36

- 76 new complaints were received in 2021/2022, Q1(16), Q2 (16), Q3 (22), Q4 (22) which is a 13% increase from 67 in 2020/2021. This is still a significant improvement compared to previous financial years (129 in 2019/20).
- Of the 76 complaints, 10 were upheld *(admission arrangements, diagnosis/treatment, lack of dignity/patient care, delay in treatment, approach/manner/dignity, appointment arrangements, discharge arrangements)*, 19 partially upheld *(care/treatment, admission arrangements, appointment arrangements, communication, approach & manner)*. 41 not upheld, 1 was retracted and 5 remain under investigation. Actions/lessons learnt recorded in Datix and managed via divisional risk and governance meetings
- 11 complaints were re-opened as further clarity was requested. A deep-dive review by PET revealed this was not because of the quality of the investigation or response but a difference of opinion by the complainant/Trust in relation to the factual/clinical information provided. There was no trend in area, individual or theme of subject of re-opened complaints.
- 743 concerns were received and successfully resolved in 2021/22, demonstrating a 44% increase from 515 in 2020/21. Our aim is to see the number of formal complaints decrease whilst the number of concerns increase, this demonstrates an open and proactive approach to resolving issues. All concerns and complaints are reviewed with the divisional teams on a weekly basis to ensure timely responses.
- 307 enquiries/requests for support were responded to in 2021/22, which is a 17% increase from 262 received within 2020/21. The general themes of our enquiries relate to the referral process, general hospital enquiries and PET support in clinic appointments.
- 83 formal complaint cases were closed in 2021/22; 11 upheld, 22 partially upheld and 50 not upheld. Themes of those not upheld largely related to diagnosis, treatment and patient care whereby the patient often disagreed with the clinical diagnosis or treatment decisions or their expectations regarding level of care was not met. The deciding factor as to whether these complaints were upheld or not often revolved around a clinical review of the case by the clinical lead and/or a patient journey review against National or local Trust standards.
- **Protected Characteristics -** 8 in total *Disability* (5) deaf [3] & visual impairment [2] *Gender* (2) all patients asked if they could be pregnant, trans status referred to in clinic letter, *Religion* (1) recorded incorrectly – All appropriately actioned. Disability Working Group to be implemented from May 2022.

Key themes for complaints/concerns: Appointment arrangements (multifactorial) were the highest theme in Q4 and communication the highest annually this is also reflected in concerns. Approach and manner has significantly reduced in comparison to previous years. As of May 2022 a working group to review appointment arrangement and communication issues has been set up involving representatives from each divisional management team, our informatics and patient access team and PET.

Summary:

- In 2021/22 83 formal complaints were closed, 743 concerns and 307 enquiries resolved demonstrating a highly performing complaints management process meeting/exceeding KPI targets. This demonstrates excellent collaboration between teams and it is encouraging to note that the numbers of complaints remain lower than previous financial years despite an increase in contacts. Increases in the number of concerns and enquiries demonstrate resolution at the earliest opportunity. Concerns and enquiries differ in nature as an enquiry is raised, often to request information, from a neutral position whereas a concern is often raised following a negative experience.

8. Compliments

There were 211 compliments received in 2021/22 compared to 203 in 2020/21. 84 of which were received in Q4 compared with 51 in Q3. All compliments received are shared with any named staff members via email as well as their line manager/senior team as well as being included in appraisal data. Compliments are also reported at divisional governance meetings monthly and are used in Trust communications such as Team Brief, Walton Weekly and the daily Safety Huddle.

9. Volunteer services

- Services have resumed in almost all areas across the Trust with 24 of the current 59 volunteers active in roles across the Trust. Roles continue to be re-introduced in a balanced way in line with infection prevention and control guidance.
- Our volunteer service provide a number of roles across the Trust including meet and greet, neurobuddies and trolley service.

10. Police/Coronial Requests

- In Q4, the number of police request for statements/health records remains static at 15 for police statements/case notes. Number of coroner's requests remains the same with 3 received in both Q3 and Q4.
- Annually, a total of 51 police requests were dealt with in 2021/22 compared to 45 in 2020/21, an increase of 13%. There was a slight reduction in coroners requests at 20 compared to 21 in 2020/21. The number of requests received are indicative of the nature of our patient group and links with the Trauma Network.

11. Claims & Coronial Inquests

Appendix 8 highlights claims received by quarter, division, and value of closed claims.

A CNST trial was held in January 2022. The Judge preferred the evidence of the Trust, and the claim was discontinued at the end of the Trial with only Defence costs to pay as qualified one-way costs shifting (QOCS) applies. This was partly due to the excellent consent process and good quality documentation.

Lessons learned from closed claims:

- Communication: Clinical Lead has written to medical/clinical staff to remind them of process for urgent referrals to radiology from OPD clinic.

Thematic Review:

- Poor documentation and allegations relating to informed consent remains an ongoing theme in many of the claims received following the Montgomery vs Lanarkshire 2015 ruling and this is highlighted to medical staff during induction and to junior doctors at mandatory training sessions to raise awareness. Work continues with regards to informed consent with the support of Trust's solicitors.
- 2 Coronial Inquests were attended in Q4. Concerns were raised during one inquest relating to the communication difficulties experienced by referring hospitals during an emergency transfer. The possibility of the issue of a Regulation 28 for preventions of future

deaths was considered but the Coroner has given the Trust 28 days to investigate and report to provide assurance regarding process. Yes we are on target and this matter was completed in Q1 22/23. The Coroner was happy with the changes made to the process and therefore felt it not necessary to trigger a Reg 28.

- There are 5 Inquests scheduled to take place over the coming months.

Appendix 2 – Governance Assurance Framework – New themes identified during Q4 21/22

Theme	Context	Analysis	Action	Recommendation
Ref 315 - Nutrition and Hydration – opened 24th March 22	If patients receive the incorrect nutrition and hydration then there is a risk to patient safety, care and experience. **Lead:** Divisional Nurse Directors Re-opened	• An overall increase in incident statistics during 2021/22. • The increased trend of Nutrition/hydration incidents with associated risk to patients were escalated by safeguarding team to the LA as a safeguarding referral under the theme of 'neglect', in being open and transparent. The Local Authority were provided with the information regarding immediate action taken and the initiatives swiftly introduced by the Trust to remedy the situation. The Local Authority was accepting of actions that were taken, and the referral was subsequently closed.	• Review Business Intelligence portal. • Review ward manager's objectives in relation to nutrition and hydration. • Implement an E-Learning package. • Review & formalise process for sharing audit outcomes. • Request daily MUST compliance for each ward. • Ensure implementation of nutrition champion programme to deliver quality account priority and improve patient experience and safety. • Working group to be formed that will be led by Divisional Management Team. • Develop nutrition and hydration Audit plan 2022-2023. • Removal of MUAC from EP2. • Use Perfect ward – meal observations. • X2 risks added to the Trust wide risk register. Ref 899 and 900, both with risk ratings of 16.	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 293 – Increase in Patient Falls – opened 24th March 22	An increase in the number of falls is evident when reviewing quarterly data and annual statistics. **Lead:** Practice Educator	• The total number of patient falls has increased and if it continues it will bring the annual falls rate to higher than previous year. It is unclear if this is a true increase in falls as we would have to review this against patient activity in the previous year. Ward cohorting and closure due to	• Arrange for per 1000 bed days comparison of falls 20/21, 21/22. • Incidents are reviewed at the Safety Huddle and monitored through the monthly assurance reports. • Falls incidents are discussed at Falls Prevention Steering group (FPSG). Monthly analysis sent to ward managers for sharing with staff. • New falls equipment has been	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are

		Covid Pandemic.	delivered to the wards and included static falls alarms in bathrooms. • Falls leaflets for inpatients are available for patients at risk of falls. New falls leaflet for outpatients with long term conditions.	made
Theme	**Context**	Analysis	**Action**	**Recommendation**
Ref 316 – Unsafe staffing levels – opened 25th April 2022	A significant increase in incidents relating to safe staffing levels has been noted following review of annual statistics. **Lead:** Deputy Chief Nurse	• An overall increase in incidents relating to unsafe staff levels can be seen following review of annual statistics, increasing from 5 in 2020/21 to 44 2021/22. • All staffing incidents reviewed by matrons and discussed with ward managers. All areas have remained safe following redeployment of staff across the Trust to reduce the risk to staff and patient safety. All areas have additional staff to support 1-1 specials, ward managers and matrons work clinically where required to ensure safety. There have been no reported red flags.	• Risk upgraded on Trust wide risk register. Rating 12. • Risk to be reviewed and updated to reflect current controls and assurance identified.	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made

Appendix 3 – Governance Assurance Framework – Items for continued monitoring

Theme	Context	Analysis	Action	Recommendation
Ref 287 – Violence and Aggression – opened 9th October 2017	The Trust is part of the Mersey Major Trauma & Critical Care and Cheshire and Merseyside Rehabilitation Network. The Trust now treats more complex and challenging patients. Feedback from incidents, staff and staff surveys highlight a higher risk of injury to staff whilst caring for challenging patients who lack capacity. There are often difficulties and delays experienced whilst trying to discharge or transfer complex patients. Lead: LSMS (Health Safety & Security Group).	• There were 74 incidents in Q4 compared with 73 in Q3. • 30 physical assaults on staff in Q4, compared with 36 in Q3. 29 of the incidents involved patients that lacked capacity. • 3 patients where responsible for 19 physical assaults (patient on staff). • On-going issue – incidents patient was deemed medically fit for discharge. These delays in discharge usually result in further incidence of violence or aggression.	• Develop a strategy to implement the National Violence & Reduction standards (Q4) – Action complete. • Continue to provide support for staff. • Violence & Aggression working group (group to meet bi-monthly). • Recommendations and actions from MIAA audit of complex discharges to be implemented. Reviewed on 22nd March 2022, at Thematic Review Group.	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 286 – Appointment cancellations / delays – opened 21st September 2021	Negative patient/family/staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in Do Not	• There has been a continuing trend in concerns received in 2021/22, regarding appointment arrangements • Review of call recordings since being provided access has enabled managers to provide timely feedback to staff. It has also allowed us to	• As appointment arrangements and the overall backlog for follow up review continues to be an issue following the pandemic. Workstreams continue to work in line with the recovery and restoration plans. • Synertec went live in May 21 and this service continues to be reviewed in order to develop to improve the services.	**Recommendation**: To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are

	Attends (DNAs), complaints and this will affect staff/patient experience and patient outcomes going forward. **Leads:** Operational Services Manager/Outpatient Access/Administration & Digital Health Records & Head of Patient Experience.	distinguish between genuinely abusive calls and patients who express frustration due to ineffective communication of the process from staff.	• 3-month Task/Finish Group complete in February 22 identified options to improve communication with patients to reduced concerns. Actions included that all patients added to waiting lists would receive a letter informing them of the same. It was also identified that current letters on PAS require a review. Complete Feb 22 • From May 22, Communication Working Group will take forward any further actions identified to proactively improve communication. Reviewed on 22nd March 2022, at Thematic Review Group.	made
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 300 – rejection of pathology samples by LCL – opened 2nd October 2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. Lead: Labs Quality & Governance Manager (Neurosurgery).	• Rejection data reports now received monthly from LCL. Approximately 60 samples a month rejected across the Trust. It is not possible to determine the number of tests this equates to. • OPD and HITU are the highest affected locations. • Rejections may increase in the near future when samples will be rejected if time of collection is not included following a Serious Untoward Incident in LCL.	• An integrated care IT system is being developed in the Pathology Cheshire and Merseyside network – expected completion date summer 2022. From then it will be decided in what order Trusts in the region will be connected to the order communication system. Next update July 2022. Lead: Head of IMT. Timescale: July 2022 Reviewed on 22nd March 2022, at Thematic Review Group.	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made

Theme	Context	Analysis	Action	Recommendation
Ref 304 – Communication – opened 19th December 2019	Communication issues have been identified via a number of sources, including the staff survey (2020/21), incidents, concerns and complaints. Lead: Head of Patient Experience/Divisional Director for Neurology/Neurosurgery.	• Communication incidents remain the same on review of quarterly statistics, 102 Q4 and 102 Q3. • Concerns relating to communication including visiting restrictions continue to be monitored (no specific trend) also continue to be identified and monitored with regards to formal complaints.	• Complaints continue to be monitored via the Board KPI Report and presented bi-monthly to Executive Team. • Divisions continue to closely monitor concerns and complaints via weekly meetings with Patient Experience Team (PET). • Actions/learning from concerns/complaints are monitored at weekly PET/Divisional meetings and recorded on Datix. • From May 22, Communication Working Group will take forward any further actions required to proactively improve communication Reviewed on 22nd March 2022, at Thematic Review Group.	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 310 – Pressure Ulcers – opened 24th March 2021	There have been a number of incidents reported via Datix of patients developing hospital acquired pressure ulcers (PU). This could potentially lead to moderate/severe patient harm and a poor patient experience. Lead: Tissue Viability Specialist Nurse.	• A total of 19 verified hospital acquired pressure ulcers recorded 2021/22. • New TVN started in November 2021 • HAPU data analysed from 2018 to current date by new TVN. • All incidents reviewed and review/outcome details scrutinised on EP2 and Datix system to assure accuracy. Completed and circulated Trust Wide.	• 12 months tissue viability training program implemented. This consists of ward-based training, one to one training and study days. • Tissue viability training dates circulated to all areas for financial year 2022/23. • Ward tissue viability link nurses requested for each area; tissue viability Link nurse list now generated. • 72-hour investigation requested and compliance with time frame improving. Completed investigations	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made

			to be added to the new expected standards of care investigation tool – pilot tissue viability investigation tool • Wound assessment charts (Ep2) updated and awaiting sign off by nursing documentation group – Complete. • Introduction of SKIN bundles for all wards; document also reviewed and awaiting sign off as above bullet point. Complete • Update Pressure Ulcer Policy to reflect changes, waiting sign off by Quality Committee. • Register to be compiled of pressure ulcer training to aid compliance Audit dissemination of education. Reviewed on 22nd March 2022, at Thematic Review Group.	
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 314 – Theatre ventilation system – opened 5th May 2021	Theatres 1 – 5 do not meet the required level of air changes per minute as required by Health Technical Memorandum (HTM) 2025 guidance. Lead: Estates Manager (BPC).	• During the annual validations of Theatre ventilation system (1 - 5) it has been identified there are not sufficient air change rates. • Recent intervention work has taken place which has provided improvements but fails to meet HTM standards. • The National Infection Rate for Theatres does not indicate a high prevalence	• A options appraisal paper was presented to divisions for discussion and direction. It was agreed that full replacement of the AHUs is required. • Engagement has taken place with design consultant to evaluate preferred options and quoations given to develop the design to tender stage. • A further paper was taken to Capital Monitoring Group for approval to proceed with Design Development. This was approved to proceed for further approval at Operational	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are made

		of infection which is an indicator of a clean environment. Additionally, it is known that the air cascade, as prescribed in HTM 2025 is correct.	Management Group. • A further paper is being developed for Board approval, including further refurbishments to Operating Theatres. • Design development business case approved. Purchase order raised for design to be develop upto, and including tender packages. • Two members of Trust staff have now successfully completed a Responsible Person (Ventilation) course. • The Trust has appointed an Authorising Engineer (Ventilation) to review processes and advise moving forward. • The Trust has set up a ventilation safety group with the 1st meeting April 2022 Reviewed on 22nd March 2022, at Thematic Review Group.	
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 305 – Legionella – opened 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. Lead: Estates Manager (BPC).	There has been an improvement over recent months of the circulation of hot water temperatures which are now in line with HSE Guidance.	• Undertake meeting with Estates Manager, Head of Risk, Consultant Microbiologist, Infection Prevention & Control Team (IPCC), Director of Nursing and Trust's external water treatment chemist to establish options for future chlorination and treatment of the water pipework. • Establish a process for re-balancing, treatment and testing that will lead towards the future removal of all	**Recommendation:** To remain on GAF and Continue to monitor via the quarterly thematic review meetings and the quarterly report to Quality Committee until improvements are

			point of use filters. • Continue programme of temperature testing to ensure stability of circulation. • Maintain flushing and regime via Compass water management system. • Water Safety Group / IPCC to monitor results of above. • Prepare a paper with options and potential capital implications for a system wide chemical treatment of the water system. • Trust has liaised with PHE regarding dosing levels. Awaiting response. • The Trust has appointed an Authorising Engineer (Water) to review processes and advise moving forward Reviewed on 22nd March 2022, at Thematic Review Group.	made

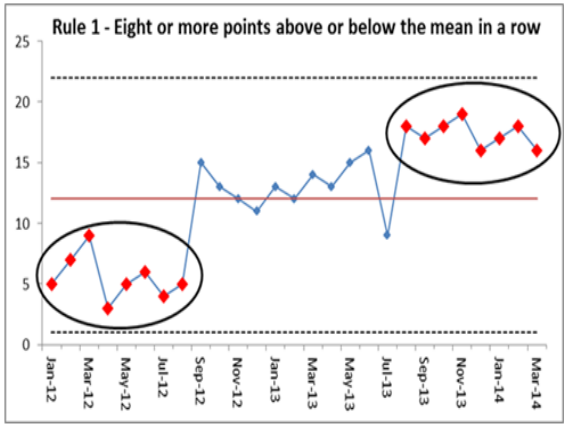
Appendix 4 – Governance Assurance Framework – Items for closure

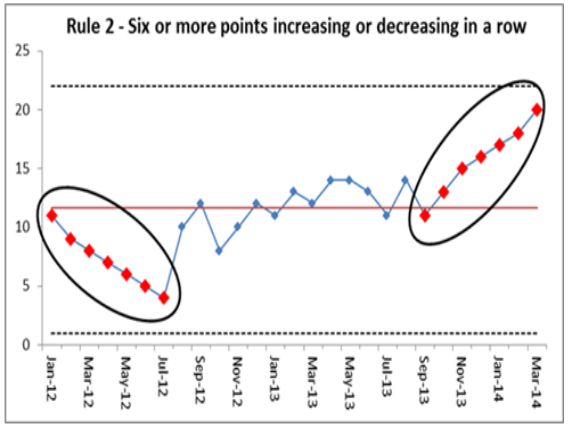
Theme	Context	Analysis	Action	Recommendation
Ref 311 – Carbapenemase Producing Enterobacteriaceae (CPE) – opened 22nd September 2021	Significant increase in CPE (Carbapenemase-Producing Enterobacteriaceae) incidents reported throughout Quarter 2. **Lead:** Infection Control Team.	Incidents of CPE have increased from 0 in Q3 to 1 in Q4.	• Enhanced screening for MDRO across high-risk areas in place. • Expert internal/external group review as needed. • Robust action plan and risk reduction actions in place. All action plans now monitored monthly via IPCC. CPE action plan almost complete • Revisit the option of routinely screening patient all patients on admission and those who are re admitted to the Trust within 12 months. • Review use of digital system to monitor screening compliance. There has been feedback that this may occur at national level and be implemented late summer 2022. • Review process to ensure that changes to policies are communicated effectively • Cleaning sign off sheet for ISS and ward managers introduced • Continue with staff education and raising awareness • Review process for rapid review to ensure learning is embedded effectively. Rapid reviews are now completed within 72hr (working day) deadline. Reviewed on 22nd March 2022, at Thematic Review Group.	**Recommendation:** Close due to sufficient controls and assurance resulting in reduction in incidence of CPE

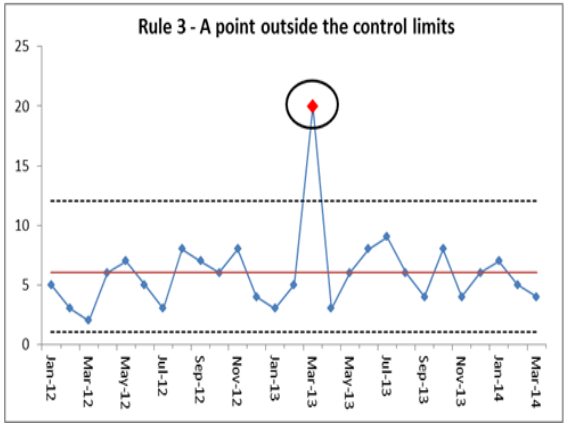
Theme	Context	Analysis	Action	Recommendation
Ref 312- Outstanding recommendations - opened 20th December 2021	If outstanding recommendations, identified from Incident investigation process, are not completed (i.e., evidence provided) within the timescales set, then there is risk to Patient Safety as a result of potential re-occurrence of incidents. Lead: Divisional Management Teams.	Outstanding recommendations by division: ○ Surgery division – 69 ○ Neurology division - 13	• Risk recently added to the Trust risk register Risk ID 885 – rating 8. • Weekly - outstanding recommendations are reviewed and monitored at Trusts Weekly safety meeting. • Monthly – numbers of outstanding recommendations monitored by divisional governance meetings. Reviewed on 22nd March 2022, at Thematic Review Group .	**Recommendation:** Close due to sufficient controls and assurance resulting in reduction of outstanding recommendations - Continue to monitor via Risk entry 885
Theme	**Context**	**Analysis**	**Action**	**Recommendation**
Ref 313 – Covid 19 – opened 20th December 2021	Following the recognised increase in regional and national Covid-19 infection rates and the introduction of mandatory vaccinations for all NHS staff by April 2022, it is identified that there will be a significant impact to all Trust services. Lead: Thematic Review Group .	If staff are not double vaccinated by April 2022, then they will be dismissed from the Trust. This will have an impact on the Trusts ability to maintain service standards leading to service disruption	• Monitor any increased infections via the daily safety huddle. • Incident reporting and investigation. • Divisions will continue to closely monitor any identified concerns and complaints associated with Covid-19 via weekly meetings with Patient Experience Team (PET). • Continue to log actions/learning from concerns/complaints associated with Covid-19 which are monitored at weekly PET/Divisional meetings. Reviewed on 22nd March 2022, at Thematic Review Group.	**Recommendation:** Close – Following the Government's decision to abandon the mandatory vaccination programme.

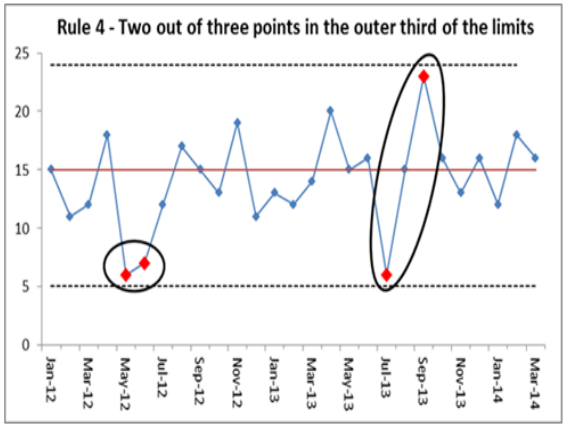
Appendix 5 – SPC chart guidance

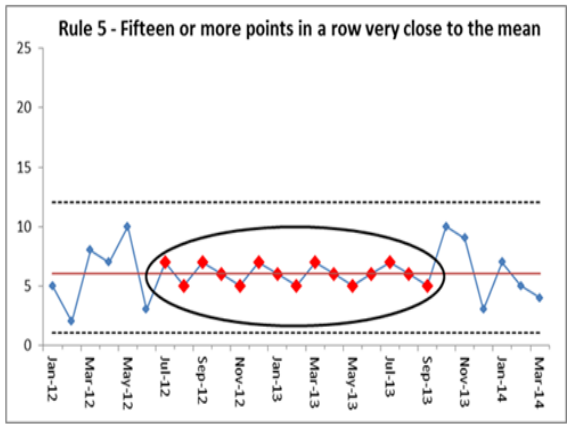
SPC Charts Special Cause Rules



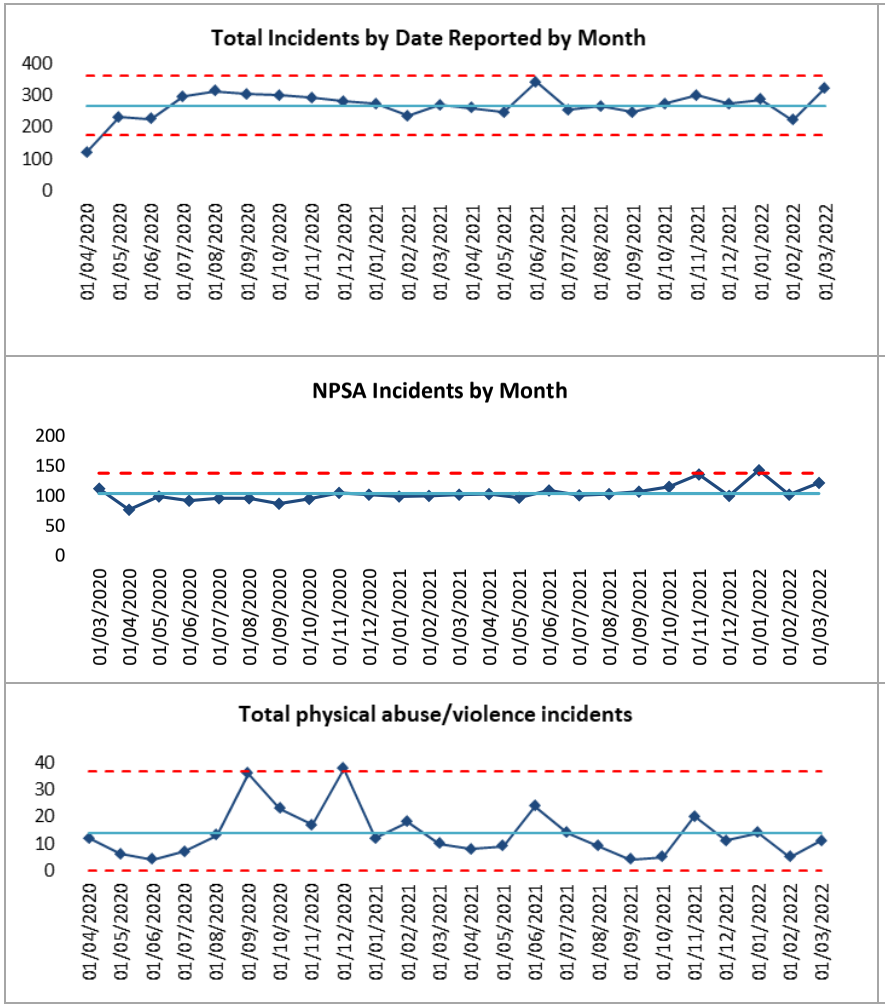


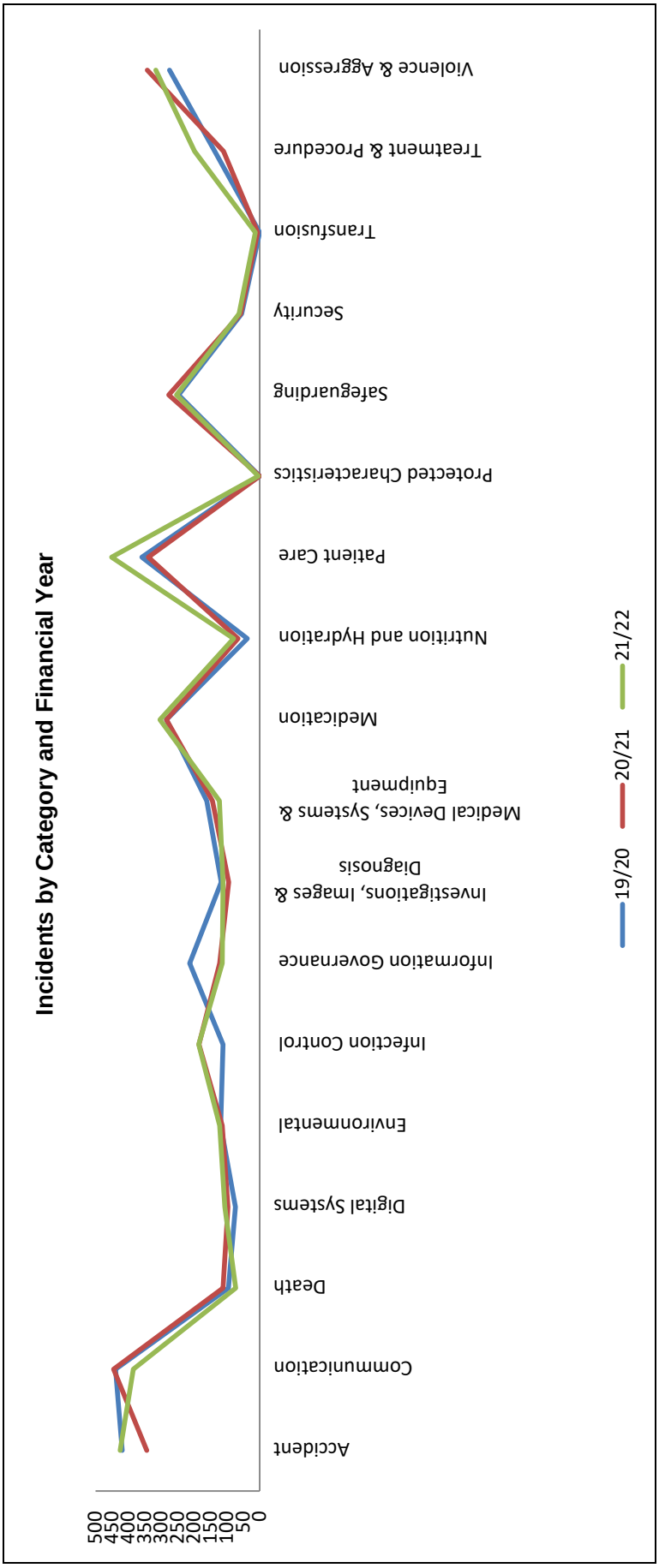


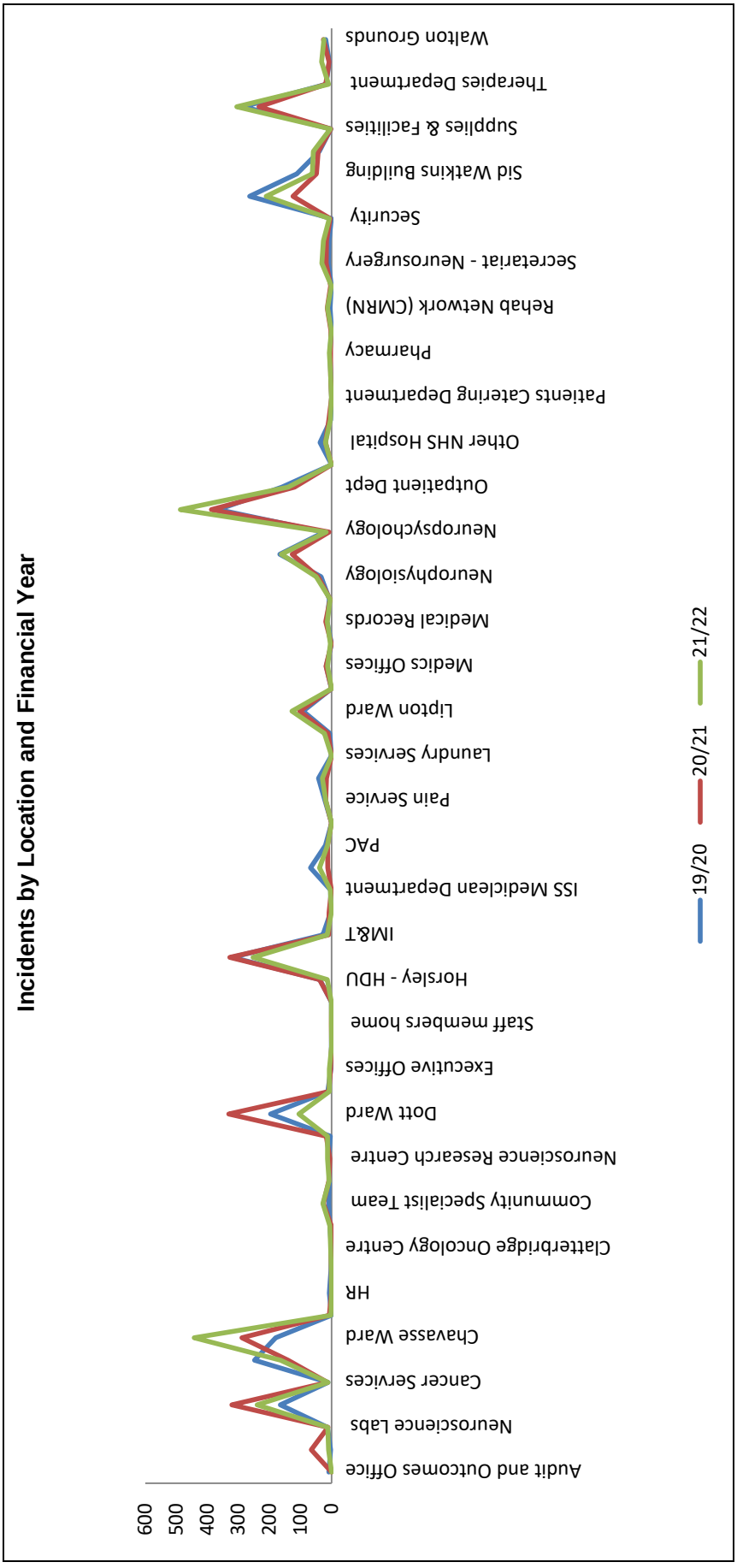




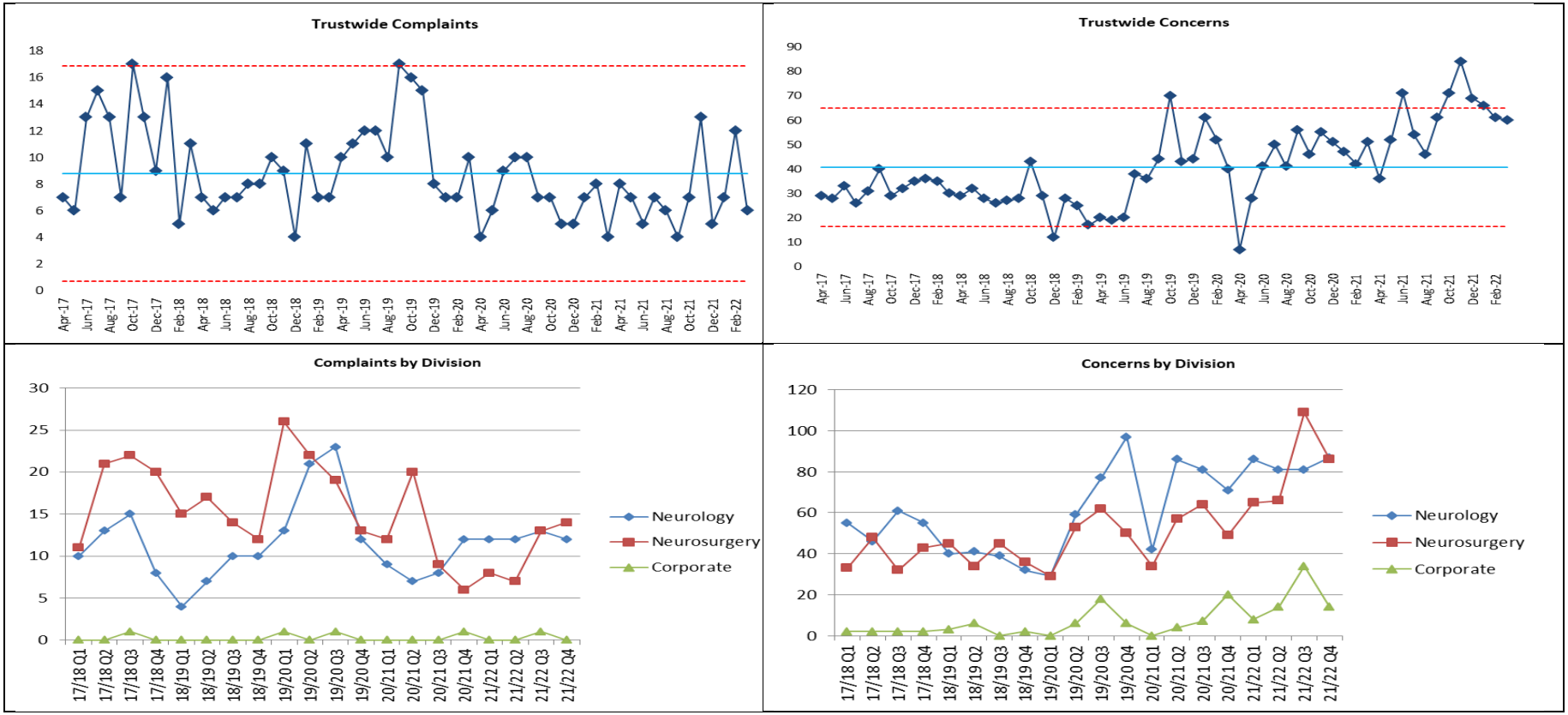
Appendix 6 – Incident & Risk Management overview

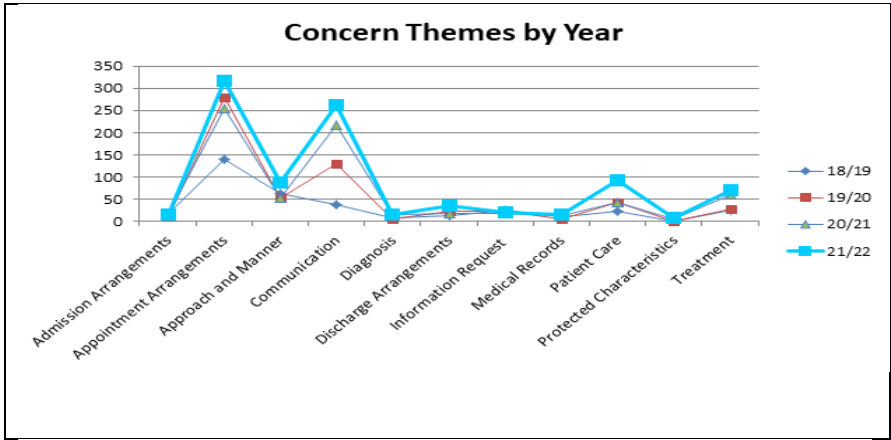


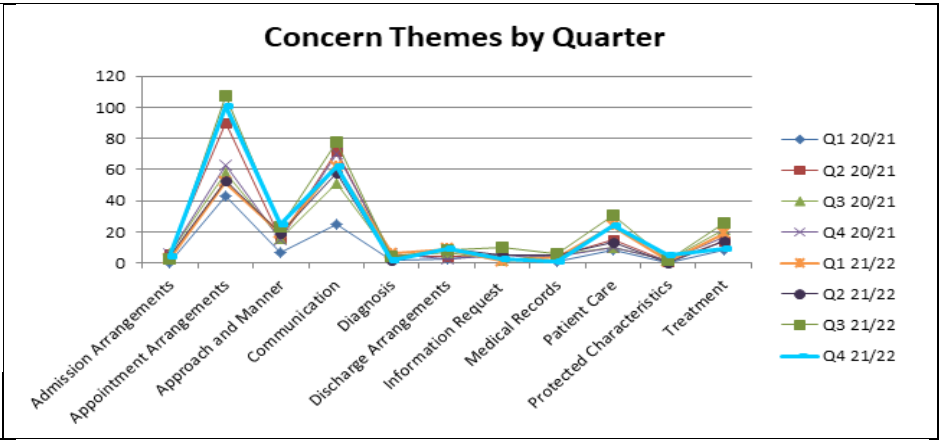

Incidents by Category and Financial Year
500
450
400
350
300
250
200
150
100
50
0
Accident
Communication
Death
Digital Systems
Environmental
Infection Control
Information Governance
Investigations, Images & Diagnosis
Medical Devices, Systems & Equipment
Medication
Nutrition and Hydration
Patient Care
Protected Characteristics
Safeguarding
Security
Transfusion
Treatment & Procedure
Violence & Aggression
19/20
20/21
21/22

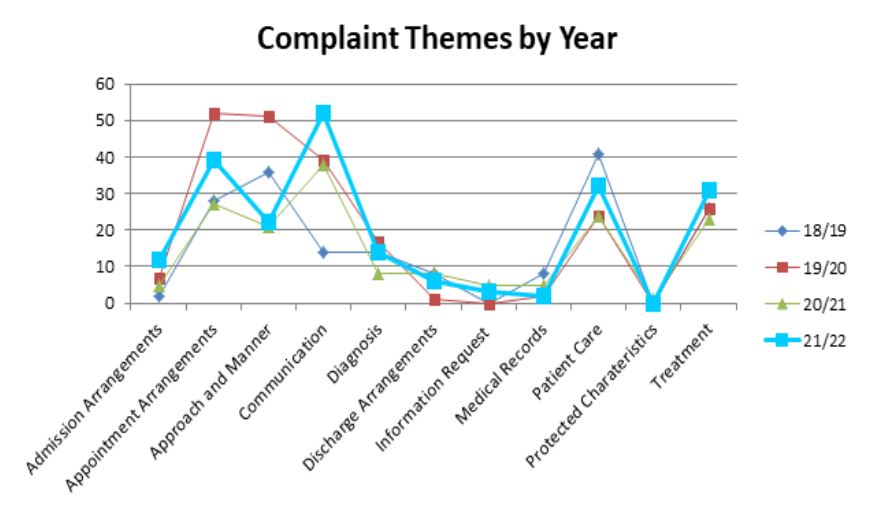

Incidents by Location and Financial Year
600
500
400
300
200
100
0
Audit and Outcomes Office
Neuroscience Labs
Cancer Services
Chavasse Ward
HR
Clatterbridge Oncology Centre
Community Specialist Team
Neuroscience Research Centre
Dott Ward
Executive Offices
Staff members home
Horsley - HDU
IM&T
ISS Medicleen Department
PAC
Pain Service
Laundry Services
Lipton Ward
Medics Offices
Medical Records
Neurophysiology
Neuropsychology
Outpatient Dept
Other NHS Hospital
Patients Catering Department
Pharmacy
Rehab Network (CMRN)
Secretariat - Neurosurgery
Security
Sid Watkins Building
Supplies & Facilities
Therapies Department
Walton Grounds
19/20
20/21
21/22

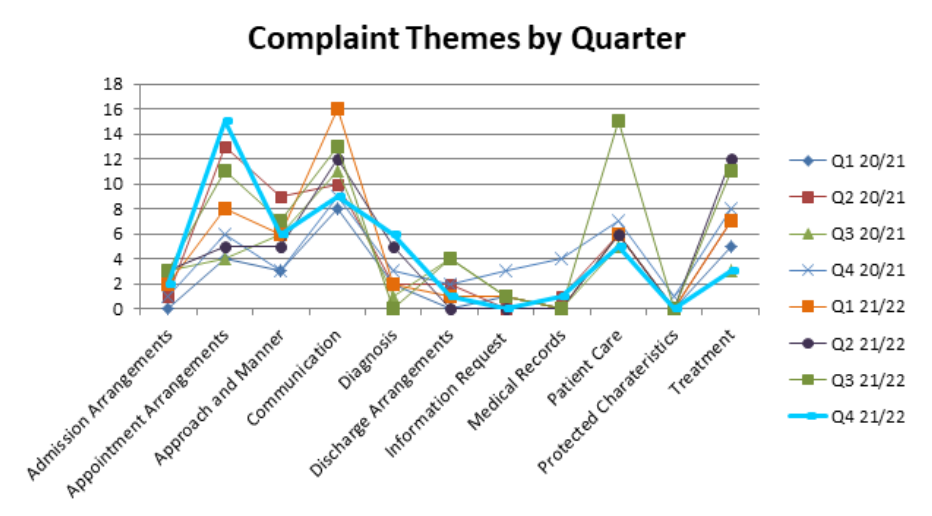
Appendix 7 – Complaints & Concerns overview




Concern Themes by Year
350
300
250
200
150
100
50
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
18/19
19/20
20/21
21/22


Concern Themes by Quarter
120
100
80
60
40
20
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
Q1 20/21
Q2 20/21
Q3 20/21
Q4 20/21
Q1 21/22
Q2 21/22
Q3 21/22
Q4 21/22


Complaint Themes by Year
60
50
40
30
20
10
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
18/19
19/20
20/21
21/22


Complaint Themes by Quarter
18
16
14
12
10
8
6
4
2
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
Q1 20/21
Q2 20/21
Q3 20/21
Q4 20/21
Q1 21/22
Q2 21/22
Q3 21/22
Q4 21/22

Appendix 8

Trust Wide	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Total new claims received	9	4	4	1	7	7
Neurosurgery claims	5	1	1	1	4	4
Neurology claims	2	3	1	0	2	1 Neu/NS
Corporate claims	2	1	2	0	1	2
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	7	7	16	4	10	8
Number of closed claims in quarter	3	3	10	7	6	6
Value of closed claims - Public liability	£0.00	£5,000	£3,920.	£1,250.	£0.00	£0.00
Value of closed claims - Employer liability	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£209,929.	£128,261.	£374,658.	£337,153.	£29,824	£1,291,650.

One claim was a Trial in Court in 2021 where the Judge preferred the claimant's evidence and won the trial.
One claim had been ongoing for some time with lessons learned at the time of the incident through RCA

The Walton Centre NHS Foundation Trust

Report to Trust Board
7th July 2022

Report Title	Medical Revalidation Annual Report
Executive Lead	Dr Andrew Nicolson, Medical Director
Author (s)	Dr Andrew Nicolson, Medical Director
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Of the 159 doctors with a 'prescribed connection' to the Trust, 151 (95%) had an annual appraisal between 1/4/21 and 31/3/22.
- Of the 36 doctors who were due revalidation, 28 positive recommendations were made to the GMC, with 9 deferrals (1 deferral with subsequent positive recommendation) and no recommendations for non-engagement.
- The Trust has a robust governance system in place to manage medical appraisal and revalidation.

Next Steps

- Continue with the current system which is in place and ensure that we comply with NHS England requirements.

Related Trust Strategic Ambitions and Themes	**Impact**		
People	Quality	Workforce	Compliance

Strategic Risks

001 Quality Patient Care	004 Leadership Development	008 Medical Education Strategy

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Medical Revalidation Annual Report 2021/22

Executive Summary

1. All medical staff are required to have an annual appraisal, as part of a five year revalidation cycle.

2. The governance processes in place in the Trust with regard to medical appraisal, revalidation and managing concerns are reported to NHS England North West through this report. In addition to this the Trust previously has completed an Annual Organisation Audit, but this has been stood down since the onset of the covid pandemic.

3. This Board report is used as evidence for the Board of compliance with the Medical Profession (Responsible Officers) Regulations 2010.

Background and Analysis

4. The Medical Profession (Responsible Officers) Regulations 2010, amended in 2013, require a governance process to be in place related to the appraisal, revalidation and managing concerns of doctors. Prior to the covid pandemic an Annual Organisational Audit was submitted in addition to this Board report, and benchmarking data produced. Since 2019/20 this has not been required, but the Trust Board has received this report annually for assurance of the Trust processes.

5. In the Trust there is an Appraisal and revalidation manager, Medical Appraisal Lead and Responsible Officer (RO). The RO is also the Trust's Medical Director, and undertakes an annual appraisal by an appointed NHS England appraiser.

6. This is the first full year of medical appraisal following a pause in 2020. This has also coincided with the embedding of a new electronic appraisal tool.

7. The Trust has an appropriate number of trained appraisers, who participate in quarterly meetings with the Medical Appraisal Lead and RO. Refresher training for appraisers is provided when required, at least every 3 years. All appraisals are reviewed by either the Medical Appraisal Lead or RO and feedback provided to the appraisee and appraiser.

8. The Trust has 159 doctors with a prescribed connection (those doctors who name the Trust as their 'designated body'). In this appraisal year, from 1/4/21 to 31/3/22, 151 (95%) of doctors had an appraisal, with 6 of the 8 misses appraisals being approved. Approved missed appraisals are most commonly due to long term sickness absence.

9. 36 doctors were due for revalidation during the 2021/22 appraisal year. In each case the RO reviews the evidence from the appraisals during the 5-year revalidation cycle and makes a recommendation to the GMC. The RO made 28 positive recommendations to the GMC, with 9 deferrals (1 deferral with subsequent positive recommendation). Deferral is a neutral act and most commonly is made where more information is required, and the requirements are clearly fed back to the doctor. There were no recommendations of non-engagement.

Conclusion

10. The Trust has a robust system in place for medical appraisal and revalidation. The Trust has achieved the target set by NHS England of >90% of all doctors having an annual appraisal.

Recommendation

To note.

Author: Andrew Nicolson, Medical Director and Responsible Officer
Date: 27th June 2022

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:		
	Name	Contact information
Responsible Officer	Andrew Nicolson	andy.nicolson@nhs.net
Medical Director	Andrew Nicolson	andy.nicolson@nhs.net
Medical Appraisal Lead	Chris Whitehead	chris.whitehead3@nhs.net
Appraisal & Revalidation Manager	Clerita Hopkins	clerita.hopkins2@nhs.net
Additional Useful Contacts		

Contents

Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

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

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

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

The Board of The Walton Centre NHS Foundation Trust can confirm that:

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

2021/2022 update: The Trust Responsible Officer (RO) is also the Medical Director. He undertakes annual appraisals by an appointed NHS England appraiser which includes his role as RO. RO network meetings have not taken place with the usual frequency in the last year but the RO has attended such meetings. Action for next year: Continue current process.

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

Yes 2021/2022 update including description of Appraisal & Revalidation support: The Trust has a well embedded and effective process for managing medical appraisal and revalidation. The RO is well supported by the Medical Appraisal Lead and Appraisal and revalidation coordinator. There is an electronic appraisal tool (L2P) which has been established since November 2020, and had been well received by medical staff (appraisers and appraisees). This includes a Consultant job planning tool which has not yet been utilised and plans to implement this have been delayed due to the impact of the covid pandemic and the subsequent focus on recovery of clinical activity. Action for next year: Continue current process.

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

2021/2022 update: GMC provide a list of all Doctors with a prescribed connection to the Trust. The list is maintained by the Appraisal and Revalidation coordinator who also receives a monthly list of starters and leavers via the HR Department. Action for next year: Continue current process.

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

List of relevant policies and date of last review:

Medical Staff Appraisal and revalidation policy, revised and due for review by LNC September 2022.

Remediation policy, approved by LNC 2021.

Medical study leave policy, revised and due to review by LNC September 2022.

Mentoring policy – approved in principle by LNC, further review September 2022.

Maintaining High Professional Standards Policy – revised June 2022.

Consultant job planning policy, reviewed in 2021. No changes made due to delays with electronic job planning. The review date has been extended to 1/3/23.

2021/2022 update: The Consultant job planning policy is due for review but has been delayed due to the impact of the covid pandemic and subsequent focus on recovery of clinical activity.

Action for next year: Update Consultant job planning policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

2021/2022 update: The last review was conducted by the MIAA in 2015. It is recommended that a peer review takes place in each 5 year revalidation cycle. As the Trust embedded a new electronic appraisal system in late 2020 and due to Covid pandemic, it was considered most appropriate to review this when the appraisal system was re-established and the electronic tool embedded. Action for next year: MIAA review of process Q1 2023.

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

List of relevant policies and date of last review: Medical Staff Appraisal and revalidation policy – includes section on the process for this group of doctors. 2021/2022 update: Locum and Short Term Doctors are provided with an opportunity for an appraisal whilst at the Trust including those with a prescribed connection to another organisation eg GP with a specialist interest. Data relevant to appraisal is available to them on request if they have their appraisal at their Designated Body. This group of doctors also have access to Educational events within the organisation and receive a Local Trust induction. Action for next year: Continue current process.

7. Where a Service Level Agreement for External Responsible Officer Services is in place

Describe arrangements for Responsible Officer to report to the Board: N/A Date of last RO report to the Board: N/A Action for next year: None required.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

2021/2022 update: 159 Doctors had a prescribed connection with the Walton Centre NHS Foundation Trust as at 31/3/22. This has increased by 8 from the previous year and by 55 from 2014.

Following the pause in medical appraisals during the covid pandemic, this was restarted in the Trust in November 2020. Through 2021/22 the process has worked well, although this has taken some time to regain engagement in the process, and it has been notable that with some medical staff this appears to relate to experiences during the covid pandemic. The focus of appraisal has been on health and well-being, with encouragement for more of a conversation with less focus on written documentation.

Between 1/4/21 and 31/3/22 151 (95%) doctors had an appraisal. Of the 8 missed appraisals, 6 were approved (mainly due to long term sickness absence) and 2 were unapproved missed appraisals. Therefore, 157 (99%) doctors either had an appraisal or an approved missed appraisal.

Action for next year: Continue current process to achieve >90% completed appraisals.

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

2021/2022 update: Approved missed appraisals were fully understood. Those unapproved were due to individual delays in setting up the appraisal meeting, and have been addressed.

Action for next year: Continue current process.

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

List of relevant policies and date of last review: Medical staff appraisal and revalidation policy. 2021/2022 update: This has recently been revised and will seek approval by LNC in September 2022 (and subsequently the Trust's Business Performance Committee). Action for next year: None required.

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

Number of available appraisers: 33 2021/2022 update: There are sufficient appraisers to carry out timely annual appraisals for all of our medical staff. The appraisal and revalidation manager monitors appraiser training and we have a process in place to ensure that update training takes place for each appraiser every 3 years. Quarterly appraiser meetings have been reinstated Action for next year: Continue current process.

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

2021/2022 update: There are quarterly meetings for appraisers with the Medical Appraisal Lead, RO and Appraisal manager. Updates from GMC / NHSE related to appraisal are fed back to the group. All appraisals are reviewed by either the RO or the Trust medical appraisal lead. All appraisees provide feedback on the appraisal and this feeds in to the appraiser's own appraisal. The feedback scores are analysed by the Medical Appraisal lead and the appraisals of any outliers are reviewed in detail. Appraisers receive online refresher training every 3 years. Action for next year: Continue current process.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

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

List of relevant policies and date of last review: Medical staff appraisal and revalidation policy. 2021/2022 update: Monthly appraisal percentage is collated and reported to the Quality Committee as part of the Trust's performance report. Annual medical revalidation report to Trust Board. Action for next year: Continue current process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**151**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**8**
Total number of agreed exceptions	**6**

Section 3 – Revalidation Recommendations to the GMC

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

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	**28**
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	**9**

Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	**0**
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	**0**

2.

2021/2022 update: There were 36 doctors due for revalidation. 28 positive recommendations were made, with 9 deferrals (1 doctor was deferred and subsequently a positive recommendation was made when the requirements were met). Deferral is a neutral act, and can be recommended to several reasons, often related to insufficient evidence which may be as a result of long term absence or in some new starters. Of those deferred, 4 were due to long term sickness absence and 5 were doctors recently started in post who required longer to provide supportive evidence.

Action for next year: Continue current process.

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

List of relevant policies and date of last review: Medical staff appraisal and revalidation policy.

2021/2022 update: All revalidation recommendations are confirmed promptly in writing to the doctor from the RO, with a summary of the evidence from appraisals during the revalidation cycle. If the recommendation is for deferral due to insufficient evidence then there is a clear written plan of requirements prior to the new revalidation date. There have been no recommendations of non-engagement but this would not take place without a discussion with the doctor.

Action for next year: Continue current process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

List of relevant policies and date of last review:

Clinical effectiveness and audit policy, revised 2022.

Raising concerns policy, revised 2021.

Safeguarding Adult policy, September 2021.

Safeguarding Children policy, February 2019.

Complaints policy, August 2020.

Incident reporting policy, December 2021.

2021/2022 update: The RO / Medical Director is also personally responsible for clinical governance for doctors. The monitoring aspects required for this part of the RO's role are through the normal reporting processes to the Divisions, Executive, Quality Committee and Trust Board. This provides the formal assurance structure.

Action for next year: Continue current process.

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

2021/2022 update: The Clinical Governance Teams provide data relating to legal claims, complaints, datix incident forms and serious untoward incidents to the Appraisal and Revalidation Co-ordinator. This data is then redacted and provided to the Doctor or directly uploaded onto their portfolio on the electronic appraisal system.

Action for next year: Continue current process.

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

List of relevant policies and date of last review: Maintaining High Professional Standards policy, 2019 - revised policy to discuss in LNC September 2022.

2021/2022 update: The Trust's process for responding to concerns about a doctor follows Maintaining High Professional Standards (MHPS). The Trust has an approved MHPS policy that has been discussed and agreed with relevant stakeholders. This has recently been reviewed and will go to LNC for approval.

Action for next year: Continue current process.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Outline arrangements and frequency for reporting to the Board: As numbers of such concerns are small these are reported as required. 2021/2022 update: If a doctor is investigated with regard to capability or conduct then this is carried out in accordance with MHPS, and as such is reported to Trust Board. Numbers of cases are reported to the Trust's People group. Action for next year: Continue current process.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

2021/2022 update: The Trusts uses NHS England's Medical Practice Information Transfer form (MPIT) to transfer information to and from other NHS organisations for new starters. Section 2 of the 'Professional work outside the WCFT' is used annually for existing staff who also work outside the Trust. Action for next year: Continue current process.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

2021/2022 update: All Trust Policies have an appropriate Equality Impact Assessment, these are quality checked by the Equality, Diversity and Inclusion Lead of the Trust for HR policies.

Action for next year: Continue current process.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

List of relevant policies and date of last review: Recruitment policy, revised June 2022, approved by Staff Partnership Committee. Due for review by LNC September 2022.

2021/2022 update: The HR Recruitment team have a robust system in place for pre-employment checks and is subject to external Audits in line with NHS 'Safer Recruitment'. The Trust is provided with locum doctors from agencies through the HTE framework who provide written confirmation of their processes as part of monitoring of the contract.

Action for next year: Continue current process.

Section 6 – Summary of comments, and overall conclusion

This year for appraisal and medical revalidation has seen a return to the 'normal' process and a full year for reporting appraisal compliance. There remains some impact from the covid pandemic and the current focus on recovery of clinical activity. The focus for appraisal has very much been on health and well-being and having a conversation, with less emphasis on detailed written documentation. This has been well received and there has been a general acceptance of a return to the appraisal process.

During this year there were 36 doctors due for revalidation, with 28 positive recommendations made to the GMC, and 9 recommendations for deferral. There were no recommendations for non-engagement.

The appraisal and revalidation process is well embedded, with robust systems in place. The Responsible Officer is well supported in his role by the Medical Appraisal Lead and the Appraisal and Revalidation Coordinator. There are systems in place for peer support of appraisers and Quality Assurance of appraisals. The Trust has been

successful in the re-implementation of the appraisal process and has achieved completed appraisals in 95% of doctors (99% if approved missed appraisals are included).

Overall conclusion:

The appraisal process has been successfully re-introduced following the pause in 2020 due to the covid pandemic, with a focus on well-being. The Trust has achieved the NHSE target of >90% completion of appraisals. There are no areas of concern.

Section 7 – Statement of Compliance:

The Board of The Walton Centre NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Walton Centre NHS Foundation Trust

Name: Jan Ross Signed:

Role: Chief Executive Officer

Date: 7/7/22

The Walton Centre
NHS Foundation Trust

Report to Trust Board
7th July 2022

Report Title	Medical Education Annual Report
Executive Lead	Dr Rhys Davies, Clinical Director for Research and Medical Education
Author (s)	Miss Elizabeth Doherty, Medical Education Development Manager
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Investment in Undergraduate faculty – successful impact & excellent feedback received
- Impact & delivery of Health Education England (HEE) Postgraduate Training Recovery Programme
- External reporting in a state of flux

Next Steps

- Exploring national opportunities for development in training offering /clinical placements
- Preparing for increasing Undergraduate numbers via Medical School
- Consolidating educator support & reinforcing internal relationships

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Quality	Compliance	Finance

Strategic Risks

008 Medical Education Strategy	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Medical Education Annual Report 2021-22

Executive Summary

1. 2021 has been framed as a year to 'reset, recover and reform' after the disruption of 2020. Effective and meaningful postgraduate training recovery and harnessing educational innovation has been forefront of the postgraduate agenda, whilst undergraduate medical education at University of Liverpool continues its work to embed a new curriculum amid COVID recovery whilst looking to the future and increasing medical school places.

2. The Walton Centre NHS Foundation Trust (WCFT) Medical Education has grown over this time, building its faculty and strengthening its position in the trust and key relationships with Research and Innovation, harnessing the unique opportunities these bring to student doctors and trainees coming to the Trust.

3. The Medical Education Annual Report is a comprehensive look back at the academic year. There has been a lot of transition and uncertainty to manage across all areas of Medical Education. Clearly Covid remains a challenge, although restrictions may be loosening and capacity returning to normal, the impact of lost clinical training and managing 'catch up' within undergraduate and postgraduate programme means secondary effects of the pandemic will be with us for some time yet.

Background and Analysis

4. Health Education England has invested significantly in a wide range of initiatives under the umbrella of Postgraduate Training Recovery. There is a drive to harness the advances in tech enhanced learning post Covid and make sure that efficiencies emerging from crisis management are not lost as we return to business as usual. WCFT has received funding to support trainee education recovery and the development of a Health and Wellbeing programme for junior doctors. This should enhance the working lives of junior doctors at the trust even further.

5. Postgraduate training is responding to national strategic programme change that the trust is managing creatively through the development of new posts, as in the case of the IMT3 Aintree/WCFT post. Neurosurgery is looking to grow its' simulation offerings with the acquisition of virtual reality training equipment. This will increase the Trusts external training possibilities and scoping of national training opportunities.

6. Undergraduate medical education has been bolstered by the appointment of two education fellows whose impact has been immense this year. Student feedback has consistently referenced the support and contribution the posts have made to their experiences. There are secured dedicated consultant educator PAs and several new lead educator roles have been created to consolidate the undergraduate faculty. The benefits of the consolidated educator faculty will be realised over the next few years as the roles become established.

7. The Director of Medical Education and Medical Education Development Manager have sought to create more transparency and understanding around education income. Allocation of Undergraduate educator PA has been a step towards achieving this goal. Communication between Finance, divisional management and Medical Education has been productive and will continue moving forwards.

8. Aims for the next year include embedding support for the new education leads and growing the educator development offering. Undergraduate supervision will be a focus for the undergraduate leads to review. Consolidating internal relationships and promoting the key role of the Medical Education can have in supporting divisional management, e.g. in the development of new and innovative training posts, will be a priority. Looking externally, scoping out innovative and diverse offerings the Trust could support, in respect of training and education for a national and international market, will be a longer term objective.

Conclusion

9. In summary, this has been a successful year. Notably Undergraduate medical education has had a fantastic year and the team should be credited with the successes achieved, in particular the two junior doctors Dr Josh Fulton and Dr Dean Walton who have been the Education Fellows are to be commended for their contribution.

10. That said, this is a dynamic phase as the Trust moves away from Covid and the pandemic and faces new challenges and opportunities. Medical Education is a conduit between strategically important external stakeholders and Trust operational (clinical) activity. To grow and develop, Medical Education will need to reinforce its role within the Trust as a business integral partner, to ensure development opportunities are identified and acted upon.

Recommendation

To Note

Author: Elizabeth Doherty, Medical Education Development Manager
Date: 28th June 2022

THE WALTON CENTRE NHS FOUNDATION TRUST

Medical Education Annual Report 2021-22

CONTENTS

FOREWORD

The Walton Centre NHS Foundation Trust as the only Neuro- specialist trust in the UK has a unique role providing comprehensive neurology, neurosurgery, spinal and pain management services, and education in those disciplines.

The Trust is proud of its strong academic links with the University of Liverpool Faculty of Health and LIfe Sciences. We provide Neurological undergraduate clinical placements as part of the MBChB qualification in addition to elective placements for UK and international undergraduate students. We continue to influence the trajectory of Neuroscience within the curriculum to break downbarriers and facilitate understanding of Neuroscience, mitigate 'neurophobia'. We are proud to support and collaborate with a number of interest groups within universities at local, national and international level.

We have consultants in principal academic positions at the University, leading ground breaking research developments in Neuroscience. We are recognised by our external oversight stakeholders, such as HEE, as an exemplar in postgraduate education. Despite challenges of COVID WCFT has been able to maintain the deeply embedded ethos of continuous education and personal development at the trust. In the context of system evolution, WCFT Medical Education has been agile and adapted its training and education programmes to fit environmental changes.

2021 has been framed as a year to 'reset' after the disruption of 2020. Effective and meaningful postgraduate training recovery and harnessing educational innovation has been forefront of the postgraduate agenda, whilst undergraduate medical education at University of Liverpool continues its work to embed a new curriculum amid COVID recovery and with one eye to the future and increasing medical school places. We look forward to the opportunities this brings to the ongoing development of Medical Education at WCFT

Dr Rhys Davies
Director of Medical Education

Michael Gibney
Director of Workforce and Innovation

OUR YEAR IN NUMBERS

The Medical Education Annual Report covers the 2020-21 academic year.

Period covered - Academic Year 2021-22

Doctors in Training	Core - 7	GP – 1	Specialty – 41
Medical Students	Year 4 - 369	Year 5 - 13	UoL Elective 20
# Consultants who are GMC Approved Educational / Clinical Supervisors	97(/140 69%)		
#GoSW Education exception reports made by Doctors in Training	0		
201-22 UG Placement RAG Report: Overall this placement has been valuable to my education	Year 4 WCFT average 1.89 (Green Outlier) All site average 1.48	Year 5 No data available	
WCFT GMC NTS 2021 Outliers	Green (positive) Anaesthetics - 2 CST - 1 IMT - 5 Neurology – 2 Neurosurgery - 4 Radiology - 2	Red (Negative) Anaesthetics - 2 CST – 4	
*GMC Enhanced Monitoring	No		
*GMC NTS Overall Satisfaction	Within national average		

*CQC monitored indicator

INTRODUCTION

This report on Medical Education covers the academic year August 2021- July 2022.

Medical Education has managed the logistics of hosting substantially more undergraduate students within a hospital environment where the effects of the pandemic were still being felt. New and innovative local and formal training posts were introduced and have become embedded over the academic year. Advances in simulation provision has been made with the purchase of state-of-the-art virtual reality equipment bolstering and enahcing the neurosurgery programme at the trust, paving the way for a national offering.

The Director of Medical Education remains responsible for medical education and training alongside the faculty of Lead Educators, Clinical Tutors and Educational Supervisors. The Medical Education faculty has received considerable investment with novel new roles emerging, notably the education appraisal lead and education fellows, which will in future reinforce support for educators as well as learners. The service is led by the Medical Education Development Manager Liz Doherty, with operational activity delivered by Medical Education Officers, Judith Dennis and Yasmin Harris, and Medical Education Administrator Amy Chapple.

Alongside the University of Liverpool, Health Education England is one of our key strategic partners. We have demonstrated responsiveness and agilty to the requirements of our partners diligently through creativity and innovation. We are striving to increase transparency in education funding and are building strong connections with finance to raise understanding of the complex needs of Medical Education across the Trust.

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FOCUS ON MEDICAL EDUCATION DEPARTMENT

Notable investment has been made in the medical education faculty this academic year. As well as dedicated remuneration to support job planned time for undergraduate supervisors there have been new consultant education leads created alongside two junior doctor clinical education fellow posts.

New Education faculty posts

- Grand Round Lead
- UG teaching – ST led
- UG teaching – CT led
- UG teaching – Neurosurgery
- Year 5 Lead
- Clinical Sciences Update Lead
- Student Research Coordinator
- 2 x Clinical Education Fellows

The new faculty members have had a positive impact on the learning environment. We can see year on year a notable improvement when comparing 2022 feedback with undergraduate student feedback from the previous year (data available on request). Key to this have been the clinical education fellows as a focal link between educational and clinical activity, enabling student learning and enhancing student experience through strengthened educational and pastoral support. Having depth in the education faculty has enabled a fairer distribution of work for Consultants involved in education, from supervision to coordination and delivery of teaching. Student placement evaluation reported the quality of bedside (ward) teaching to be of a very high standard, provided tangible evidence of the benefit the new education leads have brought (see section ‘Focus on Undergraduate’).

The role of the Student Research Coordinator will provide a direct link between students and research within WCFT. The lead has begun to establish a database of opportunities which will form a catalogue for medical students who wish to develop research, audit and QI experience.

Medical Education Officers have provided operational leadership and guidance working with the Educational Fellows on the design and implementation of student programmes, ably managing complex demands of student timetables and service delivery needs of the clinical areas.

Medical Education Development Manager has continued to work closely with the DME to raise the profile of Medical Education at a strategic level at the Trust and with external partners, working on initiatives including the PGME training recovery workstreams, .

FOCUS ON UNDERGRADUATE

Year 4

2021/22 saw a marked increase in the number of Year 4 students on placement at WCFT. The table below outlines student numbers for 20/21 compared to 2021/22:

Type of Placement	Number of Students Attending Placement Area	
	20/21	21/22
Year 4 Core Neuro	192	396

In 2021/22 on average WCFT has hosted 49.5 students per 4 week block, compared with 24 the previous year. Over an academic year there are eight consecutive blocks rotating to WCFT between September and June. For a trust of Waltons size the demand on physical and human resource is substantial. Students follow a complex and comprehensive timetable and the logistics of coordinating this schedule has been managed by the education administration team and education leads. Student satisfaction is measured by an end of placement evaluation, this data is shared with the trust as a RAG report. The information produced allows us to track trends and themes at a local level and gives insight into our performance against all sites averages.

Year 4 RAG reports has been consistently good throughout the year, with student satisfaction high regarding their experience at WCFT. The stand out themes from the feedback were the role of the education fellows, quality of teaching and learning environment and the helpfulness of the administrative office. Some of the comments received are below:

‘Excellently organised placement, credit to Yasmin, Dean and Josh’, ‘All teaching and contact with staff was excellent’ Rotation 1

‘Focus on clinical skills teaching was great help for practice’; ‘good balance…which I feel is needed to make sure you grasp the content’; ‘level of teaching was amazing, considering the nature of the placement …it was made very accessible and not at all intimidating’ Rotation 2

‘Completely changed my perception of Neurology & Neurosurgery’, ‘..best, most interactive placement I have had in medical school’, ‘…so much opportunity to learn..’ Rotation 3

‘Superlative teaching and administrative support…clinical skills and ward teaching exemplary’, ‘best run placement so far’, ‘…should be used as the gold standard model (for other placements)’, ‘…emphasis on teaching was incredible...’ Rotation 4

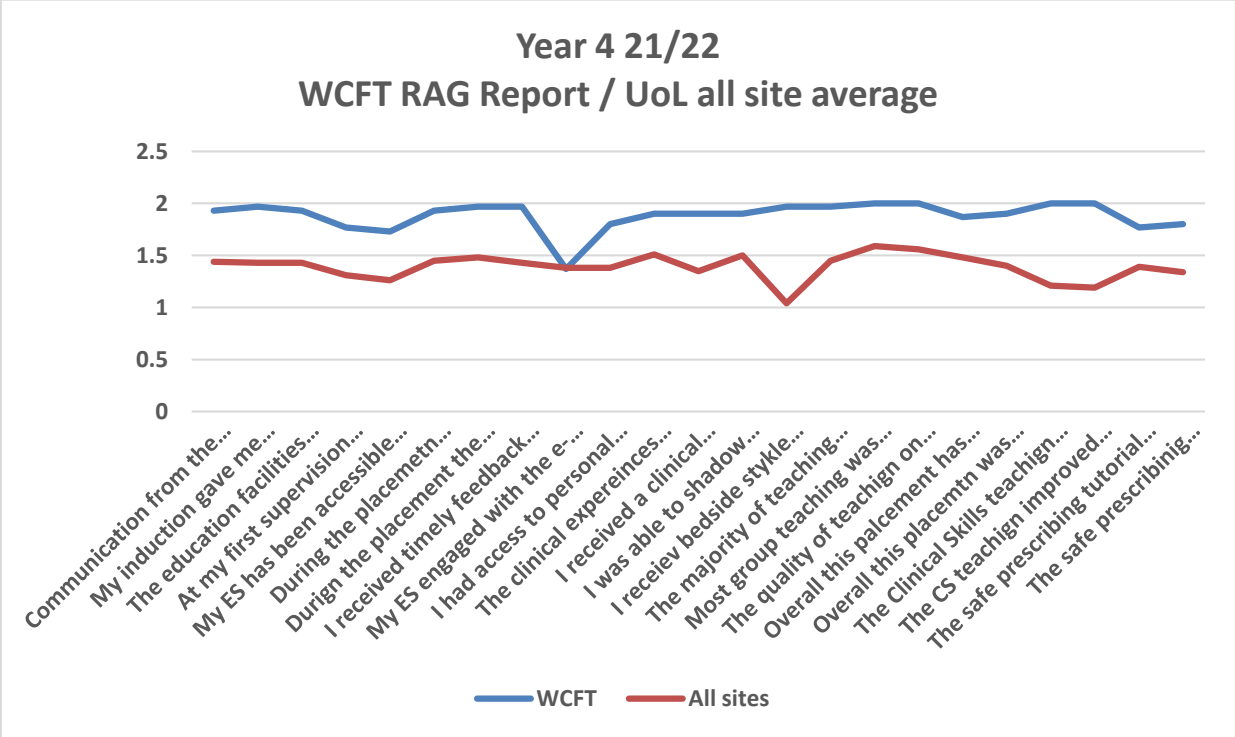
‘Dean and Josh … excellent at providing relevant clinical skills knowledge’, ‘teaching…really strengthened my understanding of neurology’ Rotation 5

‘Teaching and educationally support provided has been of the highest standard’, ‘..comprehensive placement that has really advanced my learning’ Rotation 6

The table below compares Walton’s annual average scores compared with the all site average for the period:

Question - Year 4 placement evaluation	**WCFT**	**All sites**
Communication from the placement before induction was clear and effective	1.93	1.44
My induction gave me everything I needed to start the induction	1.97	1.43
The education facilities (study space IT and teaching space) were readily available	1.93	1.43
At my first supervision meeting my aims and how the placement would support these were discussed	1.77	1.31
My ES has been accessible and supported my development	1.73	1.26
During the placement clinical staff (outside of my ES) were accessible and supportive	1.93	1.45
During the placement the undergraduate team were accessible and supportive	1.97	1.48
I received timely feedback which supported my development	1.97	1.43
My ES engaged with the e-portfolio inc sign off	1.37	1.38
I had access to personal advice and support during the placement	1.8	1.38
The clinical expereinces available to me were relevant to the palcement portfolio requirements	1.9	1.51
I received a clinical experience timetbale that was well planned and things gernally took place as planned	1.9	1.35
I was able to shadow different members of the clinical team as appropriate	1.9	1.5
I received bedside style teaching where we reviewed patient cases outside of ward round, this may have been classroom or ward based)	1.97	1.04
The majority of teaching sessions took palce as planned or were delivered at another suitable time	1.97	1.45
Most group teaching was given by experience staff e.g. consultants ST trainees	2	1.59
The quality of teaching on this placement was high	2	1.56
Overall this palcement has been valuable to my education	1.87	1.48

Overall this placement was well organsied and ran smoothly	1.9	1.4
The Clinical Skills teachign was well organised	2	1.21
The CS teaching improved my skills and undestadning	2	1.19
The safe prescribing tutorial was well organised	1.77	1.39
The safe prescribinig turoiral improved my knowledge and skills	1.8	1.34



Source: University of Liverpool Year 4 Placement RAG Report, 2020-21

The RAG report indicates Walton was scored consistently above the all-site average with a number of indicators scoring a maximum of '2'. Clinical Skills and quality of teaching where those that scored the highest. Educational supervisor engagement with e-portfolio was rated the lowest albeit still within the satisfactory bracket (in the UoL RAG score).

Year 5

Final year students complete an elective type placement known as a SAMP; this was an 8 week placement which focuses on a project or piece of work that the students participate in. There was a change to the year 5 programme which saw SAMPs reduced to 1 placement and within that placements reduced fruther to 6 weeks from the previous 8. This was to accommodate the new curriculum and also the affects of

COVID, to factor in lost clinical exposure from the year before. The SAMP rotation started at the end of April and to date there has been no feedback received from the University.

FOCUS ON POSTGRADUATE -

Health Education England – Post Covid Postgraduate Training Recovery Programme

In 2021 HEE spearheaded a recovery programme for PGME with the key aims to 'reset, recover and reform' (https://www.hee.nhs.uk/covid-19/covid-19-training-recovery-programme).

Junior doctor health and wellbeing, harnessing innovations expedited through covid as well as retaining the good practices and efficiencies emerging from covid have been a key aim of the PGME recovery work, alongside the overarching objective of addressing gaps in training brought about by the pandemic. There have been several funding awards made to Trusts to support various recovery workstreams. Using this funding we have carried out a number of interventions. To address gaps in training we consulted widely with Educational Supervisors and junior doctors. One initiative has been to set up a schedule of 'training clinics', to mitigate the direct patient contact time lost during the pandemic. Competency versus confidence is a problem forecast by HEE for higher specialty trainees approaching the end of training, (having lost the opportunity to refine professional / practical skills ahead of moving from training into their first consultant posts). We have encouraged ande supportd senior registrars in Neurology to 'act up' and consolidate confidence as independent practitioners. Peer to peer communication skills has also been identified as a training need and we have recruited a Neurologist and a Neurosurgeon to develop simulation scenarios that will form the basis of educational workshops for junior trainees. Lastly, using HEE funding we have recruited to a Consultant Health and Wellbeing Lead to oversee the development of a H&WB programme for junior doctors.

Training Programmes

Nationally postgraduate medical training is undergoing widespread transformation responding to strategic recommendations for change. Enhancing Junior Doctors Working Lives is a comprehensive HEE programme started in 2016 which has examined all aspects of PGME training. Part of this work has been the Medical Education Reform Programme (MERP), with HEE working closely with the Royal Colleges to develop the Royal College of Physicians Shape of Training report and the corresponding RCS equivalent Improving Surgical Trainin. Both programmes of

work have informed the change which we are now seeing implemented at a local trust level.

In 2019 medical training moved from 2 year core training to a 3 year internal medicine programme with the 3rd year focusing on acute medical training. In August 2021 the first of the year 3 trainees started at WCFT as part of a shared post with LUHFT (Aintree). Trainees are based at Walton but cover the on call at Aintree, fulfilling the acute medical requirements of their programme. The posts inevitably had some initial teething problems with cross site working but efforts have taken place to integrate the IMT3 alongside the acute Neurology Registrar and the IMT3 has embedded successfully.
Neurology trainees have been fewer due to trainees being out of programme and other formal leave, which as affected rota patterns and to some extent continuity. To mitigate this a trainee handbook was developed to facilitate communications. In February 2021 a trainee returned to WCFT and the trainee numbers where bolstered which alleviated the previous pressures. August 2022 will see further trianees returning to post so should mitigiate these issues moving into the new academic year.

Thrombectomy has been a pressure which Neurology trainees have acutely felt. This was transient whilst a sustainable resolution was found. Junior doctors support has been in place since March 2022. As part of the senior support provided Dr John Williamson created a informational presentation for junior doctors, which trainees reported via the JDF to be very helpful and enabled them to carry out this work confidently, mitigating concernsof the patch AD that the service driven aspect of the work might be a detraction for junior trainees.

In August 2021 Neurosurgery lower specialty trainees began a series of mini rotations through ITU, Neuropathology and Neurology. This was part of an initiative between the Waltons DME and Neurosurgery Training Programme Director to broaden surgical trainee exposure to neuroscience pathologies and conditions. Trainees reported the rotations to be very useful especially the opportunity to work in acute neurology. Covid had impact on trainee logbook numbers in 2020 -2021 ARCP time period due to drop in elective cases. This has been mitigated to a large extent as was evident on trainee logbooks in the half-yearly assessment in January 2022. ARCP outcomes have been successful in the main. The annual ARCP is to be held on 4/7/2022. 1 trainee received an outcome 2 in his last ARCP and has been given extension to his training because of less than satisfactory progress.
Despite the repercussions of Covid 2 senior trainees received their CCT (outcome 6) end of May 2022.

Neurosurgery trainee numbers have been depleted due to the numbers out of programme but we expect expecting 4 NTNs returning back to training after their out of programme period doing research between august 2022 and march 2023

Supporting trust grade doctors was a high point noted by HEENW at the last quality visit in 2017. We continue to follow this ethos and have supported non NTN trainees in their career goals. Two of them managed to pass their FRCS in the last 12 months.

In 2022 Walton became the the only neurosurgery unit in the UK and second in Europe to acquire a state of art surgical simulator. We anticipate this willbe used more extensively with the arrival of more junior trainees in august this year.

Anaesthetics and Rehabilitation Medicine programmes also experienced curriculum changes which are filtering down to trust level. In 2021 the GMC approved curriculum change to Anaesthetics training which compressed to 3 months rather than 3 months followed by 1 month. This has been a successfull change as trainees have achieved required competencies. Departmental teaching has undergone review and switched to a bi-monthly all day downtime format. This has proved an effective model and part of the day is run as a multi-professional themed shared learning day with neuro-surgeons and theatre staff, enabling interprofessional learning.

There has been a successful approach to sustainable talent management with the appointment of three consultants from local trainees and fourthwaiting to take up appointment

Teaching and mentoring opportunities for anaesthetics and surgical trainees are available via the Year 4 student groups that come to the department. The anaesthetics education leads have worked with the UG team to mplemented 4th year “Taster- day” to generate interest in specialty for 4th year medical students. This forum also provides access to multidisciplinary teaching amongst anaesthetics and surgical trainees, and opportunity for teaching and mentoring for F2 doctor.

Outside of formal education and training there have been a number of notable academic achievements by the Anaesthetics team

Consultant Dr Srinivasaiah has had the following work accepted

- abstract "Anaesthetic management and outcomes of patients undergoing embolization of brain Arterio venous malformations by “Pressure cooker technique”: Retrospective case series study. – with Dr Vijay Kumar

- Our experience of using Dexmedetomidine-Propofol sedation in patients undergoing treatment planning Magnetic resonance imaging scan for Deep brain stimulator insertion surgery during Covid 19 pandemic" for presentation at the SNACC 50th Annual Meeting, which will be held in Seattle, Washington, USA September 8-10.With Dr Patwardahan

Both co-authors joined the department through our MTI training scheme

Neuropathology continues to have one Diagnostic Neuropathology (DN) trainee who rotates between Walton, Salford and Preston and Regional Histopathology trainees visit at regular intervals for their 2 weeks of Neuropathology placement.

Neuropathology has strengthened its connections with Neurosurgery training through the laboratory blocks offered to surgical trainees in 2021-2022. The team have proactively sought to ensure undergraduate students have exposure to neuropathology and frequently contribute to their teaching programmes as well as hosting students on placement.

Medical Education management and the Director of Medical Education have sought to provide guidance to Trust divisional teams regarding the development of new training and other postgraduate educational posts. This remains an under-developed area of support and the DME and MEDM will continue conversatiosn to ensure new and emerging training opportunities are identified and acted upon.

FOCUS ON MEDICAL EDUCATION FUNDING –

Below are the DHSC tariffs for undergraduate and postgraduate training:

Type of placement	Tariff for placement activity* in 2021 to 2022
Medical undergraduate	£33,286
Medical postgraduate	£11,703 (plus, a contribution to basic salary costs)

***total annual per student / trainee placement

Source: https://www.gov.uk/government/publications/healthcare-education-and-training-tariffs-2021-to-2022/education-and-training-tariff-guidance-and-prices-for-2021-to-2022-financial-year

In 2021-22 as a Local Education Provider WCFT received approx.£2.9m in placement tariff for postgraduate and undergraduate medical education. In addition to the placement tariff, several non recurrent funding streams have been made available through HEE. As referred to earlier, the main provider of this funding has been through PGME training recovery workstream. The Director of Medical Education and Medical Education Development Manager continue to liaise with Finance to ensure open dialogue with regards to medical education income.

FOCUS ON EXTERNAL MONITORING

Health Education England

HEE is responsible for the planning, training and development of the healthcare workforce, the trust is accountable to HEE as a Local Education Provider to deliver that education and training. This is a period of relatively instability as reporting mechanisms are undergoing review and refresh, hence the limited number of external reports available

- Health Education Trust Self Assessment – this replaced the annual LEP report which was the mechanism by which trusts reported annual progress to HEENW. It has been under review since 2020. A pilot was carried out in late 2021 and HEE have advised the new iteration will be with trusts June 2022.
- Library and Knowledge Service Quality Outcomes Improvement Framework – this report has replaced the LQOF, Library Quality Outcomes Framework. The first LKS QOIF was submitted in September 2021. The HEE response was received in April 2022. There were several areas to be addressed and an action plan has been developed (appendix 1). This is due to be submitted 30th June 2022.
- Annual Accountability Report for Undergraduate Medical Education – Financial report introduced as part of the reform to the education contract in 2021. Due to be released June 2022.

GMC National Training Survey

The 2021 GMC survey returned to its usual format and set of questions, a written summary and survey data is available on request. This feedback has informed the delivery of education this academic year. The trust overall fared well with no negative outliers and two positive outliers for clinical supervision out of hours and handover. Most specialties were well evaluated by the trainees. Internal Medicine Training (junior trainees working in Neurology) feedback was excellent with six green outliers notably in supportive environment and educational governance.. In comparison, year on year Neurology registrar training hasn't been as positive as previously however the effects of the pandemic on experience and the transition to IMT can go some way to explain the dip and is expected to be an anomaly as the medical workforce and working patterns settle down.

Neurosurgery registrar feedback was also excellent with five green outliers indicating trainee satisfaction has risen since 2019. In comparison the report for core surgical training had several pink outliers, suggesting experience hasn't been as good. There is a caveat which should be acknowledged; the reporting group consisted of 3

trainees and question analysis showed generally a 3 way split in response ranging from good, neutral to poor.

University of Liverpool Medical School Assessment Report

In December 2021 the Trust submitted a self assessment quality report to the Medical School. This was a comprehensive analysis of undergraduate activity at the Trust mapped against the GMC Promoting Excellence framework. There has not been any formal response made by the Medical School to date.

LOOKING AHEAD TO ACADEMIC YEAR 2022/23

Following the upheaval of 2020-21 which brought transformation to established ways of working, we look forward to positively harnessing change for the benefit of medical education learners and educators.

We will lead on the development of a new strategy for Medical Education.

We will ensure there is clear alignment between trust ambitions and education outcomes and support the development of a workforce that support trust strategic direction

We will continue to champion Medical Education within the RIME group and be an advocate for students and trainee doctors that wish to develop research and academic experience.

We will work with University of Liverpool on the Medical School expansion and ensure engagement with wider trust colleagues

We will continue to work on our internal relationships and engagement from all specialties within the trust.

We will support the development of Trust educationalists, identifying and facilitating a pathway for those with an interest in Medical Education.

We will continue to work with Finance to develop transparency in education income.

We will begin to explore opportunities for growth in other student/learner markets nationally and internationally.

We will continue to be responsive to external changes affecting medical education and training and continue to build effective networks with stakeholders from across the health education system.