NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 1st April 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
1st April 2021
Virtual Meeting
WCFT
09:30 – 11:15

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.35	Minutes and actions of meeting held on 4th March 2021	J Rosser	Decision (d)
4	09.40	Staff Story	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update	J Rosser/ H Citrine	Information (v)
6	10.05	Recovery and Restoration - Presentation	J Ross	Information (v)
7	10.20	Integrated Performance Report	CEO/Execs	Assurance (d)
8	10.35	Staff Survey 2020	M Gibney	Assurance (d)
9	10.50	Chair's Report – Quality Committee	S Crofts	Assurance (d)
10	10.55	Chair's Report – Business Performance Committee	D Topliffe	Assurance (d)
11	11.00	Board Assurance Framework	P Buckingham	Approval (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Mixed Sex Accommodation – Annual Compliance Statement • Non-Executive Directors - Independence • Use of the Trust Seal				
CONCLUDING BUSINESS				
12	11.10	Any Other Business	J Rosser	Information

Date and Time of Next Meeting:
6th May 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

4th March 2021

Present:

Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms K Bentley	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Salter	Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary

Observing:

Ms B Strong	Public Governor – Merseyside
Ms M Worthington	Partnership Governor – Cheshire and Merseyside Neurological Alliance
Ms J Taylor	Deloitte LLP

Trust Board Attendance 2020-21

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

TB121-20/21 **Welcome and apologies**

Ms Rosser welcomed those present to the meeting via Microsoft Teams and noted that Ms B Strong was observing in her capacity as Public Governor for Merseyside and Ms M

Worthington was observing in her capacity as Partnership Governor – Cheshire and Merseyside Neurological Alliance. Ms J Taylor from Deloitte LLP was also observing in advance of the upcoming Board Development session.

TB122-20/21 **Declarations of interest**

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

TB123-20/21 **Minutes of the meeting held on 4th February 2021**

The minutes of the meeting held on 4th February 2021 were agreed as a true and accurate record.

TB124-20/21 **Chair & Chief Executive Report**

Ms Citrine reported that the second CT scanner had been installed and this would be utilised for patients across the Cheshire and Mersey system and the first patient had already been scanned.

Work to begin to shape the Provider Collaboratives was underway and a session was held and chaired by Louise Robson, CEO for Stockport, who was working with the Northern region to set up Provider Collaboratives.

An update was provided from the Specialist Trust Alliance and it was highlighted that the memorandum of understanding (MoU) for the HCP had been discussed which provided an opportunity for representation from a CEO and Chair from Specialist Trusts to be a member of the HCP Board. Karan Wheatcroft from MIAA would be working to help shape the programmes and an update on this work would be provided when available.

Ms Rosser reported that all Trusts would be required to appoint a Board-level wellbeing guardian and work was underway with Jane Mullin to take forward what the role entailed. This role was currently being undertaken by Ms Rosser but may be undertaken by somebody else going forward.

The Government white paper on Integrated care was currently under discussion at a number of forums across the region and a NHS Providers summary of the contents of the paper had been provided to all members of the Board. The paper was based around system integration, further supporting information was anticipated in April and May 2021 with greater detail. Further updates would be provided as more information became available.

Ms Rosser provided an update from a recent Cheshire and Mersey Partners Chairs meeting noting that a presentation around workforce had been provided which highlighted that the Cheshire and Mersey region had the highest rate of Nursing sickness in the country. Research by Liverpool Health Partners was underway to identify and understand why sickness was so high and Mr Gibney noted that this research had begun in March 2020 and would take some time to complete.

The Board:

- **noted the report.**

TB125-20/21 **COVID-19 Update**

Ms Citrine briefed the Board on the current COVID situation and noted that the national picture was improving and while improvements were also being noted in the North West this was at a slower rate than nationally. The Government had published a roadmap out of restrictions and the national alert level had been reduced to level 4. Command and Control structures were still in place however it was noted that the Boardroom had been

stepped down as a command centre. The number of COVID positive patients across Cheshire and Mersey was 11% however numbers within critical care remained higher, it was recognised that patients with long COVID would likely have an impact on critical care bed planning. The region's critical care was no longer in surge capacity however a delicate balance would be required when restarting activity moving forward. A plan for activity recovery was under development and this would be shared upon completion, it was noted that the timings reflected the national roadmap to tie in with face to face and social distancing rules.

It was noted that 80% of Trust staff had received their first vaccination and the rate within BAME staffing was slightly higher than this and the regional average. Mr Thakkar queried if work was underway to persuade the remaining 20% of staff to receive the vaccine. Ms Citrine noted that there had been some reluctance from younger staff and there had been some collaboration with Liverpool Women's Hospital to dispel some of the myths around effects on fertility. No staff group themes had been identified for those reluctant to receive the vaccine and it was clarified that there were no shortages of vaccines available. All staff had been invited to receive the vaccine and weekly communications to encourage staff were issued, the data had been cleansed to ensure accuracy and the Trust was still encouraging all staff to receive the vaccine. Mr Gibney noted that the national position was that staff who were identified as refusing the vaccine would have a one to one discussion with their line manager to understand the reasons why and potentially move to non-patient facing duties.

Ms Rai queried if there had been any progress regarding patient visiting and it was clarified that there had been no change at present and that visiting arrangements were consistent with those across the Cheshire and Mersey region. All Trusts across the region were working in collaboration to review visiting provision and ensure a consistent approach.

Ms Salter noted that the inpatient vaccination programme would be introduced for certain groups from the week commencing 8th March 2021.

The Board:

- **noted the report.**

TB126-20/21 **Integrated Performance Report**

Ms Citrine provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Business Performance Committee as noted within the Chair's report. It was recognised that COVID19 had affected all areas of the IPR and further deterioration around patient waits was expected in the next report. The original recovery plan had been working well which provided confidence that the Trust and operational team was on the right track re planning and this would improve further as the recovery plan post wave three was developed. The recovery plan would be submitted to BPC in March 2021 and this would also include plans for staff recovery.

Quality

Mr Crofts noted that there had been no Quality Committee meeting in February and highlighted that MSSA rates continued to be a concern. A deep dive was underway to identify any themes and the results of the deep dive would be presented upon completion. Complaint numbers were reported to be higher than during the first wave and

benchmarking work with Queens Square was underway to identify any issues and improvements that could be made in this area. It was noted that the most common themes of complaints were around communication and waiting times.

Performance

Mr Topliffe commented that plans were in place to improve on current appraisal and PDR rates. The main concerns noted by the Business Performance Committee were related to patient waits however there was an understanding on what work needs to be undertaken to begin to recover this. It was noted that all cancer patient targets continued to be met.

Workforce

Mr Gibney advised that staff sickness figures had increased since January 2021 and there were currently 7.5% of staff unavailable. It was clarified that 4.9% of this figure was due to staff sickness and the remaining 2.6% due to COVID related issues such as shielding and self-isolation.

Finance

Mr Burns noted that an improved position was reported at M10 and the Trust was now anticipating a surplus at the end of the year, this was mainly due to cancellation of non-elective work. Q1 allocations were due to be published shortly, these would initially be consolidated at HCP level and then disseminated out. An update would be provided when the agreed run rates were confirmed.

The Board:

noted the report.

TB127-20/21 **Reducing Burden and Releasing Capacity**

Mr Buckingham provided an overview of the background to the revised governance arrangements that had originally been approved in April 2020. Communications had been received from NHSE/I in January 2021 which provided support for Trusts to continue to free up management capacity and resources to focus on the challenges of the pandemic. Mr Nicolson noted that medics appraisals had been on hold nationally from March 2020 to October 2020 and revalidations that were due during this period had been deferred by 12 months for the affected staff.

Ms Bentley noted that the report mentioned there may be a potential requirement for additional training to expand the number of ICU staff and queried if there had been a requirement for this or if there were any other issues related to mandatory training due to COVID. It was noted that theatre and recovery staff had moved to ITU where required to assist and reduce the burden on the registered nurses within the department. With regards to mandatory training there had been some training modules that had been required to be put on hold however these would be reintroduced as the situation improves.

The Board:

- **Noted the Trust's position on areas set out in correspondence from NHSE/I dated 26 January 2021.**
- **Endorsed the delegated authority and emergency powers arrangements set out at s3.2 and s3.3 of the report.**

TB128-20/21 **Board Assurance Framework**

Mr Buckingham presented the Board Assurance Framework and noted that this was last presented to the Board in November 2020 and had since been reviewed by the Executive Team in January and February 2021. It was noted that amendments made had been highlighted in blue or strikethrough and section 3 summarised the changes in risk scoring. Additional reviews would be held at Board sub-committees during March 2021 and the opening BAF for 2021/22 would then be submitted to Board on 1 April 2021.

One new risk had been added to the BAF regarding medical education and it was noted that the current risk score was 15 with a target score of 10. Mr Gibney highlighted that this risk was due to the current Consultant lead stepping down and an increase in students which was a key part of the strategy. It was recognised that there was a lot of work to be undertaken and it was hoped that the score could be reduced by Autumn 2021.

Ms Citrine requested feedback regarding Risk 011 noting that a lot of changes in partnerships were underway and to ensure the risk reflected this, it was considered that the Trust was in an improved position from the previous year.

The Board:

- **approved the content of the Board Assurance Framework as presented.**
- **approved the inclusion of a new principal risk relating to Medical Education.**

TB129-20/21 **Consent Agenda**

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

- **Health Care Partnership (HCP) Memorandum of Understanding** – Confirmed adoption of the latest version of the memorandum of understanding.
- **Freedom to Speak Up Guardian Report** - Received and noted.
- **Board Cycle of Business** - Received and approved.
- **Business Performance Committee Chair's Report** - Received and noted.

TB130-20/21 **Any Other Business**

There was no other business to discuss.

There being no further business the meeting closed at 10.45am

Date and time of next meeting
Thursday 1st April 2021 at 09:30 via Microsoft Teams

TRUST BOARD
Matters arising Action Log
April 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
04.03.2021	TB128/20-21	**Board Assurance Framework** Reviews of the BAF to be undertaken at Board sub-committees during March prior to the BAF being re-submitted to Board in April.	P Buckingham	Relevant BAF entries reviewed by Quality Committee (18 Mar 21) and Business Performance Committee (23 Mar 21).	April 2021	
04.03.2021	TB128/20-21	**Board Assurance Framework** All requested to forward feedback relating to Risk ID 011 to the Chief Executive by 31/03/21.	All	Feedback received following the last Board meeting has been incorporated in the BAF Report for 1 April 2021.	April 2021	

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **May 2020** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ ~~March 2021~~ June 2021	

REPORT TO TRUST BOARD

Date 01/04/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Deputy Chief Executive
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence
Previously considered by:	• Committee Quality Committee Business & Performance Committee

Executive Summary

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

The ongoing COVID-19 pandemic has impacted the performance of a number of measures. Following a request from the Cheshire and Merseyside Hospital Cell, the Trust stepped down elective activity from mid-January with the exception of patients who urgently require surgery within one month, in order to support staffing our critical care surge capacity and support mutual aid within the Cheshire and Merseyside region. Cancer Performance has remained above targets as the Trust has continued to prioritise this activity and 6 week wait target for diagnostics has been for achieved for four consecutive months. Healthcare Acquired Infections and Harms have remained within expected low levels.

A ward scorecard has been added to the IPR this month to enable a high level overview of key performance metrics at ward level, in month.

Key Performance Indicators – Caring

Opportunity for Improvement Measures

Complaints – The number of complaints received has remained at a consistent level; however there have been significant improvements made to the timeliness that complaints are responded to. Publication of national data has been suspended due to COVID-19. Prior to this the number of complaints per 1000 WTE had been above peers and the national average.

Local data shows a reduction in raw numbers since Q4 19/20 with the number received each month typically below average.

Key Performance Indicators – Well Led

High Performing Measures

Agency Spend

Staff Friends & Family Test

Mandatory Training – Compliance in February 2021 was still above the target of 85% with some individual topics dropping below target. Compliance remains high for E-Learning topics and hopefully now training has restarted we will see an increase in topics included on study days.

Opportunity for Improvement Measures

Nursing Turnover - This has significantly improved over the last year and has shifted towards the target even though it has not been met yet and it outside of the lower control limit. At Divisional level, performance has significantly improved within Neurosurgery.

Sickness/Absence - Sickness/Absence has been consistently above the 4.75% target since July 2020. Sickness has increased across all Divisions, with Corporate Services the only Division achieving the target in Feb 21.

Appraisals – Compliance dropped below target and is now at 76.33%. At divisional level compliance has dropped in all areas and the training team are currently working with individual departments to improve compliance.

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – local performance is on plan with the exception of MSSA which has passed its year end trajectory. The Trust is generally in line with national benchmark average, also with the exception of MSSA in which incidences have increased in 20/21.

Harm Free Care – Incidences of harm remain low and are performance within expected variation.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

6 Week Diagnostic Waits – this standard has been achieved consistently in the last four months.

Underperforming Measures

Referral to Treatment – Welsh RTT performance continues to recover, but is still below the 95% target.

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity – During February 2021; Daycase and Follow Up Outpatients performed above our target for % of recovered activity of 19/20. Elective, Non Elective and New Outpatients were below the target. The reduction in elective activity to support critical care surge capacity and mutual aid within the Cheshire and Merseyside region continued during February with the Trust only providing elective activity for patients who urgently required surgery within one month. This has impacted a number of performance measures this month.

Related Trust Ambitions	• Best Practice Care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	Associated access and performance risks all contained in divisional and corporate risk registers.
Related Assurance Framework entries	Associated BAF entries: • 001 Covid-19 • 003 Performance Standards • 005 Quality
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

The Walton Centre
NHS Foundation Trust

Board KPI Report
April 2021

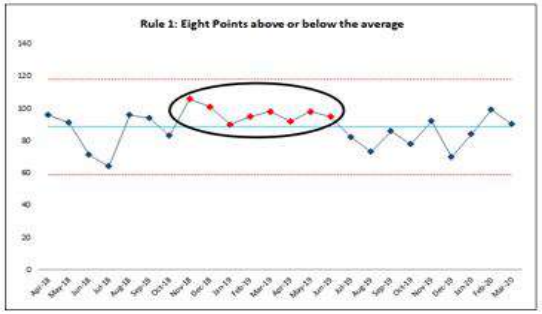
Data for February 2021 unless indicated

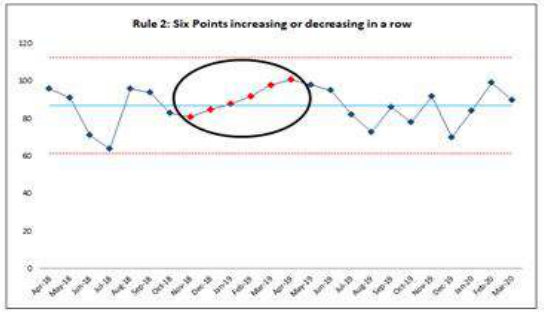
Excellence in Neuroscience

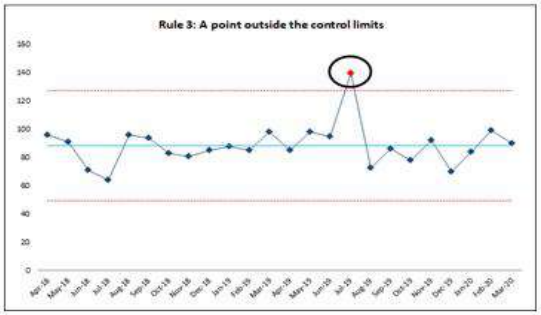
SPC Charts Rules

The Walton Centre
NHS Foundation Trust

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







All SPC charts will follow the below Key unless indicated

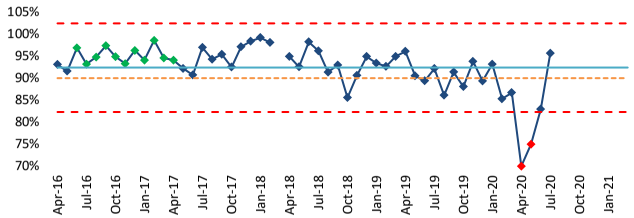
Actual — UCL — Average — LCL — National Average — Target

Operational

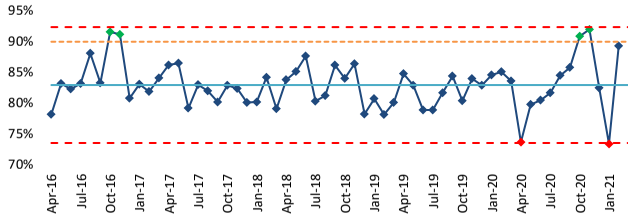
Effective - Theatres

The Walton Centre
NHS Foundation Trust

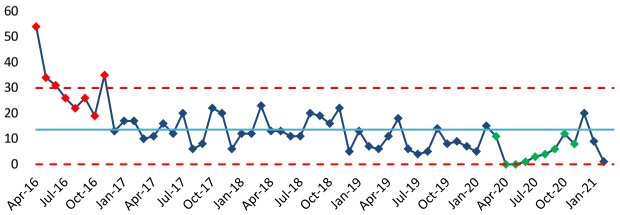
Theatre utilisation of Elective Sessions



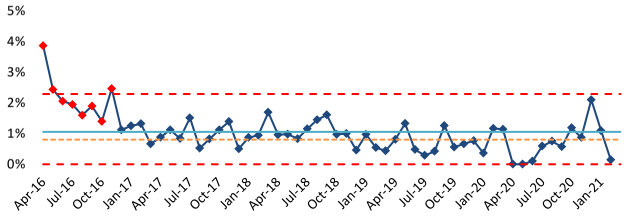
Theatre utilisation of in Session Time



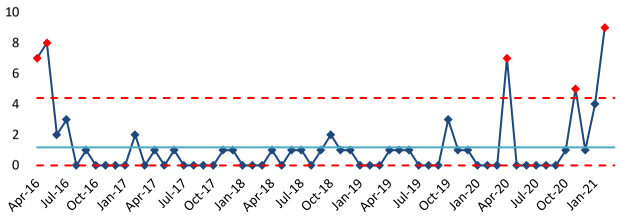
Number of Cancelled operations non clinical (on day)



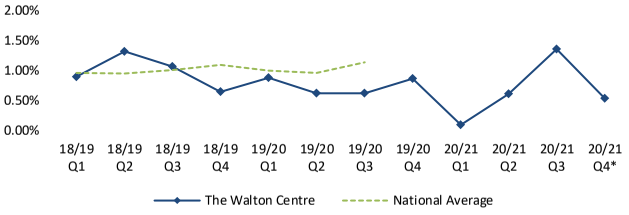
% of Cancelled operations non clinical (on day)



Number of cancelled operations not re-admitted within 28 days



Non Clinical Cancelled Ops as a % of Elective Admissions



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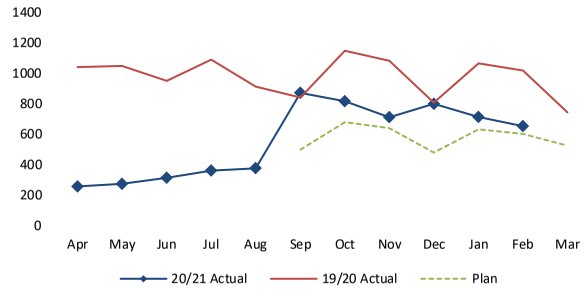
Operational

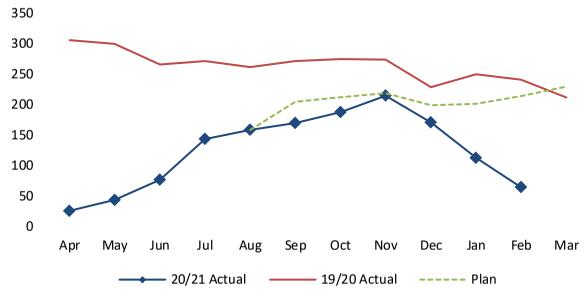
Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

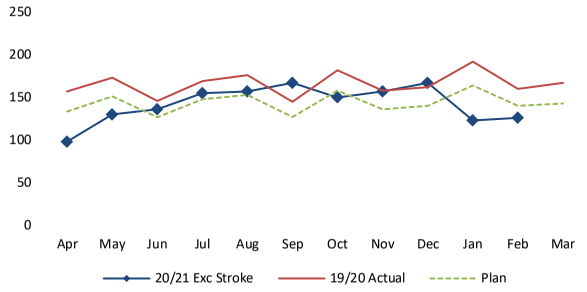
Daycase Activity v Plan



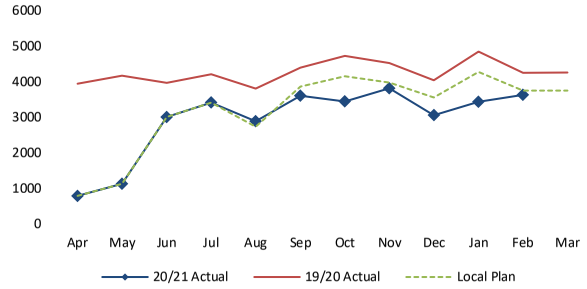
Elective Activity v Plan



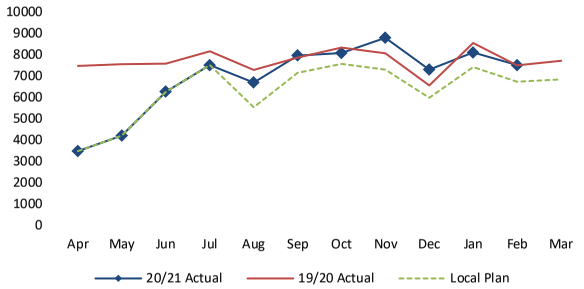
Non Elective Activity v Plan



New Outpatients Activity v Plan



Follow Up Outpatients Activity v Plan



February 21 Activity Performance

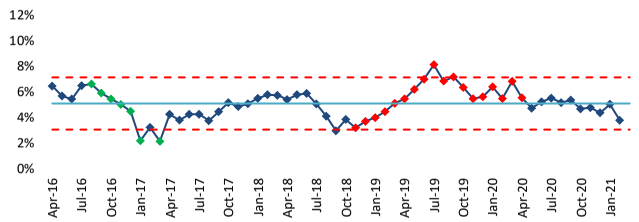
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	64.18%	59.18%
Elective	26.97%	88.98%
Non Elective	78.75%	85%
New Outpatients	85.43%	88.25%
Follow Up Outpatients	100.03%	89.73%

Quality of Care

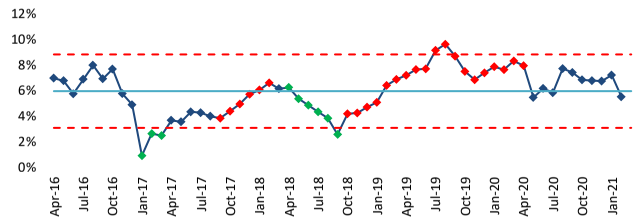
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

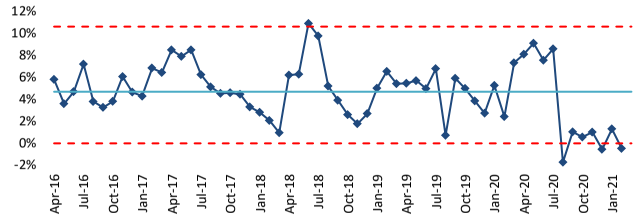
Overall Vacancy Level %



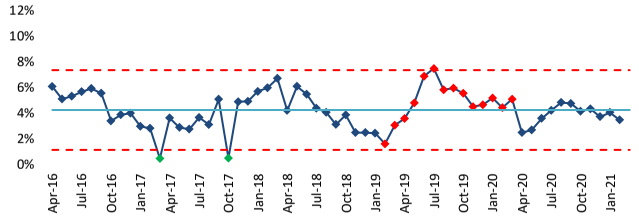
Nursing Vacancy Level %



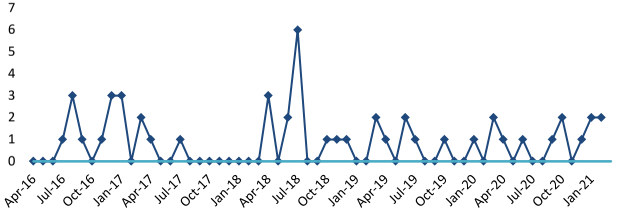
Medical Vacancy Level %



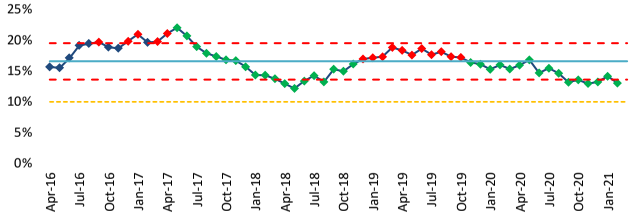
Other Staff Vacancy Level %



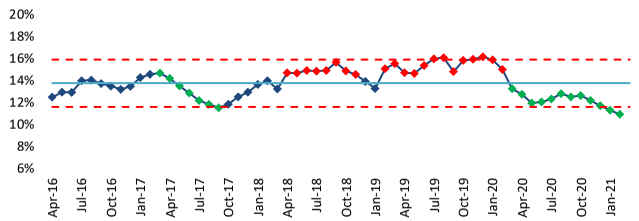
Medical Leavers



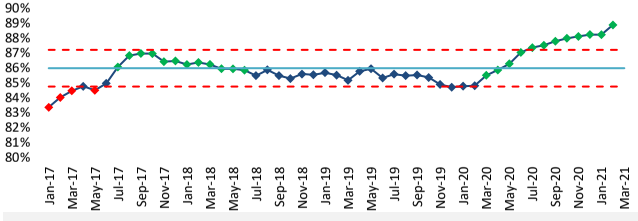
Nursing Turnover (Rolling 12 months)



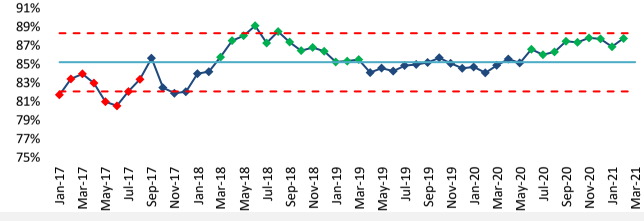
Other Staff Turnover (Rolling 12 months)



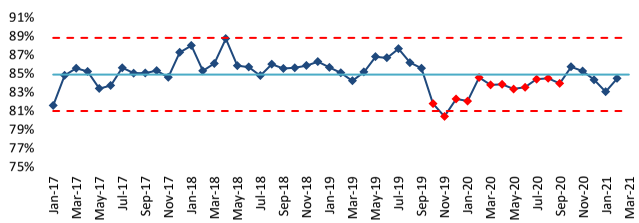
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



Narrative

Nursing Turnover

Nursing turnover has significantly improved over the last year and is within special cause variation. At division level, the target is also outside of the control limit for neurology and neurosurgery, however Neurosurgery experienced special cause variation in recent month and below the target in four of the last five months .

Sickness/Absence

Sickness/Absence has been consistently above the 4.75% target since July 2020. Sickness has increased across all Divisions, with Corporate Services the only Division achieving the target in Feb 21.

Staff Stability

Staff stability index for all staff has significant improved since March 20, this looks driven by more nursing staff remaining in post for 12 months.

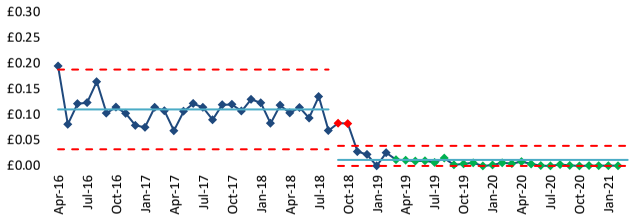
Excellence in Neuroscience

Quality of Care

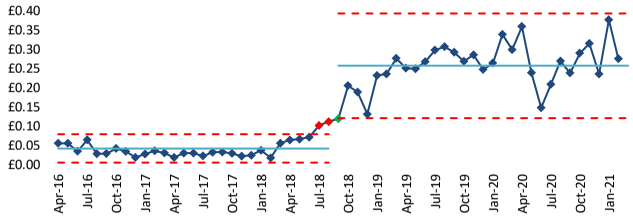
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

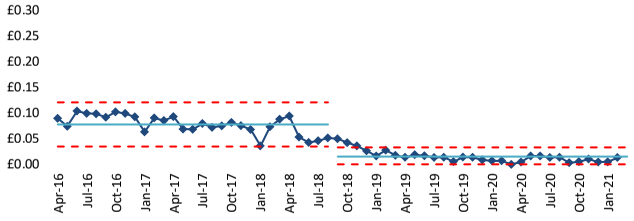
Nursing & HCA Agency Spend (£m)



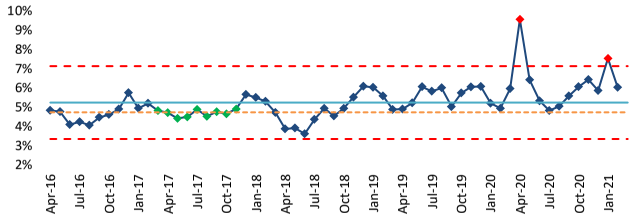
Nursing & HCA Bank Spend (£m)



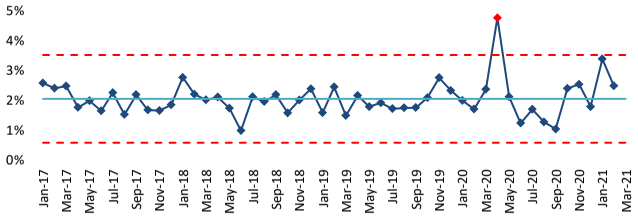
Nursing & HCA Overtime Spend (£m)



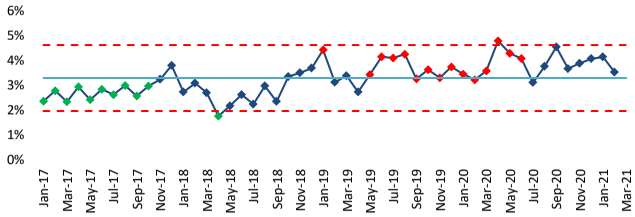
Sickness/Absence (Monthly)



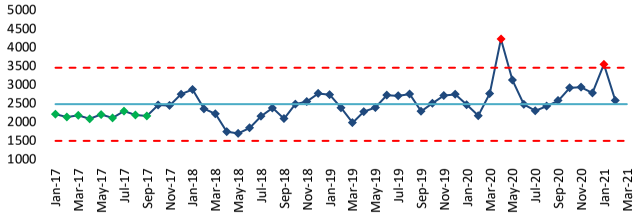
Short Term Sickness/Absence (Monthly)



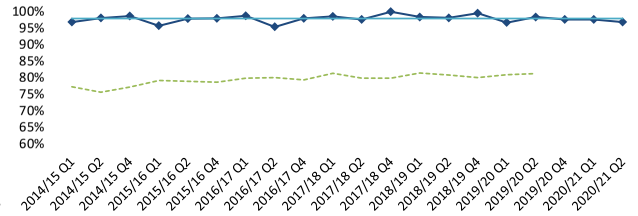
Long Term Sickness/Absence (Monthly)



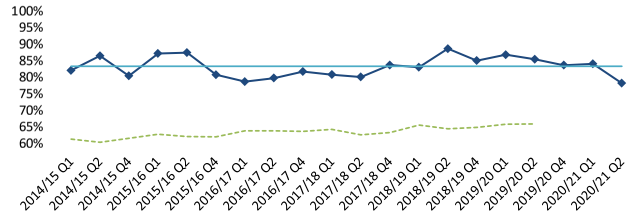
Lost Days due to Sickness/Absence (Monthly)



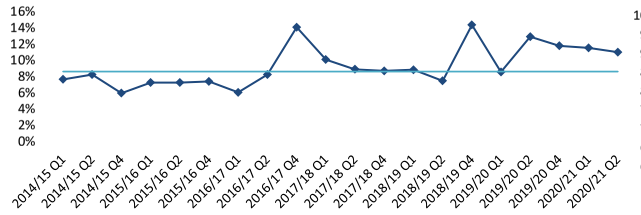
Staff FFT - % Recommend as Place of Care



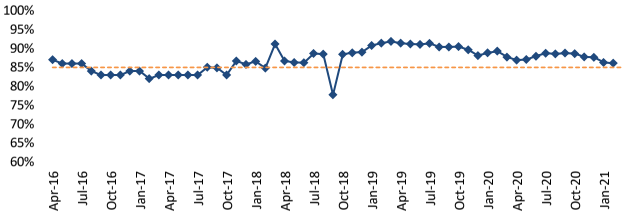
Staff FFT - % Recommend as Place of Work



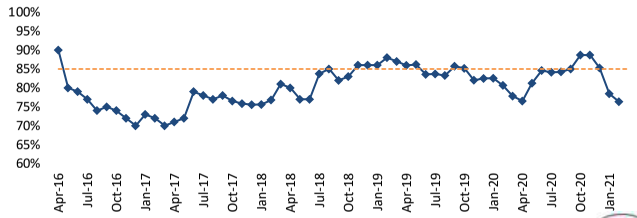
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



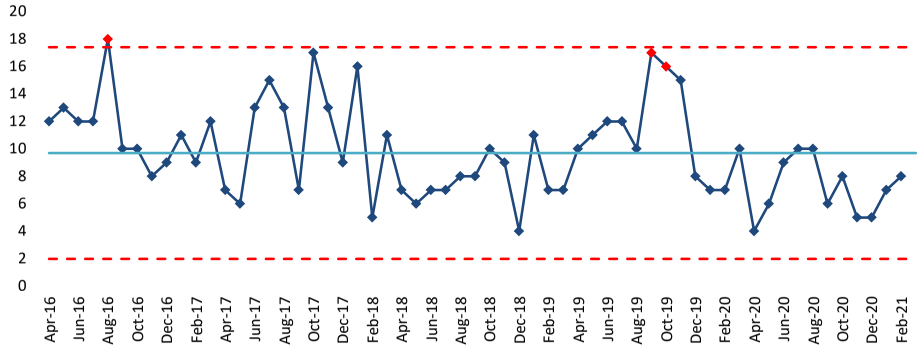
Excellence in Neuroscience

Quality of Care

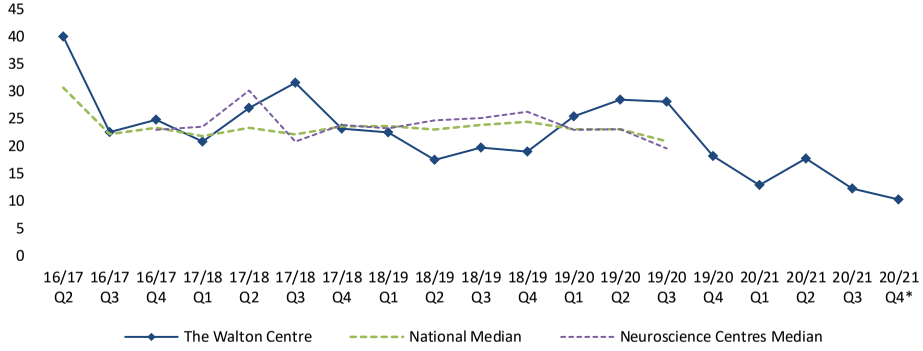
Caring - Complaints

The Walton Centre NHS Foundation Trust

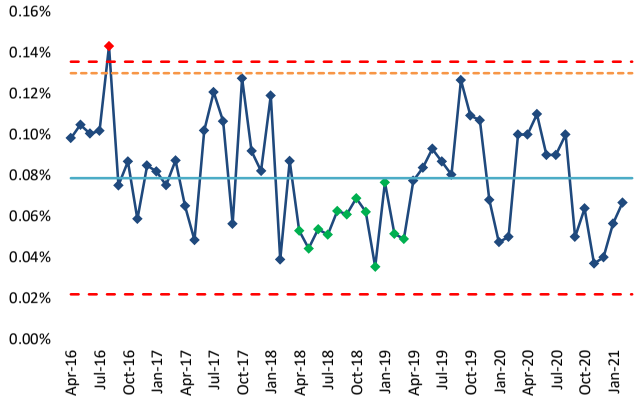
Total Complaints Received in month



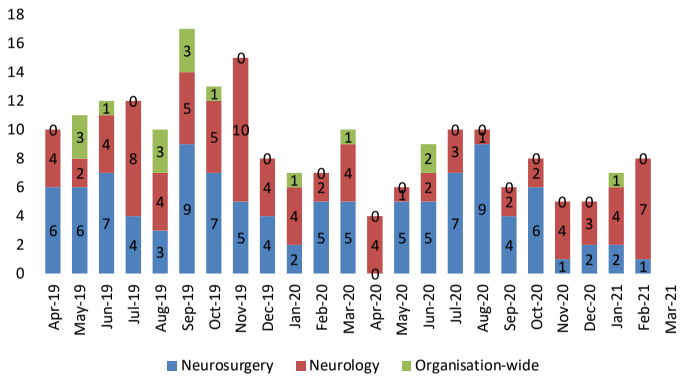
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In February 2021 the Trust received 8 complaints. 7 Neurology (1 Reopened), 1 Surgery (1 Reopened).

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation.

Publication of national data has been suspended due to COVID-19. Prior to this the number of complaints per 1000 WTE had been above peers and the national average.

Local data shows a reduction in raw numbers since Q4 19/20 with the number received each month typically below average.

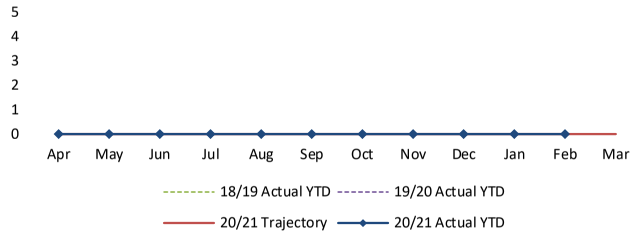
Excellence in Neuroscience

Quality of Care

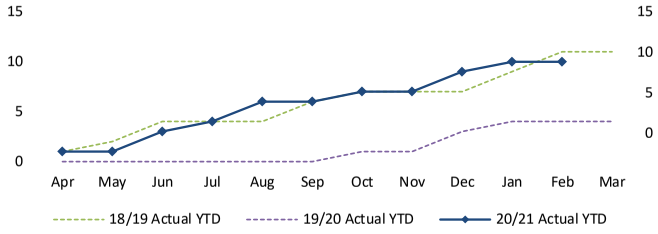
Safe - Infection Control

The Walton Centre NHS Foundation Trust

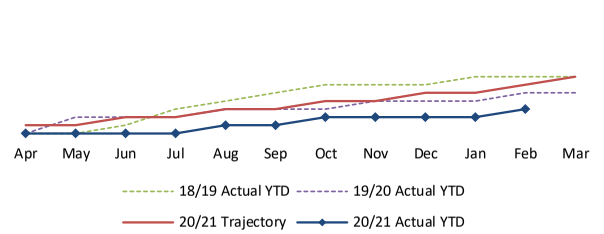
MRSA Bacteraemia



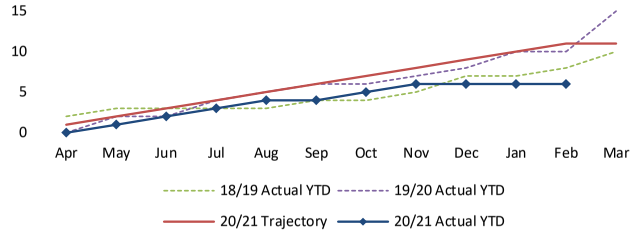
CPE



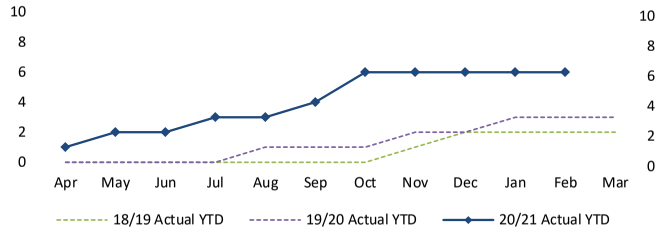
C.Diff



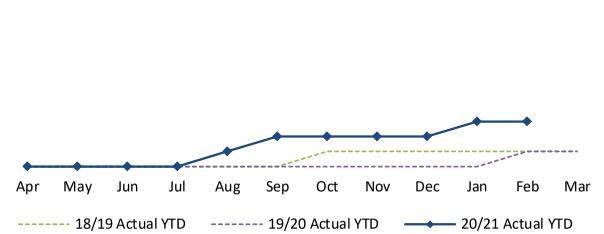
E.Coli



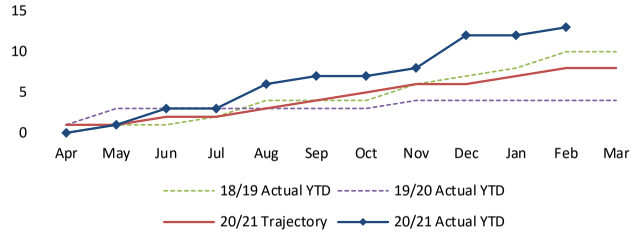
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		2	1				1	**4**
Caton		1					2	**3**
Chavasse				1		2	1	**4**
CRU		1			1			**2**
Dott		4		1	2		1	**8**
Horsley		2	2	3	2	1	8	**18**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**10**	**3**	**6**	**6**	**3**	**13**	**41**

Feburary Breakdown by Ward

C.Diff- Horsley x1
MSSA - Horsley x1

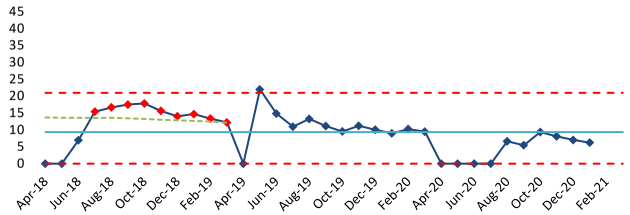
Excellence in Neuroscience

Quality of Care

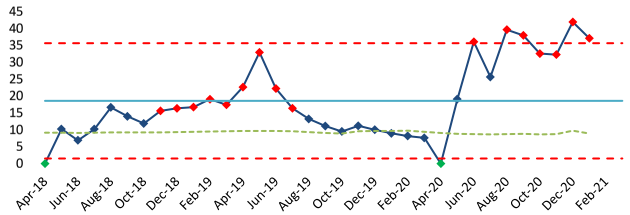
Safe - Infection Control

The Walton Centre NHS Foundation Trust

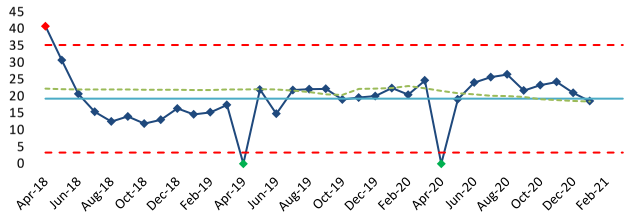
C.Diff Rate per 100,000 Bed Days YTD



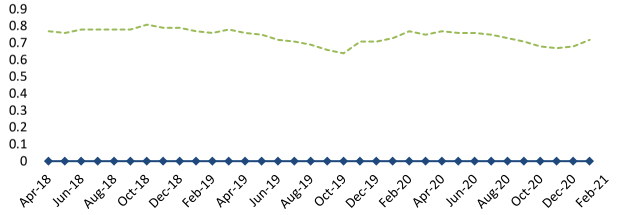
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

All infection types are within their 20/21 YTD trajectory level in February 21, with the exception of MSSA for which there has been twelve recorded instances against a year end trajectory of eight.

MSSA rates per 100,000 bed days are significantly above expected levels and the national average.

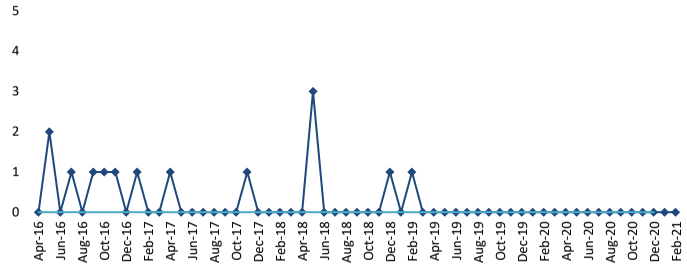
E.Coli rates have typically been better or in line with the average, while MRSA has been consistently better.

Quality of Care

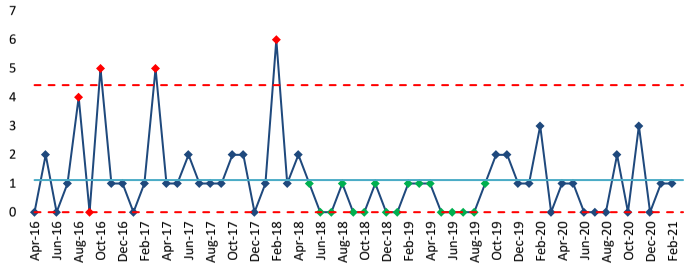
Safe - Harm Free Care

The Walton Centre
NHS Foundation Trust

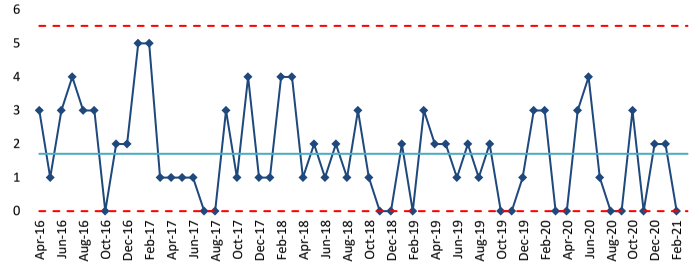
Total Moderate or Above Harm Patient Falls



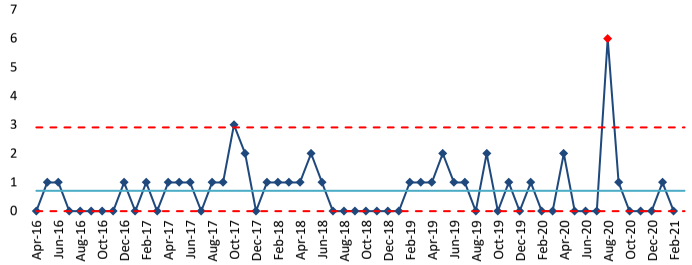
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no falls which resulted in moderate or above harm in February 21.

There was one unstageable Hospital Acquired Pressure Ulcers in February 21

There were no CAUTI incidences in Feburary 21

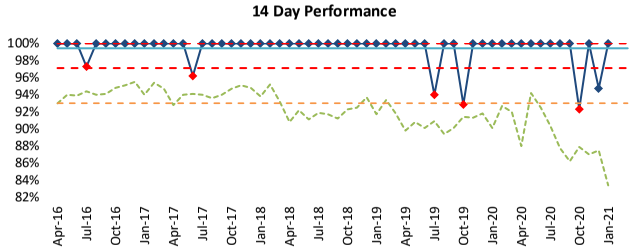
There were no VTE incidences in February 21.

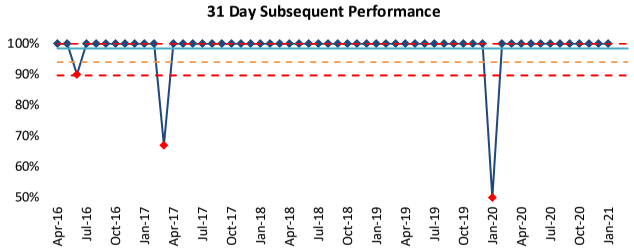
All harm measures are within normal variation.

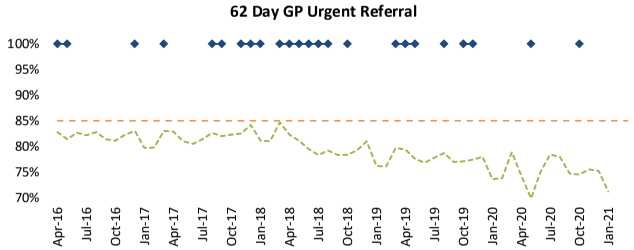
Operational

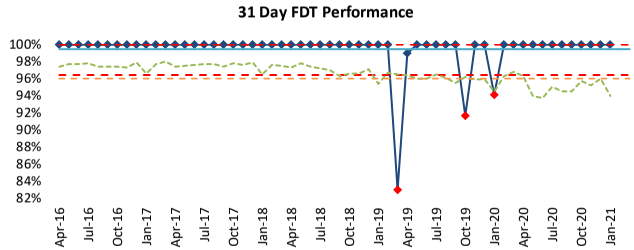
Responsive - Cancer

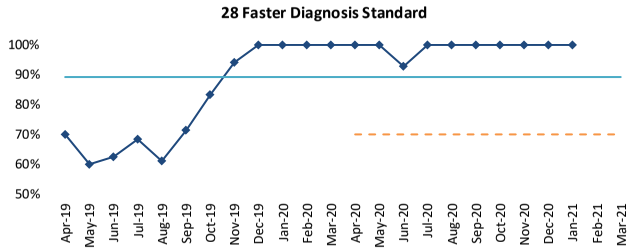
The Walton Centre
NHS Foundation Trust











Narrative

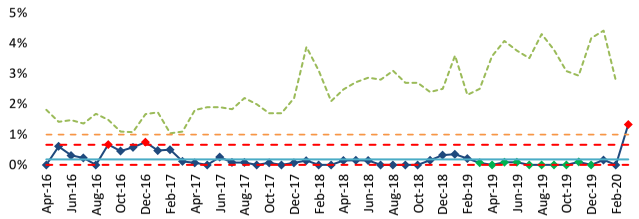
The Trust has continued to see and treat all cancer patients throughout January as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

Operational

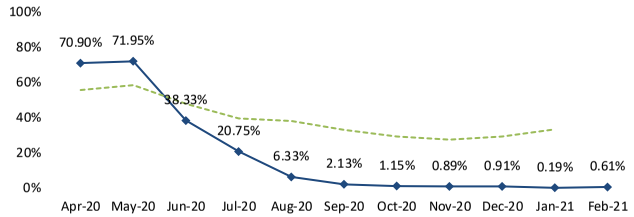
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

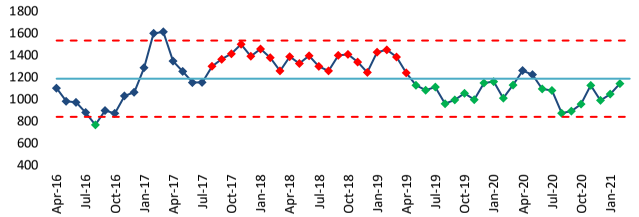
6 Week Diagnostic Performance (16/17 - 19/20)



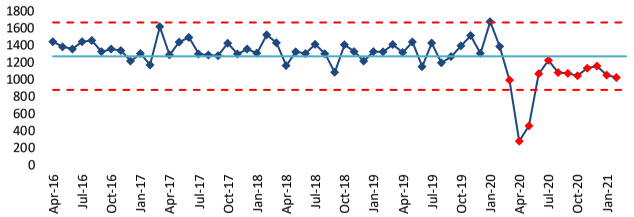
6 Week Diagnostic Performance (20/21)



Total Diagnostic Waits at Month End



Total Diagnostic Activity in Month



Narrative

Diagnostic performance in February 21 was 0.61%, resulting in six patients waiting over six weeks at month end. Performance has improved significantly since May, however due to Infection Prevention and Control measures Radiology capacity is at 90% therefore any increase in demand may impact performance.

Ward Scorecard

February 2021

The Walton Centre NHS Foundation Trust

	Safe Staffing				Workforce		Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Sickness Rate	Vacancy Rate	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	93%	160%	144%	175%	7.57%	14.13%	0	0	0	0	0	0	0	0
Caton	107%	100%	105%	109%	14.00%	6.28%	1	0	0	0	0	0	0	0
Chavasse	101%	230%	152%	248%	23.57%	21.66%	0	0	0	0	0	0	0	0
Dott	93%	160%	96%	172%	6.74%	13.14%	0	0	0	0	0	0	0	0
Lipton	96%	133%	109%	169%	5.31%	14.47%	0	0	0	0	0	0	0	0
Sherrington	100%	100%	100%	106%	12.28%	36.93%	0	0	0	0	0	0	0	0
CRU	130%	139%	114%	209%	13.90%	7.41%	0	0	0	0	0	0	0	0
Horsley ITU	98%	126%	98%	100%	6.14%	-0.95%	0	0	0	0	0	1	0	1

Excellence in Neuroscience

WELL LED

Finance

Trust I&E	In month			Year to Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,992	9,142	150	96,029	96,725	696	105,022	105,911	889
Exclusions	1,786	1,813	27	19,641	19,145	(496)	21,427	20,931	(496)
Private Patient	1	2	1	28	59	31	29	64	35
Other Operating	428	541	113	4,975	5,392	417	5,402	6,562	1,160
Total Operating Income	**11,207**	**11,498**	**291**	**120,673**	**121,321**	**648**	**131,880**	**133,468**	**1,588**
Pay	(6,112)	(6,100)	12	(66,452)	(66,545)	(93)	(72,565)	(72,647)	(82)
Non-Pay	(2,428)	(2,410)	18	(26,733)	(27,670)	(937)	(29,168)	(30,221)	(1,053)
Exclusions	(1,786)	(1,595)	191	(16,949)	(15,987)	962	(18,736)	(17,772)	964
COVID / Reserves	(621)	(472)	149	(5,804)	(4,730)	1,074	(6,408)	(6,345)	63
Total Operating Expenditure	**(10,947)**	**(10,577)**	**370**	**(115,938)**	**(114,932)**	**1,006**	**(126,877)**	**(126,985)**	**(108)**
EBITDA	**260**	**921**	**661**	**4,735**	**6,389**	**1,654**	**5,003**	**6,483**	**1,480**
Depreciation	(403)	(408)	(5)	(4,432)	(4,444)	(12)	(4,834)	(4,850)	(16)
Profit / Loss On Disp Of Asset	0	0	0	2	3	1	2	3	1
Interest Receivable	0	2	2	5	7	2	5	5	0
Financing Costs	(52)	(46)	6	(569)	(558)	11	(620)	(609)	11
Dividends on PDC	(95)	(95)	0	(1,018)	(1,043)	(25)	(1,102)	(1,138)	(36)
I & E Surplus / (Deficit)	**(290)**	**374**	**664**	**(1,277)**	**354**	**1,631**	**(1,546)**	**(106)**	**1,440**
Capital donations I&E impact	**19**	**19**	**0**	**197**	**80**	**(117)**	**216**	**106**	**(110)**
I & E Surplus / (Deficit)	**(271)**	**393**	**664**	**(1,080)**	**434**	**1,514**	**(1,330)**	**0**	**1,330**

In response to the COVID-19 pandemic, the financial regime has now moved into another phase, with the trust now being monitored against the year-end forecast of £1.3m deficit submitted in December (based on expected forecast at that time). The HCP has now been provided with a final target for 2020/21 and work is on-going to ensure that this can be achieved whilst maintaining resource into next year. The Trust will be submitting an improved forecast as part of this process.

From October (Month 7), the key changes from reporting in April – September (Month 1-6) are:

- 'Block' funding received for Top-up, COVID related costs & growth (based on fair share of sector funding) for M7-12 rather than being reimbursed directly via retrospective top-up;
- No retrospective monthly top-up funding will be received to bring Trust to breakeven.

At month 11, the Trust reported a £393k surplus position. This is a £664k improvement on the planned position.

The in-month position includes £0.2m spend incurred as a result of COVID-19.

The Trust is forecasting to breakeven after the impact of donations. The forecast includes additional M7-12 top-up funding for non-NHS income lost in 2020/21 as a result of the pandemic. The underlying forecast (with this funding removed) would be a deficit of approximately £0.5m, which is an improvement of £1.1m against the planned year end position (and £1.0m deterioration against the previous forecast). The worsening in the forecast is due to additional costs assumed for covering annual leave not taken as a result of COVID as well as potential additional charges for spinal consumables (due to a reduction in activity related savings). The financial position will be monitored to see if there are

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Feb-21	Movement
	£'000	£'000	£'000
Intangible Assets	49	202	153
Tangible Assets	82,591	81,023	(1,568)
TOTAL NON CURRENT ASSETS	**82,640**	**81,225**	**(1,415)**
Inventories	1,232	1,273	41
Receivables	9,287	5,668	(3,619)
Cash at bank and in hand	26,673	45,022	18,349
TOTAL CURRENT ASSETS	**37,192**	**51,963**	**14,771**
Payables	(18,088)	(31,442)	(13,354)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(33,116)**	**(13,354)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,847**	**1,417**
Provisions	(639)	(644)	(5)
Finance Lease	(115)	(75)	40
Loans	(25,031)	(23,635)	1,396
TOTAL ASSETS EMPLOYED	**74,285**	**75,718**	**1,433**
Public Dividend Capital	27,554	28,633	1,079
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,541	354
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**75,718**	**1,433**

STATEMENT OF CASH FLOW - 2020/21	February-21 Plan	February-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(1,277)**	**354**	**1,631**
Non-Cash Flows In Operating Surplus/(Deficit)	6,004	6,042	38
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**4,727**	**6,396**	**1,669**
Increase/(Decrease) In Working Capital	14,073	17,894	3,821
Increase/(Decrease) In Non-Current Provisions	(35)	4	39
Net Cash Inflow/(Outflow) From Investing Activities	(5,062)	(4,450)	612
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**13,703**	**19,844**	**6,141**
Net Cash Inflow/(Outflow) From Financing Activities	(2,163)	(1,495)	668
NET INCREASE/(DECREASE) IN CASH	**11,540**	**18,349**	**6,809**
OPENING CASH	**26,673**	**26,673**	**0**
CLOSING CASH *	**38,213**	**45,022**	**6,809**

*Cash flow inclusive of an additional month of commissioner payments due to providers having to deal swiftly with the Covid-19 outbreak. This is likely to reverse in March unless national policy changes

COVID-19 expenditure:

YTD £2.7m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

In month (February) spend was £222k.

COVID-19 costs are subject to independent audit if requested through NHS Improvement.

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	Jul-20 Actual £'000	Aug-20 Actual £'000	Sep-20 Actual £'000	Oct-20 Actual £'000	Nov-20 Actual £'000	Dec-20 Actual £'000	Jan-21 Actual £'000	Feb-21 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	49	91	97	35	110	206	1,346
Annual leave provision	287	(287)	52	0	0	0	0	0	0	0	0	52
PPE	62	148	259	63	10	94	0	17	(5)	4	(30)	622
Decontamination	9	8	(2)	6	(3)	9	4	0	0	2	4	37
Agile working	21	(19)	1	92	0	3	97	30	58	12	19	314
ITU	5	2	(3)	0	2	0	(2)	0	38	0	1	43
Other	37	24	18	23	18	33	32	19	22	20	22	268
TOTAL	**520**	**130**	**516**	**302**	**123**	**188**	**222**	**163**	**148**	**148**	**222**	**2,682**

Other spend includes providing free car parking for staff, increasing the number of staff uniforms for staff and a contribution towards storage costs at the Liverpool arena for PPE.

Capital

In month variance - £424k above plan.

Year to date variance - £2,201k below plan.

External funding

- Donations: Charitable funds £177k (purchase neurosurgical equipment and update junior doctors accommodation);
- Critical Infrastructure Risk (CIR): Heating & Pipework £1,091k (to reduce backlog maintenance);
- Adapt and Adopt: CT scanner £532k (increased diagnostic capacity for the local system);
- HR funding: E-rostering £280k (implement new e-rostering system within Trust);
- Digital Aspirant: IM&T £578k (IM&T innovation); and
- COVID-19: Phase 1 and phase 2 funding £316k (purchase new equipment pandemic).

With the increase in capital funding finance have been working closely with divisions to identify deferred schemes which can be delivered by 31st March 21 to ensure that the plan is delivered. The detailed capital forecast is being monitored and reviewed weekly by Director of Finance and Director of Ops and Strategy.

CAPITAL

	In month			Year to Date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Estates	30	5	25	337	141	196	842	907	(65)
IM&T	107	42	65	1,176	410	766	1,283	845	438
Neurology	43	262	(219)	2,079	240	1,839	2,122	1,820	302
Neurosurgery	142	65	77	1,560	273	1,287	1,702	2,278	(576)
Corporate	0	0	0	0	0	0	150	0	150
Capital Slippage	(137)	0	(137)	(1,902)	0	(1,902)	(2,099)	0	(2,099)
TOTAL (excl. external funding)	**185**	**374**	**(189)**	**3,250**	**1,064**	**2,186**	**4,000**	**5,850**	**(1,850)**
Donated Assets	0	0	0	129	129	0	177	177	0
CIR - Heating & Pipework	0	235	(235)	978	892	86	1,091	1,091	0
Adapt & Adopt - CT	483	483	0	516	516	0	532	532	0
E-Rostering	167	167	0	167	167	0	280	280	0
Digital Aspirant	0	0	0	0	0	0	578	578	0
COVID-19	22	22	0	190	261	(71)	316	362	(46)
TOTAL (incl. external funding)	**672**	**907**	**(235)**	**1,980**	**1,965**	**15**	**2,974**	**3,020**	**(46)**
TOTAL	**857**	**1,281**	**(424)**	**5,230**	**3,029**	**2,201**	**6,974**	**8,870**	**(1,896)**

Capital spend in month is £1,281k.

There is £235k capital spend on phase 3 heating/pipework scheme.

There has been £5k on estates schemes, £42k of IM&T spend on IPad hardware refresh and on staffing for projects, £183k of works for the installation of replacement Bi-plane and £79k neurophysiology equipment in Neurology, £64k on theatres equipment in Neurosurgery, £483k spend for the new CT scanner, £167k in relation to the installation of a new e-rostering system and £22k in relation to COVID-19 phase 2 equipment.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 2020/21 phase 3 planning process.

NHS I/E are in regular contact to monitor spending.

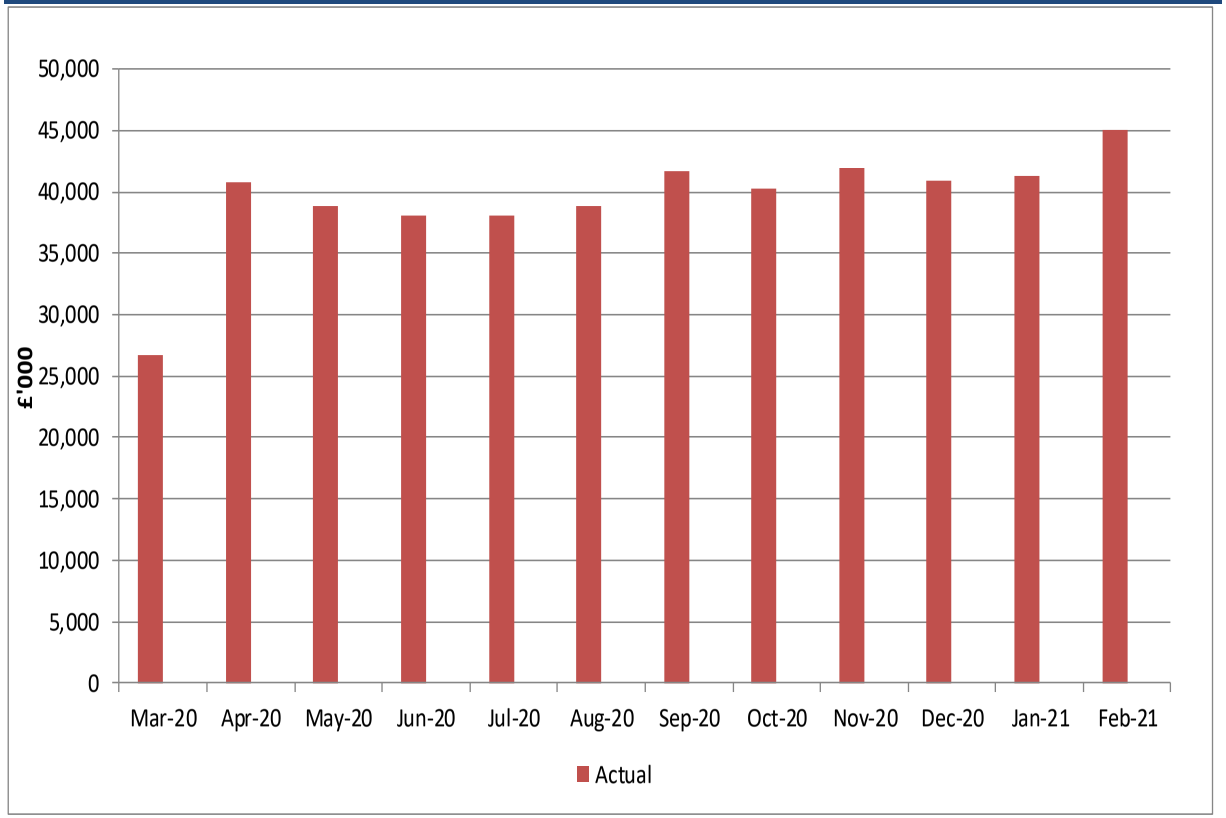
The year-end capital forecast is £8.9m which is £0.2m above the total agreed funding allocations for the year (including £1.7m agreed overspend with the C&M HCP.

As of the end of February:

Actual Cash Balance: £45.0m

Number of days operating expenses = 129 days

Cashflow against plan (Rolling 12 months)

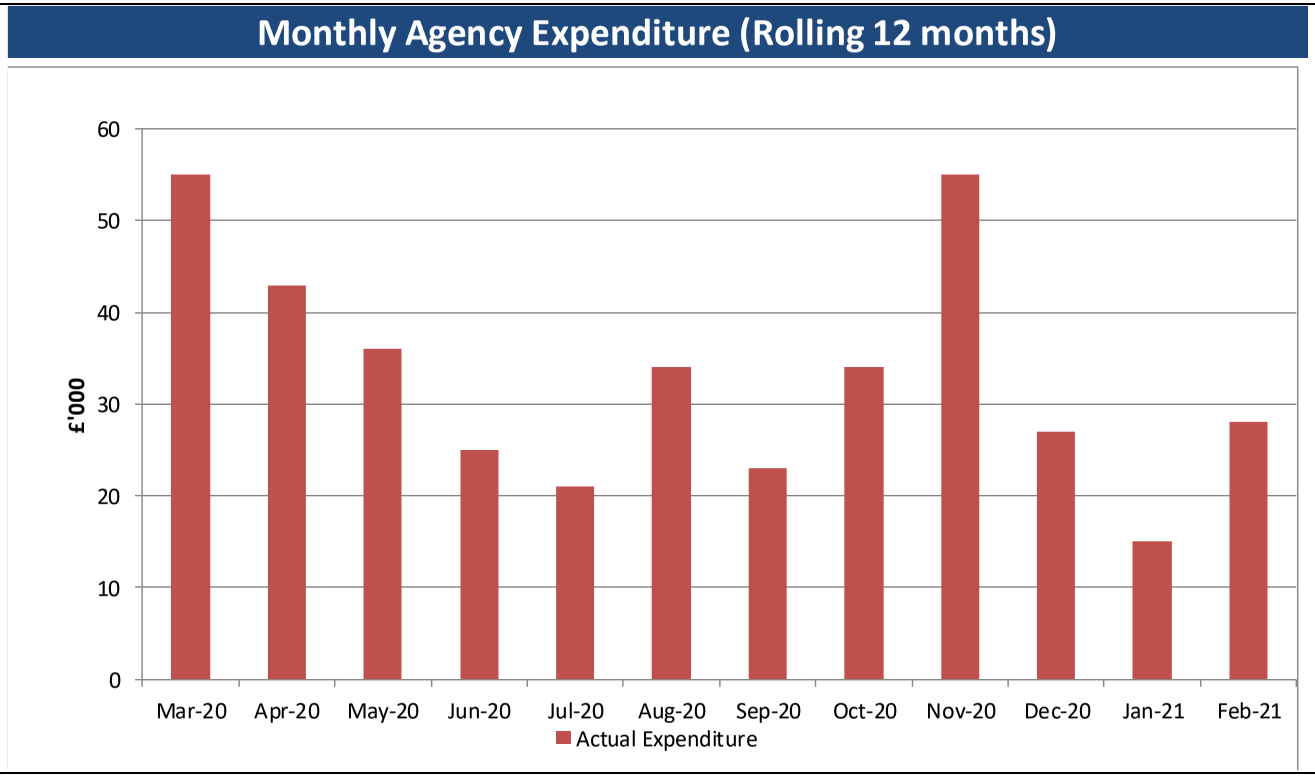


The Trust cash balance at the end of February was £45.0m. This is an increase of £3.7m from the end of January.

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

The cash position also includes £0.9m of PDC that was received in February in relation to the Trusts additional capital schemes.

Notification has been received from NHSI/E that block payments will not be made in March to bring contract payments back to an in-month payment, so the level of cash will reduce.

Agency Expenditure: In month Actual: £28k YTD Actual: £341k		Agency spend incurred in February was £28k, an increase of £13k compared to January. At the end of February, £59k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions for 2020/21

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

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the year and income being based on block values determined nationally (based on 2019/20 expenditure between November 2019 and January 2020). To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable COVID-19 and other known cost increases from 2019/20 (e.g. CNST contributions). This was the position for M1-6 with a block element of funding being allocated for Top-up, COVID-19 and growth to C&M HCP for M7-12 which is to be distributed to all organisations;
- The trust is currently being monitored against the year-end forecast of £1.1m deficit submitted to NHSE/I and C&M HCP in December;
- An Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M6-M12). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then will receive a retrospective financial penalty. This will not be applied in September or October given the impact of Covid patients in the C&M system and it is not expected that it will be applied over the remainder of the financial year due to the impact of the 2nd and 3rd waves;
- 2020/21 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this allocation does not include any phase 2 COVID-19 capital requirements or additional PDC allocated for specialist capital projects;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

As a result of the 3rd wave of COVID further guidance has been received around 2021/22:

- 2021/22 business planning deferred for at least first 3 months of 2021/22;
- Current financial regime is to continue for at least the first 3 months of 21/22 (and possibly the next 3 months dependant on levels of COVID);
- Exercise looking at 'exit run rates' for 2019/20 and 2020/21 is being undertaken by NHSE/I to determine potential level of contract funding for 1st quarter of 2021/22;
- System level targets will continue;
- Notification of 2020/21 quarter 1 allocations are due from NHSI/E imminently.

Further feedback will be provided to committee/ board members on the future financial framework once information is received from NHSE/I.

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 2020/21 and 2021/22 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	Block payments for English commissioners planned income are based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. Assumed income for Welsh commissioners is consistent with this approach (per guidance released M7-12), although high cost exclusions are now based on a pass through cost and volume basis. As part of this guidance, if activity has reduced by more than 25% below the block contract payment it will be adjusted by 10% in value increasing to a maximum reduction of 20% in value if activity reduces by more than 50%. Given that the Trust has had to cancel elective activity in January and February to support the regional COVID response there is a risk that Welsh activity will be at least 25% less than prior year activity which would mean that the contract penalties would be applied. This could result in a £720k reduction in income. National discussions are taking place around this but at this point, the original agreement remains in place. At month 11 the reduction in Welsh activity is still within agreed tolerance levels so the risk of contract penalties being applied has reduced. IOM are only paying for actual activity that has been delivered (which is reflected within the financial position), again resulting in an under payment compared to centrally assumed levels of income in line with 2019/20 outturn. Although below assumed national levels activity has been at a consistent level between M6-M11.
Current/ Future NHS Financial Framework	For the remainder of the year block funding will remain in place but COVID-19 will not be retrospectively reimbursed, with central funding allocated to the HCP for the rest of the year. C&M HCP is expected to achieve a breakeven position by the end of the financial year. STP's were required to submit phase 3 recovery plans for activity (and associated financial implications) on 1st September with final plans being submitted on 21st September. As part of this process the Trust has been completing phase 3 forecasts based on anticipated levels of activity to understand the financial implications for the Trust which have been

	submitted to the C&M Healthcare Partnership with final submissions submitted in late October. The trust is now being monitored against a year-end forecast of £1.3m deficit. This was taken from a revised submission in December. The level of forecast financial deficit across C&M has reduced to c. £10m and this is currently being accepted as the final position for C&M. However, discussions will continue to be held with NHSE/I about future expectations in light of the 3rd wave of COVID. As a result of the current national position with COVID, notification has been received that 2021/22 financial planning has been deferred for at least 3 months. In addition to this, it has been confirmed that current financial arrangements will remain in place for at the 1st 3 months of 2021/22. However it is still to be confirmed as to the value of the plan/ block funding for the Trust for Q1 in 2021/22. An exit run rate exercise is being carried out across the NHS which is likely to determine these allocations. Notification of the Q1 funding allocations is due imminently. Notification of financial planning guidance for 2021/22 is anticipated shortly which will enable a better understanding of the future financial framework.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult. However, this is likely to be greater than 1.1% given the additional NHS investments in 2020/21. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements and it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans. However recurrent efficiencies will be required to be delivered in 2021/22 and work is being undertaken to identify these.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to

	deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as fewer patients will be able to be seen given the additional PPE/ social distancing requirements). It should be noted that it was agreed by C&M HCP that Trust elective activity would be cancelled for a total of 6 weeks through January and February to be able to support the regional response to COVID, which will have had a financial impact but also an impact on waiting times and future recovery of activity.

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

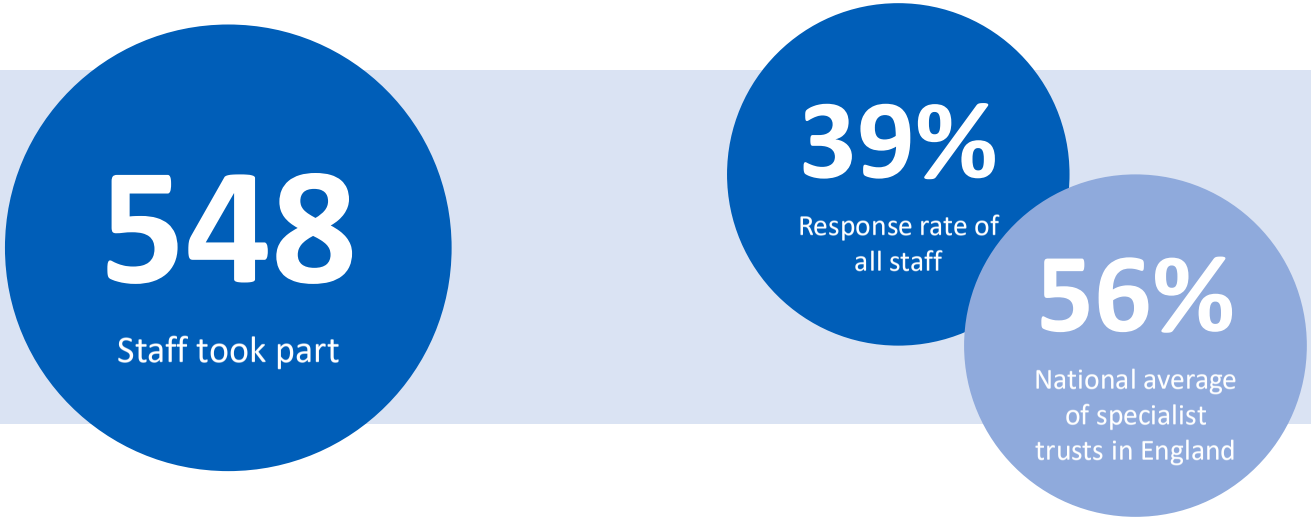
Staff Survey 2020

Mike Gibney / Jane Mullin

Background

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience



- The 2020 survey was distributed to all Trust staff between September and November 2020
- Mixed mode

Context for Staff Engagement

- The Staff Survey is an important annual strand in the organisation's overall approach to staff engagement. Other elements include:

- Established staff communications and engagement methods including a daily safety huddle, weekly email bulletin to all staff, Walton Weekly; plus a monthly team brief meeting for all heads of department which is led by the Chief Executive.
- Quarterly clinical senates draw together clinicians to discuss clinical issues and are well attended from all specialties.
- Quarterly staff listening weeks/ health and wellbeing days.
- Participation in Staff Friends and Family Test

Findings

The findings are arranged under ten themes:

- Equality, diversity and inclusion
- Health & wellbeing
- Immediate managers
- Morale
- Quality of care

- Safe environment- Bullying and harassment
- Safe environment- violence
- Team Working
- Safety culture
- Staff engagement

Findings

In the following 9 themes the Trust were **better** than the national average:

- Equality, diversity and inclusion
- Health & wellbeing- highest scoring Trust
- Immediate managers
- Morale
- Quality of care- highest scoring Trust

- Safe environment- Bullying and harassment
- Safety culture
- Staff engagement- highest scoring Trust
- Team working- highest scoring Trust

Findings

In following theme the Trust's score was **worse** than the national average:

Local Comparison

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

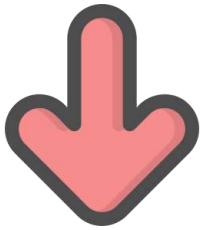
Trust	EDI	Health and wellbeing	Immediate managers	Morale	Quality of care	Safe Environment - bullying and harassment	Safe environment – violence	Safety culture	Staff engagement	Team working	Recommend as a place to work	Recommend as a place to be treated	Response rate / number of respondents
Alder Hey NHSFT	9.4	6.4	6.9	6.6	7.6	8.7	9.8	7.1	7.1	6.8	78%	91.7%	51.3% 1899
Bridgewater community NHSFT	9.5	6.2	7.0	6.4	7.5	8.7	9.9	7.1	7.2	6.9	60.2%	78.2%	50.4% 769
Cheshire and Wirral Partnership NHSFT	9.4	6.5	7.3	6.4	7.5	8.5	9.5	7.0	7.2	6.7	68.9%	75.5%	51% 1869
Countess of Chester NHSFT	9.1	6.0	6.7	6.2	7.4	8.1	9.4	6.6	7.0	6.3	65%	73.5%	42% 1716
East Cheshire Trust	9.1	6.0	6.9	6.2	7.4	8.1	9.4	6.6	7.0	6.5	66.9%	72.7%	40.4% 990
Liverpool Heart and Chest Hospital NHSFT	9.5	6.7	7.3	6.4	8.0	8.8	9.6	7.5	7.6	7.0	76%	92%	64% 1125
Liverpool University FT	9.1	6.0	6.6	6.0	7.6	8.2	9.4	6.6	6.9	6.4	64.2%	75%	43.9% 5245
Liverpool Women's NHSFT	9.5	6.5	6.8	6.3	7.6	8.7	9.8	6.9	7.1	6.8	65.9%	82%	55.3% 796
Mersey Care NHSFT	9.2	6.5	7.4	6.5	7.6	8.4	9.5	7.2	7.2	7.0	67.6%	73.8%	36.7% 2609
Mid Cheshire NHSFT	9.4	6.2	6.9	6.4	7.5	8.3	9.4	7.1	7.2	6.5	73.5%	78.3%	43.5% 2033
North West Boroughs NHSFT	9.3	6.5	7.5	6.4	7.7	8.6	9.6	7.0	7.2	7.1	66.5%	70.7%	35.6% 1344
Southport and Ormskirk NHS Trust	9.2	6.3	6.7	6.2	7.5	8.1	9.5	6.5	6.8	6.3	59.6%	58.4%	45.4% 1412
St Helens and Knowsley Teaching Hospital	9.4	6.7	7.3	6.7	8.1	8.5	9.5	7.2	7.6	7.0	78.5%	87.2%	41% 510
Warrington and Halton NHSFT	9.4	6.5	6.9	6.3	7.6	8.4	9.5	6.9	7.1	6.5	67.9%	71.3%	36% 1492
Wirral Community Health and Care NHSFT	9.4	6.1	7.2	6.3	7.3	8.7	9.9	7.0	7.1	6.6	63.9%	78.8%	52.4% 825
Wirral University Hospitals	9.3	6.0	6.6	6.1	7.5	8.1	9.5	6.6	6.9	6.3	62.1%	72.1%	40.9% 2492
The Clatterbridge Cancer Centre NHS FT	9.5	6.6	7.3	6.4	7.7	9.0	9.9	7.3	7.4	6.9	68.4%	89.5%	58.1% 862
The Walton centre NHSFT	9.3	6.8	7.1	6.6	8.1	8.5	9.3	7.2	7.6	7.0	78.9%	91.7%	38.6% 548

National Headlines

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Three of the ten key themes improved, these include; health and wellbeing, bullying and harassment and violence.



- One of the key themes worsened, team working

- The remaining six themes, including the staff engagement score, remained stable.

National Comparison

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Areas to celebrate

- In the last 3 months have you come to work despite not feeling well enough- decrease form 55.7% in 2019 to 39.6% in 2020.
- I am able to deliver the care I aspire to – 75.5% in 2019 to 82% in 2020, best in benchmarking group
- Care of patients is my Organisations top priority- 87.4% in 2019 to 91.8% in 2020, best in benchmarking group
- Morale had the best score in the benchmarking group for those staff working on a specific covid ward/area
- Staff engagement and team working for all staff had the highest score in the benchmarking group

Areas to Improve

- Safe environment- violence for all staff had the lowest score in the benchmarking group
- Team working for shielding staff had the lowest score in the benchmarking group
- Morale
- WRES/WDES

WRES

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- **The general 2020 response is not significantly different from the previous year.**
- In 2020 there was only a marginal difference between the average and the best performing trusts, with The Walton Centre scoring slightly above average.
- Of the four questions asked, there were two which showed small improvements and two which showed small deteriorations against the 2019 scores.
- Prioritise action towards the questions where the gap between White and BME responses are widest

WDES

- Of the eight questions asked, six showed some deterioration and two showed some improvement against the 2019 score
- Largest deteriorations are:

2020 NHS Staff Survey Results > WDES > Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties			
6)	2018	2019	2020
Staff with a LTC or illness: Your org	29.8%	24.4%	40.0%
Staff without a LTC or illness: Your org	22.7%	14.9%	21.3%
Staff with a LTC or illness: Average	30.8%	26.7%	29.8%
Staff without a LTC or illness: Average	21.7%	20.6%	21.6%
This metric has deteriorated on the 2019 figure with yes responses from staff with a LTC or illness falling by 15.6%.			

WDES

The Walton Centre NHS Foundation Trust

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2020 NHS Staff Survey Results > WDES > Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work			
8)	2018	2019	2020
Staff with a LTC or illness: Your org	80.0%	86.1%	70.0%
Staff without a LTC or illness: Average	75.2%	76.5%	77.0%
This metric has deteriorated on the 2019 figure with yes responses from staff with a LTC or illness falling by 16.1%.			

Collaborative approach

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Next Steps

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- Action planning for whole survey
- Participation in regular NHSI/E People Pulse survey
- Need to continually refresh ‘successful’ initiatives
- H&WB front and centre
- Create genuine lasting improvements for staff

Any questions?

The Walton Centre
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The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
01/04/21

Report Title	**Chair's Assurance Report – Quality Committee 18 March 2021**
Sponsoring Director	Seth Crofts, Non-Executive Director
Author (s)	Lisa Salter Director of Nursing
Purpose of Paper: The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Quality Committee held on Thursday 18 March 2021	
Recommendations	The Board is recommended to: • Receive and note the Quality Committee Chair's Report • Approve the revised Terms of Reference for the Quality Committee included at Annex A.

1.0 Matters for the Board's attention

- Staff story
- MSSA implementation plan
- Organ Donation update

2.0 Items for the Board's information and assurance:-

a) Staff Story (Usually a patient story)

Ms Crompton made reference to her experience and how supported she was in IPC when starting in role and how joined up the process was in managing the Covid-19 pandemic.

Ms Crompton provided a comprehensive presentation which comprised of three staff members' stories who worked throughout the 3 waves of the pandemic. Staff accessed Trust's support network which really helped. Anxiety was very high at times, especially when patients were dying of Covid-19. Concerns noted regarding staff not knowing the routines/environment, following staff moves to different wards and how this impacted on colleagues. Despite the challenges faced by staff, the presentation also demonstrated how staff found solace and support from friends and colleagues on the wards and via the Trust support platforms. Both patients and staff have coped incredibly well. Ms Crompton was thanked for a well-balanced presentation which reflected the openness and transparency of the Trust.

b) Medical Director's update

Mr Nicolson reported that a letter had been received from NHSBT commending the work of the Trust with regards to organ donation despite Covid-19. From April 2020 to September 2020 a total of 11 recipients received organ donations from 5 donors.

A patient death arising from a dislodged tracheostomy went to the Coroner's Court this week which noted a death of misadventure.

c) Integrated Performance Report

Risk assessments in neurology were an issue. Some of this was due to the pressures of one specific ward experiencing seven deaths due to Covid -19 in one week. Staff morale was low. A new ward

manager has commenced on the ward who is focussing on improving this. Assurance was given that no harm came to those patients for whom the risk assessments were delayed

Nursing staff turnover for neurology is over 30% with some attributed to internal promotion. Focus is on exit interviews with the view to retaining staff. Work is underway to review skill mix across the wards and significant work is taking place with regards to both international recruitment and general recruitment.

It was noted that MSSA remains a concern. See item i below.

d) End of Life Care update

Dr Bellieu (Specialty Clinical Lead for Palliative and End of Life Care at LUHFT) provided an update on the National Audit of Care and End of Life) NACEL 2019 survey. It was noted that the survey was taken over a short timescale and as a Specialist Trust, due to the low number of deaths (2), it is difficult to gain significant information. Some improvements however have been seen since the last review which included increased utilisation of syringe drivers and good use of anticipatory prescribing.

e) Quality & Clinical Services Strategy

Ms Salter thanked the Divisions and Trust teams for the work undertaken and completed on the Quality and Clinical Services Strategy despite the Covid-19 pandemic, which is no mean feat. The Divisional Leads provided an overview of work completed to date.

f) Quarterly Trust Risk Register Report

Mr Fitzpatrick provided the update of the Trust Risk Register noting that there are 25 risks in total. Attention was drawn to Risk 543 which related to a delay in IT projects posing a risk to patient safety. Mr. Griffiths (Head of IT) advised that during the pandemic, IT students had left the Trust which meant there were less people to complete projects. However, Mr Griffiths added that students would be returning to the work place in the summer. It was also noted that the Trust has just received digital aspirant funding which will enable work to progress quickly. Mr Fitzpatrick conveyed his thanks to those updating the risk registers in timely manner.

g) Visibility and Walk around update

Due to the Covid-19 pandemic the Walkabout & Visibility rota was altered for just the Senior Nursing Team and the Executive Team. Focus in supporting staff, discussing how things are changing in light of Covid-19.

h) Pharmacy Review on Critical Care

The situation remains similar since CQC visited, albeit pharmacy staffing in ITU during the week has increased by the addition of an extra band 7 pharmacist. The issue has been discussed with the pharmacy lead at LUHFT and no incidents have arisen despite there being no cover pharmacy cover on ITU at the weekend. It remains on the risk register. It was noted that there is an on-call pharmacist available if required..

i) MSSA Quality Improvement Report

Ms Oulton presented the report noting that there have been 13 cases of MSSA 8 of which were on ITU. The Trust is an outlier in the North West and is the 2nd highest in the region. A request was made to have new KPI timescales to be added to the report with the Quality & Improvement Group reviewing this. A check is also to be made to ensure that MSSA features on the Risk Register for ITU. Work on improvement in this area was noted.

j) Pharmacy Quarterly KPI Report

Ms Sparrow presented the report. For TTOs (discharge drugs) verified on the wards, there was a drop to 64% due to staffing issues. Ms Sparrow agreed to contact Mr. Foy with regards to SPC charts so the Committee could better analyse the data. It was noted that no harm came to patients from the two pharmacy errors that occurred.

k) Board Assurance Framework

Mr. Buckingham presented the paper and noted that it will be presented to Trust Board in April 2021.RIDDOR incidents are to be added to Risk 004.

l) Quality Committee Effectiveness Review & Terms of Reference (ToR)
The Effectiveness Review and ToR were reviewed and ratified by the Committee. A copy of the revised Terms of Reference is included at Annex A for approval by the Board of Directors

m) Health & Safety ToR
Mr. Fitzpatrick presented the paper. Amendments are to be made to Divisional Operations Manager from Divisional Managers. Ms Salter and Mr Fitzpatrick to discuss if the Deputy Head of Risk is to be added back into the group as he is the Safety Manager.

n) E, D & I Standard Operating Procedure (SOP)
Clinical engagement is required for the SOP. Mr. Lynch will share the document with Dr. Nicolson and Ms Salter. Ms Salter and Mr Lynch to finalise SOP.

o) Minutes/chairs' reports

- **Infection, Prevention & Control** – instigated new tool for investigating hospital acquired covid infections. NHSE/I visit to the Trust due to high numbers of Covid-19 outbreaks. Actions are being monitored by the IPCC.
- **Clinical Effectiveness & Services Group** – Work is on-going to develop a 24 hour Thrombectomy service
- **Health & Safety Group –** below trajectory for fire training compliance.

p) AOB
None presented.

3.0 Progress against the Committee's annual work plan
The Committee continues to follow its annual work plan. The work cycle for 2021 -22 was presented and ratified by the Committee.

4.0 Recommendation

The Board of Directors is recommended to:

- Receive and note the Quality Committee Chair's Report
- Approve the revised Terms of Reference for the Quality Committee included at Annex A.

QUALITY COMMITTEE

Terms of Reference

1.0 CONSTITUTION

1.1 The Walton Centre NHS Foundation Trust Quality Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference are set out below, subject to any future amendments by the Board of Directors
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1.2 The Quality Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

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

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

2.0 PURPOSE

2.1 The purpose of the Committee is to provide the Board of Directors with assurance that there is a comprehensive and integrated approach to patient safety and quality throughout the organisation, that high standards of care are provided by the Trust and that risks to the safety of patients and staff, patient experience and clinical effectiveness have been identified and mitigated.

3.0 DUTIES AND RESPONSIBILITIES

3,1 To inform the development and provide assurance against the following strategies, associated policies, action plans and annual reports:

- Quality Strategy
- Quality Account

3.2 To approve any clinical strategies underpinning the Quality Strategy such as Patient Experience, End of Life Care, Clinical Effectiveness and Audit.

3.3 Quality

a) To agree the Trust-wide clinical priorities and oversee the development and implementation of continuous improvements in the quality and outcomes of care for patients

b) Receive regular presentations defining “What Quality Looks Like to Me” at individual service level to enable the Committee to understand operational challenges and opportunities to strengthen quality and share good practice

c) Oversee the Trust's arrangements for maintaining compliance with the Care Quality Commission's essential standards and monitor any associated action plans

d) Monitor systems for obtaining and maintaining any licences relevant to clinical activity in the Trust. For example registration with CQC, Human Tissue Authority, Radiation use and protection regulations (IR (ME) R and those associated with annual declarations of compliance

3.4 Safe

a) Monitor the Trust's arrangements for compliance with obligations for the protection of children and vulnerable adults (safeguarding); and the Trust's effective participation in partnership arrangements for these ends; (Mental Health Act 1983)

b) Monitor the Trust's systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control;

c) Monitor the Trust's arrangements to ensure compliance with statutory and regulatory requirements in relation to the Health and Safety of patients and staff (Health & Safety at Work Act 1974)

d) Receive and scrutinise annual reports in relation to the above prior to submission to the Board of Directors

e) Maintain oversight of the implementation of actions arising from internal or external reports, including inquiries and investigations that relate to services provided by the Trust

f) Monitor the arrangements for recognising, reporting and reviewing or investigating deaths where appropriate and ensure that lessons are learnt and implemented.

g) Ensuring the Trust acts on learning from HM Coroner's Inquests and specifically on Regulation 28 Reports

3.5 Effective

a) Monitor the Trust's arrangements for ensuring that care, treatment and support is delivered in line with legislation, standards and evidence based guidance, including NICE, GIRFT, radiation use and protection regulations (IR(ME)R) and other expert professional bodies, to achieve effective outcomes

b) Approve the annual Clinical Audit programme, and monitor progress on a regular basis providing assurance to the Audit Committee as necessary that the outputs and actions arising from clinical audit influence Trust-wide quality improvements

3.6 Patient Experience

a) Monitor the Trust's arrangements for ensuring patients' ***and families*** views and feedback are captured and where relevant incorporated within service improvements.

b) Monitor and receive assurance on action plans and progress reports in response

to serious incidents, near misses and other incidents and ensure that there are processes in place to enable lessons learnt to be cascaded and implemented

c) Monitor the effectiveness of the Trust's systems for complaints ***management*** ~~handling,~~ and legal challenges, ensuring that; trends are identified, ***appropriate actions are identified and taken at the right time*** ~~that the Trust takes appropriate action at the right time~~ and that lessons are learnt and implemented.

d) Monitor levels of patient satisfaction via the 'Friends and Family' test and oversee the delivery of any associated action plans.

e) Consider the findings from national patient surveys and monitor the development of and implementation of appropriate action plans

f) Oversee the Trust's arrangements for maintaining compliance with the Equality Act 2010 requirements including:
    - Undertaking of Equality Impact Assessments
    - Monitoring of the Equality and Diversity Action Plan

3.7 Policies

To consider and approve relevant policies, procedures and guidelines in relation to Patient Safety, Patient Experience and Clinical Effectiveness and to escalate to the Board of Directors, with an appropriate recommendation, any that may require approval at that level in line with the Scheme of Reservation and Delegation.

3.8 Board Assurance Framework and Risk

3.8.1 To monitor the strategic risks within the Board Assurance Framework that are relevant to the Committee's remit, and provide assurance to the Board that such risks are being effectively controlled and managed.

3.8.2 Review operational risks with a score of 12 and above relevant to the Committee's remit.

3.8.3 To ensure that any risks identified from quality impact assessments of cost improvement schemes or service changes are monitored appropriately

4.0 MEMBERSHIP AND ATTENDANCE

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

Voting members

- 3 x Non-Executive Directors
- Director of Nursing & Governance
- Medical Director

4.2 There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

4.3 A Non-Executive Director will chair the Committee and in the event of a vote will have a second casting vote. Membership of the Committee will be disclosed in the annual report

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4.4 **Core members**

The following non-voting members will be required to attend meetings of the Committee:

- Deputy Director of Nursing & Governance
- Director of Operations for Neurosurgery
- Director of Operations for Neurology
- Clinical ~~Director~~ ***Lead Risk & Governance*** Neurosurgery
- ***Divisional*** Clinical Director Neurology
- Divisional Nurse Director Neurology
- Divisional Nurse Director Neurosurgery
- Quality Manager / Speak up Guardian
- Head of Patient Experience
- Head of Risk
- Lead Nurse for Infection Control
- ***Head of Information & Business Intelligence***

4.5 Both voting and core members are expected to attend a minimum 75% of Committee meetings during each financial year.

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

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

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

4.9 **Quorum**

The Committee will be deemed quorate provided 3 members are present including:

- At least two Non-Executive Directors
- At least one Executive Director

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

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

5.2 The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration

5.3 The Committee has established the following groups to support it in fulfilling its duties:

- ***Quality &*** Patient Safety Group
- Clinical Effectiveness and Services Group
- Safeguarding Group
- ~~Health and Safety Group~~ ***Health, Safety & Security Group***
- Patient Experience Group
- Infection Control Committee
- ~~Quality Assurance Group~~ ***(amalgamated in Quality & Patient Safety Group***
- Neurosurgery Divisional Governance Group
- Neurology Divisional Governance Group
- Corporate Division Governance Group
- Organ and Tissue Donation Committee
- Human Tissue Act Group
- ***Equality, Diversity & Inclusion Group***

The Committee will receive summary reports and consider the minutes of the above groups following each meeting.

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

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will meet at least 9 times per year.

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

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

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

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

7.0 EQUALITY ACT (2010)

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

8.0 REVIEW

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

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
1 April 2021

Report Title	**Chair's Assurance Report – BPC 23 March 2021**
Sponsoring Director	David Topliffe – Chair of Business Performance Committee
Author (s)	Jan Ross, Director of Operations and Strategy
Purpose of Paper:	
The Business Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Business Performance Committee held on 23 March 2021.	
Recommendations	The Board of Directors is recommended to: • Receive and note the BPC Chair's Report • Approve the revised Terms of Reference of the Committee included at Annex A of the report

1.0 Matters for the Board's attention
In between the February and March meetings voting members of the Committee approved the following business cases:

- Operating tables (re-life/replacement of 5 operating tables) = £269k
- Microscope (re-life/replacement) = £330k
- Microscope (addition to support the new spinal service) = £330k

The draft 2021/22 financial budget was noted as a work in progress and may be subject to change following the publication of national guidance. A further update would be presented at Closed Board in April.

The results of the Staff Survey for 2020 were noted with key focus topics agreed for follow up and discussed at the meeting in June 2021.

The Committee would recommend to Trust Board the approval of the updated Terms of Reference.

The Operational performance recovery plan had been prepared and awaited formal endorsement at HCP level.

2.0 Items for the Board's information and assurance
The Committee received the following updates:

a) 2021/22 Business Planning / Draft Budget
The Committee received a presentation covering the background to the 2021/22 business plan acknowledging that 20/21 was an unprecedented time with significant changes to the financial regime. Key planning assumptions on income and expenditure were outlined together with other assumptions and the initial 21/22 plan was outlined showing a significant efficiency requirement (if the Trust was to deliver a breakeven position). This was a material worsening from the initial 20/21 plan submitted in March 20. The Committee were asked to note the position included undelivered CIP from 19/20 and 20/21). Some potential improvements to plan were outlined together with the next steps and the key risks for 2021/22.

The Committee discussed the presentation particularly the CIP element. The fluid situation of financial planning was acknowledged noting that until national guidance was published the situation was likely to change. An updated plan would be presented at Closed Board on 1 April.

b) Integrated Performance Report

Operations – Cancer performance remained above target and the diagnostic 6 week standard had continued to meet target since November 20. The underperformance of RTT and waiting times continued and the key concern was how to get activity back on track and reduce waiting times.

Workforce – Staff sickness had reduced to 6.04% and this had made a big difference in some areas. Nursing turnover remained high particularly in Neurology but the first group of international nurses were due to arrive in the first week in May. A lot of work had been taking place to support the arrival of the nurses. An update was given on how appraisal underperformance would be improved going forward and it was requested that the Committee be provided with an idea of the levels and reasons for the long term sickness levels at a future meeting.

Finance – At M11 the Trust reported an in month £393k surplus against a planned deficit of £271k. The M11 forecast was to breakeven assuming receipt of £0.5m additional funding for non-NHS income from NHSI. There was an income over-performance of £291k in month and expenditure was underspent by £373k. There were £222k of Covid costs incurred in February resulting YTD in Covid costs of £2,682k.

Capital incurred £1,281k in M11 with £3,029k spend YTD. Excluding Covid YTD, capital spend was £2,768k against a plan of £5,040k. Details of additional funding were provided including critical infrastructure funding; digital aspirant and charitable funding. It was forecast that the Trust will over deliver on the capital plan by the end of the financial year by £1.7m as discussed with Cheshire & Mersey Healthcare Partnership with total capital spend projected to be £8.8m (£5.8m plus £3m from additional funding).

The cash balance at the end of February was £45m. The current cash position includes 12 payments for 11 months given the arrangements during the pandemic, but to manage the cash to the annual payment, no payment would be made in March. It was expected that the current financial arrangements would continue for Q1 and Q2 of 21/22.

c) Power Outage Briefing Paper

The Committee received a briefing on the incident regarding the power outage at the Trust on 2 December 20 when two power interruptions took place resulting in the Trust's Business Continuity Plan being implemented. Learning and actions detailed in the paper were reviewed. It was agreed that a further review of the action plan would be brought to the meeting in June. Discussion took place around the respective roles of Business Performance Committee and Quality Committee in the reporting of this issue and that governance should be clarified in this regard.

d) 2020 Staff Survey Results

The Committee were presented with the results of the staff survey conducted by Quality Health. The surveys had been completed online and the response rate was 39% which was lower than in previous years. The Trust had scored either better or the same as the national average in eight of the nine themes contained within the survey and would reflect upon the themes where the score was worse than the national average and develop an appropriate action plan in particular around results relating to morale and relationships with immediate managers. Discussion took place around:

- Staff response rate;
- Staff morale and what would be put place to measure this (NHS People Pulse);
- Reasons for possible deterioration of relationships with line managers;
- Acknowledgement that the focus on the appraisal process will address the line manager issue;
- Safe environment, relating to the unpredictable behaviour of the cohort of patients lacking capacity which already has its own BAF risk; and

- The results of equality, diversity and inclusion significant testing and the gap in scores between White members of staff and BME staff.

The action plan would return to the Committee in June 2021 together with comprehensive benchmarking data.

e) Annual Effectiveness and Terms of Reference Review

The Committee were provided with the responses received for the Effectiveness Review which included replies from all voting Committee members together with 4 responses from non-voting members. A range of positive outcomes together with areas where some further development may be required were summarised within the report. It was agreed that a small sub-group would work up an action plan to realise improvements arising from the Effectiveness Review.

The Committee would recommend to Trust Board to approve the Terms of Reference with the proposed addition of the Director of Workforce and Innovation as a voting member and the inclusion of Heating and Pipework Group as a supporting management group. The revised Terms of Reference, with proposed amendments identified in black italics / strikethrough are included at Annex A to this report.

f) Board Assurance Framework

The BAF containing 7 principal risks where the Business Performance Committee was identified as the Assurance Committee were discussed. There had been no significant movement in risk scores with the exception of Risk 013 relating to the scope of capital allocation and Risk 014 relating to the delivery of the financial plan. Both risks had the residual score reduced. One new risk was added for 2021/22 relating to potential income risks associated with the Healthcare Partnership (HCP) financial system. Discussion took place around the risk relating to cyber security and this was highlighted as a risk for deeper review going forward.

g) Terms of Reference – Information Governance Security Forum

The Committee noted the minor changes and approved the Terms of Reference.

h) 2021-22 Cycle of Business

This was noted by the Committee for the forthcoming year.

i) Spinal Cord Injury Transformation monies

The Committee noted the progress to date and the recurrent investment for the development and implementation of improved pathways for spinal cord injured patients. A background was provided and it was explained that there were 8 regional spinal cord injury centres in England with Southport & Ormskirk Hospital being the centre for the North West. As injuries of this nature had grown in order to improve pathways and provide care closer to home for patients monies identified in the paper were as a direct result of a national transformation initiative. The Trust had received first stage approval and was waiting to hear back from the national team. There was not expected to be any risks around this as the Trust was represented on the panel and working group. It was noted by the Committee that recruitment to the posts outlined in the paper was not considered to be an issue.

j) Operational Performance Recovery Plan

The report provided to the Committee and updated presentation at the meeting detailed the proposed approach for recovery of services within the Trust with the main priority being to reduce the waiting list backlog and the associated interdependencies along with ensuring services were sustainable for the long term and also ensuring staff were working in a healthy work environment. Committee were asked to note that changes may be made following publication of national guidance on 26 March. Discussion took place around:

- Challenge of 52 week waiters and capacity at Halton Hospital;
- The signing off of the Plan;
- Explanation of 'bounce back' of referrals;
- Financial impact and scenarios; and
- Feedback from staff and stakeholders to the Plan.

The Committee noted the recovery plan acknowledging it required formal endorsement at HCP level.

k) Items presented under Consent Agenda

Three Chair's Reports from sub groups that had taken place were received and noted.

3.0 Progress against the Committee's annual work plan

The Committee continued to follow its annual work plan this month with 3 chair's reports contained within the Consent Agenda.

4.0 Recommendation

The Board of Directors is recommended to:

- Receive and note the BPC Chair's Report
- Approve the revised Terms of Reference for the Committee included at Annex A of the report.

BUSINESS PERFORMANCE COMMITTEE

Terms of Reference

1.0 CONSTITUTION

1.1 The Business Performance Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to any future amendments approved by the Board of Directors.

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

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

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

2.0 PURPOSE

2.1 The purpose of the Committee is to provide the Board with assurance that the Trust's operational, financial and workforce plans are viable and that risks have been identified and mitigated. The scope and remit of the Committee encompasses: operational performance; workforce and organisational development; transformation and efficiency improvement; estates & facilities; finance, investment and procurement and information management & technology (IM&T).

3.0 DUTIES AND RESPONSIBILITIES

The main functions of the Committee are:

3.1 Strategy Development & Assurance

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

- The Trust's Strategy 2018 – 2023
- The Board Assurance Framework
- People Strategy
- Communication & Engagement Strategy
- Transformation Strategy
- Estate Strategy
- Finance and Procurement Strategy

- Financial Plan
- Long Term Financial Plan
- Information Management & Digital Strategy
- Information Governance Strategy Framework and Policy
- Business Intelligence & Informatics Strategy

3.2 **Policies**

Consider and approve relevant policies, procedures and guidelines in relation to operational performance and improvement, workforce, finance, IM&T and estates and to escalate to the Board of Directors, with an appropriate recommendation, any that may require approval at that level.

3.3 **Board Assurance Framework and Risk**

Monitor the principal risks to strategic objectives within the Board Assurance Framework that are relevant to the Committee's remit, and provide assurance to the Board that such risks are being effectively controlled and managed.

Review operational risks with a residual risk score of 12 and above relevant to the Committee's remit.

More specifically, for each business segment:

3.4 **Performance**

a) Monitor the performance of metrics in line with the NHS Oversight Framework and contractual targets

b) Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly

c) Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks to inform the organisation, support continual improvement and assure the Board of Directors. Consider both leading and lagging indicators and harness data analytics.

3.5 **Transformation and Efficiency**

a) Review the process for developing the transformation programme, provide oversight of the programme and seek assurance on the effectiveness of delivery of the programme within the Trust.

b) Consider and recommend any major transformation plans that the Trust should undertake.

3.6 **Workforce and Organisational Development**

a) Review progress against the Trust's People Strategy and Communication & Engagement Strategies

b) Seek assurance on the development and delivery of comprehensive workforce plans

c) Monitor performance against key workforce lagging indicators including sickness absence, appraisal review, mandatory training and turnover. Develop leading indicators to measure personal development, engagement and organisational development.

d) Monitor progress against equality and diversity goals arising from the Equality Delivery System, WRES, WDES, gender pay gap reporting and other regulatory requirements to ensure compliance with the Equality Act 2010.

e) Seek assurance that the essential standards of quality and safety in relation to staff (as determined by CQC's registration requirements) are being met by every service that the organisation delivers.

f) Ensure that there is a Training Needs Analysis process in place across the Trust and monitor its effectiveness.

g) Provide assurance to the Board on compliance with relevant HR legislation and best practice

h) Monitor any action plans relating to the staff survey and seek assurance that satisfaction levels are improving.

i) Monitor the implementation of the health and wellbeing programme, including the delivery of Occupational Health services

3.7 **Estates and Facilities**

a) Review progress against the Trust's Estates Strategy and monitor related plans and their implementation

b) Monitor the Trust's Sustainable Development Management Plan and ensure that the Trust meets its obligations under the Climate Change Act and that the Adaptation Reporting requirements are complied with

3.8 **Finance, Investment and Procurement**

a) Review the financial elements of the Trust's Operational Plan against the Long-Term Financial Plan and ensure that key assumptions are both realistic and deliverable (the Board of Directors will remain responsible for approval of the Operational Plan).

b) Monitor the financial performance of the Trust, the financial forecast and the key financial risks and mitigations or corrective plans

c) Monitor delivery of the Capital Expenditure Programmes and seek assurance on the

preparation of comprehensive programmes for subsequent years.

d) Recommend the Capital Expenditure programme to the Board of Directors for approval and review Capital and Revenue investment proposals over £150k and less than £500k in accordance with the Scheme of Reservation and Delegation (SoRD) / Standing Financial Instructions (SFI)

e) Monitor delivery of the Cost Improvement Programme and seek assurance on the preparation of comprehensive programmes for subsequent years, recommend the Cost Improvement Programme to the Board of Directors for approval.

f) Review and assess the financial implications of performance against the Trust's principal contracts.

g) Review contract award proposals (in line with the SoRD and SFI) and make appropriate recommendations to the Board of Directors.

h) Review financial performance against CQUIN targets

i) Consider the financial impact of opportunities to grow new income streams and the market share of existing services.

3.9 **Information Management & Technology, Data Security, Digital and Intelligence**

a) Review the Digital, Information Management and Technology (IM&T), Business Intelligence and Informatics programmes of work to ensure alignment with the Trust's strategic plans and monitor progress on major schemes.

b) Review the Trust's Information Governance, Data Security and Protection arrangements and monitor the Trust's plans and Toolkit submission in relation to this.

3.10 **External Reviews**

a) Review recommendations arising from external reviews of areas within scope of the Committee and monitor progress on actions to address recommendations.

4.0 MEMBERSHIP AND ATTENDANCE

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

Voting members

- 3 Non-Executive Directors
- Director of Strategy and Operations
- Director of Finance and IT
- Director of Workforce & Innovation

4.2 There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's

Constitution.

4.3 A Non-Executive Director will chair the Committee and in the event of a vote will have a second casting vote. Membership of the Committee will be disclosed in the annual report

4.4 **Core attendees**
The following non-voting members will be required to attend meetings of the committee:

- Deputy Director of Nursing and Governance
- Deputy Medical Director
- Deputy Director of Finance
- Divisional Director of Operations for Neurosurgery
- Divisional Director of Operations for Neurology
- Head of Commercial Engagement and Marketing
- Patient Access & Performance Director

4.5 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting

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

4.7 Both voting members and core attendees are expected to attend a minimum 75% of Committee meetings during each financial year.

4.8 An open invitation exists for all members of the Board of Directors to attend Committee meetings and, with permission from the Chair, to participate in the Committee's discussion.

4.9 **Quoracy**
The Committee will be deemed quorate provided 3 members are present including:

- At least two Non-Executive Directors
- At least one Executive Director

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

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

5.2 The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration.

5.3 The Committee has established the following management groups to support it in fulfilling its duties:

- Capital Management Group

- Digital Systems Programme Board
- Information Governance & Security Forum
- Local Negotiating Committee
- Staff Partnership Committee
- Resilience Planning Group
- Medical Devices and Facilities Group
- Transformation Group
- Heating and Pipework Committee

The Committee will receive summary reports from the above management groups following each meeting.

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

5.5 The Committee will, from time to time, establish other task or project groups to address specific issues on a 'task and finish' basis and will receive regular progress reports from such groups.

6.0 PROCEDURAL ISSUES

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

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

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

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

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

7.0 EQUALITY ACT 2010

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

8.0 REVIEW

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

Report to the Board of Directors
Date: 1st April 2021

The Walton Centre NHS Foundation Trust

Title	**Board Assurance Framework 2021-22**
Sponsoring Director	Lisa Salter Director of Nursing and Governance
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	• Executive Team

Executive Summary

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review and approval. The BAF was last reviewed by the Board of Directors on 4 March 2021 and relevant BAF entries were subsequently reviewed by the Quality Committee and Business Performance Committee on 18 March and 23 March 2021 respectively. There have been no changes to either the Trust's strategic objectives or the associated principal risks. Consequently, the BAF entries previously agreed by the Board will form the opening BAF for 2021/22.

There are currently a total of 14 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, have been reviewed by Executive Directors in advance of the Board meeting on 1 April 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table at s3 of the report details the opening risk scores for 2021/22.

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Board Assurance Framework supports the Annual Governance Statement which is a requirement of the annual report in line with the NHS Improvement Annual Reporting Manual.
Action required by the Board	The Board of Directors is recommended to: a) review and approve the opening BAF content for 2021/22 as detailed at Appendix 1 b) approve the inclusion of the new risk relating to the HCP Financial System (Risk ID X2) c) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board

1.0 Introduction

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review and approval.

2.0 Background

Boards are required to develop a Board Assurance Framework (BAF) that serves to inform the Board of the principal risks threatening the delivery of its strategic objectives. The Board identified a set of Ambitions in the Trust Strategy which form the strategic objectives for the Trust. These are to:

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

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.

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;

3.0 Current Position

The BAF was last reviewed by the Board of Directors on 4 March 2021 and relevant BAF entries were subsequently reviewed by the Quality Committee and Business Performance Committee on 18 March and 23 March 2021 respectively. There have been no changes to either the Trust's strategic objectives or the associated principal risks (see below regarding a proposed new principal risk). Consequently, the BAF entries previously agreed by the Board will form the opening BAF for 2021/22.

There are currently a total of 14 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, have been reviewed by Executive Directors in advance of the Board meeting on 1 April 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been

updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table below details the opening position for risk scores in 2021/22 (the 'Current' risk scores from Quarter 4 2020/21 become the 'Initial' risk scores for 2021/22).

Risk ID	Title	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
001	**Covid-19** Impact of COVID-9 on delivery of strategic objectives	**20**			
002	**Operational Performance** Inability to meet operational performance standards	**20**			
003	**Harm to Staff** Inability to prevention harm to staff	**12**			
004	**Quality** Inability to deliver the benefits within the Quality Strategy,	**16**			
005	**Our staff** Inability to attract, retain and develop sufficient numbers of qualified staff	**16**			
006	**Estates** Inability to maintain the estate to support patient needs	**12**			
007	**Digital** Inability to deliver the benefits of the Digital Strategy	**12**			
008	**Cyber Security** Inability to prevent Cyber Crime.	**16**			
009	**Innovation** Inability to identify innovative methods of delivery	**12**			
010	**Partnerships** Inability to influence partnerships and the future development of local services impacts on organisational sustainability	**12**			
011	**Research and Development** Inability to maintain and grow the Trust's research and development agenda.	**12**			
012	**Capital** Allocation of capital set by the STP to the Trust will not support the full capital plan	**9**			
013	**Financial Plan** Inability to deliver the financial plan for 2021-22	**8**			
014	**Medical Education** Ensuring quality, capacity and capability of Medical Education	**15**			

There has been no significant movement in risk scores since the last review by the Board of Directors on 4 March 2021. One new risk has been identified for adding to the BAF following review by the Business Performance Committee:

X2	**Health Care Partnership – Financial System** The move to an integrated Health Care Partnership financial system along with changes to tariff and population based specialised commissioning could destabilise the Trust's income base.

A copy of the proposed BAF entry is included for review by the Board at the end of the BAF at Appendix 1.

4.0 Next Steps

BAF entries will continue to be reviewed by the relevant lead Committees in accordance with agreed business cycles. The next iteration of the BAF, reflecting the position for Quarter 1 2021/22, is scheduled for review by the Board of Directors on 1 July 2021.

5.0 Recommendations

The Board of Directors is recommended to:

a) review and approve the opening BAF content for 2021/22 as detailed at Appendix 1
b) approve the inclusion of the new risk relating to the HCP Financial System (Risk ID X2)
c) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board.

Risk ID: 001	Date risk identified: February 2020	Date of last review:	March 2021
Risk Title:		Date of next review:	July 2021
If the Covid-19 pandemic continues for an extended period then the Trust may be unable to deliver its strategic objectives leading to regulatory scrutiny and reputational damage.		CQC Regulation:	Regulation 16 Assessing and Monitoring service provision
		Ambition:	1. Deliver best practice in care and treatments
		Assurance Committee:	Board of Directors
		Lead Executive:	Director of Operations and Strategy

Linked Operational Risks		
806	Reduced staffing	16
793	Poor patient experience and outcomes	16
807	Failure to adhere to social distancing measures	16
813	Mutual aid and training and development requirements	16
796	Identification of nosocomial Covid-19 infections	16
	Further linked operational risks with ratings between8-12 are included on the Covid-19 Risk Register at Appendix 2	
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Catastrophic 5	Possible 4	20
Current	Catastrophic 5	Possible 4	20
Target	Catastrophic 5	Unlikely 2	10

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Loss of life, Patients / Staff 2. Disruption to business as usual 3. High levels of sickness absence	National Lockdown with effect from 6 January 2021

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. Major Incident Plan – Jan 2018 2. Business Continuity Policy Oct 2019 - Command and control 3. Business Continuity Plans and escalation plans for all departments 2018 4. Infection Prevention and Control Policy and Programme 2020 5. Visitor Policy – March 2020 6. Flu Policy – April 2019 7. Health & Wellbeing Programme – Aug 2018 8. Shiny Minds App – Approved Aug 2018 9. Daily Staff Bulletin based on PHE advice 10. COVID WCFT Standard Operating Procedure– approved by Exec March 2020 11. Psychological support for staff available via internal helpline 12. FIT Testing and Training of key staff 13. Modification of estate to provide additional capacity in ITU 14. SLA with Aintree for Pharmacy/Pharmaceutical supplies 15. Regional Operations Meeting – Weekly 16. Cheshire & Merseyside EPRR Network Meeting – twice per week 17. Critical Care Network Operational Meeting 18. Corona Bill – passed March 2020 19. Staff vaccination programme via LUHFT Covid Vaccination Hub 20. **Weekly LAMP testing**	1. Push deliveries being managed centrally 2. Mutual aid being managed through hospital cell 3. **Vaccination programme and vaccine availability** 4. **Risk of further Covid waves as a result of mutations and new variants**

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 COVID-19 Control Meetings Daily Safety Huddle Divisional Daily Huddle Infection Prevention and Control Committee – bi-monthly Pandemic Testing Reported to Resilience Planning Group Aug 2019 Daily Executive Meeting Ethics Committee **Level 2** Infection Prevention & Control Quarterly Report – Quality Committee Quarterly Governance Report –Quality Committee, Trust Board Covid-19 Update – Trust Board EPRR Self-Assessment – Nov 2019 Trust Board Assessment of Interim Governance arrangements to Trust Board – April 2020 Covid-19 Board Assurance Framework **Level 3** Daily Sit Rep Reports submitted to NHS Digital EPRR – Self Assessment submitted to NHSI – Nov 2019 NHSI National call – weekly NHSE/I Visit – February 2021	1. Asymptomatic screening provides inconsistent results 2. Managing potential consequences of enhanced regional testing regime

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Terms of Reference, membership and reporting arrangements re Ethics Committee to be finalised	AN	End of April	Completed
2	Ongoing participation in regional and national plans	JR	~~March 2021~~ **July 2021**	On track

Risk 002	Date risk identified April 2020	Date of last review:	March 2021
Risk Title: If the Trust does not see and treat patients in a timely manner then it will not meet the NHS constitutional standards leading to poor patient outcomes and experience, regulatory scrutiny and reputational damage.		Date of next review:	July 2021
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	1 Deliver Best Practice in care and treatments
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Operations and Strategy

Linked Operational Risks			Consequence	Likelihood	Rating
			Major	Likely	
43	Failure to meet mandatory waiting time standards	16	Initial 4	5	20
815	RTT / Average Wait performance and volume of 52-week waiters	16	Major	Likely	
			Current 4	5	20
			Major	Unlikely	
Risk Appetite	Cautious		Target 4	2	8

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 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	Average Wait Performance Overdue Follow up waiting list in Neurology remains a concern Reduction in overall activity due to the impact of COVID-19 Self-isolation guidance impacting on patient choice Increasing waiting list size **52-week breaches increasing**

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. Draft Operational Plan 2020-21 - discussed at Exec Feb 20 2. Workforce Plan 2018-2019 3. COVID-19 Recovery Plan Phase 3 4. Job Planning for consultants - Ongoing for 2020-21 ~~5. Regional Operations Meeting – Weekly~~ 6. ~~Cheshire & Merseyside EPRR Network Meeting – twice per week~~ 7. National Call – NHSI – Weekly 8. Performance Dashboard in Real-time 9. **From October 2020, no longer accept GP referrals for pain as per NHSE published guidance in relation to Adult Pain Service Specification for Tier 3 services.** 10. **Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly** 11. **Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly** 12. **Development of Recovery and Restoration plans for 2021/22**	~~1. Draft plan based on assumptions pre COVID-19~~ 2. Workforce plans do not take into account impact of sickness, shielding requirements due to COVID-19 ~~3.~~ 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 behaviours.**~~pre COVID and does not factor in patient staff behaviours and new ways of working~~ ~~4. Real time visibility of Performance data~~ 5. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 6. Lack of clarity re waiting time standard - RTT /Average wait going forward ~~7. Increase in pain referrals across C&M due to de-commissioning of service at other providers~~ 8. **Planned transfer of Spinal services from LUHFT early 2021/22 – impact in relation to overall Trust RTT performance is currently unknown.**

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 Weekly monitoring of performance of RTT Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly PA Consulting have been contracted to work through C&M data and plan based on assumptions and winter plans. **Level 2** Integrated Performance Report – **Reported monthly at Trust Board** ~~Trust Board April 2020, BPC May 2020~~ COVID Update – Reported at Board meetings from April 2020 **Level 3** Meetings with Commissioners – bi-monthly	1. Transformation Board delayed due to COVID response 2. C&M approach to access and planning

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Transformation Board to be formally established and re-focused to address outpatient productivity flow and theatres in the context of COVID-19 Recovery	DoSO	~~March 2020~~ ~~June 2020~~ **April 2021**	~~Delayed~~ **Commenced**
2	Implementation of COVID Recovery Plan to increase activity	DoSO	End of July	Phase 1 complete

3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	~~Delayed~~ **Superseded**
4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	~~End of July~~ **May 2021**	~~Not started~~ **Commenced**
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue	DoSO	~~End of June~~ **May 2021**	~~On track~~ **Delayed**
6	Continued Job Planning for consultants for **2020/21** ~~2019-20~~	DoSO	Mar 2021	On track
7	**Data requested from LUHFT to inform RTT position.**	**DoSO**	**June 2021**	**On track**

Risk ID: 003	Date risk identified April 2020	Date of last review:	March 2021
Risk Title: Due to the specialist nature of patients with a higher incidence of violence and aggression, **if** the Trust does not establish effective processes to prevent harm, then staff and/or patients may experience physical harm which could lead to high turnover, sickness absence, litigation and regulatory scrutiny.		Date of next review:	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

Linked Operational Risks				Consequence	Likelihood	Rating
455	If controls are not put in place to manage violent and aggressive patients, then there is a risk to staff safety. (Neurology Division)	12	Initial	Major	Possible	
				4	3	12
			Current	Major	Possible	
				4	3	12
			Target	Moderate	Possible	
Risk Appetite	Cautious			3	3	9

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Physical Injury /- Emotional/psychological impact on staff and other patients - Low morale - Increased sickness levels - Litigation - Involvement with Regulators e.g. HSE, CQC, NHE/II - Increase in staff turnover	**Physical Assaults on staff** **2018/19** **Q1 = 45 Q2 = 34** **Q3 = 50 Q4 = 18** **2019/20** **Q1 = 27 Q2 = 45** **Q3= 40 Q4 = 29** **2020/21** **Q1 = 22 Q2 = 56** **Q3 = 78** **Related Claims** 1 claim received in 2019/20 **Staff Survey (relating to staff reporting physical harm)** **2020 - 20.3% (**against the national average of 4.1%) **2019 - 22.3%** (15.25% higher than acute specialist sector average of 5. 7%) **2018 – 21.9%** (National average 2018 over 6.7%, compared to best performing Trust at 1.8%)

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. Violence and Aggression Policy - approved Feb 2018 2. Lone Worker Policy - approved Feb 2018 3. Mental Capacity Act Policy - approved Jul 2019 4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach) 5. Security Function (ISS) 6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required 7. Personal Safety Trainer Programme of work Apr-2019 8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 9. Additional Consultant reviews RVs where V&A has increased 10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot) 11.Restraint Training rolled out in CRU **and other ward areas** **12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are agressive**	1. Lack of agreed KPI's within the Security Contract 2. Compliance with statutory and mandatory training 3. Restraint Training to be rolled out across all wards 4. Psychologist sessions to be rolled out to all wards
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 **Monday-Sunday** Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – bi monthly Violence and Aggression Group – **quarterly** Transformation Board - monthly **Level 2** Annual Governance Report – Quality Committee Quality Dashboard – Quality Committee – monthly 2020 **Level 3** Staff Survey 2020 Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance Oct 2018 – actions completed Dec 2019 Quarterly review meetings with commissioners CQC Inspection Report 2019 Investors in People Health & Wellbeing Gold – re-accredited May 2019 **Investors in People re-evaluation retained as Gold in 2020**	1. Outcome of Shiny Minds App to be evaluated 2. Lack of benchmarking data across similar Trusts – **to commence with Queen's Square in Q1 20201/22** 3. Evaluation of LAST LAP (Looking After Staff That Look After People) initiative ~~required~~ **- due in Q1 2021/22** ~~4. Outcome of Investors in People re-evaluation for 2020 not yet received~~

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	KPI's for the Security Contract to be developed and monitored by the Health Safety and Security Group	LS	~~End of Nov 19~~ ~~Oct 2020~~ **June 2021**	Delayed
2	Continued focus on statutory and mandatory training compliance Trust Wide – in line with new social distancing requirements	MG	~~End of March 2021~~ **June 2021**	On track
3	Pilot of Shiny Minds App to be evaluated	MG	~~End of March 2020~~ ~~September 2020~~ ~~December 2020~~ **June 2021**	Delayed
4	Benchmarking of nurse turnover of similar Trusts across Cheshire & Merseyside	LS	End of Sept 2020	Complete
5	Roll out of Looking After Staff to Look after Patients to all wards	LS	End of Aug 2020	~~Not started~~ **Complete**
6	Audit of LASTLAP to be completed	LS	~~Jan 2021~~ **Quarter 1 2021/22**	~~Not started~~ **On track**
7	Outcome of Investors in People to be reported	MG	~~Jan 2021~~ **June 2021**	On track
8	Roll out of Restraint Training across all wards	LS	~~March 2021~~ **June 2022**	~~On track~~ **Delayed**
9	Roll out of psychology sessions across the wards for staff health and well being	LV	~~March 2021~~ **June 2021**	On track

Risk ID: ID004	Date risk identified April 2020	Date of last review:	March 2021
Risk Title: If the Trust does not deliver the benefits identified within the Quality Strategy, then excellent patient and family centred care will not be sustained leading to potential harm, poor patient experience and reputational damage		Date of next review:	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

Linked Operational Risks				Consequence	Likelihood	Rating
				Major	Likely	
			Initial	4	4	16
				Major	Likely	
			Current	4	4	16
				Major	Unlikely	
			Target	4	2	8
Risk Appetite	Cautious					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Key objectives not met - Poor - patient experience - Reputational damage - Standards of care	1. Increase in reported deaths from 78 in 2018/19 to 92 in 2019/20. 2. An increase in the number of formal complaints received with 129 in 2019/20 compared to 95 in 2018/19 3. 1 Never Event – November 2019 4. 15 cases of E Coli against a threshold of 12 for 2019/20 5. Operation or procedure wrongly sited – December 2019 6. 2 Category 3 Pressure Ulcers – December 2019 / Feb 2020 7. Increase in Nosocomial Infections 8. **Covid-19 pandemic**

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 Strategy 2020 – 23 – approved Sept 2019 2. KPI's for Year 1 of the Quality Strategy March 2020 3. CARES Review Programme 2019-20 4. HCAI Reduction Plan 2019-20 5. FOCUS Programme 19-20 6. Theatre Utilisation Programme 7. Patient Family Centred Care Group 8. COVID-19 Recovery Plan – May 2020 9. Clinical Audit Plan – approved June 2020 10. IPC –strategic COVID 19 Plan January 2021 11. **Trust Recovery Roadmap**	1. Alignment of year 1 priorities across all strategies not tested 2. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 3. Lack of resource within IPC to support Covid-19 response 4. **Covid-19 pandemic – reduction in staffing**
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 Departmental Huddle Theatre User Group Divisional Governance Meetings – monthly Mortality Review Group – monthly Serious Incident Group - monthly Transformation Board Balance Score Cards – monthly **Operational Management Board - monthly** **Level 2** Quality Dashboard – Quality Committee – monthly Quarterly Governance Report IPC Annual Report – May 2020 Safeguarding Annual Report – May 2020 Annual Governance Report 2019/20 Medicines Management Annual Report – July 2020 Quality Strategy Progress Report – July 2020 COVID- Update to Trust Board – monthly **Level 3** CQC Inspection Report 2019 Weekly reporting to CQC Relationship Manager Review meeting with Commissioners – Quarterly National Inpatient Survey Results – September 2020 **CQC Mental Health Inspection – December 2020**	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Review of all Trust Strategies to ensure alignment of priorities in year 1/2	J Ross	~~April 2020~~ Aug 2020	Not started
2	Recruit to Tissue Viability Team or test alternative options to fulfill the role	L Vlasman	~~May 2020~~ Sept 2020	Completed
3	Transformation Board and reporting arrangements to be introduced	J Ross	~~February 2020~~ June 2020	Completed
4	On-going participation in discussions to ensure influence in future system wide plans	H Citrine	~~March 2020~~ March 2021	On track
5	Recruit to additional post within the IPC Team to lead on the response to Covid	L Vlasman	~~March 2021~~ **May 2021**	On track
6	**Address reduction in staffing due to Covid-19.**	**L Vlasman**	**June 2021**	**On track**

Risk ID: 005	Date risk identified April 2020	Date of last review:	March 2021
Risk Title: **If the Trust does not attract, retain and develop sufficient numbers of qualified staff, both medical and nursing, in shortage specialties, then it may be unable to maintain service standards leading to service disruption and increased costs**		**Date of next review:**	July 2021
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Workforce and Innovation

Linked operational risks		Consequence	Likelihood	Rating
None identified	Initial	Major 4	Likely 4	16
	Current	Major 4	Likely 4	16
Risk Appetite **Cautious**	Target	Major 4	Possible 3	12

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Reduced patient safety and poor patient experience • Business continuity • Reputational damage • Reduced staff morale • Sickness increases • Staff Turnover increases	Nursing Turnover Overarching Staff Turnover Sickness Absence Statutory and Mandatory Training

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. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning 2019 3. Five year education plan to ensure supply 2017 4. Quality Strategy Sept 2019 5. People Strategy revised in line with the national People Plan Sept 20 6. Staff Experience Action Plan Oct 20 7. Partnership working with universities to recruit newly qualified staff 8. Extension of apprentice roles July 2019 9. Involvement with Regional Talent Management Board 10. WCFT Health and Wellbeing Programme 11. NHSP Bank 12. Collaborative Bank within NWest 13. COVID-19 Recovery Plan 14. MoU across C&M in relation to staffing during COVID-19 15. National Nursing Bursary – 2020/21 16. Staff Survey regarding working during COVID-19 17. Agile Working Project 18. De-briefs following first wave of COVID 19. Mental Health First Aid Training 20. Collaborative International Recruitment 21. Virtual recruitment days for Qualified Nursing staff	1. Implications of Brexit i.e. Visas on recruitment not yet known 2. Changes to pension arrangements 2020/21 and implications for recruitment and retention still not understood 3. Traditional training no longer appropriate due to social distancing and therefore alternative delivery methods to be developed 4. Continued national shortage in supply of nursing staff 5. Lack of clarity regarding annual leave and TOIL nationally

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 Daily escalation undertaken and all outcomes are reported to Senior Nursing Team. Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events – quarterly **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC – Sept 2020 Communication and Engagement Strategy – Trust Board Sept 2020 **Level 3** Staff Survey March 2020 Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance Investors in People Accreditation 2020 – Gold Status	1. Outcome of Shiny Minds App to be evaluated 2. Delivery of National People Plan

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Outcome of Brexit and implications for recruitment and retention not fully understood. Ongoing involvement and discussion with NHS Employers, NW Staff Partnership Forums and Brexit Council for Liverpool.	DoW	Ongoing ~~Mar 2020~~ ~~Dec 2020~~	Complete
2	Outcome of national review of the 2015 NHS Pension Scheme and its implications awaited	DOW	~~Dec 2020~~ March 2021	On track
3	Alternative solutions for statutory and mandatory training in development whilst socially distanced training continues	DOW	March 2021	On track
4	Continued progress to develop a C&M Collaboration at Scale for Nursing Workforce and progress recommendations	DoW	End of March 2020	Delayed
5	Outcome of Shiny Minds app to be evaluated	DOW	~~End of March 2020~~ ~~September 2020~~ ~~Dec 2020~~	Complete
6	On-going participation in National/Regional Meetings to inform local policy and realign strategy where necessary	DOW	March 2021	On track
7	Await outcome of Investors in People Assessment process for 2020 not received	DOW	November	~~On track~~ **Complete**
8	Commit to international recruitment as part of a regional collaborative campaign	DoW & DoN	May 2021	On track

Risk ID: 006	Date risk identified April 2020	Date of last review:	March 2021
If the Trust does not deliver the priorities within the Estates Strategy then the existing estate may not meet the needs of patients or support operational performance leading to poor patient experience and reputational damage and a building/ estate not fit for purpose.		**Date of next review:**	July 2021
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Operations and Strategy

Linked Operational Risks				Consequence	Likelihood	Rating
305	Legionella positive samples found in water outlets in Walton Centre.	16	Initial	Major	Possible	
				4	3	12
301	Fire Safety Compliance	12	Current	Major	Possible	
				4	3	12
			Target	Major	Unlikely	
				4	2	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?*
- Unsafe environment for staff - Patient safety/ - Compromised quality of care" - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance	The Trust currently has a costed backlog maintenance schedule which is updated annually for the purpose of the ERIC return submission. This schedule highlights high, significant, medium and low level backlog maintenance requirements.

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. Estates Strategy – approved 2015 2. Operational Plan 2019-20 3. Revenue and Capital budgets - Ongoing 4. Backlog Maintenance Register June 2018 **5.** Maintenance Programme **6. Estates related policies** • Electrical Safety Policy - • Water Management Policy - 2014 • Control and management of Contractors 2018 • Fire Safety Policy - 2010 7. Specialist contracts - Ongoing 8. Site based partnership/SLA with Aintree Hospital - 2016 9. Contractual agreement with specialist contractors Ongoing 10. Recovery Plan following COVID-19 11. Water Management Action Plan including remaining Legionella actions	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post COVID-19 2. Under resourced Estates function 3. Limited access to certain areas prevents visual inspection 4. 20% reduction required for 2019-20 Capital Programme 5. Lack of a Sustainability Development Management Plan 6. Policies require review to ensure that they are reflective of current legislation 7. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 8. Capital programme now being managed at an STP level. 9. Programme for Pipework replacement incomplete 10. The national Premises Assurance Model (PAM) not yet in place

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 Safety Huddle Water Safety Group – reporting into IPC Committee Health & Safety Group Contract review meetings with AUH – monthly Heating and Pipework Project Board – monthly **Level 2** Capital Programme approved by Trust Board – March 2019 **Level 3** 6 Facet Survey – Jul 2019 CQC Inspection Report Aug 2019 NHS Digital acceptance of ERIC return 2018 Cladding Review – Sept 2016 Fire Brigade post-incident review of Fire Processes - 2019	1. Limited AUH planned maintenance/KPI reporting in place 2. Lack of reporting of sustainability data

Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**

1	Work with NW specialist trusts North West QIP for specialist trusts to consider wider solutions for hard and soft FM . .	J Ross	March 2020	Delayed
2	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of AUH via monthly meetings	J Ross	March 2020	Delayed
3	Develop a Sustainability Development Management Plan as part of Estates Strategy review and establish sustainability reporting to BPC	J Ross	~~Jan 2020~~ ~~September~~ March 2021	Delayed
4	Ongoing monitoring of Phase 3 Heating and Pipework Programme	J Ross	March 2021	Ongoing
5	Roll out of Premises Assurance Model and reporting	J Ross	March 2021	Not started

Risk ID: 007	Date risk identified April 2020	Date of last review:	March 2021
Risk Title: **If the Trust does not maintain and improve its digital systems through implementation of the Trust's Digital Strategy, it may fail to secure digital transformation leading to reputational damage or missed opportunity**		**Date of next review:**	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:5	Adapt advanced technology and treatments enabling our teams to deliver excellent patient and family centered care.
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Linked Operational Risks		
670	System failure of Electronic Referral Management System (ERMS)	12
Risk Appetite	**Moderate**	

	Consequence	Likelihood	Rating
Initial	**Major** 4	**Possible** 3	**12**
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?*
• Organisation misses opportunity to modernise systems and processes for delivery of effective patient care • Missed objective • Reputational damage • Poor patient experience	EPR Programme paused during initial phase of Covid-19 Trust has bid for Digital Aspirant funding from NHS Digital which has yet to be formally granted. This funding will help to deliver the EPR and wider Digital Strategy over the next two years.

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. Digital Strategy – approved January 2020 2. Outpatient Transformation Project 3. Inpatient Transformation Project 4. Theatres Project 5. Paper Light Project 6. EPR Milestone group with clinical representation 7. IT Technical Programme of work 8. Cyber Security Programme 9. PMO Function underpinning the Digital Strategy 10. Member of North Mersey / C&M H&C Partnership – aligning strategies 11. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 12. Post covid EPR rollout plan for 20/21 13. Digital Transformation Programme 2021-23 to be completed Q1 2021/22 to lay out competition of digital roadmap for the organization 14. Digital Aspirant status to allow Digital Transformation to achieve HIMSS Level 5/6	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy post COVID-19 across Hospital Cell may be different to Trust's internal digital strategy 3. Additional investment required for remote working due to Covid-19 Given the pressures on the capital programme, EPR may need to be re-phased to enable this investment. 4. Change in national priorities around Digital post Covid response may not be aligned to Trust digital priorities

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 IGSF –monthly Digital Prioritisation Group - quarterly Clinical Risk Group Executive Team review of C&M Hospital Cell Digital Objectives ISMS Certification IS27001 accreditation September 2020 **Level 2** Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group C&M CIO Digital Collaboration Group **Level 3** Critical Applications Audit – Jan 2020 ePatient Neurophysiology system – Limited Assurance Jan 2020 Digital Matrix Index score 2018 ISMS Certification IS27001 accreditation Aug 2019	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives (to be completed and agreed Q1 2021/22). ~~Awaiting final MoU from NHS Digital to approve access to the Digital Aspirant Programme along with associated funding.~~

Cyber security CertCare progress monitored by NHS digital Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to STP by C&M Digit@LL	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Approval of the milestone plan by Digital Programme Board	AN	~~April 20~~	Complete
2	Regular updates regarding the Trust's Digital objectives and alignment to the C&M Hospital Cell objectives around digital to Exec Team **Update 1 Apr 21 – Slide deck containing HCP project dependencies and full Digital projects is shown at Operational Management Board and Digital Programme Board along with HCP updates**	MB	March 2021	~~On track~~ **Complete**
3	New Digital Strategy	MB	May 2021	Commenced
4	Digital Aspirant MoU signed by all parties	MB	March 2021	~~On track~~ **Complete**

Risk ID: 008	Date risk identified: April 2020	Date of last review:	March 2021
Risk Title: If methods of Cyber Crime continue to evolve then the Trust may receive a cyber-attack leading to service disruption, loss of data and financial penalties.		Date of next review:	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Linked operational Risks	Consequence	Likelihood	Rating
A cyber security attack could impact on a wide range of Trust operations / systems / processes depending on the area targeted.			
	Major	Likely	
Initial	4	4	16
	Major	Likely	
Current	4	4	16
	Moderate	Possible	
Target	3	3	9
Risk Appetite: Cautious			

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/NIS Directive - Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.	Q1 72 Carecerts (3 High, 3 Medium,66 Low Level) Q2 67 Carecerts (6 High Level, 61 Low Level) Q3 66 Carecerts (2 High Level, 64 Low Level)

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 Ongoing 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 11. ISO27001 Accreditation process Annual 12. Member of the Cheshire and Mersey Cyber Security Group Ongoing 13. Pilot for NHS Digital Programmes relating to Cyber security Ongoing 14. CareCERT Processing on a regular basis Ad Hoc 15. Cyber Security Dashboard Jul 2019 16. Network groups - IG - Radiology etc Ongoing 17. Proactive monitoring of national cyber alert status	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.

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 TIAG review of CareCERTs - Weekly Cyber Security Awareness Presentation to Executive Board - July 19 **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board July 2020 **Level 3** ISO27001 – accreditation August 2019 for 3 years MIAA audits of Data Security and Protection Toolkit –Jan 2020 - Substantial Assurance (draft outcome Jan 2021 – Substantial Assurance)	1. Cheshire & Merseyside system wide recovery response not tested 2. Third party assurances required regarding satellite sites 3. Ongoing work with NHS Digital to inform funding requirements

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Close working with MIAA to inform C&M system wide disaster recovery exercise **Update 1 Apr 21 – First HCP Cyber Incident Management exercise scheduled for 30 Mar 21**	MB	~~Aug 2020~~ March 2021	On track

2	Cheshire & Merseyside Digital Cyber Group supporting work to establish 3rd party assurances of satellite sites. assurances of cyber security. Delayed due to change of working practice post Covid **Update 1 Apr 21 – Delayed. Desktop Exercise outputs will help assurances. C&M working close as partnership with organisations including the Walton Centre.**	MB	~~Aug 2020~~ ~~March 2021~~ **May 2021**	~~On track~~ **Delayed**
3	On-going work with NHS Digital to inform funding requirements for Cyber Security post Covid **Update 1 Apr 21 – Work will continue on funding requirements in 2021/22.**	MB	~~Aug 2020~~ March 2021	~~On track~~ **Complete for 20/21**
4	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid **Update 1 Apr 21 – Workshops with Specialist Trusts held Feb/Mar 21 to agree way forward. MIAA to run Cyber tools training in Q1 2021/22 under Digital Aspirant funding to ensure compliance.**	MB	~~Aug 2020~~ ~~March 2021~~ **May 2021**	~~On track~~ **Delayed**

Risk ID: 009	Date risk identified: April 2020	Date of last review:	March 2021
Risk Title:		Date of next review:	July 2021
If the Trust does not identify innovative methods of delivery then it will not maintain its centre of excellence status leading to unwarranted variation, increased costs and an inability to meet the future needs of patients.		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
• Inability to retain clinical staff if unable to fulfil their innovation/research ambitions • Ensuring sufficient workplace capacity to maintain innovative practices, treatments and boundary scanning • Ensuring that the inevitable financial and Covid-19 pressures do not distract from the Trust's commitment to innovation • Challenging risk aversion, complacency and the status quo where employees become demotivated • Too many innovations that are not fully implemented, acknowledged and celebrated • The Trust's innovation agenda becoming weakened in an environment of meeting/emerging system change • Local and national political developments	Initial	Major 4	Possible 3	12
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Trust reputational impact at a time of system change and Covid-19 impacts 2. Inability to improve patient care and deliver efficiencies 3. External scrutiny e.g. CQC well-led	Achievement of Innovation Strategy Objectives: • Short term (2019/20) – Largely completed (some Covid-19 delays) • Medium term (2020/22) – Largely completed (some Covid-19 delays) • Long term (2022/24) – To be progressed

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 Strategy 2019/24 2. Innovation Pipeline 3. Stakeholder Analysis 4. Innovation Strategy Communication Plan 5. Development of internal processes / information resources to support innovation 6. Developing additional funding streams 7. Investors in People accreditation (2020)	1. Competitor Analysis to be completed (to be finalized when Communications & Marketing Manager starts in March 2021) 2. Wider consultation with Trust stakeholders still emerging and managed through the communications plan (some Covid-19 delays. Consideration required on how best to involve patients in innovation decision making) 3. Complex alignment between Innovation and other teams has progressed significantly but more work is needed 4. Multi-team working to improve consideration of innovations developed outside the Trust and address risk aversion 5. Innovation processes. guidance and methodology not yet fully developed 6. Income generation model (for the Spinal Improvement Partnership) approved but contracts still being negotiated

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 • Innovation Team Meeting – monthly • Medical Innovation Group – bi-monthly • Regular innovation meetings with procurement, IT, IG, service improvement, clinical and other teams • Executive Team approval of innovation business cases and initiatives **Level 2** • Innovation bi-monthly update to RIME Committee • RIME Committee Chairs Report to Trust Board • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • CQC Inspection report 2019 • CQC well-led criteria now includes innovation	1. Benefit realization for innovative business cases not yet feasible due to limited time that Trust has had Innovation posts in place 2. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency and potentially commercial innovators to identify appropriate process

	Corrective Actions: To address gaps in control and gaps in assurance	Action Owner	Forecast Completion Date	Action Status
1	Competitor analysis to be 1inalized and presented to Trust Board	DW&I/HCE&M	TBC (due to COVID-19)	On hold
2	Further engagement of stakeholders through communication and engagement (including patient involvement)	DW&I/HCE&M	Review progress Q3 2021/22	On track
3	Benefits realization of Multitom Rax Business Case to be presented to Executive Team and Trust Board	DW&I	April 2021	On track
4	Further development of innovation processes and guidance	DW&I/HCE&M	Q3 2021/22	On track
5	Peer Review/review process	DW&I/HCE&M	Q3 2021/22	On track
6	Income generation initiative (Spinal Improvement Partnership) being prioritised	DW&I/HCE&M	~~October 2020~~ March 2021	On track
7	Investors in People Assessment	DW&I	October 2020	Completed

Risk ID: 010	Date risk identified: April 2020	Date of last review:	March 2021
Risk Title: **Establishment of a Cheshire & Mersey ICS will change the external landscape and how the Trust operates and influences within Cheshire and Merseyside with a potential risk that this could have a negative effect on the Trust.**		**Date of next review:**	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Strategic Priority:	All Strategic Priorities
		Assurance Committee:	Trust Board
		Lead Executive:	Chief Executive

Linked Operational Risks		**Consequence**	**Likelihood**	**Rating**
Potential link to all high level operational delivery risks	**Initial**	**Major** 4	**Possible** 3	**12**
	Current	**Major** 4	**Possible** 3	**12**
	Target	**Major** 4	**Unlikely** 2	**8**
Risk Appetite	**Cautious**			

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
Potential reduction of Trust autonomy with a consequent impact on delivery of objectives.	• Hospital Cell and Governance arrangements determined at regional level without consultation • Changes in national policy due to COVID-19 • **White Paper indicates decreased autonomy for individual Trusts with increased control by ICS / central Government**

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. Trust Strategy 2019-2023 2. Communication and Engagement Strategy 2020 3. Active membership of Cheshire and Merseyside Health Partnership (C&MHCP) and Collaboration at Scale Programme 4. Member of Liverpool Health Partnership 5. Member of Liverpool PLACE 6. Member of Trauma Partnership ~~7. CEO one of 4 CEOs leading In Hospital Cell~~ 8. Membership of Specialist Trust Alliance 9. Medical Directors Group STP level 10. Chief Operating Officer Group STP level 11. Membership of DOFs Group STP level 12. Management Side Chair of NW Staff Partnership Forum 13. Membership of Director of Nursing Group STP level 14. Membership of Director of Workforce Group STP level 15. Neuroscience Programme Board – Quarterly 16. Revised MoU provides for Specialist Trusts to have 1 x Chair and 1 x CEO representative on the HCP Board which will aid influence	1. Hospital Cell and Governance arrangements potentially result in greater influence for larger providers 2. Financial arrangements now determined across STP level 3. Clarity on the ability of Provider trusts to influence future ICS arrangements 4. Completion of review of Stakeholder Analysis 5. Lack of clarity on planned legal challenges and full details of White Paper **6. Lack of certainty on future ICS financial arrangements – clarification anticipated Q1 2021/22**

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 Executive Team meetings – weekly **Level 2** Chair and Chief Executive Reports - Trust Board **Level 3** Board to Board meeting of Specialist Trusts - February 2020 Updates from HCP on progress and plans with opportunity to comment on drafts to influence direction of travel e.g. HCP MoU One to One meeting between CEO of HCP and CEO of Walton Centre	• Long term role and purpose of in hospital cell not determined • Outcomes of NHS England 'Changing Landscapes' • Lack of clarity on future od specialist commissioning • Potential impact on services outside future ICS arrangements

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Ongoing engagement with regional partners	CEO	March 2021	Ongoing
2	Meeting with Mrs J Bene (CMHCP)	CEO	January 2021	On Track

Risk ID: 011	Date risk identified: April 2020	Date of last review:	March 2021
Risk Title: If the Trust does not maintain and grow the Trust's research and development agenda it may negatively impact upon its centre of excellence status leading to loss of income, reduced profile and inability to recruit/retain the most ambitious clinical staff.		Date of next review:	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research, Innovation & Medical Education (RIME) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
• Ensuring sufficient workplace capacity and capability to maintain, grow and develop the research function • Establishing a sustainable financial model that balances income streams, notably commercial income • Inability to secure sufficient grant based funding • The Walton Centre brand not aligned to research ambitions and/or not strong enough to attract commercial sponsors • Portfolio of research not aligned to key strategic priorities for the Trust (e.g. spinal centre of excellence developments) or for the region given key needs in neuroscience related ill health (e.g. neurological disability in early life, chronic pain, neurodegeration) • Competing and emerging system change • Local and national political drivers e.g. COVID-19 and in the short term, the implications of Brexit negotiations on promoting/ attracting research	Initial	Major 4	Possible 3	12
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Trust reputational impact at a time of system change 2. Inability to recruit and retain the most ambitious clinical staff 3. External scrutiny e.g. CQC well-led 4. Damage to key strategic partnership (e.g. LHP)	• Achievement of Research and Development Strategy Objectives 2019/24 • Clinical trails patient recruitment targets • Income targets – overall and commercial • Internal feedback processes

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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 5. Promotion of research agenda with patients, carers and staff 6. Undertaking external/independent review of the performance of the NRC	1. Work ongoing in redesign of NRC with resource implications 2. Completion of audit action plans 3. Clarity of purpose and roles in the emerging system infrastructure 4. Income generation model approved but contracts to be negotiated 5. Review/development of principles for time dedicated to research 6. External review by an expert to ensure quality assurance

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 • Senior Neuroscience Research Group chaired by the Chief Executive • Sponsorship Oversight Group • Research Capability Funding Sub-committee • Roy Ferguson Compassionate Care Award Group **Level 2** • Research update to RD&I Committee • RD&I Committee Chairs Report to Trust Board **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019	1. Ongoing service redesign incomplete (review pending) 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	Organisational change process supported by Human Resources	DW&I &CDRD	TBC (due to COVID 19)	On hold
2	Senior Neuroscience Research Group with agreed action	DW&I & CDRD	September 2020	On track
3	Internal NRC redesign work	Internal R&D Team	Ongoing	On track
4	Investors in People Assessment	DW&I	October 2020	On track
5	External review undertaken by Caroline Murphy, Kings College London	DW&I	November 2020	On track

Risk ID: 012	Date risk identified October 2020	Date of last review: March 2021
Risk Title: There is a risk that the allocation of capital set by the STP to the Trust will not support the full capital plan for 2020-21 **There is therefore a risk that the Trust will overspend the capital allocation or defer schemes which may result in maintenance and revenue costs or deterioration of the Estate.**		**Date of next review:** July 2021
		CQC Regulation: 17 Good Governance
		Ambition: Be financially strong and invest in services
		Assurance Committee: Business Performance Committee
		Lead Executive: Director of Operations and Strategy

Linked Operational Risks		Consequence	Likelihood	Rating
None Identified				
		Moderate	**Possible**	
	Initial	**3**	**3**	**9**
		Moderate	**Possible**	
	Current	**~~4~~ 3**	**~~4~~ 3**	**~~16~~ 9**
		Moderate	**Possible**	
Risk Appetite	**Target**	**3**	**3**	**9**

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on STP footprints and based on the Trust's initial capital plan (not final). The plans were oversubscribed and therefore there was no opportunity for the trust to submit a higher final plan (given the planning round was suspended due to Covid-19). - On-going replacement equipment will not be able to be paid through capital given the Trust's Capital Resource Limit (CRL) has been set at £4.0m; - Any overspend on capital against out CRL will need to be covered by the other Trusts in the STP (reducing their ability to spend capital); - Impact on revenue budgets should there be a risk to patient safety;	Between the draft plan and the intended final plan submission, some additional material capital requests have been raised. The Trust was provided with additional CRL in 2019/20 and spent in line with this; however it will not have the flexibility to do this in year and has competing requirements as well as committed schemes totaling c£3.8m which gives it minimal flexibility at all in the management of the programme.

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 Group reviews all capital business cases and sanctions expenditure based on budget allocations – Chaired by DO&S; 2. SFI's/SORD have appropriate approval levels for capital expenditure so DoF&IT / DO&S are sighted on expenditure; 3. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc.; 4. Monthly reporting of capital expenditure in board report so cumulative spend is transparent to senior management and board members. 5. **Regional underspend forecast in December 2020 providing additional flexibility in-year.**	1. Unplanned replacement of equipment that fails will lead to additional spend against plan; 2. Some items are not specified in detail and therefore there is an ability to substitute items in year which means capital slippage is difficult to manage. 3. **Limitations of regional approach to capital allocations** 4. **Any utilisation of regional underspend in 2020/21 may result in a corresponding reduction in the Trust's capital allocation for 2021/22.**

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 forecasting of the capital position between Finance and the key stakeholders to understand the latest projected year end spend. Capital Management Group – discusses any capital expenditure up to £50k and includes work around prioritizing schemes when there are pressures on the budget /forecast. Business case and approval process at this forum to manage value for money. **Level 2** Executive Team - Expenditure up to £100k is approved through this group with regular updates on the capital programme presented. Business case and approval process at this forum to manage value for money. **Level 3** Business Performance Committee / Board – capital plan approved and all cases >£100k ~~<£250k~~ **£500k** are approved by BPC and above ~~£250k~~ **£500k** are approved by Board. **Participation in the regional Directors of Finance meeting.**	1. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend. 2. Priorities may change in year which may lead to pressures against the plan. 3. Market prices may differ from estimates once equipment is purchased. 4. 2020/21 planning process suspended so unable to submit a final capital plan. Process managed through STP. 5. **Assurance on ability to spend balance of allocation during Q4 2020/21**

Corrective Actions:	**Action**	**Forecast**	**Action**

To address gaps in control and gaps in assurance		Owner	Completion Date	Status
1	Long term capital plan to be completed to ensure all requirements and replacements known	DoF/DoSO	31 Mar 21	On track – continuous review
2	Operational Management Board to help manage priorities and help to manage demand	DoS		Completed
3	Ensure that maintenance contracts are all up to date so equipment covered	DoF/SoSO	Ongoing	On track
4	Regular capital forecasts to provide up to date position on the year end projections	DoF	Ongoing	On track
5	Continued discussions with STP DoF to ensure aware of capital pressures and so allocations forthcoming as required from other provider underspends.	DOF	Ongoing	On track

Risk ID: 013	Date risk identified October 2020	Date of last review:	March 2021
Risk Title: If the Trust does not deliver the financial plan for ~~2020~~ ~~21~~ **2021/22 due** to the changes in the financial framework and the impact of Covid-19 then it will fail to meet its financial duties and may be unable to deliver its strategic objectives leading to regulatory scrutiny		**Date of next review:**	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Underlying Operational Risks		Consequence	Likelihood	Rating
None Identified	Initial	Major 4	Likely 4	16
	Current	Major 4	Unlikely 2	8
Risk Appetite **Cautious**	Target	Major 4	Unlikely 2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Financial risk rating may decline and lead to increased regulatory scrutiny • Potential breach of statutory duties • Inability to deliver strategic objectives • Loss of decision making responsibilities	Original plan submission of £1.5m deficit. Given overall C&M position, HCP were requested to improve the position. Currently (M10) forecasting a year end surplus of £0.5m for HCP submission. This position could change depending on performance in M11-12 (including uptake of further activity.

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. Financial plan submitted for 2nd half of year 2020-21 - October 20 2. Capital Programme – approved by HCP August 20 and regularly monitored by Capital Management Group 3. Finance and Procurement Strategy – approved July 2019 4. Budgetary Control Process including run rate information - monthly 5. Standing Financial Instructions (SFI's) & Scheme of Reservation and Delegation – approved November 2020 6. Divisional Finance meetings to highlight on-going financial issues - monthly 7. Block Contract in place due to COVID-19 (to remain in place for Q1 2021/22 and may be extended to Q2) 8. Current allocations in second half of year are improving the Trust's position against plan/forecast.	1. Financial plan not approved – overall balance at HCP level so further submissions likely to be required; Overall HCP financial plan not approved. Ongoing forecast submissions have been required on a regular basis to assess closure of the financial gap. 2. Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21 – run rates only a guide rather than a control; 3. Block contract based on 19/20 values and not fully representative of 20/21; **Given that the block contract will remain in place for Q1 2021/22 it is currently not clear whether the block contract values will be amended and whether they will be representative of 2021/22 given the intermittent stop/start of elective activity and potential ongoing Covid requirements** 4. **Formal p**lanning approval governance processes not in place due to rapid turnaround of submissions; ~~5. Elective incentive scheme may result in loss of income to the Trust which is not factored into the current deficit position;~~ 6. QIP plan ~~may still~~ **will** be required **in 202/22** to close the gap to individual plans **(although value not yet clear)**. Planning delayed due to pandemic response **(until at least Q2 2021/22)**; 7. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance 8. **NHSE/I negotiated a reducing contract value with Wales as activity reduces in tranches of 25%. This could reduce payments should lockdown mean that activity is cancelled.**

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 Monitoring expenditure and income against budgets via Finance Covid allocation to recover directly related costs Bed Management Meetings – daily Performance Management Review meetings – monthly Executive review of financial position ~~and recovery plans~~ – ~~weekly~~ **monthly** NHSI/E review of financial position ~~and recovery plans – weekly~~ **on a regular basis** **HCP review of system-wide financial position – monthly** **Level 2** Integrated Performance Report – monthly review by Business Performance Committee Integrated Performance Report – review by Trust Board each meeting	1. Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21; 2. Financial Framework suspension means Trust not being managed via regulator directly but through system / regional approach which is reviewing overall balance; 3. Covid expenditure audit by external party yet to be carried out so unsure if any expenditure will need to be repaid; 4. **Covid cost allocation insufficient to cover actual costs incurred.**

Financial Plan **2021/22 internal business planning being undertaken despite national delay in business planning** ~~Update on Recovery Plan reviewed by BPC Jan 2020~~ ~~Weekly review of Recovery Plan by Execs~~ **Level 3** Internal Audit review of Accounts Payable – ~~High Assurance – Apr 20~~ **Substantial Assurance Jan 2021** Internal Audit review of Accounts Receivable – High Assurance – ~~April 20~~ **Jan 2021** Treasury Management Review – High Assurance – ~~April 2020~~ **Jan 2021** Internal Audit review of General Ledger – High Assurance ~~April 2020~~ **Jan 2021** Internal Audit review of Budgetary control (including CIP) – high assurance - ~~April 2020~~ **Jan 2021** Internal Audit review of financial reporting – High Assurance – April 2020 ESR Payroll – Substantial Assurance – April 2019 GIRFT Review – Spinal Contract Review Meetings with Commissioners – bi-monthly Internal Audit review of coding systems – Substantial assurance – Dec 19	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	~~Weekly~~ **Bi-monthly** update to Finance NED to ensure NEDs are kept up to date with latest finance requirements	DoF	March 2021	On track
2	DoF on HCP planning group weekly calls	DoF	March 2021	On track
3	Raising issues with non-English commissioners to NHSI/E	DoF	March 2021	On track

Risk ID: 014	Date risk identified: December 2020	Date of last review:	March 2021
Risk Title:		Date of next review:	July 2021
Ensuring the ongoing quality, capacity and capability of Medical Education for the Trust that is sustainable over the longer term.		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
		Catastrophic	Possible	
	Initial	5	3	15
		Catastrophic	Possible	
	Current	5	3	15
		Catastrophic	Unlikely	
Risk Appetite	Target	5	2	10
	Cautious			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Compliance with education contract and operational delivery of undergraduate and postgraduate clinical placement outcomes: • Supervision • Teaching • Site infrastructure Internal educational governance, succession planning and support for educators and learners	• Difficulties experienced recruiting to undergraduate supervisor roles. Approx 24 consultants signed up as supervisors for 4th year programme but just 10 have committed thus far. Reasons for withdrawing include not having activity within current job plan as well as post-covid service pressures • Postgrad supervisors also drawn from same supervisor 'pool', exacerbating demand on a limited consultant resource • Challenges responding to rapid changes in teaching delivery / accessing external platforms and databases e.g. university Zoom teaching. Facilitating student access to clinical activity remotely. WiFi strength • Perception can be education is an addition rather than integral, can make educator roles less attractive and is a lost opportunity to develop potential education leaders.

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 2. Lead educator roles established with DME engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and 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. SOPs have been created to standardize and assure processes.	1. Ensuring educator roles are fully understood along with commitment required, activity has transformed over past 5 years, SOP / definition of role expectations to provide transparency for trust and individual 2. Silo working - communication between postgrad and undergrad in regard to available resource, are expectations to be a joint supervisor realistic? 3. Will a template of an optimal week be adequate to help inform / support supervisors during job planning process or is more robust 'intervention' needed? No routine auditing cycle of SOPs.

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 Neurology registrar engagement in undergraduate education is encouraged and facilitated. They attend the UG operational working group and support the undergrad programme facilitating and developing aspects of the timetable. These measures engage junior doctors and ensure they are developing an appreciation for education delivery. They are encouraged to develop as educationalists by senior colleagues and for those that remain at the trust will be supported by CSD to hone experience as they progress. We have evidence this approach is successful by the appointment of a former trainee to the role of deputy CSD, other registrars due to be appointed who demonstrate interest in contributing to education which will be supported by the ed team Students and doctors in training have been able to remotely join teaching via MS teams and Zoom. Feedback has been good suggesting delivery has been successful. **Level 2** **Level 3**	1. Medical Education Committee now reports to RIME and will provide quarterly performance updates as well as an annual report of activity as a means to assure the Board of activity and performance against the HEE Quality Framework. This is a new relationship and the effectiveness will be evaluated over the next year.

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1				

Risk ID: X2	Date risk identified December 2020	Date of last review:	March 2021
Risk Title: The move to an Integrated Health Care Partnership financial system along with changes to tariffs and population based specialised commissioning could destabilise the Trust's income base.		Date of next review:	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance

Underlying Operational Risks		Consequence	Likelihood	Rating
Understanding of impact on capacity / staffing of any changes in flows etc.	Initial	Major 4	Likely 4	16
	Current	Major 4	Likely 4	16
	Target	Major 4	Possible 3	12
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Potential deterioration of the Trust's financial position through commissioning / tariff changes; - Loss of decision making responsibilities as move to system based financial targets; - Working with 2 different tariff systems (Wales); - Loss of key relationships in commissioning to Trust.	Recent NHSI/E consultation shows that there will be a move to system working Tariff consultation also requested feedback on changes to both tariff and the move to population based funding.

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. Trust engagement on C&M HCP meetings. 2. Existing relationships with Specialised Commissioning through the transitional period. 3. Trust has fed back on consultation to changes on tariffs / population based commissioning. 4. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) on this agenda. 5. DoF currently a member of the weekly HCP finance planning group so able to raise issues and get an understanding of direction of travel in relation to HCP position. 6. CEO is part of in hospital cell which is likely to be influential in the Provider Alliance which constitutes part of the HCP structure.	1. Move to system allocations via HCP puts trust at risk as no longer dealing with commissioners who have detailed knowledge of trust services. 2. Larger acute trusts with underlying structural deficits may have a bigger influence with HCP in terms of funding allocations. 3. Some of Walton Centre patient population lies outside C&M HCP and therefore does not align with population basis for commissioning / funding allocations. 4. Trust basis for funding based on historical local tariffs recognising disproportional costs of delivery may not be taken into account for services leaving trust with financial gap. 5. Affordability given the C&M system already has a large deficit historically with the Trust may having to take a proportion of this deficit. 6. Governance around the provider model and how this fits in with the wider HCP financial system delivery

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 review of risks at Board level and on-going review of mitigations. **Level 2** Risk being reviewed across several organisations and also by FoSH so potential to influence the agenda. Transitional period in 2021/22 will ensure that financials will be broadly in line with current regime for a year until full implementation of population based commissioning. c75% of current referrals within the current HCP boundary with 12% outside so not as fragmented population base for referrals given the size of C&M HCP (the rest are Wales / IOM) which limits though does not eliminate financial risk. **Level 3**	1. Move from existing regulatory relationship with NHSI/E and commissioning relationships with NHSE, Specialised Commissioning to single relationship with HCP and how this will work. 2. Post transitional period finances i.e. population based commissioning will still leave a potential c12%+ income at risk if they no longer are commissioned from Trust. 3. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR.

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with HCP on system development. Previously responded on consultation, fed back on Memorandum of Understanding. Separately also fed back to NHSI/E on tariff consultation.	ALL	Ongoing	On track

2	Meeting planned with HCP DoF and Specialist Trust DoFs to show how specialist trusts can support the system in terms of finance and activity restoration etc.	DoF	Feb 21	On track
3	Review of out of HCP referrals / activity to understand the largest CCG's and formulate what can be done to continue activity into 2022/23 with the Trust.	DoF	Mar 21	On track
4	Continue to work with FoSH around a national response on how specialised trusts will benefit the new way of system working.	CEO/DoF	On-going	On track
5	Continue to provide mutual aid during the pandemic response to enhance reputation as a system player.	DOO/CEO/MD	On-going	On track

Covid 19 Risk Register
Date Report produced: 24/03/2021

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
806	01/10/2020	Business Continuity	**If school children are sent home due to displaying Covid 19 symptoms, parents will need to self-isolate for 14 days and children will need to be swabbed then there is a risk of reduced staffing in all areas of the trust during this period of time.**	Moderate	Almost Certain	High 15	1.Systems in place for the swabbing of children including a SOP 2. No children under the age of 2 to be swabbed at the trust 119 to be used for this group of children. 3. Support provided to the management of swabbing arrangements and outpatients department 4. Daily staffing and bed meetings to manage safe staffing. 5. Daily safety huddle and daily command and control. 6. Daily communications 7. Close working with NHSP 8. Close working with the bed management team to ensure we are using bed capacity appropriately 9. Redeploying staff across all areas.	1. Reliance on bank and agency and redeployment of staff. 2. Dependant on LUHFT for swab results. 3. Shifts not covered low fill rates.	1. Team in place for managing and arranging the swabs and the governance around this 2. SOP in place. 3.Daily safety huddle / command and control.	1. Being able to manage the amount of children sent home from school and the reduction in staffing. 2. Reduced capacity in the lab to process the swabs and delays in results and further delays in getting staff back to work.	1. Continue with daily safety huddle, command and control and bed meetings 2. Working closely with NHSP to see if all staff can be registered on NHSP 3. Ensure SOP is used and staff are compliant 4. Work closely with LUHFT to ensure that the text messaging service is in place	01/05/2021	Deputy Director of Nursing & Governance
793	07/07/2020	Business Continuity	**If increased cancellations, capacity/demand and limitations on the number of patient visitors continue, due to Covid-19, then there is a risk of poor patient experience and outcomes.**	Moderate	Almost Certain	High 15	1. Divisions working towards getting back to normal activity - via telephone/video consultations in order of patient need. 2. New telephone line in PACs recording calls. 3. Any identified themes and trends are escalated to Deputy Director of Nursing and Governance and Director of Nursing and Governance. 4. Patients receive regular updates and communication from the division. 5. Visiting continues to be restricted due to the increased levels of Covid 19 across Cheshire and Merseyside	1. As this is a new risks there are currently no identified gaps. Will continue to monitor.	1. Patient Experience Team escalating all new concerns/complaints on a weekly basis in a weekly meeting with both Divisions. 2.Regular communication with patients and families from the Division. 3. Calls to loved ones campaign initiated by the Divisional Nurse Directors using Ipads, mobile phones and social media.	1.Will continue to monitor for gaps in assurance, currently none.	1. None currently identified.	31/03/2021	Deputy Director of Nursing & Governance

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
807	01/10/2020	Business Continuity	**If compliance with the 2 metre social distancing rule is not adhered too, then there is a risk of staff contracting Covid 19.**	Major	Likely	High 16	1. All staff are provided with appropriate PPE. 2. Social distancing is enhanced in all staff rooms. 3. Posters and floor markings are in place. 4. Patient day rooms are now in use for staff to be able to manage breaks across 2 areas to support with social distancing. 5. Staggered break time. 6. Additional staff areas i.e. marque sort to support social distancing during staff break time.	1. Non-compliance with IPC control measures	1. Continuous promotion of IPC guideline's 2. Managers working with the areas to ensure social distancing is maintained 3. Daily safety huddle 4. Daily walkabout to monitor the use of PPE 5. Observational audits by the IPC team.	1. Non-compliance with IPC guideline and social distancing	1. Continue with promotion via daily safety huddle 2. Regular communications reminding staff of PPE guidance 3. Managers to review all of their break areas to ensure they are compliant with social distancing 4. Additional areas that can be used for breaks to be implemented into break areas.	27/04/2021	Deputy Director of Nursing & Governance
796	13/07/2020	Business Continuity	**If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19.**	Major	Likely	High 16	1.Implementation of national guidance to reduce nosocomial infections 2. COVID-19 screening regime 3. Infection Prevention Policies and SOPs. 4. Daily updates via safety huddle and communication bulletin 5. Compliance with Operating framework for urgent and planned services within hospitals 6. Chavasse is designated RED ward 7. SBARs and action plan 8. Observations of PPE	1. Potential for asymptomatic Covid-19 positive patients to be admitted to trust 2. Non compliance with IPC control measures. 3. Communication process between transferring organisations	4. Covid-19 BAF 5. Covid-19 dashboard 1. SITREP to NHSE/I 2. Surveillance outcomes 3. Screening programme	1.Non compliance with IPC interventions as per guidance 2.potential of importing COVID-19 cases from the community 3. Delay in transferring symptomatic patients to Chavasse	1.Outbreak meeting held daily as required. 2.Rescreening of patients then repeat screening in 5 days then at 14 days to enhance detectability. 3.Enhanced staff and patient screening 4.Admitted patients must be symptomatic or positive to move onto Chavasse ward (reinstate Chavasse as the red status ward). Symptomatic patients to remain in amber bay 5. Staff breaks reviewed to enable social distancing 6.Ensure enhance cleaning is completed (2 stage process) 7.Daily meeting to be held in the boardroom 9am (1/2 hour) – bed managers to maintain ward patient status on the wall. 8. Continue to liaise with PHE 9. Ensure 2 metre guidance is adhered to.	29/04/2021	Lead Nurse Infection Prevention & Control/Tissue Viability

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
797	13/07/2020	Risk Assessment	**If controls are not put into place to prevent surgical face masks being used for self-harm attempts of suicide, there is a risk to patient safety.**	Catastrophic	Unlikely	Mod 10	1. Patients monitored and observed closely. 2. Any concerns escalated appropriately. 3. Neuropsychiatry and Neuropsychology input when required 4. Masks only used within clinical areas.	1. No gaps in controls, storage space to be provided for surgical masks to ensure they are placed in a safe storage area.	1. No incidents to date August 2020. 2. Neuropsychiatry service monitored and manages any risk identified.	1. Patients may not express suicidal tendencies.	1. None currently identified.	25/05/2021	Advanced Neuropsychiatry Nurse Practitioner
827	13/01/2021	Business Continuity	**If the level of activity associated with Welsh specialist activity fall below 25% of prior year levels there is a financial risk to the Trust due to the national agreements put in place (where a percentage of block income will be withheld dependant on the reduction in activity levels). It is more likely that activity will fall below the agreed levels as a result of the 3rd wave of COVID-19 as elective activity is likely to be cancelled to help the region wide response to the pandemic). There is also a financial risk to the Trust if IOM related activity reduces materially (as the IOM administration is paying for activity undertaken).**	Moderate	Likely	Mod 12	1.NHSE/I have agreed a payment mechanism with Wales for months 7-12 which means that block income will be received but with income being withheld if activity falls below agreed percentages compared to last financial year. 2.Close monitoring of activity levels compared to last financial year. 3.On-going dialogue with NHSE/I around the national agreement (and amounts of income withheld if activity falls below certain levels) given the 3rd wave of COVID currently being experienced (and requirement to cancel elective activity to support the region). 4.The Trust has implemented a number of new ways of working to meet COVID guidance including Telehealth.	1.IOM & Welsh affordability likely to be more of a problem going forward and strength of relationship cannot mitigate this. 2.Requirement to cancel elective activity to support region wide response to 3rd wave of COVID-19. 3.Patients unwilling to attend appointments due to fear of COVID-19. 4.Patients access to digital technology. 5.Reduced capacity due to social distancing/ IPC requirements.	1.Regular review of risks at Board level and on-going review of mitigations 2.Monthly report to BoD and BPC regarding income position and any issues with commissioners 3.Regular updates to BPC 4.On-going dialogue with NHSE/I 5.On-going communication with commissioners.	1.Uncertainty whether financial framework will be amended as a result of wave 3 covid. 2.Uncertainty of financial framework post March 2021. 3.We have no control over the NHSE/I decisions around the financial framework going forward. 4.Previously agreed contracts unlikely to be honoured. 5.IOM have stated that they will only pay on a PBR basis.	1.Risk will continue to be monitored by Board of Directors and through Business Performance Committee. 2.Continue to discuss risk around Wales financial agreement with NHSE/I. 3.Financial modelling of finances to be carried out once new financial framework is published. 4.Year end financial forecasts regularly undertaken to understand potential financial risks.	30/04/2021	Deputy Director of Finance
810	09/09/2020	Adverse Event /Incident	**If a neurosurgical registrar were to test positive for COVID then there is a risk that the on call system could collapse. This is due to the office space being too small to accommodate social distancing.'**	Major	Possible	Mod 12	1. Registrars to wear masks 2. Meetings via MS Teams to minimise face to face attendance 3. Shared desks in secretariat	1.Mask wearing during breaks	1. None currently identified.	1. None currently identified.	1. None currently.	31/05/2021	Divisional Director of Operations - Neurosurgery

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
812	15/10/2020	Business Continuity	If staffing levels decrease, then there is a risk to staff's health and wellbeing and work life balance not being maintained.	Major	Possible	Mod 12	1. Well established health & wellbeing programme 2. Shiny minds resilience app available for staff 3. Closed staff Facebook for mutual support 4. Regional/National helplines 5. Trust 24/7 counselling 6. Mental Health First Aid training has commenced. 5. Access to Cheshire and Merseyside Resilience Hub	1. No face to face support.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. 2. Work with NHSP to ensure gaps are covered 3. Testing capacity is sufficient to date.	1. Ability to manage absences across the Organisation.	1. On line training for Mental Health First Aiders. 2. Debriefs to learn lessons 3. Review of health and wellbeing communications. 4. Daily safety huddles, and tactical command groups. 5. Trusts counselling service are providing a number of workshops for frontline staff on site.	25/05/2021	Deputy Director of Workforce & Innovation
813	15/10/2020	Business Continuity	If the Walton centre is required to support the C&M system with capacity there are several associated risks including training and development – staff may not be experienced in caring for and managing different conditions. Neuroscience patients will have reduced access to services and will wait longer.	Major	Possible	Mod 12	1. Support system decision making ensuring clinical outcomes are taken into account. 2. TWVC CEO is part of the hospital cell 3. TWVC MD participates in a weekly call 4. TWVC director of operations supports all regional calls 5. Phase 3 plans submitted 6. TWC is currently working in partnership with Cheshire and Merseyside to implement the recovery plan.	1. Overall decision making is made at a system level	1. Commissions aware of TWC clinical decision making and current waiting list size they are supportive are continuing with elective activity Discussions taking place with LUFT about available capacity that would support the system with minimal impact on neurological patients.	1. none currently identified.	1. Currently none identified.	30/04/2021	Deputy Chief Executive
798	20/07/2020	Business Continuity	If staffing levels are unable to be maintained within the Pathology departments, as a result of Covid 19, there is a risk to service delivery.	Moderate	Likely	Mod 12	1. Environmental risk assessments detailing social distancing and other measures to reduce risk of transmission of Covid-19 while working in the laboratory. 2. Neuroscience Labs Business Continuity Plan in place.	1. Many measures in place however cannot guarantee elimination of transmission risk. 2. Track and trace may require all staff within each department (Neuropathology or Neurobiochemistry/Neuroimmunology) to self isolate even with safety measures in place. 3. BCP does not take into account loss of ALL staff within the department.	1. None currently identified.	1. None currently identified.	1. None currently identified.	29/04/2021	Quality & Governance Manager - The Neuroscience Laboratories

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
783	05/05/2020	Business Continuity	**If the Covid-19 pandemic continues for an extended period, then there is a risk to staff safety following evidence indicating Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected by Covid-19.**	Major	Possible	Mod 12	1. Staff will be advised to follow guidance on shielding as and when appropriate. These employees cannot remain in work during this time, but if well, may wish to explore home working. 2. Adjustments to working practices may include working remotely or moving to a lower risk area. 3. Actions to be taken for staff will depend upon their medical condition and how stable it is. 4. Where a condition is unstable and there may be an increased risk to staff, Managers may seek support from the Occupational Health & Wellbeing Team and/or HR. 5. Staff redeployed or working from home will be fully supported in completing their role. 6.BAME staff have been offered access to the vaccine as a priority.	1. Currently no gaps in controls	1.Risk Assessment Guidance - COVID-19 made available via communications to staff. 2. All BAME staff have received an individual letter with a risk assessment attached asking them to discuss with their manager. 3. All managers have been asked to ensure they proactively speak to all of their BAME and vulnerable staff to complete a risk assessment 4. Decisions about possible redeployment, special leave, working from home will be agreed with the individual based on the results from the risk assessment. 5. monitor uptake of vaccine.	1. The possibilities of remote working for clinical staff are reducing. Opportunities for redeployment to a lower risk area are reducing.	1. Risk Assessments for all vulnerable staff are now completed. Actions taken for individual staff will depend upon the outcome from the risk assessment. Risk assessments to be reviewed and updated for shielding staff returning to site.	30/05/2021	Deputy Director of Workforce & Innovation
779	20/04/2020	Business Continuity	**If an increased demand for oxygen supply continues across the Trust (supplied by Aintree University hospital), due to Covid 19, then there is a risk that oxygen supply to patients may be affected.**	Major	Unlikely	Mod 8	1. Liaison with Aintree to keep consumption levels under review 2. Increased monitoring 3. Increased deliveries from O2 supplier 4. clinical and estates co-ordination	1.Unknown escalation of COVID-19 patients requiring oxygen support 2. Walton Centre dependent upon Aintree Hospital bulk liquid oxygen supply	1. LUH document "oxygen infrastructure review - COVID-19 clinical scenario response" 2. Regular readings taken from back-up oxygen manifold. 3. Feedback from Aintree re:site wide situation and Walton Centre consumption. 4. Predicted calcs undertaken between S Shaw / S Holland & Mike Hill 5. Regular contact between Command and Control, Estates team, Risk team and Anaesthetics team 6. Back up/resilience plan in place 7. Various NHSEI Cas Alerts	1. Aintree Hospital back up plan involves moving Walton Centre onto "older" bulk oxygen supply which is normally reserved for resilience. This may compromise our system resilience options	1. Close communication between Aintree and Walton Centre Estates teams 2. Continual monitoring of VIE and back up supply 3. local agreement with oxygen supplies for top up of VIE and bottle exchange/delivery, as needed 4. Increased maintenance 5. close liaison between clinical and estates teams	30/05/2021	Estates Manager

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
774	08/04/2020	Business Continuity	**If staffing levels within the Material Management Team are unable to be maintained, as a result of covid 19, then there is a risk to transfers of supplies to clinical areas and service delivery.**	Major	Unlikely	Mod 8	1. Staff situation is monitored by Acting Head of Procurement and Head of Materials Management on a daily basis to ensure that there are sufficient staff to manage delivery of stocks onto wards and clinical areas. 2. A number of finance staff are also being trained in materials management so that they can cover staff absence if required 3 .Ordering of stocks can be done remotely	1. No gaps in controls	1. Deputy DoF constantly monitoring staff situation and ensuring that staff are trained to support this area	1. Given the high infection rate if a number of cover staff from other departments are also unable to support then this may delay stock put away	1. Continue to expand the pool/resource of staff that are trained to cover with stock put away duties.	28/05/2021	Deputy Director of Finance
775	20/04/2020	Business Continuity	**If safe staffing levels are unable to be maintained as a result of Covid 19, then there is a risk to patient care.**	Moderate	Possible	Mod 9	1. Specialist Nurses working on wards. 2.Other clinical staff supporting ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3.Admin staff redeployed where possible, register of staff who can support the wards held centrally. 4. Working closely with NHSP. 5.Considering staff from national Bring Back Staff campaign. 6.Staffing reviewed through Command and Control twice daily	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness or may need to return to their own areas of work	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Work with NHSP to ensure gaps are covered.	1. Being able to manage absences across the organisation. External factors i.e. no summer school clubs for child care.	1.Daily Huddle. Command and Control room. 2. Daily review of staffing. Redeployment register held centrally. 3.HR team supporting ward managers with management of absences. 4. Local and National Health and Well being programme of support in place. 5.Daily communications to staff. 6. Donations being received for staff 7. Risk assessments to be reviewed for shielding staff returning to site.	31/05/2021	Deputy Director of Workforce & Innovation

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
773	08/04/2020	Business Continuity	**If supplies of PPE equipment continue to be of short supply nationally, then the Trusts may not have sufficient PPE for staff to treat patients.**	Moderate	Possible	Mod 9	1. Trust stock levels are now stable, the Trust has additional reusable PPE and clinical consumables. 2. Nationally this is recognised as an issue. This has resulted in the introduction of a national stock recording and ordering system. 3.Regionally Trusts are working together and ensuring that orders of stocks are being received and distributed. 4. A 'mutual aid' system has been implemented across C&M to enable Trusts to share stock where there are shortages. 5. Daily stock returns (including usage levels) are submitted to NHSE and C&M collaborative. 6. WCFT is also working closely with other Specialist Trusts to ensure that all organisations have equitable share of supplies (e.g. WCFT have received a supply 8833 3M masks from Bridgewater and CWP).	1. Trust dependant on the Department of Health/NHSE for deliveries of PPE and critical consumables. The situation has improved in the past months with daily deliveries of PPE. Daily monitoring of stock levels and usage help identify potential shortages in advance.	1. Deliveries for Covid stock are now reaching the Trust, due to increased availability on a national basis. 2. Head of Procurement and Head of Materials Management are in constant contact with Supply Chain and also wards to ensure that stocks are kept as complete as possible moving to a 'push model' of supply (supplying people who need it). 3. Sufficient stock for the majority of PPE items are now received with other key items being monitored on a daily basis. 4. Daily stock levels (and usage) provided to NHSE and C&M collaborative to ensure that all Trusts have adequate stocks (through a mutual aid scheme). 5. Shortages are raised via NHS England's National Supplier Disruption Service to ensure stocks do not deplete.	1. Central Teams/MOD determine PPE to be delivered by Push, therefore they do not always supply the required PPE. Global shortages for specific PPE with no suitable alternative e.g. FFP3 3M 8833 masks. Lack of freedom to source PPE through local procurement as items will be provided through the national route. PPE shipments will not be guaranteed to support increased activity within the Trust. 2. PPE shipments may not be guaranteed to support increased activity within the Trust.	1. In partnership with other Trusts/Social Care etc., potential to work collectively to develop the local PPE supply chain to mitigate risks (in support of anchor institution objectives).	30/05/2021	Deputy Director of Finance
808	01/10/2020	Business Continuity	**Neurology Division - If safe staffing levels are unable to be maintained as a result of COVID 19, then there is a risk to patient care and activity performance within the Neurology division.** **This includes staff absences due to childcare i.e. children being sent home from school with or without symptoms.**	Moderate	Possible	Mod 9	1. Redeployment of Specialist Nurses working on wards. 2. Identified other clinical staff suitable to work in ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3. Admin staff redeployment where possible, register of staff who can support the wards held centrally 4.Working closely with NHSP. 5. Ward staffing reviewed through daily bed meeting. 6. Testing capacity for household members. 7. Established rotation of working from home practices for key admin staff. 8. Cross Divisional weekly activity performance meeting. 9. Virtual, telephone and face to face outpatient activity in place aligned to phase 3 guidance.	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness/childcare responsibilities/self isolation or may need to return to their own areas of work. 2. Outpatient activity ceasing if COVID surge happens, there is a risk the medical and specialist nurses will be needed to increase staffing numbers in ward areas.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Wards working with NHSP to ensure gaps are covered 2. Testing capacity is sufficient to date. 3. No externally reportable activity breaches.	1. Being able to manage absences across the divisional admin and clinical teams. 2. External factors i.e. school clubs for child care / children being sent home from school.	1. None currently identified.	25/05/2021	Divisional Director of Operations - Neurology

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	2	3	4	5
	Negligible	Minor	Moderate	Major	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	2	3	4	5
	Rare	Unlikely	Possible	Likely	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

NHS
The Walton Centre
NHS Foundation Trust

REPORT TO THE TRUST BOARD
1st April 2021

Title	**Eliminating Same Sex Accommodation - Declaration of Compliance 2020/21**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing & Governance
Author (s)	Name: Lisa Salter Title: Director of Nursing & Governance
Previously considered by:	N/A

Executive Summary

The Trust is required to provide an annual declaration against 'eliminating mixed sex accommodation'. A declaration of compliance is published on the Trust's website to ensure patients and their families can be assured of the arrangements the Trust has in place, this declaration is attached.

At the time of preparing this report, the Trust was compliant with the Eliminating Mixed Sex Accommodation requirements for the period 1 April 2020 to 31 March 2021 and no mixed sex breaches have occurred. The Director of Nursing & Governance will advise the Board accordingly at the meeting on 1 April 2021 should this situation change during the remaining days of March 2021.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	As detailed in the report
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	N/A
Any associated legal implications / regulatory requirements?	Compliance with Commissioners
Action required by the Board	Delete as Appropriate • To consider and approve the Declaration of Compliance

The Walton Centre
NHS Foundation Trust

Eliminating Mixed Sex Accommodation
Declaration of Compliance 01/04/20 - 31/03/21

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The Walton Centre NHS Foundation Trust is committed to providing every patient with same sex accommodation because it assists in safeguarding their privacy and dignity when they are often at their most vulnerable.

The Walton Centre NHS Foundation Trust strives to achieve and be compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. In general, the Trust has the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only occur when clinically necessary, for example where patients need specialist support and equipment such as in the Critical Care Unit.

We have confirmed with our commissioners that should we not meet the required standard, we will report it and discuss it with them. We also assess this as part of our matron's audits to ensure that the classification is deemed to be correct.

Our volunteers help patients to complete the surveys which assesses whether the Trust has achieved the elimination of mixed sex accommodation and have maintained the patient's individual privacy and dignity requirements.

- Throughout 2020 / 2021 the Trust were compliant with eliminating mixed sex accommodation, we had 0 (zero) mixed sex breaches.

The staff within the Trust continue to work hard to ensure the safety, wellbeing and privacy and dignity of patients is maintained as part of eliminating mixed sex accommodation.

Lisa Salter
Director of Nursing and Governance
April 2021

Report to the Board of Directors
Date: 1st April 2021

Title	**Non-Executive Directors - Independence**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	Not Applicable

Executive Summary

The purpose of this report is to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.

Provision B.1.1 of the NHS Foundation Trust Code of Governance requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent. The provision states that ***"The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement".*** The Board of Directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.

Declarations of Independence, based on the criteria detailed at s2 of the report, have been completed by the Chair and each of the other Non-Executive Directors. Copies of the completed declaration forms are held by the Interim Corporate Secretary. All Non-Executive Directors, with the exception of two, have declared that they do not meet the criteria and therefore would consider themselves to be independent. The circumstances relating to the two negative declarations are set out at s3 of the report.

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	Provision B.1.1 of the NHS Foundation Trust Code of Governance requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent.
Action required by the Board	The Board of Directors is recommended to: a) receive the report and confirm a positive conclusion on the independence of the Chair and the other Non-Executive Directors.

1.0 Introduction

The purpose of this report is to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.

2.0 Background

Provision B.1.1 of the NHS Foundation Trust Code of Governance requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent. The provision states that ***"The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement".*** The Board of Directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination.

The Code of Governance sets out relevant criteria as follows:

- Whether the individual had been an employee of the Trust within the last five years
- Whether the individual has, or has had within the last three years, a material business relationship with the Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust
- Whether the individual has received, or receives, remuneration from the Trust in addition to a Director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme
- Whether the individual has close family ties with any of the Trust's advisers, directors or senior employees
- Whether the individual holds cross-directorships or has significant links with other directors through involvement in other companies or bodies
- Whether the individual has served on the Board of the Trust for more than six years from the date of their first appointment
- Whether the individual is an appointed representative of the Trust's university, medical or dental school.

3.0 Current Situation

Declarations of Independence, based on the criteria detailed at s2 of the report, have been completed by the Chair and each of the other Non-Executive Directors. Copies of the completed declaration forms are held by the Interim Corporate Secretary. All Non-Executive Directors, with the exception of two, have declared that they do not meet the criteria and therefore would consider themselves to be independent.

Ms J Rosser and Mr S Crofts have both made negative declarations in relation to term of office (and are otherwise fully compliant with the criteria). Ms J Rosser served as a Non-Executive Director with the Trust from 2006 to 2016. In 2017 Ms J Rosser was appointed to the position of Trust Chair following an open recruitment process. Given the break in service, the 'clock start' for Ms J Rosser's tenure is 2017 and therefore her length of service is within the six year threshold for independence. Mr S Crofts was first appointed to the Board in 2013 and his engagement was originally scheduled to be completed in October 2020. However, given the prevailing pandemic situation at the time, the Council of Governors was mindful of the need to retain experienced Directors during a challenging period for the Trust and to maintain stability of Board composition. Consequently, having

taken into account his length of service, the Council of Governors approved a 12-month extension to Mr Crofts' appointment and his term of office will now be completed in October 2021.

In reaching a conclusion on Non-Executive Director independence, the Board should take into account the outcomes of the declaration process together with members' observations on the independent nature of colleagues' performance. The conclusion of the Board of Directors will support an appropriate statement in the Annual Report 2020/21.

4.0 Recommendations

The Board of Directors is recommended to:

b) receive the report and confirm a positive conclusion on the independence of the Chair and the other Non-Executive Directors.

Report to the Board of Directors
Date: 1st April 2021

Title	**Use of the Trust Seal**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	Not Applicable
Executive Summary The purpose of this report is to advise the Board of Directors of the occasions where it was necessary to use the Trust Seal. There were no occasions where it was necessary to use the Trust Seal during 2020/21.	
Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	There are no associated legal implications and/or regulatory requirements at the current time.
Action required by the Board	The Board of Directors is recommended to: a) receive the report and note that the Trust Seal was not used during 2020/21.

1.0 Introduction

The purpose of this report is to advise the Board of Directors of the occasions where it was necessary to use the Trust Seal.

2.0 Background

The Trust Seal is used infrequently and use of the Seal is usually in relation to the signing and sealing of documents relating to land and property transactions. The Trust's Standing Financial Instructions require that use of the Trust is formally reported to the Board of Directors on an annual basis.

3.0 Current Situation

There have been no occasions where it was necessary to use the Trust Seal during 2020/21. Board members are requested to note that the Seal was last used on 6 September 2016.

4.0 Recommendations

The Board of Directors is recommended to:

a) receive the report and note that the Trust Seal was not used during 2020/21.