Public Trust Board Meeting

Thursday 7 April 2022

Agenda and Papers

Excellence in Neuroscience

PUBLIC TRUST BOARD MEETING
Thursday 7 April 2022

Boardroom

09:30am – 12.15pm

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies (v)	Chair	N/A
2	09.30	Declaration of Interests (v)	Chair	N/A
3	09.35	Minutes and actions of meeting held on 3rd March 2022 (d)	Chair	Decision
4	09.40	Patient Story (v)	Chief Nurse	Information
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update (v)	Chief Executive Officer	Information
6	10.10	Key Deliverables 2021/22 against the Trust Strategy 2018-2023 (d)	Chief Executive Officer	Information
7	10.20	Board Assurance Framework Closure Report 2021/22 (d)	Corporate Secretary	Approve
INTEGRATED PERFORMANCE REPORT				
8	10.35	Integrated Performance Report (d)	Chief Executive Officer	Assurance
9	10.40	Business Performance Committee: • Chair's Assurance Report (d) • Terms of Reference	Committee Chair	Assurance Approval
10	10.55	Quality Committee: • Chair's Assurance Report (d) • Terms of Reference (d)	Committee Chair	Assurance Approval
STRATEGY				
11	11.10	Trust Strategy (p)	Medical Director	Approve
12	11.30	Cheshire & Merseyside NHS Prevention Pledge (d)	Chief People Officer	Information
13	11.45	Violence Prevention and Reduction Strategy (d)	Chief Nurse	Approve
BREAK				
FINANCE				
14	12.00	2022/23 Operational Plan Update (v) • Revenue • Capital	Deputy Chief Finance Officer	Information
CHAIR'S ASSURANCE REPORTS FROM BOARD COMMITTEES				
15	12.05	Neuroscience Programme Board (d)	Committee Chair	Assurance
16	12.10	Research, Innovation and Medical Education Committee (v)	Committee Chair	Assurance
CONSENT AGENDA				
		• Mixed Sex Accommodation Annual Statement of Compliance (d) • Revocation of Vaccination as a Condition of Deployment (VCOD) Mandate (d) • Use of the Trust Seal 2021/22 (d)		

Item	Time	Item	Owner	Purpose
CONCLUDING BUSINESS				
17	12.15	Any Other Business (v)	Chair	Information

Date and Time of Next Meeting: 9.30am, 5 May 2022, Boardroom, The Walton Centre

UNCONFIRMED
Minutes of the Public Trust Board Meeting
Meeting held via Microsoft Teams
3 March 2022

Present:

Karen Bentley	Non-Executive Director (NED)
Seth Crofts	Non-Executive Director – Acting Chair (AC)
Paul May	Non-Executive Director (NED)
Su Rai	Senior Independent Director (SID)
David Topliffe	Non-Executive Director (NED)
Ray Walker	Non-Executive Director (NED)
Mike Burns	Chief Financial Officer (CFO)
Mike Gibney	Chief People Officer (CPO)
Andy Nicolson	Medical Director (MD)
Jan Ross	Chief Executive (CEO)
Lisa Salter	Chief Nurse (CN)
Lindsey Vlasman	Acting Chief Operating Officer (ACOO)

In attendance:

Katharine Dowson	Corporate Secretary (CS)
Lisa Judge	Head of Patient Experience (HoPE) (item 4)
Christine Burness	Guardian of Safe Working (GoSW) (item 9)
Ayo Barley	Head of Equality, Diversity and Inclusion (item 15)
Andrew Lynch	Equality and Inclusion Lead (item 15)
Owen Williams	Chief Executive, Northern Care Alliance (item 15)
Gill Woods	Personal Assistant (minutes)

Observer:

Elaine Vaile	Communications and Marketing Manager

1 Welcome and apologies

1.1 The Acting Chair welcomed everyone to the meeting. No apologies had been received as all members were present.

2 Declarations of interest

2.1 NED – RW declared that that he was currently working for Mersey Care NHS Foundation Trust, on a consultancy basis, but that this role would be coming to an end on 31 March 2022.

3 Minutes of the meeting held on 3 February 2022

3.1 NED-SR referred to item 8 Mortality and Morbidity Reports (Quarters 2 and 3) and asked for the point she made around reporting Black, Asian and Minority Ethnic (BAME) mortalities in the report going forward to be noted.

3.2 NED-DT referred to item 7 IPR and said he would like the following comment to be added …. *The addition of a RAG rating summary table to the executive summary was commended as providing a very helpful overview, but it was noted that finance was missing. It was agreed to add finance to give a fully integrated overview of the principal indicators reviewed by both Quality and Business Performance Committees.* The Committee agreed to this addition to the minutes.

3.3 NED-SR referred to item 15 Audit Committee Key Issues Report and requested the following addition to the minutes…. *Mersey Internal Audit Agency (MIAA) had advised that there were no concerns relating to a* ***positive*** *audit opinion being provided.*

3.4 Subject to the above amendments the minutes were agreed as an accurate record of the meeting.

3.5 **Action tracker**
Item Ref 11 Board to review the continuation of emergency powers - status to be changed to Green.

4 Patient Story

4.1 The HoPE introduced the patient who was diagnosed with Parkinson's Disease in 2014 and for a few years was treated successfully as an outpatient. When the prescribed medication was becoming less effective the patient was assessed for Deep Brain Stimulation (DBS) procedure to ease symptoms. The patient described the delight experienced when the electrical stimulation improved the symptoms of the Parkinson's disease considerably. The patient described the impact of their condition on their physical and mental health prior to having DBS and how there was now hope for the future.

4.2 The patient spoke of the amazing care received at the Trust by medics but described some administration errors particularly around communication and incorrect information for appointments. The patient suggested that a case manager would be beneficial for patients. When asked to comment on any other improvements the slightly insensitive approach of the anaesthetist, added to anxiety felt when the patient became claustrophobic in surgery (which then had to continue under general anaesthetic).

4.3 The patient was thanked for sharing the experience with the Board and wished well as their journey progressed. The patient responded that they felt very lucky living in the catchment area for The Walton Centre.

4.4 **The Board recorded their thanks to the patient for sharing their story**

5 Chair & Chief Executive's Report

5.1 On behalf of the Board, the CEO acknowledged and thanked Acting Chair, Seth Crofts, on his last Board meeting before leaving the Trust. On a personal level she thanked him for stepping into the Acting Chair role when the previous Chair was on sick leave and being an enormous help to her as a new CEO. Mr Crofts had always acted in a professional manner and been a huge support to so many during his eight years at the Walton Centre firstly as a NED and latterly as Acting Chair.

5.2 In response Mr Crofts thanked CEO for her comments and said he had learned an immense amount during his time at the Trust and he had been pleased to bring his experience as Pro Vice Chancellor and Dean in the Faculty of Health at Edge Hill University. He added the Walton Centre was a fantastic organisation and it had been a real privilege for him to work at the Trust.

5.3 The CEO reported that there had been no national guidance for the NHS following the lifting of Covid restrictions on 24 February 2022. The Trust continued to work with its own

guidance of relaxed visiting measures and adhering to Person Protective Equipment requirements. This was reinforced through communication bulletins and daily staffing huddles.

5.4 LAMP testing for Covid 19 would cease at the end of March with a move to lateral flow testing which would no longer be supplied free of charge. This was a concern from a Board perspective but further national guidance was expected on this issue. Sickness absence remained high at around 7% and was being closely monitored.

5.5 The Board were informed that Integrated Partnership Board (ICB) continued to recruit to key roles and Chair interviews were taking place shortly and the Director of Nursing role was being advertised. Appointments were expected shortly for the Accountable Office at Place level.

5.6 CEO advised that there had been some national and regional talks regarding the NHS' response to the situation in Ukraine.

5.7 Formal feedback from the incident at Liverpool Womens Hospital had not been received but feedback from some high level meetings indicated a review of issues such as resources, security, operational support and a review of evacuation processes would require evaluation particularly in regard to weekend working for smaller trusts.

5.8 The substantive Chief Operating Officer post at the Trust had now gone out to advert with a closing date of three weeks time.

5.9 James Sumner, currently CEO at Mid Cheshire had been appointed as CEO at Liverpool University Hospitals FT (LUFHT).

5.10 **The Board noted the verbal update.**

6 Recovery and Restoration Update

6.1 ACCO provided an update on the Trust's recovery and restoration programme. The first draft of the activity plan had been submitted on 14 February 2022 and some changes were made following feedback. A second draft would be submitted on 21 February and final submission would be 17 March 2022.

6.2 Diagnostic and cancer related targets were all on track. Performance in theatres was improving and the Board were informed that the three 28 day breaches were long term patients who had now been operated on.

6.4 Targets had been achieved for both elective and day cases and the recovery plan remained on target.

6.5 **The Board noted the progress made against the Trust's recovery and restoration programme.**

7 Integrated Performance Report

7.1 The CEO provided an overview of the Integrated Performance Report (IPR), noting that the report had been discussed in detail at Committee meetings as noted in the relevant key issues reports. Areas of concern remained much the same around staff appraisals, sickness and mandatory training. Infection prevention and control had shown a slight improvement following measures put in place. Elective recovery was performing well but further improvements were required.

7.2 **Performance**

ACCO provided an update on 104 week waiters. These were all spinal patients with complex surgery requirements and once the spinal surgeons had transferred from LUHFT on 1 April 2022 these patients would be seen. It was confirmed the patients had been clinically validated as conditions for surgery may change every three to six months.

7.3 ACCO added that the Trust had until 2025 to eliminate any 52 week waits but had put a trajectory in place to complete all surgery by December 2022.

7.4 **Workforce**

CPO referred to the sickness indicators showing staff sickness at 10%, however as of 2 March 2022 this had reduced to 6.8% with 1.1% being Covid related.

7.5 Appraisal compliance stood at 75% but total figures were now being looked at (i.e ensuring staff on maternity leave / long term sick had been removed from the data). Mandatory training remained under target but with sickness levels improving was expected to reach more usual levels. Nursing turnover continued to come down but did not mask the underlying economic drivers of retention and turnover. Vacancy levels were considered healthy.

7.6 NED-KB asked for reassurance that staff sickness was the main reason for the cancellation of mandatory training and not apathy. CPO replied that it was not considered to be an indifferent approach to mandatory training by staff but more the fact it was not popular and that during the pandemic all training had slipped and it was considered that staff training would get back to usual levels when normal working arrangements resumed.

7.7 It was acknowledged that appraisal was important in order for staff to have meaningful objectives. Areas that had been challenged during the pandemic were also now challenged as activity increased and there was a relationship between activity going up and appraisal levels coming down. When asked to explain where the Trust compared regionally it was reiterated that the Trust continued with mandatory training and appraisals when it could have suspended both elements as part of '*reducing the burden*' recommendations.

7.8 The CPO added that by maintaining appraisals and mandatory training it was expected that the Trust would be in a good positon to recover compliance. Some trusts in the system reached 20% sickness with 400 Covid patients so had been significantly challenged.

7.9 **Quality**

CN reported on the extensive work that had taken place on infection prevention with a back to basics approach and for January and February there had been no hospital

acquired infections. There had been some nosocomial infection in the form of Covid 19 in December with the Omicron variant. Some elements of visiting in line with Christmas easing had now been put in place .

7.10 In response for more information around pressure ulcer grading CN said there had been a presentation at Quality Committee from the new Tissue Viability Nurse that detailed a new approach to recording of pressure ulcer data and training at ward level which had resulted in extensive positive learning.

7.11 **Finance**

The CFO updated that at Month ten the Trust reported an in-month £110k surplus against a planned deficit of £95k (£205k better than plan). The main reason for the improvement being the receipt of £311k Elective Recovery Fund (ERF) income for Q3 which had previously not been thought likely to have been received as this depends on the system achieving. ERF for Q4 had not been assumed.

7.12 Income over performed by £352k in-month with £3,451k year to date over-performance. Expenditure in month was overspent by £148k with non-pay £348k underspent against plan in-month. Exclusions had over spent in-month by £366k. Covid costs of £133k were incurred and the cash balance at the end of January stood at £36.6m which equated to 93 days of operating costs. Capital spend in month was £2,584k against a plan of £1,650k.

7.13 A query was raised in relation to the global challenge on energy costs and if the Trust was foreseeing a financial impact. Assurance was provided that LUHFT (who provide the energy supply with the Trust) had forecast for H2 (October 2021-March 2022) with a 200% increase so there were sufficient funds to cover a large increase in energy / utility bills. The CFO added that work was taking place nationally on utilities and trusts have been advised to pick this up with the national team as a collaborative NHS approach would lead to economy of scale and potential savings from the current charges.

7.14 Explanation was given that bank spend had reduced and this was due to tightening up of controls around E-rostering by the Deputy CN. CN added that data would be presented at Board level from April 2022 onwards and it was hoped further reductions in bank spend would be seen with the Key Performance Indicators (KPI) that had been put in place.

7.15 Following a request for an update on Cost Improvement Programmes (CIP) CFO said the finances were still being worked on and these would only be for recurrent schemes at present. Any schemes flagged as Amber would go to Quality Committee for review. Schemes would be discussed in more detail in the financial plan section of the agenda.

7.16 The situation remained mixed across the system. All trusts would be in balance at the end of the financial year so any surplus would be put back into the system, however no formal governance arrangements had been put in place and how this would happened remained unclear with the ICS not being a formal organisation until July 2022.

7.17 **The Board noted the Integrated Performance Report**

8 Staff Survey Results

8.1 CPO presented the executive summary of the 2021 National NHS Staff Survey undertaken in the Trust by Quality Health. The 2021 survey was distributed between September and December 2021 and completed by 600 staff.

8.2 In context there were 17 scores in the top 20% range and 10 scores in the lower 20% range. The highest score was 'having a voice that counts' with people who had a negative experience feeling like they were being listened to. Areas to improve on were in relation to learning (and that included appraisal). The appraisal process would be looked at as part of an engagement process with staff. The Trust was broadly in line with the sector scores of similar organisations. There were some low scores regarding staff feeling they were recognised for their work.

8.3 The next steps would include a comprehensive action planning day with input from staff, trade unions and divisional representation. When complete this would be presented to Business Performance Committee for review.

8.4 Comments and concerns from NEDs around the staff survey results were made notably:

- The continuing discomfort around appraisal rates and whether it was more an indication that all was not well with staff.
- The acknowledgement that a lot of work had taken place to improve violence and aggression but the continued need to ensure staff were aware the Trust was doing everything possible to improve the situation.
- The concern around cover for staff on maternity leave was raised. Assurance was given that this depended on the area in question and maternity leave was back filled in patient facing areas (nursing in particular) by looking at the establishment to ensure safe staffing and using bank staff. CEO added that maternity leave was managed in the organisation with different mitigations in place in different areas.
- The requirement that staff abuse would be part of the action plan. It was envisaged this problem was more around tackling unacceptable behaviours which would recommence when training programmes, such as *building rapport*, were back in place.
- The positive scores on health and wellbeing were noted.

8.5 NED-RW asked whether it came as a surprise that 3 of the bottom 10 scores related to appraisal. CPO said he was not surprised but what was of concern was the response around objectives and that staff were not clear of what was being asked of them following an appraisal. The receipt of the full survey by 31 March 2022 would enable further evaluation of this issue.

8.6 **The Board noted the results of the 2021 National NHS Staff Survey**

9 Guardian of Safe Working Quarterly Report

9.1 The Guardian of Safe Working joined the meeting and explained the report had since been updated to reflect more recent data from registrars and that there were 28 exception reports from neurology registrars in the period November 2021 to January 2022 and not 32 as originally stated.

9.2 A background was provided on the European Working Time Directive Junior Doctor Contract and the rest period a junior doctor should take whilst working 24 hours on call. If the junior doctor failed to achieve the required rest they were compensated by the Trust and a breach was recorded. Since August 2021 there had been an increase in exception reports, exclusively from Neurology Registrars mainly as a result of thrombectomy cases out of hours or who had delayed admission and / or repatriation. A process was being put in place to address this issue and would be presented to the Board when the next quarterly report was due.

9.3 MD explained the shift pattern for a Neurologist which was predominantly outpatient based and if they worked to a shift pattern it would have an impact on day work. The problem was not due to the need for more junior doctors but more around having a plan in place to improve the situation. When the operating procedures for thrombectomy were finalised it was envisaged there would be a positive impact on the work schedule.

9.4 The paying of a fine to the junior doctor was explained and agreed it was not an ideal solution but it had been drawn up in the junior doctor contract that a breach in safety due to the doctor not receiving adequate rest had been requested. Part of the fine was given to GoSW to use for the benefit of junior doctors to improve / upkeep facilities in the junior doctors mess etc. The reporting of breaches did take place but the Trust was not an outlier and there were plans to place to improve the situation. A request to look at the data to see if there were any patterns in the recording of breaches was agreed and a summary would be shared to the Board in the next update.

9.5 MD summarised that in terms of breaches it was not due to the registrars doing out of hours work and that the investment in the SMART team would be more of a solution. Monitoring to ensure the problem had been resolved or was improving would take place following that.

9.6 **The Board noted the Guardian of Safe Working Quarterly report**

10 Freedom to Speak Up Guardian Quarterly Report

10.1 CN presented the report in the absence of the Freedom to Speak up Guardian (FTSU). The report provided an update on the role and plans for strengthening current speak up arrangements and highlighted concerns raised with the FTSUG during quarters 2 and 3 2021/22.

10.2 There had been 6 concerns raised in quarters 2 and 3 none of which related to patient safety. The concerns centred around attitudes and behaviours. Staff would continue to be encouraged to deal with situations themselves after being signposted accordingly.

10.3 Information was provided on speak up month which took place in October 2021 and how this was promoted throughout the Trust. Positive feedback had been received on the role of the FTSUG but there was a need to look at the process around that to reflect more reliable feedback.

10.4 An updated self-review tool for Freedom to Speak Up had been released and outcomes of that would be incorporated into the next report. It was agreed this would provide an opportunity for the Board to look at Freedom to Speak Up as a whole and the work undertaken.

10.5 Explanation was provided around comments relating to service change and how feedback was actually given to that service in order to provide assurance on new process and changes to ensure staff felt more engaged.

10.6 **The Board were assured on the work of the Freedom to Speak Up Guardian for quarters 2 and 3 2021/22 and would consider completion of the revised NGO FTSU self-review following the publication of the National Guardians Guidance to boards (to be presented in the next quarterly report)**

11 Infection Prevention and Control Board Assurance Framework

11.1 CN presented the report on behalf of the Lead Nurse for Infection Prevention and Control. The purpose of the report was to outline the processes in place to manage the risk of Covid 19 including the identification of the current gaps and mitigating actions. The document was lengthy and quite operational and should have had a summary report alongside it and apologies were given for that omission. The text highlighted in yellow related to national changes within the document.

11.2 In the future the report would be taken to the Infection Prevention and Control Committee and a report presented back to Trust Board in 6 months (with the Covid 19 IPC BAF as an appendix). Any risks and concerns would be presented to Quality Committee on a quarterly basis.

11.3 NED-RW said a summary paper would be helpful particularly as there had not been a Quality Committee meeting in February. He queried if there were any other risks Board should be aware of. CN said that an area of concern had always been ventilation and a paper on air handling units would be discussed by the Executive Team next month and then fed to Trust Board.

11.4 **The Board noted the Infection Prevention and Control Board Assurance Framework**

12 Draft Annual Plan

12.1 CFO presented the 2022/23 Financial Planning Update to provide Board with the key dates from the HCP planning timetable. It was noted the timescales were tight and subject to change. The final plan would be presented to Board for approval before submission to NHSE/I on 28 April 2022.

12.2 The first draft showed a £13.3m deficit with main reasons being a 10% higher than 21/22 pay forecast; a 10% increase in staffing levels and non-pay 10% higher than the 21/22 forecast. The second draft showed a reduction of £3.6m with the main improvement due to proposed income allocations from commissioners being higher than initially planning.

12.3 Key assumptions within the plan were shared with a 2% system CIP applied. Income and costs for both new transcranial ultrasound and transfer of spinal services had been included. The efficiency requirement was explained; version 1 of the plan had assumed a 2% system CIP requirement but if the Trust was required to breakeven the overall CIP requirement would be £12.5m (£2.8m CIP and £9.7m deficit). Possible opportunities to reduce the gap were outlined with the possibility of ERF income generation if targets within planning guidance were achieved was highlighted.

12.4 Capital within the system was shown, together with work undertaken by divisions to prioritise 3 year capital plans. It was considered that the process around prioritising capital was another piece of work to be undertaken and that digital could not be prioritised over clinical needs just because the funding was being matched. Next steps and further work were to take place before financial plans were submitted were outlined.

12.5 It was acknowledged by NEDs that there was a large amount of work still to take place. One question referred to the impact on the cash reserves held by the Trust should it fail to breakeven. CFO said the Trust was well covered for cash and it was a good indication as to the health of the organisation but the Trust had to get as close to breakeven as possible. The departments would need to work together (finance and operationally) in order to reduce the deficit and that was the next step in the process.

12.6 When asked his biggest worry the CFO said the plan was multi-faceted and was not just a finance department issue and that workforce and the operational teams needed to work together to delivery activity and CIP and ensure income was at the correct levels and reconciled back to commissioners.

12.7 NED-KB referred to the discussion at the recent Business Performance Committee on CIP and said that sometimes change only happened if resources were put into it and she offered to lend support to that. CFO added that there may have to be some fixed resources put in place to help get some of the transformation projects up and running.

12.8 **The Board noted the draft annual plan update.**

13 Board Cycle of Business

13.1 Noted by the Board.

14 Business Performance Committee Key Issues Report

14.1 Noted by the Board.

15 Deprivation Measures as an Indicator of Equality

15.1 CEO introduced the item explaining that since she commenced as CEO and took over the chairing role of the Strategic BAME Advisory Committee she had wanted to move on to analyse data in order to demonstrate the impact that the committee was having. On hearing Dr Owen Williams, Chief Executive of Northern Care Alliance, speak about using deprivation measures as an indicator of equality she felt that was what the Trust needed to do. Following discussion at the Strategic BAME Advisory Committee it was agreed this was the way to move on and Dr Williams kindly agreed to talk to the Board on his findings.

15.2 The Head of Equality, Diversity and Inclusion and Equality and Inclusion Lead joined the meeting for this item.

15.3 Dr Williams introduced himself and provided a background of his work in local government and the commercial sector. He asked those present to consider two questions during the presentation; through your day to day custom and practice do you exacerbate health inequalities and how would you know?

15.4 The presentation covered back to basics on health inequalities. The presentation went on to cover patients in P2 category (elective care waiting times) and the difference in the weekly average waiting time for white patients (8 weeks in March 2021) compared to 15.2 weeks for BAME patients. When this data was analysed and changes in practice were made, the figures for October 2021 showed a marked reduction in the average waiting time and more of a levelling up between the patient groups (5.7 weeks for white patients and 8.8 weeks for BAME).

15.5 The presentation went on to look at the difference in waiting times for **all** patients in IMD1-2 compared to IMD9-10 and it was clear the more affluent the patient was the more likely they would wait a shorter timeframe for care. A similar pattern continued for maternity care (since January 2020 BAME mothers were proportionately more likely to have had a miscarriage or still birth).

15.6 In summary Dr Williams said his plea was to try and encourage as many boards as possible to get things to move from passive and to think about how to use the information presented to change practice.

15.7 Questions were put to Dr Williams from members of the Board and discussion took place around the following:

- Intersectionality and whether the experiences of women in terms of health outcomes or BAME patients generally should be looked at
- How the Trust would get into the community to tackle the issues
- How the improvement in waiting times presented was achieved
- How to improve interaction between clinicians and patients. (Dr Williams would share guidance prepared by a colleague via an email to CEO)
- How to achieve equitable outcomes as well as improving equality
- Using patient experience data as a starting point defined by postcodes
- What the next steps should be

15.8 It was considered by Dr Williams that there was no silver bullet solution to the problem but it was a case of getting out into the community; reflect on good examples and networking and how to change attitudes towards patients. To use data and benchmarking to look at principles and work to start to see a change in practice (such as asking clinicians to check with patients if the date given for care was suitable for them). Build relationships at primary level and target interest groups / forums such as housing associations and ask to be on their agendas.

15.9 CEO said the next steps would be to look primarily at data and be clear about what would have the biggest impact in areas of concern. This would be shared a Board level for agreement on areas to focus on.

15.10 AC thanked Dr Williams for an insightful and thought provoking presentation. The Board had been inspired by what they had heard and looked forward to progressing the issues with the support of the Strategic BAME Committee.

5.11 **The Board received the presentation with thanks**

16 **Consent Agenda**

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

16.2
- **My Planned Care Patient Platform** – the report was noted.

16.3
- **Terms of Reference for Strategic BAME Advisory Committee**– the Terms of Reference were approved.

17 **Any Other Business**

17.1 There was no other business to be discussed.

18 **Review of Meeting**

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

There being no further business the meeting closed at 13.00

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

Trust Board Attendance 2021-22										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Ms J Rosser	✓	✓	✓	✓	A	A				
Mr S Crofts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms S Rai	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof N Thakkar	✓	✓	✓	✓	A	✓	✓	✓		
Mr D Topliffe	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms K Bentley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr P May									✓	✓
Mr R Walker									✓	✓
Ms H Citrine	✓									
Mr M Burns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr M Gibney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr A Nicolson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms J Ross	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms L Salter	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr M Woods			✓	✓	✓	✓	✓			
Ms L Vlasman								✓	✓	✓

TRUST BOARD
Matters arising Action Log
March 2022

(green)	Complete & for removal
(amber)	In progress
(red)	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
03/02/22	11	**Reducing the Burden and Releasing Capacity** Board to review the continuation of emergency powers again in July 2022.	KD		July 22	(green)

Report to Trust Board
7 April 2022

Report Title	Key Deliverables 2021/22 against the Trust Strategy 2018 - 2023		
Executive Lead	Jan Ross Chief Executive Officer		
Author (s)	Julie Riley Deputy Director of Strategy	Andy Nicolson Medical Director / Deputy Chief Executive	
Action Required	To approve		
Level of Assurance Provided			
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls	
Key Messages			
• Due to the Covid-19 pandemic and the changing pace within the Health system it was necessary to review the 2018-2023 Trust strategy to ascertain if it was still fit for purpose and update if necessary. • Following review it was decided to rewrite the Trust strategy and finalise the existing one. This is the final operational plan of the 2018-2023 strategy providing updates from 2021/2022.			
Next Steps			
None.			
Related Trust Strategic Ambitions	**Impact**		
All	Not Applicable	Choose an item.	Choose an item.
Strategic Risks			
Not Applicable	Choose an item.	Choose an item.	
Equality Impact Assessment Completed			
Strategy ☐	Policy ☐	Service Change ☐	
Report Development			
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Not applicable			

Key Deliverables 2021/22 against the Trust Strategy 2018-2023

Executive Summary

1. The attached slides detail the key deliverables associated with the 2018-2023 Trust strategy for the year 2021 to 2022.

2. It provides updates in the areas of:
   - Deliver best practice care
   - Provide more services closer to home
   - Invest be financially strong
   - Adopt advanced technology and treatments
   - Be recognised as excellent in all we do
   - Lead research, education and innovation

Background and Analysis

3. In 2018/19 the organisation took and inclusive approach to refreshing the Trust strategy involving key stakeholders in the process.

4. The Vision: Excellence in Neuroscience

5. The vision is Excellence in Neuroscience. Striving for outstanding patient outcomes and the best patient, family and carer experience. While continue to cherish the standards have achieved, whilst exploring how to enhance these further, shaping neuroscience treatments and care for the future.

6. The strategy includes a:
   - Purpose
   - Ambitions
   - Values

7. These can be seen in the attached slides (Appendix 1) along with two commitments and 2021/22 updates for each one.

Conclusion

8. Considerable achievements have been attained as can clearly be seen in the attached updates. Due to the changing NHS landscape and the recovery required from the impacts of the Covid-19 pandemic it is considered time to conclude this strategy.

Recommendation

9. To note the updates.

10. To approve the closure of the Trust Strategy 2018 - 2023.

Author: Julie Riley, Deputy Director of Strategy
Date: 31st March 2022

Appendix 1

Trust Strategy Executive Operational Plan 2021/22
2 key priorities for each Ambition

Our Approach – Recap.

In 2018/19 we took an inclusive approach to refreshing our strategy involving:

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

Our Vision

Excellence in Neuroscience

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

Our Purpose

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

Our vision is what we strive for and our purpose is what we do. Our purpose has been chosen by our staff to reflect our culture, what we believe in and what we strive to deliver for our patients and their families.

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

Our Ambitions

We will:

DELIVER
best practice care

PROVIDE
more services closer to patients' homes

INVEST
be financially strong

LEAD
research, education and innovation

ADOPT
advanced technology and treatments

RECOGNISE
be recognised as excellent in all we do

Our Values

To meet our ambitions we need to ensure a learning culture, that empowers staff to believe they can make and lead change, be curious and seek continuous improvement.
We want all staff to feel comfortable being open and honest, treating patients and each other with dignity and respect and we do this through our Walton way values; Dignity, Respect, Caring, Pride and Openness.

Our successful strategy will mean that we have:

- Improved waiting times for out-patient access and for planned surgical treatment by 20%.
- Eradicated 52 week waits for patients.
- Provide a thrombectomy service 24/7.
- Full implementation of the Regional Spinal network as sole provider, with access across C&M.

In 20201/22 our commitments are;

1. Ensuring all patients have equity of access to our services and are seen and treated in a timely manner.
2. Expand clinical services to provide spinal surgery and thrombectomy for the whole Cheshire and Merseyside population.

In 2021/22 we delivered :

1. Due to the Omicron Covid19 variant and the delay in transfer of Spinal services from LUFT the waiting list delays have increased further. However we have a robust plan to have zero 104 week waiters by Summer 2022 and zero 52 week waiters by Dec 2022. In addition the regional merger, including TUPE of staff, will be complete by April 2022.

2. The Walton Centre commenced 24/7 Thrombectomy service as planned Activity in October 2021 :
    - April – September 2021 - 53 accepted and completed. (Average per month – 9)
    - October - January 2021 - 48 accepted and completed - 45 since 24/7 Average per month 12

Our successful strategy will mean that we :

- Engage with partners (Trusts, commissioners, patients, third sector) through the Neuroscience Board to deliver enhanced neurology, neurosurgery and pain services across C&M
- Continue collaboration through the Specialist Trust Alliance to deliver join models of working, such as procurement and ED&I

In 2021/22 our commitments are;

1. Coorodinate Neuroscience care across the Cheshire and Merseyside system, reporting through the Neuroscience Programme Board and HCP
2. Work collaboratively through the Cheshire and Merseyside Specialist Trust Alliance

In 2021/22 we delivered :

1. A relaunch of the Neurosciences Board with updated membership to reflect the membership and priorities of the ICS Transformation Board
2. Introduced A3 reporting for the projects
3. Developing a work plan in collaboration with the Specialist Trust Alliance to reflect Place needs and care
4. Joint ED&I post implemented in partnership with the Specialist Trust Alliance

Our successful strategy will mean that we have:

- Been successful in the award of the national contract for Transcranial Magnetic Resonance Guided Focused Ultrasound Thalamotomy as the second UK provider
- Met all external financial targets.
- Continue to work with commissioners to adapt to changes in the NHS financial systems whilst maintaining risk rating 1 equivalent

In 2021/22 our commitments are to;

- Invest in innovative projects to support improved clinical outcomes – Transcranial Magnetic Resonance Guided Focused Ultrasound Thalamotomy.
- Meet all financial targets and remain risk rating 1 or equivalent, whilst adapting to new challenges as NHS and regional finance approaches change.

In 2021/22 we delivered:

- The Trust tender to deliver the service was successful and NHSE will commission this service from 1st April 2022
- The Trust was able to purchase the required equipment which was included within the 2021/22 capital spend.
- The financial planning and monitoring regime has remained on a 6 month basis following Covid (rather than 12 months pre Covid)
- The Trust is forecasting to deliver break even I&E position by the end of 21/22 which is in line with Cheshire and Merseyside HCP system and national expectations
- The Trust is forecasting to deliver its capital plan in line with system capital allocation for 21/22

Our successful strategy will mean that we have:

- Enhanced staff satisfaction and efficiency by developing a truly agile working environment.
- Successfully implemented IT projects overseen by the Digital Programme Board.
- Completed IT projects which will enhance staff experience (e.g. EPR) and patient experience (e.g. Trust website)

In 2021/22 our commitments are;

1. An environment that provides a flexible working space to deliver agile working safely and ensures staff and patient satisfaction.
2. A digitally enhanced organisation, which supports efficient clinical services that enhance staff and patient experience.

In 2021/22 we delivered:

1. Hot bookable pod rooms were created to allow flexible hybrid working
2. Agile equipment available to all staff who require hybrid access
3. Hot desks within offices created to allow rota staffing
4. Direct Access implemented to create full working desktop access from home
5. Digital Aspirant Programme and project status on-track by NHS Digital
6. Digital Programme Board overseeing delivery of all digital projects in place
7. Digital reporting to Business Performance Committee and Executive Team completed on monthly basis to ensure governance.
8. Development of ITU system to join up with EPR
9. Ongoing expansion of the eP2 system
10. Connection to Exchange Programme for regional document sharing
11. Development of the PHR within the community
12. Website redesigned and launched

Our successful strategy will mean that we have:

- Continue to be assessed as Investors In People Gold.
- Continue to be recognised as an exemplar in Health and Wellbeing
- Improve year on year in the staff and in-patient surveys
- Maintain CQC outstanding rating.

In 2021/22 our commitments are;

1. Be recognised as the employer of choice with staff health and wellbeing at the heart of what we do.
2. Providing outstanding care that is recognised by patients, staff and regulators

In 2021/22 we delivered:

1. Re-accredited as IIP
2. Remain committed to IIP industry standard for health and wellbeing
3. HEE funding to appoint a Medic Health and Wellbeing Lead
4. Introduction of Mental Health First Aiders across the Trust
5. Extended health and wellbeing and psychology support during the pandemic
6. Working with external provider to further develop the Trust and Health and Wellbeing Strategy
7. Introduction of wellbeing conversations for all staff
8. Development of monthly calendar covering a wide variety of health related subject areas (including finance and social wellbeing.

Our successful strategy will mean that we have:

- Increased the number of clinical staff who are actively engaged in clinical research
- Enabled staff with research ambitions to develop their research further through dedicated time and support
- Been the first Trust in the UK to introduce Neuro VR simulator which will enable neurosurgeons to practice and develop expert skills in open and endoscopic brain surgery in a VR environment.

In 2021/22 our commitments are;

1. Develop a structure to enable clinical staff to achieve research ambitions
2. Develop and work closely with our charity to introduce a novel virtual simulator for training in neurosurgical techniques

In 2021/22 we delivered;

1. Successful campaign launch for VR simulation equipment
2. Temporary appointment of Clinical Research Unit Manager
3. Review of work plans for those involved in CRU
4. Ongoing job plan reviews for medical staff to incorporate research time
5. Ongoing job plans for non-clinical staff to incorporate research time

Report to Trust Board
7 April 2022

Report Title	**Board Assurance Framework (BAF) Closure Report 2021-22**
Executive Lead	Lisa Salter Chief Nurse
Author (s)	Katharine Dowson Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- BAF recommended for closure for 2021-22
- Business Performance Committee (BPC) have recommended risk scoring changes to two risks

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

- Closure of 2021-22 BAF
- New principal risks for 2022-23 to be set by the Board.

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Leadership	Not Applicable	Choose an item.	Choose an item.

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Meeting	2 Mar 22	K Dowson Corporate Secretary	All risks reviewed and updates to each risk made
RIME Committee	2 Mar 222	K Dowson Corporate Secretary	Changes made to BAF risk 011 Research & Development
Quality Committee	17 Mar 22	K Dowson Corporate Secretary	No changes proposed
Business Performance Committee (BPC)	22 Mar 22	K Dowson Corporate Secretary	Proposed reduction in scoring of 2 risks.

Board Assurance Framework Closure Report 2021-22

Executive Summary

1. The Board are asked to review the 2021-22 BAF and approve its closure for the year.

Background

2. 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 2018-2023 which form the strategic objectives for the Trust. These were 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.

3. The new Trust Strategy 2022-2025, which is due to be approved at the beginning of the year, sets out new objectives and therefore new principal risks will need be agreed by the Board for 2022-23.

4. 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.

5. 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.

6. Relevant BAF entries were last reviewed by the Board of Directors on 2 February 2022. The new BAF is scheduled for review by the Board of Directors on 7 July 2022, following agreement by the Board on the new principal risks to the Trust's strategic objectives.

Updated Position

7. Each of the BAF risks are included in this paper in appendices with proposed updates highlighted in red/strikethrough following review at the Executive Team, Quality Committee,

Business Performance Committee (BPC) and Research, Innovation and Medical Education Committee (RIME) through March 2022. No additional BAF entries were identified through this review process and no proposals were made to change risk appetite or targets.

8. Two risks are aligned to the Board of Directors directly. These are BAF001 Covid-19 and BAF010 Partnerships.

9. Table 1 below details the movement in risk scores and risk appetite from Quarter 4 2020/21 to Quarter 4 2021/22.

Table 1 Risk Scores and Risk Appetite

Risk ID	Risk Appetite	Title	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
001	Cautious	**Covid-19** Impact of COVID-9 on delivery of strategic objectives	20	16	12	12	12
002	Cautious	**Operational Performance** Inability to meet operational performance standards	20	16	9	9	9
003	Cautious	**Harm to Staff** Inability to prevention harm to staff	12	12	12	9	9
004	Cautious	**Quality** Inability to deliver the benefits within the Quality Strategy,	16	12	12	12	12
005	Cautious	**Our staff** Inability to attract, retain and develop sufficient numbers of qualified staff	16	16	16	16	16
006	Cautious	**Estates** Inability to maintain the estate to support patient needs	12	12	12	9	9
007	Moderate	**Digital** Inability to deliver the benefits of the Digital Strategy	12	8	8	8	8
008	Cautious	**Cyber Security** Inability to prevent Cyber Crime	16	16	16	16	16
009	Cautious	**Innovation** Inability to identify innovative methods of delivery	12	12	12	12	12
010	Cautious	**Partnerships** Inability to influence following establishment of the ICS may impact Trust negatively	12	12	12	9	9
011	Moderate	**Research and Development** Inability to maintain and grow the Trust's research and development agenda.	12	12	12	12	12
012	Moderate	**Capital** Allocation of capital set by the STP to the Trust will not support the full capital plan	9	9	9	9	6
013	Cautious	**Financial Plan** Inability to deliver the financial plan for 2021-22	8	12	12	16	8
014	Cautious	**Medical Education** Ensuring quality, capacity and capability of Medical Education	15	9	9	6	6
015	Cautious	**HCP Financial System** Trust income destabilised as result of transition to HCP financial system		16	16	16	16
016	Cautious	**Infection Prevention and Control** Risk to patients safety and experience if hospital acquired infections increase				9	9

Risk Scoring

10. There are two changes to risk scoring which were recommended by BPC as outlined in Table 2 below. These were both due to forecast end of year positions which identify that the planned position is highly likely to be met.

Table 2 Changes to Risk Scoring

BAF Risk	Title	Current Score	Proposed Score	Change	Comments
012	**Capital**	**9**	**6**	↓	This risk was specifically about the risk of overspending the capital allocation. There is now additional allocation available if the Trust overspends so this risk has been substantially mitigated. Score 6 (3 x 3)
013	**Financial Plan**	**12**	**8**	↓	The Trust is on track for achievement of a balanced end of year position and therefore the likelihood of the risk occurring has moved to unlikely, resulting in a score of 8 (4 x 2)

Conclusion

11. Updates and changes to all risks have been made but these have been minimal as there was a substantial update in quarter 3 and this is the end of year position. The detailed BAF risks are attached as appendices. Also attached is a glossary of terms (Appendix 1) and the agreed Trust risk descriptors (Appendix 2).

Recommendation

To approve

Author: Katharine Dowson
Date: March 2021

Risk ID: 001	Date risk identified: February 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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:	Acting Chief Operating Officer

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	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	16
Further linked operational risks with ratings between 8-12 are included on the Trust Risk Register		
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Catastrophic	Likely	
	5	4	20
	Moderate	Likely	
	3	4	12
Target	Major	Unlikely	
	4	2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Disruption to business as usual 2. High levels of sickness absence leading to delays in treatment of patients due to decreased workforce 3. Infection Prevention and Control pathways will have to remain in place.	1, Continued uncertainty regarding new variants and lockdown relaxation 2. >90% of staff double vaccinated 3. Booster vaccination campaign has now commenced and staff have been encouraged /supported to have their vaccinations 4. Staff testing encouraged as twice weekly 5. Visiting remains restricted

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. Regional Operations Meeting – Weekly 15. Critical Care Network Operational Meeting 16. Corona Bill – passed March 2020 17. Staff vaccination programme via LUHFT Covid Vaccination Hub 18. Weekly LAMP testing available for front-line staff until 31 March 2022 19. Command & Control Inbox for National communications 20. Booster programme from September 2021 21. Internal patient vaccination plan 22. New BAF risk focused on IPC agreed ~~proposed for~~ Q3 2021-2 23. Promotion and guidance of all available testing options for staff	1. Staff compliance with LAMP testing and IPC procedures post-lockdown easing 2. Mutual aid requests being managed through hospital cell 3. Risk of further Covid waves as a result of mutations and new variants 4. Compliance with Booster campaign and flu campaign

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 Divisional Daily Huddle Infection Prevention and Control Committee – monthly IPC Audits and Root Cause Analysis for cases Senior staff walk-abouts recommenced Regular staff reminders regarding IPC procedures, through Trust communications and daily safety huddles. **Level 2** Infection Prevention & Control Quarterly Report – Quality Committee Quarterly Governance Report –Quality Committee, Trust Board Covid-19 Update – Trust Board	1. Staff compliance with IPC guidelines including testing 2. Risk of further Covid waves as a result of mutations and new variants.

Covid-19 Board Assurance Framework Trust Elective Recovery Plan **<u>Level 3</u>** Daily Sit Rep Reports submitted to NHS Digital NHSE DON's National call – bi-weekly NHSE/I Visit – February 2021 – action plan completed	

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	MD	End of April 2021	Completed
2	Ongoing participation in regional and national plans (Recovery Plans)	COO	~~March 2021~~ ~~July 2021~~ ~~September 2021~~ September 2022	On track
3	Promotion and support for staff who have not had the Covid-19 vaccination with a communications plan	CN	July 2021	~~On track~~ Completed
4	Promotion and encouragement for staff to follow Trust IPC guidance (LAMP / Lateral Flow / General IPC guidelines)	CN	~~October 2021~~ March 2022	~~On track~~ Ongoing
5	Encourage all staff to be fully vaccinated ~~and in particular support those staff who will be required by law to be double vaccinated by 1 April 2022 to be aware of the requirements~~	CN	April 2022	Commenced

Risk 002	Date risk identified April 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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.		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:	Acting Chief Operating Officer

Linked Operational Risks		
43	Failure to meet mandatory waiting time standards for patients causing a poor patient experience and reduction in patient safety	16
815	RTT / Average Wait performance and volume of 52-week waiters	16
323	Capacity pressures associated with workforce, theatres and ward beds	16
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Major	Almost Certain	
	4	5	20
Current	Moderate	Possible	
	3	3	9
Target	Moderate	Unlikely	
	3	2	6

Key Impact or Consequence

- 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

Performance:

What evidence do we have of the risk occurring i.e. likelihood?

Average Wait Performance
Overdue Follow up waiting list in Neurology remains a concern
Reduction in overall activity due to the impact of COVID-19
IPC pathway control for electives
Increasing waiting list size
Volume of 52-week waiters

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

1. Draft Operational Plan 2020-21 - discussed at Exec Feb 20
2. COVID-19 Recovery Plan Phase 3
3. Performance Dashboard in Real-time
4. 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.
5. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly
6. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly
7. Submission of Recovery and Restoration plans for 2021/22
8. Use of Halton Hospital to deliver Pain daycase activity from May 2021
9. Stretch recovery target set for 100% of 2019/20 activity
10. Daily COO-led performance catch up
11. Divisional recovery plans
12. 52 week recovery plan
13. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners.
14. All 52-week plus waiters have been clinically reviewed and validated

Key Gaps in Control:

Where we are failing to put controls/systems in place?

1. Activity plans do not take into account impact of sickness, shielding requirements due to COVID-19
2. COVID-19 Recovery Plan based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviors / compliance.
3. ~~Impact of~~ Transfer of Spinal services from LUHFT December 2021 ongoing ~~– impact in relation to overall Trust RTT performance is currently unknown, neurosurgery are currently validating the data. This will be completed in January 2022.~~

Assurances:

What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?

Level 1
Daily performance review with Divisions
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.
Divisional plan presented to support recruitment of key staff
Daily monitoring of critical staff absences at Huddle.

Level 2
Integrated Performance Report – Reported monthly at Trust Board
Recovery and Restoration Update provided at Trust Board

Level 3
Meetings with Commissioners – monthly

Gaps in Assurance:

Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

1. Transformation Board delayed due to COVID response
2. C&M approach to access and planning
3. Non-elective activity / ICU capacity
4. Thrombectomy demands
5. Sickness and self-isolation of critical staff
6. Recruitment and retention of key staff

	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	~~April 2021~~	~~Commenced~~ Completed
2	Implementation of COVID Recovery Plan to increase activity	COO	~~End of July~~ Sept 2022	~~Phase 1 complete~~ On track
3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	Superseded
4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	May 2021	~~Commenced~~ Completed
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue. NHSI pilot ongoing.	COO	~~May 2021~~ March 2022	Pilot Delayed
6	Continued Job Planning for consultants for 2021/22	COO	~~Mar 2021~~ Mar 2022	On track
7	Data requested from LUHFT to inform RTT position.	DoSO	June 2021	Complete
8	Closer monitoring of position and forecasted position	COO	September 2021	Complete
9	Divisions to provide workforce recovery plan in key areas (Theatres)	COO	September 2021	~~On track~~ Complete
10	Bed repurposing project to increase efficiency and respond to changing demand	COO	~~March 2022~~ April 2022	Commenced December 2021
11	Overdue follow up waiting list is to be monitored by the division by undertaking a validation exercise and a review of the patients to determine what patients can be moved over to PIFU	COO	March 2022	On track

Risk ID: 003	Date risk identified April 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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.		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks		
455	If controls are not put in place to manage violent and aggressive patients, who are violent and aggressive then there is a risk to staff safety. (Neurology Division / Neuro Surgery Division)	12
Risk Appetite	Cautious	

	Consequence	Likelihood	Rating
Initial	Major	Possible	
	4	3	12
Current	Moderate	Possible	
	3	3	9
Target	Minor	Possible	
	2	3	6

Key Impact or Consequence

- Physical Injury /- Emotional/psychological impact on staff and other patients
- Low morale
- Increased sickness levels
- Litigation
- Involvement with Regulators e.g. HSE, CQC, NHSE/I due to increased level of RIDDOR reports, staff harm due to violence and aggression (V&A), 4 fractures reported to HSE in past 12 months (2020/21)
- Increase in staff turnover
- Potential for HSE visit due to increase in RIDDOR incidents related to fractures

Performance:

What evidence do we have of the risk occurring i.e. likelihood?

Physical Assaults on staff

2019/20	2020/21	2021/22
Q1 = 27 Q2 = 45	Q1 = 22 Q2 = 56	Q1 = 41 Q2 =27
Q3 = 40 Q4 = 29	Q3= 78 Q4 = 40	Q3 = 36

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%) **– .02%.**

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

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. 11.Restraint Training rolled out in CRU and other ward areas – 287 staff have completed Restraint Training
12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are aggressive
13. National Violence Reduction Standards issued:
14. V&A Strategy in development in line with national standards – update on action plan was provided to Quality Committee October 2021. Due at Board for approval in April 2022
15. Baseline audit completed – reported to Health, Safety & Security Group May 2021
16. Special Observation of Patients Policy in place
    Post-incident staff debriefing in place (MDT approach)
17. Violence and Aggression Prevention operational group established July 2021

Key Gaps in Control:

Where we are failing to put controls/systems in place or where are we failing to make them effective?

1. Lack of agreed KPIs within the Security Contract – in place from April 2022
2. Compliance with statutory and mandatory training

Assurances:

What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?

Level 1

Trust Safety Huddle – daily Monday- Friday
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 **–** bi-monthly
Transformation Board - monthly

Level 2

Annual Governance Report – Quality Committee
Quality Dashboard – Quality Committee – monthly

Gaps in Assurance:

Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

1. Lack of benchmarking data across similar Trusts – to commence with Queen's Square in Q1 2021/22 awaiting information as delayed due to Covid

<u>Level 3</u> Staff Survey 2020~~1~~ 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 and interim review in December 2021 confirmed this.	

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 Update Sep 21 – The new contract will go live in April 2022 with KPIs in place.	CN	~~End of Nov 19~~ ~~Oct 2020~~ June 2021	~~Delayed~~ Completed
2	Continued focus on statutory and mandatory training compliance Trust Wide – in line with new social distancing requirements	CPO	~~End of March 2021~~ ~~June 2021~~ March 2022	~~On track~~ Delayed
3	Pilot of Shiny Minds App to be evaluated	CPO	~~End of March 2020~~ ~~September 2020~~ ~~December 2020~~ June 2021	~~Delayed~~ Completed
4	Benchmarking of nurse turnover of similar Trusts across Cheshire & Merseyside	CN	End of Sept 2020	Complete
5	Roll out of Looking After Staff to Look after Patients (LASTLAP) to all wards	CN	End of Aug 2020	Complete
6	Audit of LASTLAP to be completed Update 17 Jun 21 – Audit completed in May 2021	CN	~~Jan 2021~~ Quarter 1 2021/22	Complete
7	Outcome of Investors in People to be reported	CPO	~~Jan 2021~~ June 2021	~~On track~~ Completed
8	Roll out of Restraint Training across all wards Update Sep 21 – Incorporated in new training package and now delivered as part of induction and all refresher training. Additional sessions have been offered including bespoke training in response to current incidents.	CN	~~March 2021~~ June 2021 Sep 21	~~On track~~ ~~Delayed~~ ~~On track~~ Completed
9	Roll out of psychology sessions across the wards for staff health and well being	DCOO	March 2021 June 2021	On track Completed
10	Implementation of Violence and Aggression Prevention operational group.	CN	July 2021	~~On track~~ Complete
11	Benchmarking commenced with Queen's Square regarding management of patients displaying violent and aggressive tendencies. Awaiting information, delayed due to Covid.	DCN	~~Nov 2021~~ March 2022	On track
12	Quality Committee Approval of Violence and Aggression strategy in line with national standards	DCOO	March 2022	On track

Risk ID: 004	Date risk identified April 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks		
543	If delays in completion of IT projects continue, then there is a risk to patient safety, specifically the risk of a loss, duplication and inaccurate key data on reports generated by Epatient (EPN) system, resulting in a lack of clinical confidence in the accuracy of the reports.	15
753	If demand for acute in-patient assessment continues to exceed capacity, there is a risk to patient care.	12
621	If Neurophysiology reports are delayed (Exceeds Trust Target of 14 days), then there is a risk of negative clinical impact on patient care.	12
Risk Appetite	**Cautious**	

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

Key Impact or Consequence

- Key objectives not met
- Poor patient and family experience
- Reputational damage
- Standards of care

Performance:
What evidence do we have of the risk occurring i.e. likelihood?

1. Increase in reported deaths from 92 in 2019/20 to 112 in 2020/21 which was due to Covid-related deaths and from the acute stroke service which was temporarily transferred from LUFT. (45 deaths in year to December 2021 and rolling 12 month Risk Adjusted Mortality Index (RAMI) better than expected through 2021/22
2. Reduction in the number of formal complaints received with 67 in 2020/21 compared to 129 in 2019/20
3. Zero Never Events in 2020/21. (One to date in 2021/22)
4. 13 cases of MSSA against a threshold of 8 in 2020/21
5. Increase in Nosocomial Infections
6. Covid-19 pandemic and visiting suspended
7. C-Diff and Klebsiella trajectory not currently being met in 2021/22 and MSSA infections increasing.

~~8.~~ There has been an increased incidence of HCAI this financial ~~year which it is proposed to monitor via a new BAF risk 016~~

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

1. Quality Strategy 2020 – 23 – approved Sept 2019
2. KPIs for Year 2 of the Quality Strategy approved March 2021and reviewed and approved in August 2021 by Quality Committee.
3. CARES Review Programme 2021/22
4. HCAI Reduction Plan 2021/22
5. FOCUS Programme 2021/22
6. Theatre Utilisation Programme
7. Patient Family Centred Care Group – on hold due to Covid, Patient Experience Group still running
8. COVID-19 Recovery Plan – May 2020
9. Clinical Audit Plan – CESG June 2021
10. IPC – strategic COVID 19 Plan January 2021. IPC BAF reviewed at Trust Board November 2021 and March 2022
11. Trust Recovery Roadmap
12. Virtual visiting with 'Facetime' etc. and regular phone calls to family / next of kin by nursing and medical staff
13. Monthly meetings with staff to manage quality accounts within timescales
14. Additional new BAF risk added ~~proposed~~ for Infection Prevention and Control February 2022

Key Gaps in Control:
Where we are failing to put controls/systems in place or where are we failing to make them effective?

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. All vacancies now filled
4. Covid-19 pandemic – reduction in staffing due to sickness and shielding, different ways of working implemented

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – Daily Ward / Departmental Huddle Theatre User Group Divisional Governance Meetings – monthly Mortality Review Group – monthly Serious Incident Group - monthly Transformation Board Balance Score Cards – monthly Operational Management Board - monthly **Level 2** Quality Dashboard – Quality Committee – monthly Quarterly Governance Report IPC Annual Report – May 2021 Safeguarding Annual Report – June 2021 Annual Governance Report 2020/21 Medicines Management Annual Report – December 2021 Quality Strategy Progress Report – March 2021 COVID- Update to Trust Board – monthly – now part of business as usual in CEO report Mortality Report to Quality Committee **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meeting with Commissioners – Quarterly National Inpatient Survey Results –moved from national score of 9th to 8th in 2020/21 - published October 2021 CQC Mental Health Inspection – December 2020 CQC Interventional Radiology Inspection – published December 2021	

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	CEO	~~April 2020~~ Aug 2020	~~Not started~~ Complete
2	Recruit to Tissue Viability Team or test alternative options to fulfill the role	DCOO	~~May 2020~~ Sept 2020	Completed
3	Transformation Board and reporting arrangements to be introduced	CEO	~~February 2020~~ June 2020	Completed
4	On-going participation in discussions to ensure influence in future system wide plans	CEO	~~March 2020~~ ~~March 2021~~ March 2022	On track
5	Recruit to additional post within the IPC Team to lead on the response to Covid	DCOO	~~March 2021~~ May 2021	~~On track~~ Complete
6	Address reduction in staffing due to Covid-19. Ongoing work required to address staffing due to increased variants and efficacy of vaccinations.	DCOO	~~June 2021~~ March 2022	On track

Risk ID: 005	Date risk identified April 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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		CQC Regulation:	Regulation 18 Staffing
		Ambition:	Excellence in patient care and staff wellbeing
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked operational risks

ID	Risk	Score
140	If the Trust fails to achieve the agreed internal compliance target rate for all statutory and mandatory training topics, there is a risk to the achievement of CQC standards and regulatory requirements.	12
141	If Clinical and Medical Staff are unable attend mandatory training sessions, as a result of increased workload, there is a risk to the Trust achieving CQC standards and other external regulatory requirements.	12
3232	If capacity pressures, associated with workforce, theatres and ward beds continue then there is a risk the Trust will fail to deliver activity associated targets and financial plan.	16

	Consequence	Likelihood	Rating
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?*
• Reduced patient safety and poor patient experience • Business continuity • Reputational damage • Reduced staff morale • Sickness increases • Staff Turnover increases • Staff capacity to attend training and development and complete annual appraisals	Nursing Turnover Overarching Staff Turnover Sickness Absence Statutory and Mandatory Training Quarterly Pulse Survey Feedback from staff support sessions Vacancy rates Appraisal Rates

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

1. Annual Operational Plan and workforce plan ~~- March 2019~~
2. Annual succession planning started 2019
3. Five year education plan to ensure supply – 2017 - 2022
4. Quality Strategy 2020-2023 approved Sept 2019
5. People Strategy revised in line with the national People Plan in Sept 20
6. Staff Survey / People Action Plan - June 21
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 North West
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. Debriefs following first wave of COVID
19. Mental Health First Aid Training
20. Collaborative International Recruitment – 38 arrived, 50 forecast for 2022/23
21. Virtual recruitment days for Qualified Nursing staff
22. Quarterly Staff Pulse Survey – commenced April 2021
23. Alternative methods of training devised and a blended approach is in place
24. Regular updates received re pensions and visa arrangements
25. Freedom to Speak up Guardian
26. Board Wellbeing Guardian
27. Exit Interview and Flexi Working Audit Planned
28. Hybrid training models developed to enable ongoing delivery of training with social distancing
29. Extension to pension flexibility out to consultation
30. New Wellbeing Strategy
31. Agreed schedule of Deputies engagement sessions x1 per month

Key Gaps in Control:
Where we are failing to put controls/systems in place?

1. Implications of Brexit i.e. Visas on recruitment not yet known
2. Changes to pension arrangements 2020/21 out to further consultation ~~complete~~ though implications for recruitment and retention still not understood
3. Continued national shortage in supply of nursing staff

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 Staff Support sessions provided by NOSS Participation in Quarterly People Pulse Survey **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC – Mar 2021 (linked to People Plan) Communication and Engagement Strategy – Trust Board Sept 2020 **Level 3** Outcomes of 2020 Staff Survey. 2021 Staff Survey to commence September 2021 Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance Investors in People Accreditation 2020 – Gold Status, 2021 interim report received December 2021 Investors in People Wellbeing Award 2021 – Gold Status Final evaluation of Shiny Minds app	1. Delivery of National People Plan

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	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.	CPO	Ongoing ~~Mar 2020~~ ~~Dec 2020~~	Complete
2	Outcome of national review of the 2015 NHS Pension Scheme and its implications awaited	CPO	~~Dec 2020~~ ~~March 2021~~ March 2022	On track
3	Alternative solutions for statutory and mandatory training in development whilst socially distanced training continues	CPO	March 2021	~~On track~~ Complete
4	Continued progress to develop a C&M Collaboration at Scale for Nursing Workforce and progress recommendations	CPO	~~End of March 2020~~ June 2022	Delayed
5	Outcome of Shiny Minds app to be evaluated	CPO	~~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	CPO	March ~~2021~~ 2022	On track
7	Await outcome of Investors in People Assessment process for 2020 not received	CPO	November	Complete
8	Commit to international recruitment as part of a regional collaborative campaign Update June 2021 – Arrival of recruits delayed due to Covid-19 situation. Update January 2022 – Delayed recruits arrived. Further 50 committed for 2022/23	CPO & CNO	~~May 2021~~ Dec 2021	~~On track~~ ~~Delayed~~ Completed

Risk ID: 006	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: 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:	February 2022
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Acting Chief Operating Officer

Linked Operational Risks

ID	Risk	Score
305	Legionella positive samples found within water systems in Walton Centre	12
301	Fire Safety Compliance – works to reinstate fire compartmentation are now complete and ongoing contractor management process is now in place. The risk register has been amended accordingly and the level recently adjusted down to a risk score of 8	8
220	Air Handling Plant for Theatres 1-5 not delivering air to operating rooms to comply with recommendations of Health Technical Memorandum (HTM) 03-01	16

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

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

- Unsafe environment for staff
- Patient safety - Compromised quality of care - Poor patient experience
- Business continuity
- Reputational damage
- Financial impact
- Legal Compliance

Performance:

What evidence do we have of the risk occurring i.e. likelihood?

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

1. Estates Strategy – approved 2015
2. Operational Plan 2019-20
3. Revenue and Capital budgets - Ongoing
4. Backlog Maintenance Register - updated June 2021
5. Maintenance Programme
6. **Estates related policies**
   - Electrical Safety Policy - 2020
   - Water Management Policy – 2021
   - Fire Safety Policy 2019
   - Control and management of Contractors 2018
   - Health & Safety Policy 2019 - 2022
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
12. Premises Assurance Model – completed 2021
13. Completed Phase 3 of the heating replacement scheme
14. Remedial works through site to increase hot water circulation temperatures
15. Continued flushing of water outlets
16. Replacement of thermostatic mixing valves
17. Sink and pipework replacement programme, as possible
18. Use of 'point of use' filters to clinical outlets
19. Completion of the fire compartmentation reinstatement works
20. Sustainability plan update in progress – draft approved by BPC and Board in December 2021 and ~~to be~~ submitted to NHSIE in January 2022. Feedback awaited.

Key Gaps in Control:

Where are we failing to put controls/systems in place?

1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post COVID-19
2. Limited access to certain areas prevents visual inspection
3. Policies require review to ensure that they are reflective of current legislation
4. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives
5. Capital programme now being managed at an ICS level.
6. Programme for Pipework replacement incomplete
7. The national Premises Assurance Model (PAM) outcomes

Assurances:

What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?

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

Gaps in Assurance:

Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

1. Limited Aintree University Hospital planned maintenance/KPI reporting in place
2. Lack of reporting of sustainability data

Level 3 6 Facet Survey – updated July 2021 CQC Inspection Report Aug 2019 NHS Digital acceptance of ERIC return 2021 Cladding Review – Sept 2016 Fire Brigade post-incident review of Fire Processes - 2019 ERIC Returns - annually Reinforced Aerated Autoclaved Concrete (RAAC) review 2021 Premises Assurance Model (PAM) Assessment 2021	

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. This work continues to progress with Soft FM services being tackled in 1st wave	DCOO	~~March 2020~~ March 2023	Delayed
2	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of Aintree University Hospital via monthly meetings. Estates are currently reviewing resource and cost impacts in advance of recommendation	DCOO	~~March 2020~~ March 2022	Delayed
3	Integrate Trust Sustainability Plan into Estates Strategy review and establish reporting to BPC. Walton Centre "wider" Estates Strategy to be incorporated into forthcoming ICS Estates Strategy. Sustainability Plan now Board approved and submitted to ICS. Local action plan to be developed. WC Estates Strategy to be incorporated into wider "system" strategy currently being led by LUFT	DCOO	~~Jan 2020~~ ~~September~~ ~~March 2021~~ September 2022	Delayed
4	Ongoing monitoring of Phase 4 Heating and Pipework Programme	DCOO	~~March 2021~~ March 2022	Ongoing
5	Roll out of Premises Assurance Model and reporting	CEO	March 2021	~~Not started~~ Complete
6	Design process initiated for upgrade works to Theatres 1-5 due to non-compliant Air Handling Units	DCOO	April 2022	Commenced

Risk ID: 007	**Date risk identified April 2020**	**Date of last review:**	December 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:**	February 2022
		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:	Chief People Officer

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

	Consequence	**Likelihood**	**Rating**
	Major	Possible	
Initial	4	3	12
	Major	Unlikely	
Current	4	2	8
	Major	Unlikely	
Target	4	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 but has now restarted Trust bid successfully for Digital Aspirant funding approved by NHS Digital. 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. Outpatient Transformation Project 2. Inpatient Transformation Project 3. Theatres Project 4. Paper Light Project 5. Digital Transformation Board aligned to governance groups across the organisation (structure sign-off by Executive Team Q1 21/22) 6. IT Technical Programme of work 7. Cyber Security Programme 8. PMO Function underpinning the Digital Strategy 9. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 10. Post covid EPR rollout plan for 20/21 11. Digital Transformation Programme (LoA/MoU NHSD/X) 12. Digital Aspirant status to allow Digital Transformation 13. HiMSS Level 5 achieved, planning for Level 6 14. New Digital strategy with stakeholder involvement facilitated by MIAA 15. Representation on HCP Programme Boards 16. Head of IM&T SRO for upcoming NHSX 'What Good Looks Like' HCP Programme Board.	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. 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 Information Governance & Security Forum –monthly Digital Prioritisation Group - quarterly Clinical Risk Group Executive Team review of C&M Hospital Cell Digital Objectives Information Security Management Systems Certification IS27001 accreditation September 2020 **Level 2** Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group C&M Chief Information Officers Digital Collaboration Group National Chief Information Officer Weekly Meetings **Level 3** Critical Applications Audit – Jan 2020 Healthcare Information and Management System Level 5 Q1 2021/22	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. Workshops facilitated by MIAA Q2-3 2021/22.

Information Security Management Systems Certification IS27001 accreditation December 2021 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 HCP by C&M Digit@LL NHSX monitoring Digital Aspirant via CORA against LoA.	

	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	MD	~~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	CFO	March 2021	Complete
3	New Digital Strategy with MIAA / C&M HCP	CPO	~~May 2021~~ ~~December 2021~~ April 2022	Commenced
4	Digital Aspirant MoU signed by all parties	CFO	March 2021	Complete

Risk ID: 008	Date risk identified: April 2020	Date of last review:	December 2021
Risk Title:		Date of next review:	February 2022
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.		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked operational Risks				
Risk Appetite	Cautious			

	Consequence	Likelihood	Rating
Initial	Major	Likely	
	4	4	16
Current	Major	Likely	
	4	4	16
Target	Moderate	Possible	
	3	3	9

Key Impact or Consequence

- Loss of operational and clinical disruption or a ransom;
- Potential financial loss due to loss of activity
- Likely to lead to financial, business and operational impacts as well as reputational damage;
- potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover
- Non-compliance with Data Protection Laws/Network and Information Systems Directive
- Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.

Performance:
What evidence do we have of the risk occurring i.e. likelihood?

Q1 20/21 - 72 Carecerts (3 High, 3 Medium,66 Low Level)
Q2 20/21 - 67 Carecerts (6 High Level, 61 Low Level)
Q3 20/21 - 66 Carecerts (2 High Level, 64 Low Level)
Q1 21/22 - 64 Carecerts (1 High Level, 63 Low Level)
Q2 21/22 – 72 Carecerts (2 High Level, 20 Low Level)

Cyber security attacks are increasing and ongoing work is required to keep up to date
Log4j High Vulnerability identified at global 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

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
18. Daily National update logging of log4j remedial work
19. Purchases made in March through IT Capital and Digital Aspirant Capital programmes will help increase the Trust's Cyber Security footprint, as outlined below:
    - **Interoperability** – Upgrade to the latest supported Microsoft Windows Operating System to continue to receive critical security updates
    - **NHS Mail** – Migration to the latest supported Microsoft Exchange platform to continue to receive critical security updates
    - **Backups** – Transition to immutable "offline" backups to protect against ransomware attacks
    - **Datacentre** - Upgrade to the latest supported VMware platform to continue to receive critical security updates
    - **SQL** - Migration to the latest supported Microsoft SQL platform to continue to receive critical security updates

Key Gaps in Control:
Where we are failing to put controls/systems in place or where are we failing to make them effective?

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?

Level 1

TIAG review of CareCERTs - Weekly
Cyber Security Awareness Presentation to Executive Team - July 19

Level 2
Monthly report from Information Governance Forum to Business Performance Committee
Annual Report of Senior Information Responsible Officer - Trust Board

Gaps in Assurance:
Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

1. Third party assurances required regarding satellite sites
2. Ongoing work with NHS Digital to inform funding requirements
3. Local skillsets limited resourcing(001)
4. Log4J National systems status still unknown

October ~~July~~ 202~~0~~1 **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) External Penetration Testing – May 2021 Regional Desktop Exercise – March 2021 Internal Desktop Cyber Exercise – May 2021 Trust Board Cyber Security Training – April 2021 Full Cyber Library completed by C& M HCP – August 2021	

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	CFO	~~Aug 2020~~ ~~March 2021~~ Nov 2021	On track Completed
2	C&M 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.	CFO	~~Aug 2020~~ ~~March 2021~~ ~~May 2021~~ August 2021	~~On track~~ ~~Delayed~~ Completed
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 Update Jan 2022 - Working on regional solution 2022/23 with Digital Lead	CFO	~~Aug 2020~~ ~~March 2021~~ June 2022	~~On track~~ Complete for 20/21 Delayed
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. Revisiting with HCP with new digital lead and Cyber skillsets	CFO	~~Aug 2020~~ ~~March 2021~~ ~~May 2021~~ ~~September 2021~~ June 2022	~~On track~~ ~~Delayed~~ Partially Complete
5	Recruit Cyber lead fixed term 24 months / service to underpin current processes with MIAA / C&M HCP.	CFO	~~Aug 2021~~ April 2022	On track

Risk ID: 009	Date risk identified: April 2020	Date of last review:	February 2022
Risk Title:		Date of next review:	June 2022
The Trust needs to embed a culture of innovation to underpin its status as a Centre of Excellence, develop/implement ground breaking patient treatments and attract/retain a world class workforce ~~consultant body.~~		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:	Chief People Officer

Linked Operational Risks	
No linked risks	
Risk Appetite	Cautious

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

Key Impact or Consequence

1. Impact on Trust reputation
2. Inability to improve patient care and deliver efficiencies
3. External scrutiny e.g. CQC well led
4. Inability to retain clinical staff if unable to fulfil their innovation/research ambitions
5. Sufficient workplace capacity and resourcing must be maintained to ensure innovative practices, treatments and boundary scanning
6. Risk aversion, complacency and the status quo if staff demotivated
7. Too many innovations will not be fully implemented, acknowledged and celebrated
8. The Trust's innovation agenda becomes weakened in an environment of meeting/emerging system change

Performance:
What evidence do we have of the risk occurring i.e. likelihood?

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
- Individual projects being successfully delivered
- Local and national political developments
- Financial and Covid 19 pressures may distract from commitment to innovation

Key Controls or Mitigation:
What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated

1. Innovation Strategy 2019/24 developed
2. Strategy review to be undertaken in the context of Covid-19-related capacity issues
3. Strategy development required to clarify alignments/distinction between "innovation" and "commercial innovation" activities
4. Innovation Pipeline
5. Stakeholder Analysis
6. Innovation Strategy Communication Plan
7. Development of internal processes / information resources to support innovation
8. Developing additional funding streams
9. Investors in People accreditation (2020)

Key Gaps in Control:
Where we are failing to put controls/systems in place or where are we failing to make them effective?

1. Covid-19 delays and impact on resourcing is delaying progress / reducing capacity
2. Lack of clarity around "innovation" and "commercial innovation" activities led by different directorates
3. Competitor Analysis to be completed (to be finalised by Communications & Marketing Manager, subject to prioritisation
4. 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)
5. Complex alignment between Innovation and other teams has progressed significantly but more work is needed (Covid and resourcing limitations has delayed)
6. Multi-team working to improve consideration of innovations developed outside the Trust and address risk aversion
7. Income generation model (for the Spinal Improvement Partnership) approved by Board but contracts still being negotiated - some Trust resourcing issues
8. The Trust may not be incentivised to develop new income streams if system level accountability and block finances remain post-pandemic.

Assurances:
What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?

Level 1

- Innovation Team Meeting – monthly (currently meeting less frequently due to resourcing issues)
- Medical Innovation Group – bi-monthly (Meeting membership to be revised in 2022 to widen clinical representation to reflect the full range of services offered by the Trust)
- Regular commercial/ innovation meetings with procurement, IT, IG, service improvement, clinical and other teams
- Executive Team approval of innovation business cases and initiatives
- RIME Committee approval of Charity Committee innovation funding applications

Gaps in Assurance:
Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

1. Benefit realisation for innovative business cases not yet feasible due to resourcing limitations and lack of defined metrics
2. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency and potentially commercial innovators to identify appropriate process

Level 2

- Innovation bi-monthly update to RIME Committee
- RIME Committee Chair's Report to Trust Board and Council of Governors
- 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

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Competitor analysis to be initiated and presented to Trust Board	CPO	~~TBC (due to COVID-19)~~ July 2022	~~On hold~~ Delayed due to Covid
2	Further engagement of stakeholders through communication and engagement (including patient involvement)	CPO	~~Review progress~~ ~~Q3 2021/22~~ TBC due to Covid-19	~~On track~~ Delayed due to Covid
3	Benefits realisation of Multitom Rax Business Case to be presented to Executive Team and Trust Board	CPO	~~April 2021~~ April 2022	Delayed due to Covid On track
4	Further development of innovation processes and guidance Update January 2022 – processes largely in place and ongoing process to assess and improve is business as usual	CPO/ HCE&M	Q3 2021/22	~~On track~~ Complete
5	Peer Review/review process	CPO/ HCE&M	~~Q4 2021/22~~ September 2022	~~On track~~ Delayed due to Covid
6	Income generation initiative (Spinal Improvement Partnership) being prioritised Update January 2022 – Covid added > 1 year delay due to resourcing and project complexities limiting progress. Contracting in progress	CFO/ HCE&M	~~October 2020~~ ~~March 2021~~ ~~August 2021~~ ~~October 2021~~ February 2022	Delayed due to Covid. On track
7	Investors in People Assessment January 2022 update – The Trust underwent reaccreditation assessment for the 'we invest in people' standard in September 2020 and was accredited Gold Award status. The first annual review was undertaken in November 2021 and maintained Gold Award accreditation. Next review is due to be undertaken in November 2022 The Trust also underwent reaccreditation assessment for the 'we invest in wellbeing' standard in June 2021 and was awarded Gold accreditation. The first annual review is due to be undertaken in June 2022.	CPO	October 2020	Completed
8	Addressing resourcing issues in Innovation / Commercial team and strategic review. Update January 2022 – Commercial strategy underway, due to BPC in February 2022. Needs to align with Trust Strategy and changes to service.	CPO	~~June 2021~~ ~~Q2 & Q3 2021~~ December 2022	~~On track~~ Ongoing

Risk ID: 010	Date risk identified: April 2020	Date of last review:	December 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:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Strategic Priority:	All Strategic Priorities
		Assurance Committee:	Trust Board
		Lead Executive:	Chief Executive

Linked Operational Risks

Potential impact on all high level operational delivery risks and financial requirements/regime.

Risk Appetite	Cautious

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

Key Impact or Consequence

Potential reduction of Trust autonomy with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance and finances.

Performance:
What evidence do we have of the risk occurring i.e. likelihood?

- Hospital Cell and Governance arrangements determined at regional level with limited consultation
- Changes in national policy due to COVID-19
- Health and Care Bill in process of going through Parliament indicates decreased autonomy for individual Trusts with increased control by ICS / central Government, but ongoing accountability for Trusts for individual organisational performance
- Establishment of Provider Collaboratives (CMAST)
- Guidance published on ICS and ICBs including model Constitution

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

1. Trust Strategy 2018-2023 review and consultation underway for an approval by April 2022
2. Communication and Engagement Strategy 2020 - 2025
3. Active membership of Cheshire and Merseyside Health Partnership (C&M HCP) and Collaboration at Scale Programme
4. Member of Liverpool Health Partnership
5. Member of Liverpool PLACE
6. Member of Trauma Partnership
7. Membership of Specialist Trust Alliance
8. Medical Directors Group HCP level
9. Chief Operating Officer Group HCP level
10. Membership of Directors of Finance Group HCP level
11. Management Side Chair of NW Staff Partnership Forum
12. Membership of Director of Nursing Group HCP level
13. Membership of Director of Workforce Group HCP level
14. Neuroscience Programme Board – Quarterly
15. Revised MoU provides for Specialist Trusts to have 1 x Chair and 1 x CEO representative on the HCP Board which will aid influence
16. Member of the newly-established Provider Collaborative
17. ICS CEO and interim Chair appointed, other senior roles being recruited

Key Gaps in Control:
Where we are failing to put controls/systems in place or where are we failing to make them effective?

1. Hospital Cell and governance arrangements potentially result in greater influence for larger providers
2. Financial arrangements now determined across HCP level – BAF 15
3. Clarity on the ability of Provider trusts to influence future ICS arrangements
4. Completion of review of Stakeholder Analysis
5. Potential for Health and Care Bill to not pass through parliament in time and 1 April 2022 date may not be met
6. Leadership appointments not yet all in place and interim Chair 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?

Level 1
Executive Team meetings – weekly
Weekly C&M CEO meeting

Level 2
Chair and Chief Executive Reports - Trust Board
Part of C&M Provider Collaborative Meeting

Level 3
Part of Specialist Trust Alliance
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 meetings between CEO of HCP and CEO of Walton Centre
Part of ICS Transformation Programme Board (Neurosciences Programme)

Gaps in Assurance:
What are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

- Long term role and purpose of in hospital cell not determined
- Outcomes of NHS England ‘Changing Landscapes’
- Lack of clarity on future of specialist commissioning
- Potential impact on services outside future ICS arrangements
- Postponement of arrangements due to Covid-19

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 2022	Ongoing
2	Meeting with Jackie Bene (CMHCP)	CEO	January 2021	Complete
3	Meeting with Sheena Cumiskey arranged	CEO	Sep 2021	Complete
4	Ensure Trust engaged in developing system and taking on system roles – CEO appointed to Lead Nurse in Hospital Cell from October 2021	CEO	March 2022	Ongoing
5	Involvement in Provider Collaborative – attendance at CEO development session and CEO and Chair's briefings, Audit Committee briefings from MIAA regarding ICS arrangements.	CEO	March 2022	Ongoing
6	Specialist Trust alliance established building on collaborative working.	CEO	March 2022	Ongoing

Risk ID: 011	Date risk identified: April 2020	Date of last review:	December 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:	February 2022
		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:	Chief People Officer

Linked Operational Risks		Consequence	Likelihood	Rating
None identified.	Initial	Major 4	Possible 3	12
	Current	Major 4	Possible 3	12
Risk Appetite: Moderate	Target	Major 4	Unlikely 2	8

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

Key Controls or Mitigation: *What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated*	Key Gaps in Control: *Where we are failing to put controls/systems in place or where are we failing to make them effective?*
1. Research and Development Strategy 2019/24 2. MHRA Inspection Audit, peer review etc. 3. New partnerships with universities, other trusts and system level collaborations 4. Prioritisation of commercial trials and development of new income streams 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 Neuroscience Research Centre (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 • Principle Investigators Forum • Sponsorship Oversight Group • Research Capability Funding Sub-committee • Roy Ferguson Compassionate Care Award Group **Level 2** • Research update to RIME Committee • RIME Committee Chair's Report to Board of Directors **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019	1. Service redesign still in implementation phase, impact not assessed 2. Organisational change process suspended due to COVID-19 3. Engagement/utilisation of LHP and SPARK inconsistent

	Corrective Actions: *To address gaps in control and gaps in assurance*	Action Owner	Forecast Completion Date	Action Status
1	NRC organisational service change process supported by Human Resources.	CPO &CDRD	April 2022 (due to COVID 19)	~~On hold~~ On track
2	Senior Neuroscience Research Group in place ~~with agreed action~~	CPO & CDRD	~~September 2020~~ June 2022	On track
3	Investors in People Assessment	DW&I	October 2020	~~On track~~ Complete
4	External review undertaken by Caroline Murphy, Kings College London. Report and findings to be presented at RIME committee in March 2021.	DW&I	November 2020	~~On track~~ Complete
5	Clinical Director of Research and Head of LHP SPARK have begun to meet on a regular basis, it is envisaged this relationship will enable growth of closer working between WCFT and LHP to enable reciprocal engagement. Workshops are planned between NRC function and LHP.	Clinical Director of Research & Development	April 2022	On track

Risk ID:	**012**	**Date risk identified**	**October 2020**	**Date of last review:**	December 2021
Risk Title: There is a risk that the allocation of capital set by the HCP to the Trust will not support the full capital plan for 2021-22 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:**	February 2022
				CQC Regulation:	17 Good Governance
				Ambition:	Be financially strong and invest in services
				Assurance Committee:	Business Performance Committee
				Lead Executive:	Chief Finance Officer

Linked Operational Risks

- Specific capital risks reviewed as part of CMG agenda
- Some on-going long term schemes are subject to funding allocations through ICS (given capital allocations are based on 1 year only) which means difficulty in identifying resources for multiple year projects.

	Consequence	Likelihood	Rating
	Moderate	**Possible**	
Initial	**3**	**3**	**9**
	Moderate	**Unlikely**	
Current	**3**	**2 ~~3~~**	**6 ~~9~~**
	Moderate	**Unlikely**	
Target	**3**	**2**	**6**

Risk Appetite	**Moderate**

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on ICS footprints with the Trust's capital resource limit (CRL) allocated from the HCP total. The Trust's allocation was 50% higher than if based on historical capital allocation calculations but was nonetheless oversubscribed. - 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 £6.2m - Any overspend on capital against out CRL will need to be covered by the other Trusts in the HCP (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 received additional capital funding in 2020/21 through Public Dividend Capital as well as additional CRL agreed with the HCP. It is unlikely that this will be repeated in 2021/22 which gives minimal flexibility in management of the capital programme. The Trust currently has one of the lowest capital spends year to date (Sep 21) of its overall allocated plan in the North West.

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 are we 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 COO 2. SFIs/SORD have appropriate approval levels for capital expenditure so CFO / COO 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. Capital prioritisation being undertaken by Ops, Clinical and Finance staff utilising a range of criteria to enable RAG rating of all schemes and prioritisation of the capital plan 6. Regular capital updates provided to BPC (in addition to updates provided in the Finance IPR).	1. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend 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. Reliance on specific items which cause delays if not available 5. Priorities may change in year which may lead to pressures against the plan 6. Market prices may differ from estimates once equipment is purchased 7. Clarity of how future revenue costs associated with capital and digital investment will be funded in the long term.

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 prioritising 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. Business Performance Committee / Board – capital plan approved and all cases >£100k < £500k are approved by BPC and above £500k are approved by Board. Regular updates on Capital expenditure and forecasts to BPC. **Level 3** Participation in the C&M Directors of Finance meeting where capital allocations / funding and forecasts are discussed to enable decisions to be made regarding moving funds within the system. External audit annually on capital expenditure	1. Level of capital resources limit (CRL) are based on allocations from HCP and not the former basis which enabled Foundation Trusts the freedom to generate their own cash resources to spend on capital requirements; 2. The timeliness of national decisions on when additional capital is available / can be spent which could lead to a reduction in the ability to spend capital given funds cannot be carried forward into future financial years; 3. Capital allocations are currently based on 1 year limiting decision-making / resource allocations on longer term projects.

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Long term capital plan to be completed for 2022/23 to ensure all requirements and replacements known	DoF/DoSO	~~31 Mar 21~~ ~~31 Oct 21~~ 31 Mar 22	On track – continuous review
2	Application of criteria for capital schemes to prepare prioritised capital programme.	DoF/DoSO	~~11 Jun 21~~ 31 Mar 22	On track – continuous review
3	Ensure that maintenance contracts are all up to date so equipment covered	DoF/SoSO	~~Ongoing~~ 31 Mar 22	On track
4	Regular capital forecasts to provide up to date position on the year end projections	DoF	~~Ongoing~~ 31 Mar 22	On track
5	Continued discussions with HCP DoF to ensure aware of capital pressures and so allocations forthcoming as required from other provider underspends.	DOF	~~Ongoing~~ 31 Mar 22	On track

Risk ID: 013	**Date risk identified: October 2020**	**Date of last review:**	December 2021
Risk Title: If the Trust does not deliver the financial plan for 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 and levels of financial efficiencies will not be deliverable		**Date of next review:**	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive	Chief Finance Officer

Underlying Operational Risks				**Consequence**	**Likelihood**	
135	If the move to the blended payment approach and population based commissioning allocations continue then this may lead to a risk of reduced allocations for the Trust.	16		**Major**	**Likely**	**Rating**
323	If capacity pressures, associated with workforce, theatres and ward beds continue then there is a risk the Trust will fail to deliver activity associated targets and financial plan	16	**Initial**	**4**	**4**	**16**
				Major	**Likely**	
Additional Elective Recovery Fund (ERF) income is based on the delivery of % of 2019/20 activity. If these thresholds are not achieved it could lead to a detrimental impact on financial performance.			**Current**	**4**	**2 4**	**8 ~~16~~**
				Major	**Unlikely**	
Risk Appetite	**Cautious**		**Target**	**4**	**2**	**8**

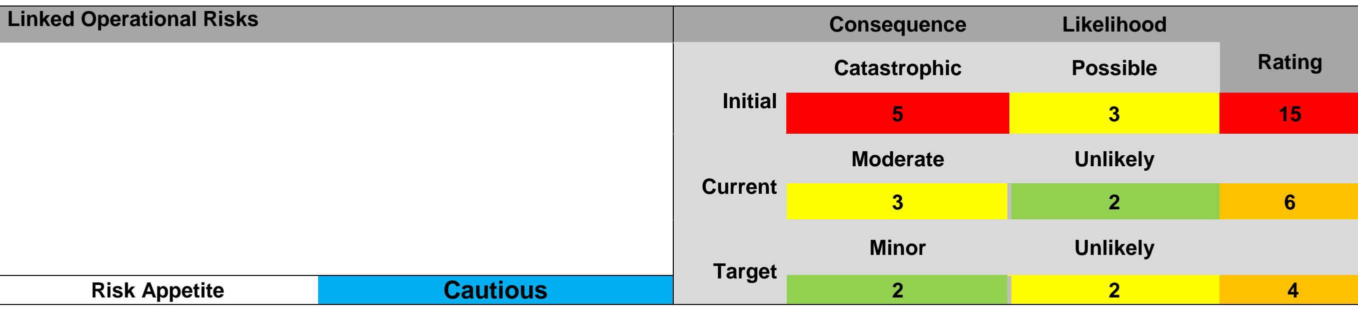
Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• Financial risk rating may decline and lead to increased regulatory scrutiny - ratings suspended 2021/22 • Potential breach of statutory duties • Inability to deliver strategic objectives • Loss of decision making responsibilities • Reduced ability to influence across the system	Original plan submission £1.4m deficit (for H1 2021/22). Break even position was set as a target for delivery and was achieved, in accordance with system plans, (resulting in an increased efficiency requirement for the Trust). Additional income anticipated through Elective Recovery Fund (ERF) to bridge this gap but benefit lost through initial removal of Covid top-up and growth funding from the HCP. Additional £1.6m allocated to the Trust to partially address this gap which reduced the level of required financial savings in H1 and supported the delivery of a breakeven position. H2 2021/22 – initial plan submission £1.5m deficit. Additional system funding allocated with a requirement to deliver breakeven position (with requirement for system to breakeven). To help achieve breakeven, it was assumed that additional income would be received through Elective Recovery Fund (ERF) as well as 2.5% efficiency requirement (system target). Currently on track to deliver breakeven.

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 H1 2021/22 in May 2021 and for H2 2021/22 in November 2021 2. Capital Programme – allocation by HCP in April 2021 and regularly monitored by Capital Management Group. See BAF Risk ID 012 3. Finance and Procurement Strategy – approved July 2019 and progress report to BPC May 2021 and October 2021 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 for H1 2021/22 due to COVID-19 8. Monthly financial forecasts based on current run rates to assess anticipated H1 position compared to plan. 9. Monthly reporting to Board of financial performance through the Integrated Performance Report	1. Financial plan approved by BPC (with delegated authority from the Board) in November 2021. Extremely short system and national deadlines meant that there was insufficient time to gain full assurance that a breakeven position was achievable 2. Expenditure budgets based on H1 run rates (excluding planned ERF margin) updated for anticipated changes in H~~1~~2 2021/22. This caused a particular issue for trusts who planned for ERF as these allocations were stripped out in H2 leaving a gap. Budgets do not take account of agreed establishments or long term historical allocations for non-pay for departments 3. Block contract based on ~~Q3~~ H1 values in 2021/22 amended for planned ERF margin, specific H2 agreed pressures and allocation of central HCP funding. It is currently not clear whether the H2 block contract values will cover expenditure run rates given the need to deliver restoration at risk should the system not deliver and the higher proportion of CIP to be delivered coupled with unknown ongoing Covid requirements 4. QIP plan will be required in H2 to close the gap to deliver a break even plan. Value of QIP to be delivered 2.5% which is above the national average given the financial position of the HCP. Recurrent savings for ~~H1~~ 2021/22 impaired by methodology for allocations, lateness in plan submissions and difficulty in identifying schemes whilst trying to deliver elective restoration. Aim to cover QIP non-recurrently in H2 allowing time to identify and deliver recurrent savings in 2022/23 when it is hoped to move back to 'business as usual' 5. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance and remain on a payment by results basis 6. Currently no guidance on financial regime beyond March 22 as national guidance has yet to be issued. Consequently, financial planning for the next financial year is not possible.

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 Calculation of forecast position for the H2 financial period for comparison against budgets - monthly Covid allocation to recover directly related costs Bed Management Meetings – daily Performance Management Review meetings – monthly Executive review of financial position – monthly NHSI/E review of financial position on a monthly 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 Financial Plan – regular measurement of actual performance against plan including monthly reforecasting to provide assurance around year-end financial plan. Five year financial planning exercise being undertaken, in collaboration with Operational teams, despite lack of national guidance beyond March 2022. **Level 3** Internal Audit review of Accounts Payable – Substantial Assurance Jan 2021 Internal Audit review of Accounts Receivable – High Assurance – Jan 2021 Treasury Management Review – High Assurance –Jan 2021 Internal Audit review of General Ledger – High Assurance Jan 2021 Internal Audit review of Budgetary control (including CIP) – high assurance - 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 –monthly Internal Audit review of coding systems – Substantial assurance – Dec 19 Unqualified opinion on 2020/21 Annual Accounts by external auditors	1. H2 2021/22 plan is based on H1 run rates which makes meaningful comparison of budgets is not accurate 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. This now seems unlikely.

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Bi-monthly update to Finance NED to ensure NEDs are kept up to date with latest finance requirements	CFO	March 2022 - ongoing	On track
2	Weekly feedback from the HCP Finance Advisory Reference Group on the direction of travel for HCP finances.	CFO	March 2022 - ongoing	On track
3	Raising issues with non-English commissioners to NHSI/E	CFO	March 2022 - ongoing	On track

Risk ID: 014	**Date risk identified: December 2020**	**Date of last review:**	December 2021
Risk Title:		**Date of next review:**	February 2022
If the Trust does not develop and grow its capacity in line with increasing delivery requirements, there will be an adverse impact on the quality of its medical education and therefore its reputation over the long 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:	Chief People Officer



Linked Operational Risks		**Consequence**	**Likelihood**	**Rating**
	Initial	Catastrophic 5	Possible 3	15
	Current	Moderate 3	Unlikely 2	6
Risk Appetite: Cautious	**Target**	Minor 2	Unlikely 2	4

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• Failure to comply with Education Contract (the formal agreement between WCFT and DHSC / HEE) • Failure to meet education and training standards as mandated by regulatory bodies e.g. GMC • A weakened internal education leadership & governance framework / advocate for educators • No obvious trajectory for developing future educationalists • Negative impact on the trusts external reputation as centre of academic excellence and subsequent ability to attract highest calibre medics.	• Difficulties experienced during the 2020/21 academic year recruiting to undergraduate supervisor roles • Postgrad supervisors also drawn from same supervisor 'pool', exacerbating demand on a limited consultant resource • Challenge experienced responding to rapid changes in teaching delivery / accessing external platforms and databases e.g. university Zoom teaching and WiFI strength. Ability to facilitate remote student access to clinical activity • Feedback from consultants anecdotally and via GMC trainer survey indicates a small level of dissatisfaction against predominantly positive results. This is in regard to the amount of time provided for training as a pressure to meet clinical targets which can perpetuate a perception that medical education is an addition, rather than an integral activity within clinical work. • Trainee doctor feedback has suggested education progression for 'SHO' grades can be perceived to be limited and therefore WCFT placements educationally unfulfilling.

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 Director of Medical Education (DME) engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and meets at least bi-monthly, more frequently when planning for the new academic year. Clinical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed. 6. SOPs have been created to standardise and assure processes. 7. Delivery of education has been consolidated with new roles including two education fellows at a junior doctor grade and six named lead educator roles for consultants (August 2021) 8. SPA has been allocated for undergraduate educational supervision to ensure consultants who perform this role are formally recognised and remunerated through job planned activities (July 2021) 9. Educational Supervisor guidance based on GMC trainer standards and UoL placement expectations has been issued to relevant consultants and shared with Directorate managers to support job planning discussions (August 2021) 10. Joint working between Neurology postgraduate education leads to address junior doctor experience / progression concerns and modify practical and clinical exposure. 11. Medical Education quarterly and annual reports to Research, Innovation and Medical Education (RIME) Committee.	1. New undergraduate roles are untested 2. Educator support under development including educational appraisal 3. No routine auditing cycle of SOPs 4. Silo working - communication between postgrad and undergrad in regard to available resource 5. Remuneration associated with educational activity is not always clear cut, this may make it difficult to recruit new people to educator roles

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Medical Education Committee minutes • Medical Education overarching Action Plan • Medical Undergraduate Working Group minutes • Junior Doctor Forum (held alongside Guardian of Safe Working) **Level 2** • Medical Education Quarterly Report to RIME Committee • Medical Education Annual Report to RIME Committee • HEENW Annual Education Return Board report • End of Placement Feedback – Undergraduate • Placement Exit Survey – Postgraduate **Level 3** • GMC NTS – Postgraduate Trainee and Trainer • UoL Clinical Undergraduate placement RAG reports • Annual Education Self-Assessment Report – HEENW	1. Medical Education membership of RIME is embryonic and the impact, in terms of facilitating and raising board level consideration of the medical education agenda, is still to be evaluated

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Creation of new SPA funded enhanced education roles, including recognition for Undergraduate supervision to support DME/Clinical Sub Dean with education delivery. Effectiveness of new roles to be reviewed after 12 months.	DME	July 2022	On track
2	Creation of document – Guidance for Educational Supervisors sets expectations for role and responsibility	DME	August 2021	Complete
3	RIME work plan reviewed with consideration of Medical Education contribution to the Committee. Update January 2022 - As of 2020 Medical Education now reports to Research, Innovation and Medical Education Committee and will provide quarterly performance updates as well as an annual report as a means of informing and assuring Board	CPO	~~Ongoing~~	~~On track~~ Complete
4	Medical Education SOPs to be reviewed/ratified by Director of Medical Education/relevant groups	DME/CPO	~~Ongoing~~ June 2022	On track
5	Educational Appraisal is a new role as part of the enhanced education roles created summer 2021, will support improved educator support. An appointment is still to be made; discussions are ongoing with potential candidates.	DME/MD	~~Ongoing~~ June 2022	On track
6	Education Fellows are helping the admin team overcome silo working with practical support to ensure equitable allocation of clinical experiences for Undergraduate and Postgraduate learners. Success to be evaluated via student and junior doctor satisfaction surveys	DME / Clinical Education Fellows	May 2022	On track

Risk ID: 015	Date risk identified December 2020	Date of last review:	December 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:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Finance Officer

Underlying Operational Risks

135	If the move to the blended payment approach and population based commissioning allocations continue then this may lead to a risk of reduced allocations for the Trust.	16
Understanding of impact on capacity / staffing of any changes in flows etc.		
Risk Appetite	Cautious	

	Consequence	Likelihood	Rating
Initial	Major 4	Likely 4	16
Current	Major 4	Likely 4	16
Target	Moderate 3	Possible 3	9

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 different tariff systems (Wales and Isle of Man) - Loss of key relationships in commissioning to Trust. - Impact on specialist Trusts of new arrangements	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. ~~Lack of clarity around financial regime beyond September 2021 (block funding has remained in place for Apr-Sep 2021)~~ Block funding remains in place for the full financial year 2021/22, with a requirement for the system (and as such the Trust) to deliver a breakeven position. Financial planning guidance issued in December 2021 returns to a 12 month financial planning requirement. System requirement to deliver a breakeven position in 2022/23. Second national tariff consultation for 2022/23 has been launched following feedback received. The deadline for this re-consultation is 25 March 2022.

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 (2022/23) 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. CFO currently a member of the FoSH Finance Group which is reviewing impact of the new financial framework on the system for specialist providers and engaging with the wider system on potential changes 6. Progression of commercial strategy to explore new / alternative sources of income to mitigate any potential reduction of income in relation to core NHS contracts. 7. Critical Care and rehabilitation tariffs have been discussed with Specialised Commissioning to see if there is any flexibility for change given latest intelligence.	1. Lack of detailed understanding on how commissioning will occur given the changes from NHSE to HCP 2. Larger acute trusts with underlying structural deficits may have a bigger influence within the 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 disproportionate 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 meaning that the Trust may have 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, especially around some timescales required for delivery of financial returns (and incompatibility with Board / Committee meetings) 7. ~~Lack of clarity on future financial framework beyond 31 March 2022.~~ Lack of confirmed tariff for 2022/23 ~~longer term financial planning creates further uncertainty for the Trust.~~

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 Review of financial position at every Board and ongoing monitoring through financial controls and processes. **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. Trust engaging on the collation of a 5 year plan with specialist trusts in C&M to understand what the longer term finances look like for each of the trusts. **Level 3** External Audit of Annual Accounts and going concern considerations	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	~~On-going~~ 30 April 22	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.	CFO	Ongoing	On track
3	Review of out of HCP referrals / activity to understand the largest CCGs and formulate what can be done to continue activity into 2022/23 with the Trust.	CFO	~~Mar 21~~ ~~Sep 21~~ 30 June 2022	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/CFO	Ongoing	On track
5	Continue to provide mutual aid during the pandemic response to enhance reputation as a system player.	DCOO/ CEO/ MD	Ongoing	On track
6	Prepare internal 5-year financial plan based on anticipated changes to tariff to understand longer term financial risks for the Trust and support strategic planning.	CFO / COO	~~Sep 21~~ 30 June 22	On track

Risk ID: 016	Date risk identified: January 2022	Date of last review:	n/a
Risk Title: If hospital acquired infection rates increase then there is a risk to patient safety and experience as the Trust has already exceeded its health care associated infection trajectories for hospital acquired infections i.e. MSSA, C. difficile, Klebsiella, E.coli.		Date of next review:	March 2022
		CQC Regulation:	Regulation 12 Safe Care and Treatment
		Ambition:	Best practice care/patient safety
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse (Director of Infection Prevention & Control)

Linked Operational Risks				Consequence	Likelihood	Rating
96	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.	12	Initial	Moderate 3	Likely 4	12
47	If high numbers of hospital acquired infections (MSSA, Ecoli, CDIF) continue, then there is a risk the Trust may exceed it set trajectories.	16	Current	Moderate 3	Possible 3	9
Risk Appetite	Cautious		Target	Moderate 3	Unlikely 2	6

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Litigation - Involvement with Regulators e.g. CQC, NHSE/I - Risk to patient safety & experience - Quality of care - Reduction in Friends and Family Test (FFT)	• Mandatory surveillance • RCA outcomes • IPC audit outcomes • Post Infection Reviews (PIR) • IPC audit • Matron audit • Thematic reviews • Perfect Ward Audits introduced January 2022
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. Rapid reviews currently undertaken to identify any lapse in care 2. Environmental scores monitored monthly with any underperformance addressed immediately 3. IPC policies and procedures. Thematic review in progress to account for impact of pandemic 4. Referral Form for admissions/transfers of patients assesses risks. 5. Clinical/non clinical education programme i.e. induction/Health & Safety 6. An Infection control specialist nurse visits wards on a daily basis for assessment of any patient with the potential of infection 7. Antibiotic ward rounds are held in collaboration weekly across acute Wards and daily on ITU, in collaboration with microbiology, infection control and medical representation.	1. Rapid reviews are not consistently undertaken within 72 hours. 2. Availability of side rooms 3. Requirement for long term antibiotics deep-seated Neuro specific infections e.g. discitis's, cerebral abscess 4. ANTT not fully embedded across Trust 5. Competency assessments not agreed across Trust 6. Limited and prolonged antibiotic use for the treatment of neurological infections increases risk of clostridium difficile 7. Omission of infection control risks/screening results when patient transferred into the Trust from referring Trust 8. Some patients with particular conditions are at higher risk of non-compliance with infection prevention measures
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?*
1. Audits of antibiotic compliance presented to the Infection Prevention & Control Committee 2. Quarterly infection prevention reports to Quality Committee/Board. 3. Minutes of divisional risk and governance. 4. Mandatory Training data. 5. IPC audit data 6. Daily escalation completed and circulated across the Trust 7. Learning from incidents is embedded across the Trust 8. Monitoring of action plans on a weekly basis by DCN, Divisional Nurses and Divisional Directors	1. Some RCAs are not undertaken in a timely manner 2. Training/competency data is not held on one system.

Corrective Actions: *To address gaps in control and gaps in assurance*		Action Owner	Forecast Completion Date	Action Status
1	Management of Urinary Catheter policy approved	Advanced Practitioner	December 2021	Complete
2	HCAI action plan monitored weekly to ensure completion in a timely manner, some outstanding actions	~~DCN~~ Divisional Nurses	January 2022	In progress
3	Project underway to map, allocate and agree frequency and location of competencies of nursing staff and transfer to Oracle Learning Management (OLM)	DCN	June 2022	In progress
5	Infection Prevention Society competency programme in progress by RN`s newly recruited to IPC team	Lead Nurse IPC	September 2022	In progress
6	Antimicrobial audit established	Lead Nurse IPC	December 2021	Complete
7	Thematic review of IPC policies and procedures ongoing, to take account of pandemic and ongoing learning	~~DCN~~ Lead Nurse IPC	March 2022	In progress
8	Meeting with Heads of Department twice monthly to ensure RCAs completed in a timely manner	~~DCN~~	March 2022	In progress
9	ANTT relaunch and monthly monitoring to be undertaken	~~DCN~~ Divisional Nurses	December 2022	In progress
10	Implementation of Perfect Ward to provide transparency on audit data	DCN	~~February 2022~~ March 2022	In progress

Board Assurance Framework Glossary

ANTT	Aseptic Non Touch Technique
BPC	Business and Performance Committee
C&M	Cheshire and Merseyside
CFO	Chief Finance Officer
CMAST	Cheshire & Merseyside Acute and Strategic Trusts (Provider Collaborative)
COO	Chief Operations Officer
CQC	Care Quality Commission
DCN	Deputy Chief Nurse
DHSC	Department of Health and Social Care
DoSO	D
EPR	Electronic Patient Record
ERIC	Estates Returns Information Collection
FoSH	Federation of Specialist Hospitals
FFT	Friends and Family Test
GMC	General Medical Council
HCP	Health & Care Partnership (Cheshire& Merseyside) in place to 31 March 2022*
HEE(NW)	Health Education England (North West)
HFAI	Health Facility Acquired Infection
ICB	Integrated Care Board
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
ICO	Information Commissioners Office
ICS	Integrated Care System (Cheshire & Merseyside) in place from 1 April 2022*
IG	Information Governance
IOM	Isle of Man
ITU	Intensive Therapy Unit
KPI	Key Performance Indicator
LoA	Letter of Authority
LHP	Liverpool Health Procurement
MHRA	Medicines and Healthcare products Regulatory Agency
MIAA	Mersey Internal Audit Agency (Internal Auditors)
MoU	Memorandum of Understanding
MSSA	Methicillin-sensitive Staphylococcus Aureus
NHSD	NHS Digital (information, data, IT systems)
NHSE	NHS England
NHSEI	NHS England and NHS Improvement
NHSI	NHS Improvement
NHSP	NHS Providers
NHSX	NHS X (IT transformation)
NRC	Neuroscience Research Centre
RAG	Red-Amber-Green (scoring)
RCA	Root Cause Analysis (Investigatory Technique)
RN	Registered Nurse
PMO	Project Management Office
RIME	Research, Innovation and Medical Information (Committee)
SOP	Standard Operating Procedure
SORD	Scheme of Reservation and Delegation
SPA	Supporting Professional Activities
SPARK	Single Point of Access to Research and Knowledge
SRO	Senior Responsible Officer
UoL	University of Liverpool
WCFT	The Walton Centre NHS Foundation Trust

*dependent on the passage of the Health and Care Bill through parliament.

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

CONSEQUENCES

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

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

Report to Trust Board
7th April 2022

Report Title	Integrated Performance Report		
Executive Lead	Lindsey Vlasman - Interim Chief Operating Officer		
Author (s)	Mark Foy - Head of Information & Business Intelligence		
Action Required	To note		
Level of Assurance Provided			
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls	
Key Messages			
• See summary for performance overview			
Next Steps			
• Ongoing			
Related Trust Strategic Ambitions	**Impact**		
	Finance	Quality	Workforce
Strategic Risks			
002 Meeting operational performance standards	001 Impact of Covid 19 on delivery of strategic objectives	Choose an item.	
Equality Impact Assessment Completed			
Strategy ☐	Policy ☐	Service Change ☐	
Report Development			
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Not applicable			

Integrated Performance Report

Executive Summary

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

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Activity Restoration
Referral to Treatment Stops

Opportunity for improvement
Theatres
Referral to Treatment Waits

Underperforming
N/A

Workforce Indicators

High Performing
N/A

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
Complaints
Moderate Harm Falls
CAUTI
VTE
Hospital Acquired Pressure Ulcers

Opportunity for improvement
N/A

Underperforming
Infection Control

Finance Indicators

High Performing
Income and Expenditure:

- In month - £65k ahead of plan
- YTD - £58k ahead of plan
- FC – breakeven (in line with plan)

Cash balance £41.3m equivalent to 105 days operating expenses

Opportunity for improvement
Capital:

- YTD - £6.5m behind plan
- Forecast – in line with plan

BPPC (by value) – Target 95%:

- Non-NHS – 93%
- NHS – 75.5%
- Total – 86.1%

Conclusion

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

Recommendation

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

Author: Mark Foy – Head of Information & Business Intelligence
Date: 30/03/2022

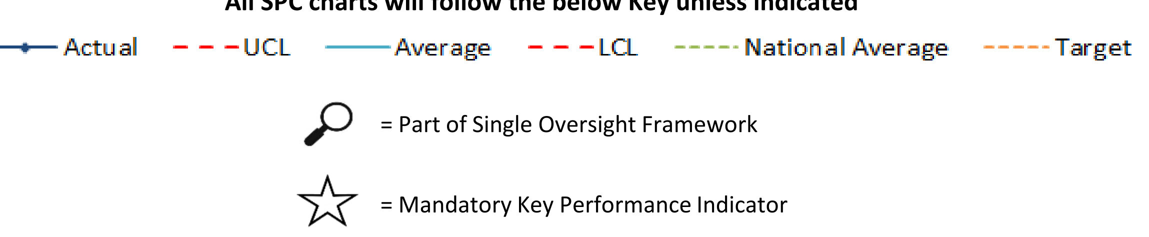
Board KPI Report
April 2022

Data for February 2022 unless indicated

Explanation of SPC Charts and Assurance Icons

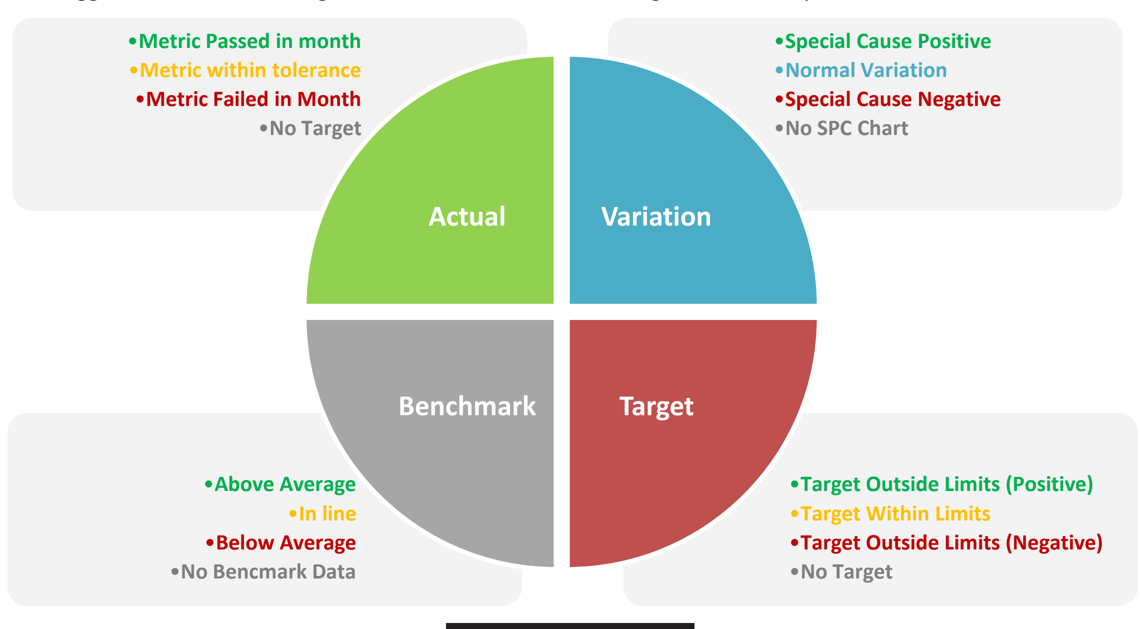
SPC charts are widely used in this report int order to provide increased assurance, insight and an indication of future performance. To maximise insight the charts will also include any targets and benchmarking where applicable.

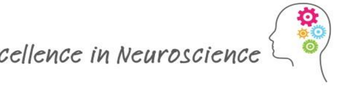
All SPC charts will follow the below Key unless indicated



Assurance Icons (Colour Key)

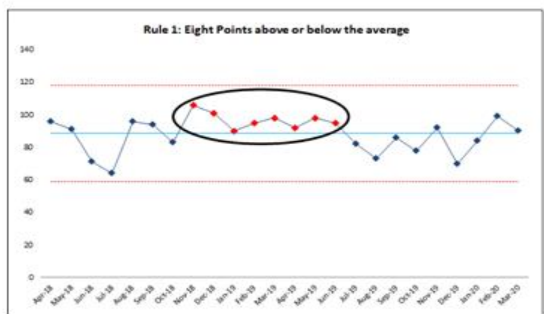
All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.

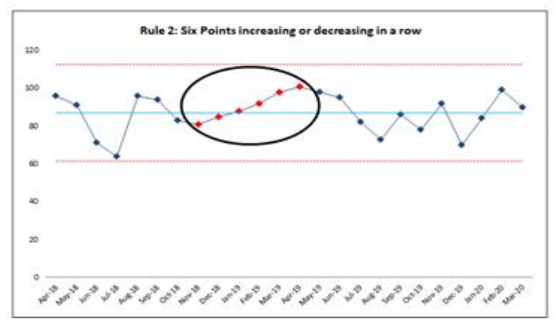


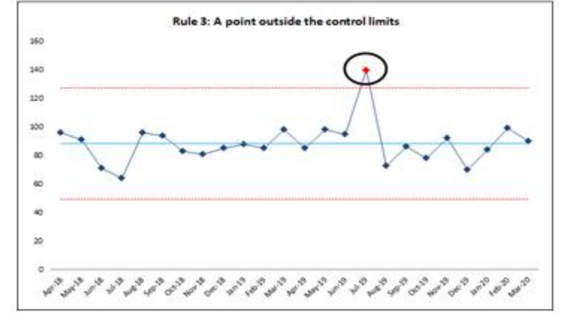


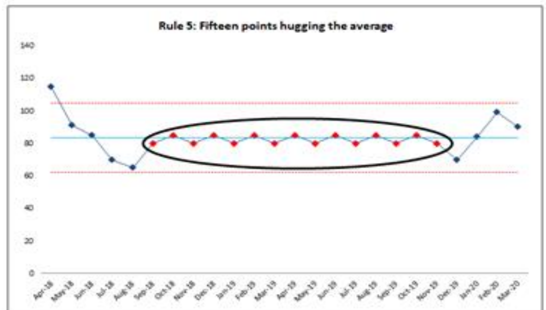
SPC Chart Rules

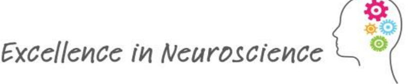
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).











Operations & Performance Indicators

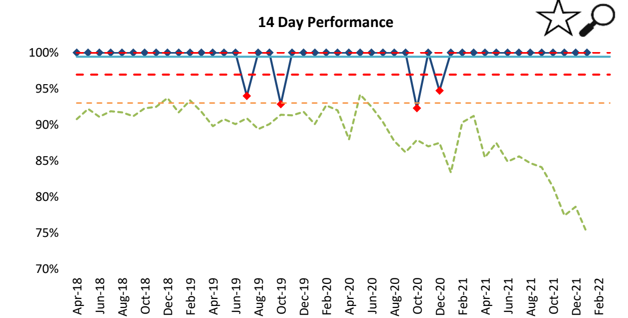
Operational

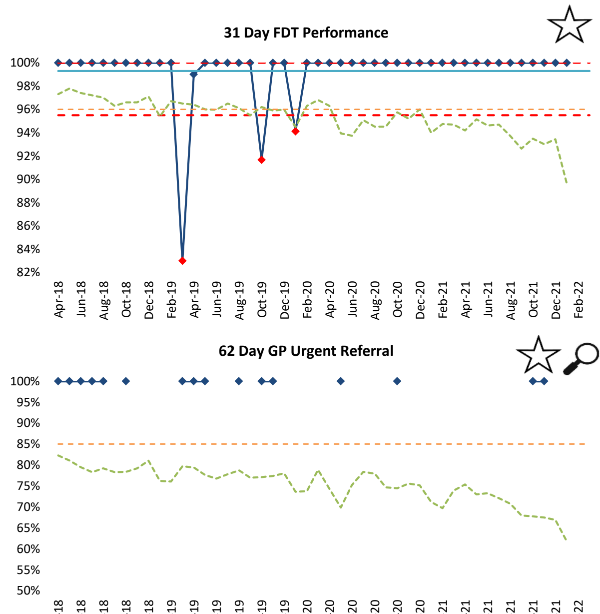
Responsive - Cancer Standards

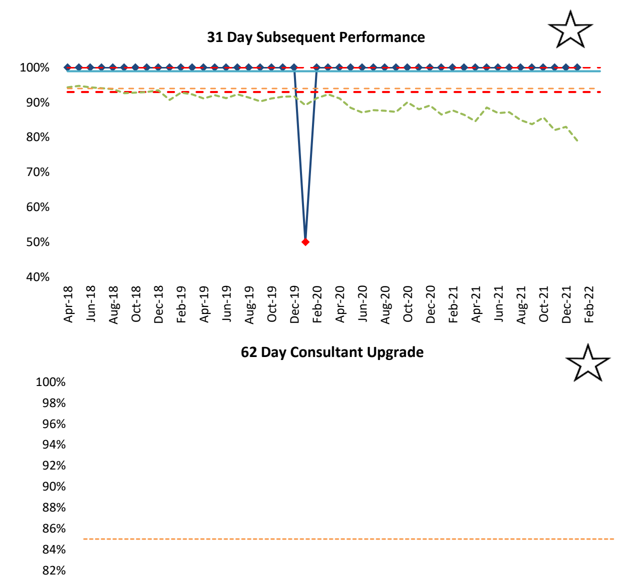
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

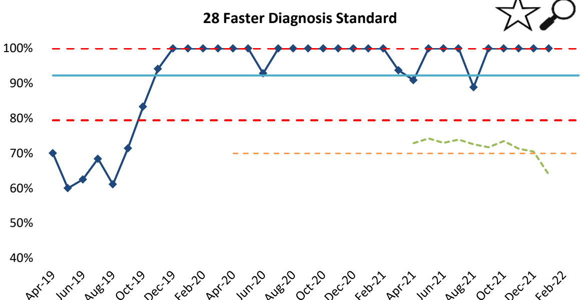
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

Associated Risks
001 - Covid-19
003 - Performance Standards





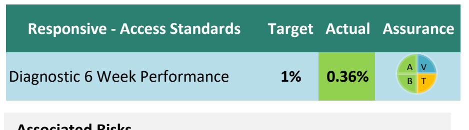




Operational

Responsive - Diagnostics

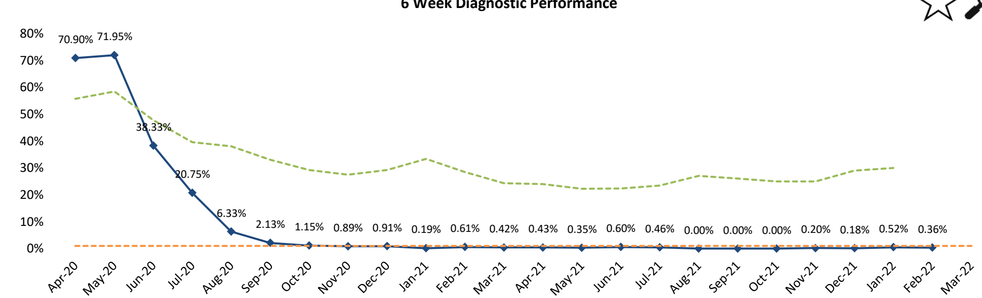
Excellence in Neuroscience



Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.36%	A V B T

Associated Risks
001 - Covid-19
003 - Performance Standards

Achievement against the Diagnostic 6 week standard has been met in month. There were four 6 week breaches in month.



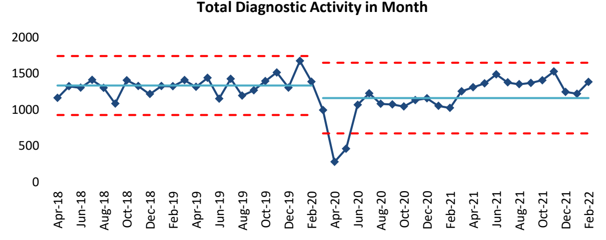
Diagnostic Breaches by Type

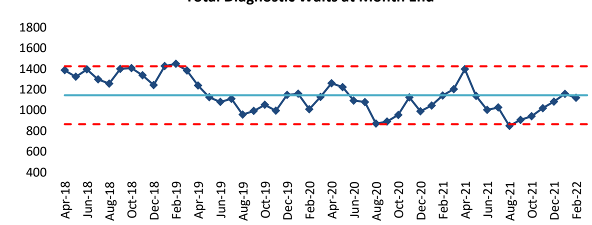
60
50
40
30
20
10
0

35 10 1 | 17 2 | 11 | 10 | 8 1 | 2 | 6 1 | 5 | 5 | 4 | 6 | 4 | 2 | 2 | 6 | 4

Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22

MR CT EMG SLEEP





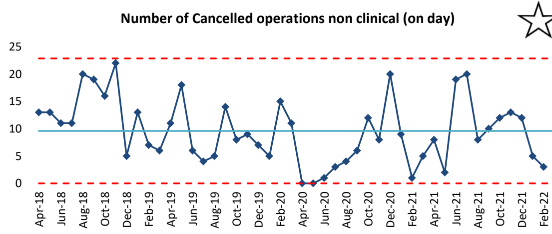
Operational

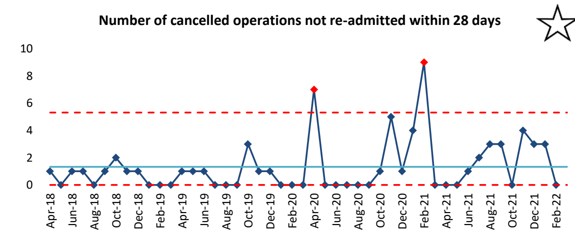
Effective - Theatres

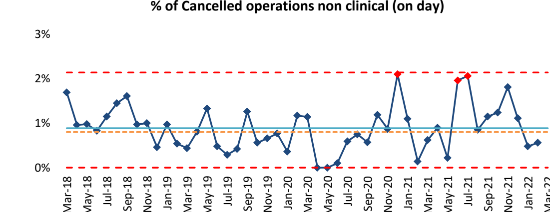
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	3	A V B T
% Cancelled operations non clinical on day	0.80%	0.56%	A V B T
28 Day Breaches in month	0	0	A V B T
Theatre utilisation of Elective Sessions	90%	96.94%	A V B T
Theatre utilisation of in Session Time	90%	81.61%	A V B T

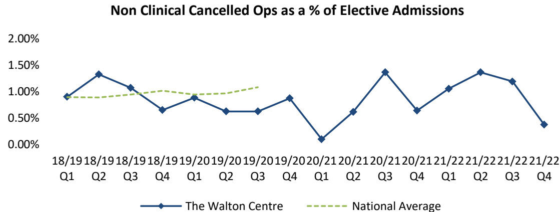
Non Clinical Cancellations

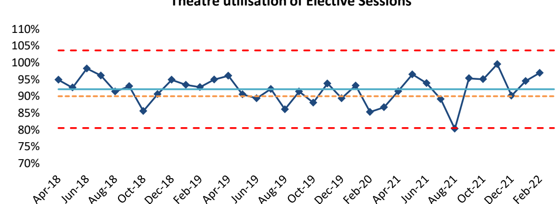
There were 3 patients cancelled at last minute for non-clinical reasons in February 2022, the reasons for the cancellations were list overrun (1), and no ITU Bed Available (2).

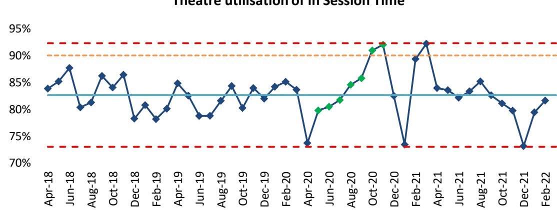












NHS The Walton Centre NHS Foundation Trust

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Operational

Effective - Activity Recovery Plan

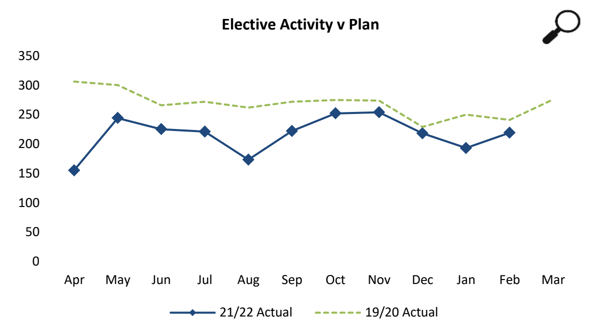
February 22 Activity Performance

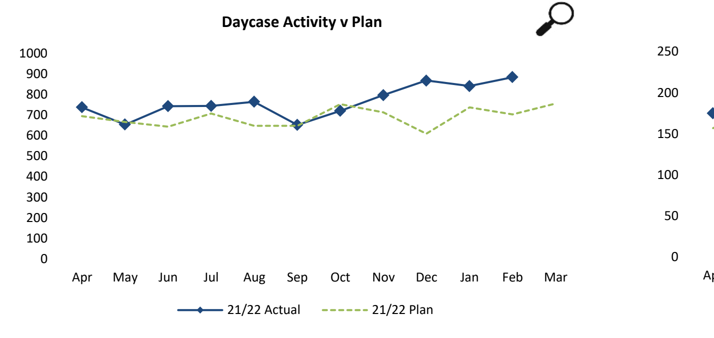
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	125.75%	89%
Elective	90.87%	89%
Elective & Daycase Total	**116.84%**	**89%**
Non Elective	84.38%	-
New Outpatients	91.23%	100%
Follow Up Outpatients	107.46%	100%
Outpatient Total	**101.59%**	**100%**

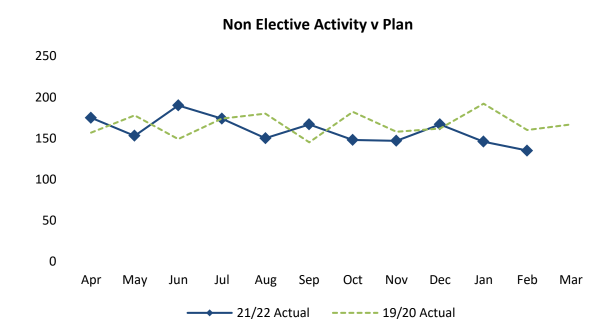
Continuing on from H1, each Trust was required to submit activity trajectories for the remainder of 2021/22 (referred to as H2) by month against the pre-COVID activity levels (comparing with the baseline of actual 19/20 SUS activity levels). The Trust has refreshed the activity plans and is forecasting delivery of 100% of all outpatients and 89% of elective and daycase activity as per national guidance.

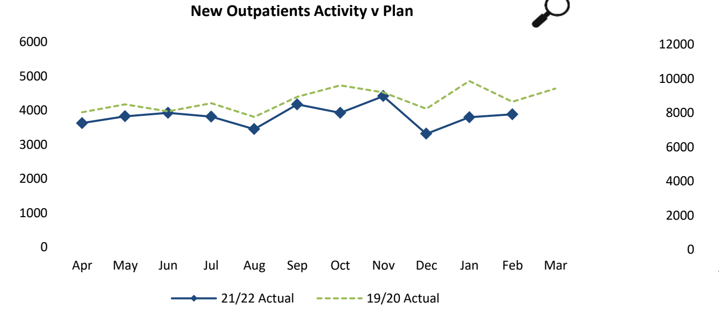
Daily operational huddles continue to review the activity performance against plan, taking into account the new methodology for Elective Recovery Fund (ERF).

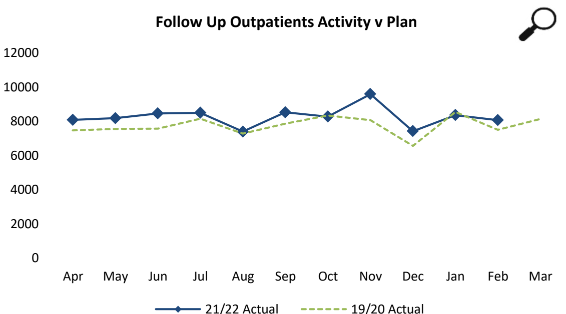
During February 2022 the Trust achieved the elective and daycase target of 89% at 116.84% as well as the total Outpatient target at 101.59% (versus 100%).











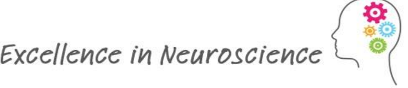
Operational

Effective - Elective Recovery Fund

Month	Raw Admitted Stops			Raw Non Admitted Stops			Working Day Tariff Adjusted Performance %
	19/20	21/22	%	19/20	21/22	%	
Oct	287	230	**80.14%**	2161	2098	**97.08%**	99.74%
Nov	278	253	**91.01%**	2047	2122	**103.66%**	94.10%
Dec	201	224	**111.44%**	1807	1755	**97.12%**	98.48%
Jan	277	181	**65.34%**	1998	2037	**101.95%**	91.88%
Feb	258	221	**85.66%**	1774	1970	**111.05%**	100.63%
Mar	283			1935			

During H2 Trusts are required to deliver 89% of RTT stops compared to 19/20. ERF funding is based on a working days adjusted tariff model.

In February the Trust stopped 85.66% of admitted pathways and 110.05% of Non Admitted pathways compared to 19/20. When adjusted for working days and tariff the Trust delivered 100.63% of 19/20 performance.



Workforce Indicators

Workforce

Well Led - Workforce KPIs

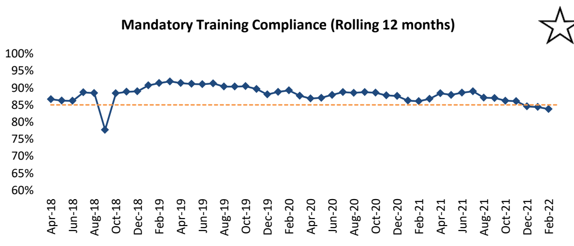
Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	74.57%	A V B T
Mandatory Training Compliance	85%	83.80%	A V B T

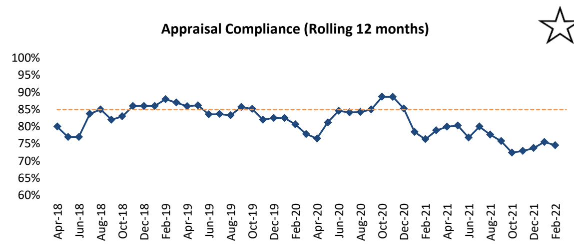
Mandatory Training Compliance

Overall mandatory training compliance in February 2022 remained below the target of 85%.

Appraisal Compliance

Appraisal compliance in February 2022 is 74.57% . The training team are continuing to work with individual departments to improve compliance.





NHS
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NHS Foundation Trust

Workforce

Well Led - Workforce KPIs

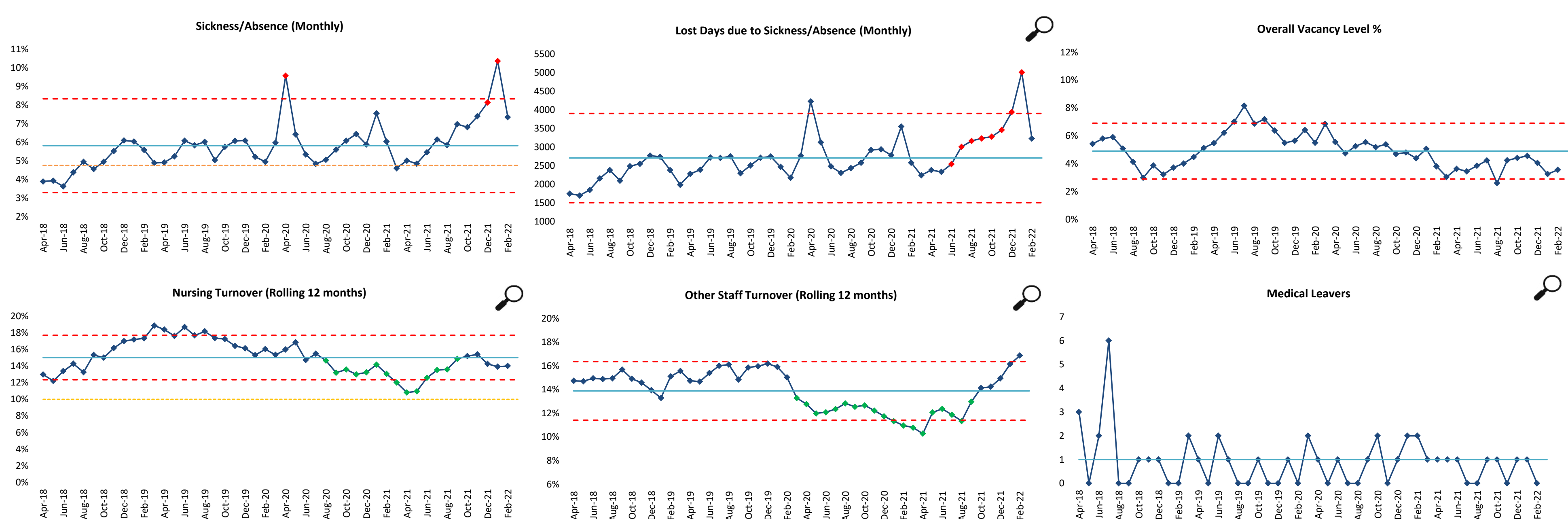
Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	7.35%	
Vacancy Levels	-	3.56%	
Nursing Turnover	10%	13.99%	
Other Staff Turnover	-	16.86%	

Sickness/Absence

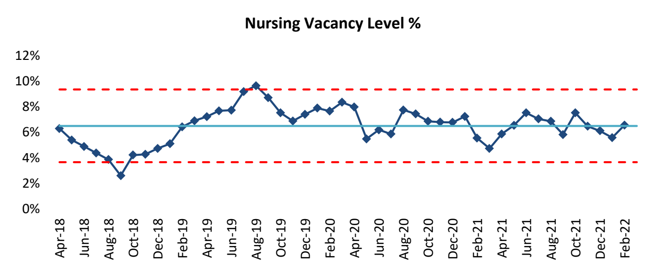
Sickness/Absence levels in February 2022 were above the target of 4.75% at 7.35% and has returned to normal variation.

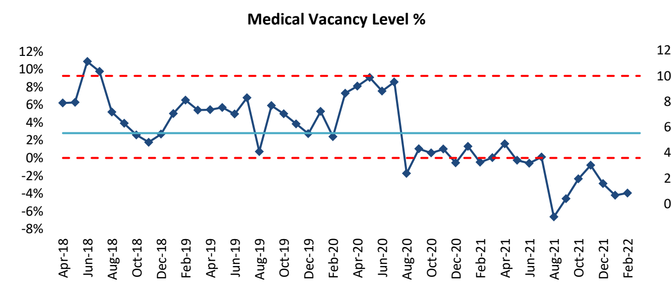
Nursing Turnover

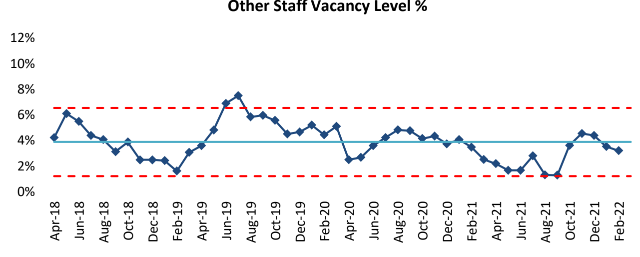
Nursing turnover now stands at 13.99% for February 2022. The position has returned to normal variation after a period of sustained improvement.

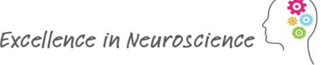


Quality of Care
Well Led - Workforce KPIs



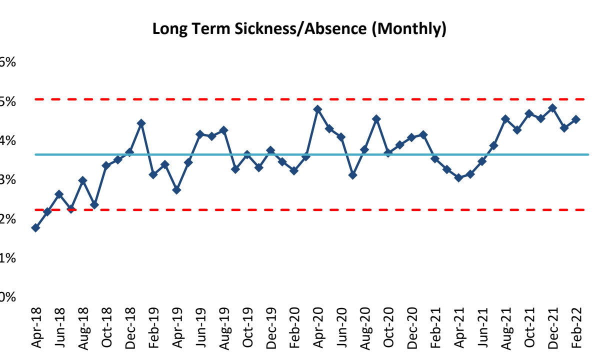


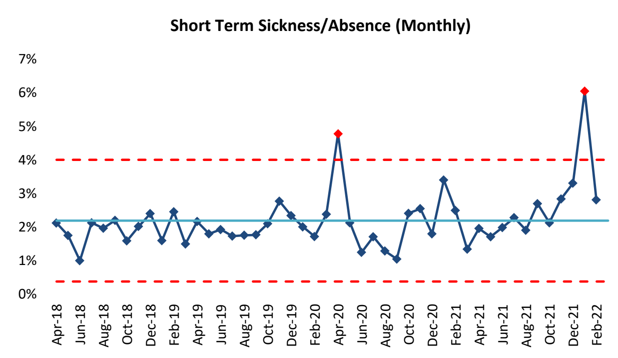


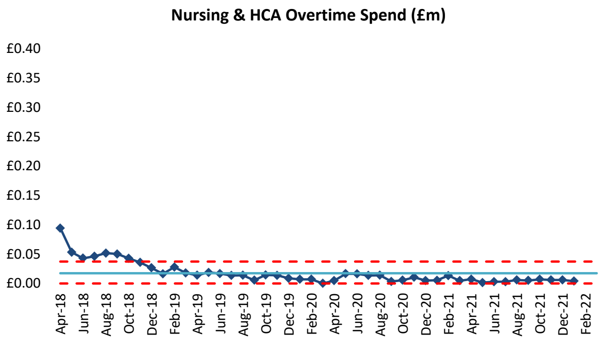


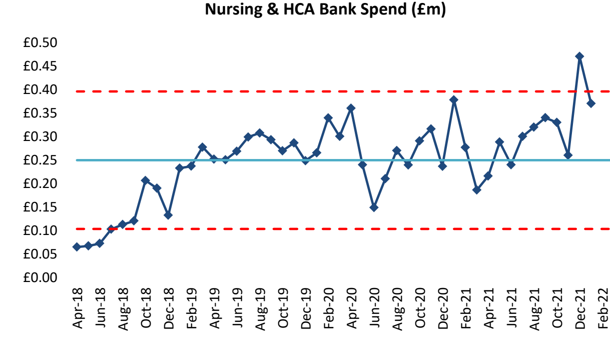
Quality of Care

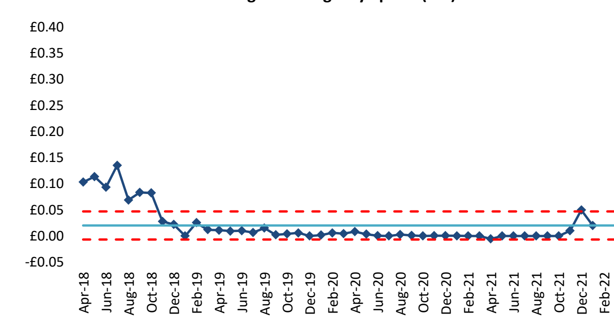
Well Led - Workforce KPIs

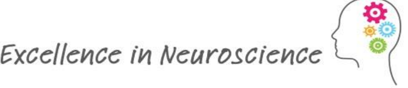








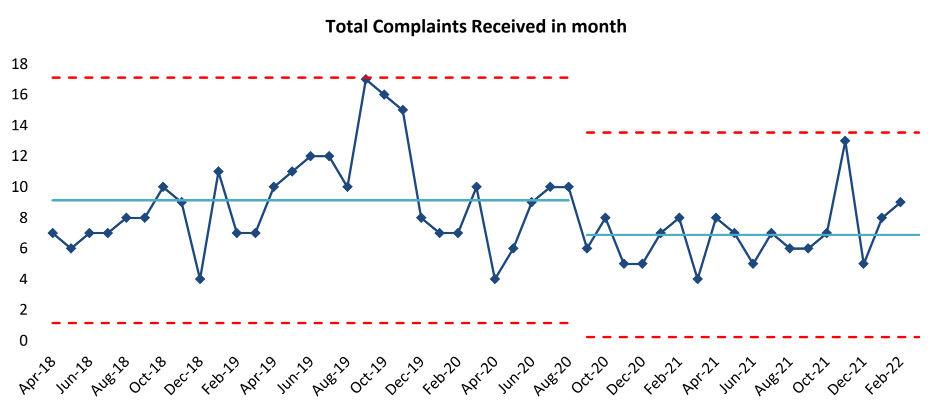


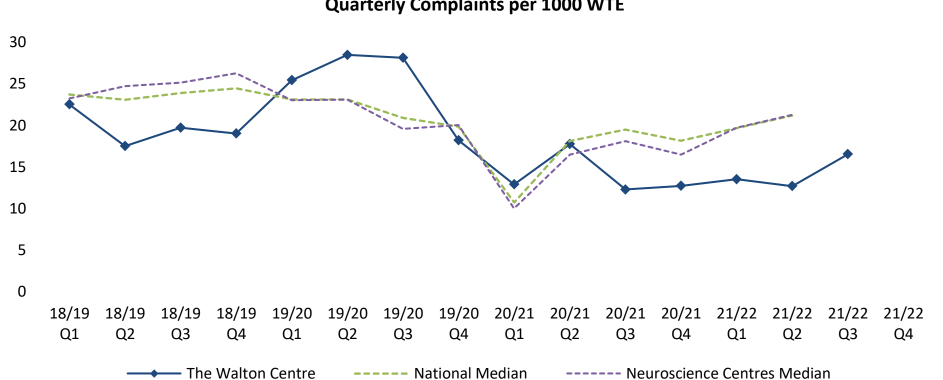


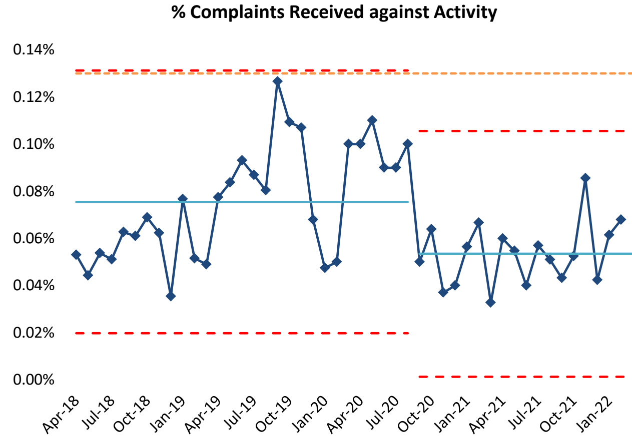
Quality Indicators

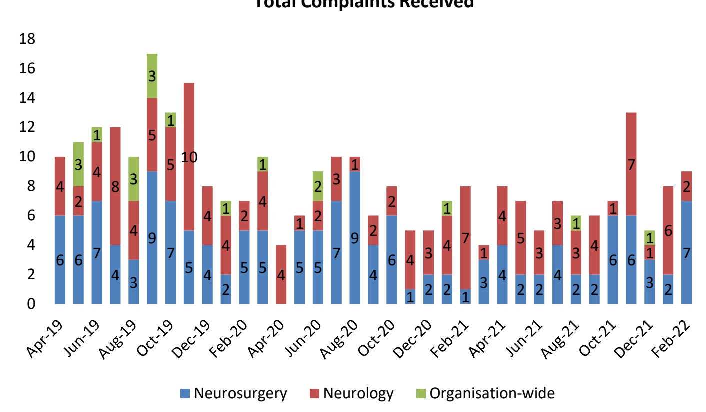
Quality of Care

Caring - Complaints









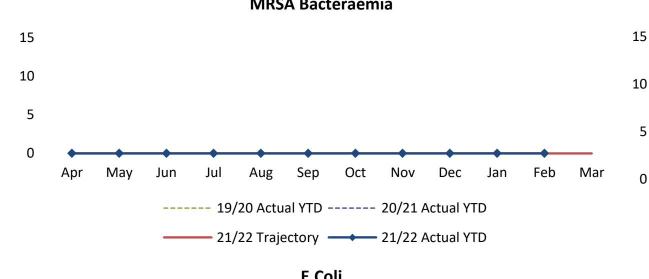
In February 2022 the Trust received 9 new complaints; 2 Neurology and 7 Surgery. Of the 9 complaints received; 3 related to admission or discharge arrangements, 4 related to treatement or diagnosis and 2 relating to approach and manner.

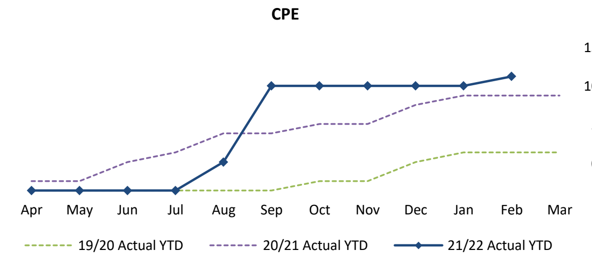
Of the new complaints received in February; 1 was upheld, 2 partially upheld and 2 ongoing. The remainder were not upheld.

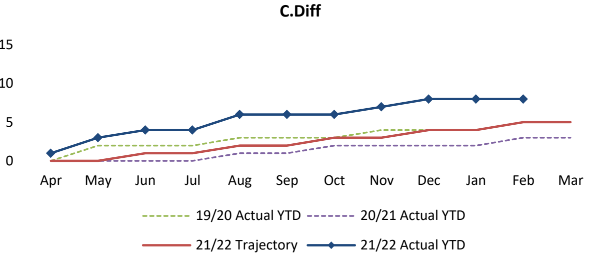
The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 0 to 13 at an average of 6 per month. The number of complaints received has significantly dropped during recent months.

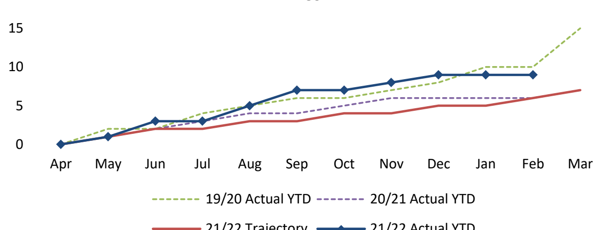
Due to the reduction seen the Trust is now below the national average and neuroscience centres average up the latest published period of Q2 2021/22.

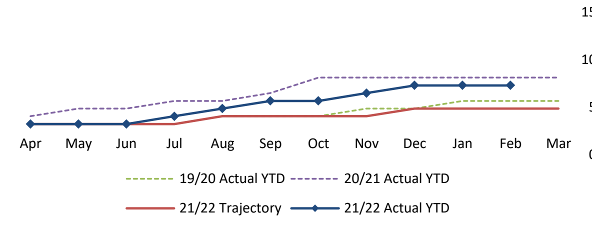
Quality of Care
Safe - Infection Control

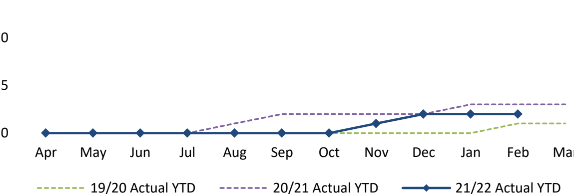


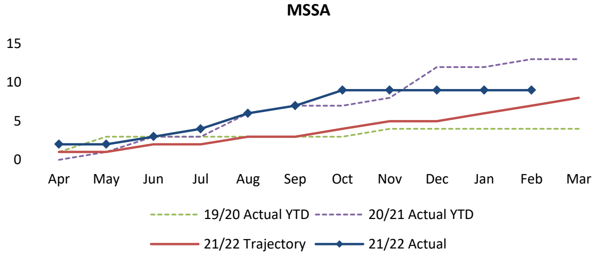












Total Healthcare Acquired Infections 2021/22

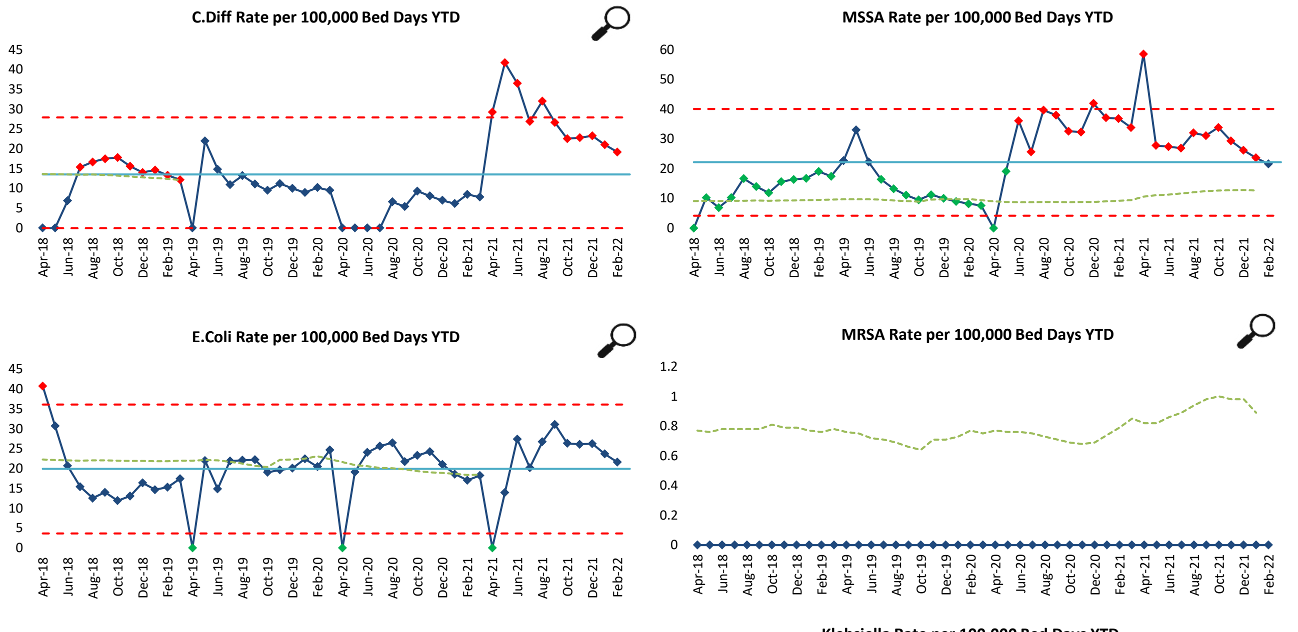
	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		4	1	2				**7**
Caton				1				**1**
Chavasse				1	1	1	2	**5**
CRU			1					**1**
Dott				1			1	**2**
Horsley			5	3	4		6	**18**
Lipton		1						**1**
Sherrington		7	1	1		1		**10**
Total	**0**	**12**	**8**	**9**	**5**	**2**	**9**	**45**

February Breakdown by Ward
1x CPE - Lipton

Excellence in Neuroscience

Quality of Care

Safe - Infection Control



There has been improvements in the numbers of HCAIs over the last 2 months with no infections reported in January 22 and only 1 (CPE) in February 2022.

There are currently nine MSSA instances reported year to date against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 22.16 which is significantly above the latest national average (12.66).

There have been eight C.Diff instances year to date against a year end trajectory of five. The rate per 100,000 bed days is currently at 19.20

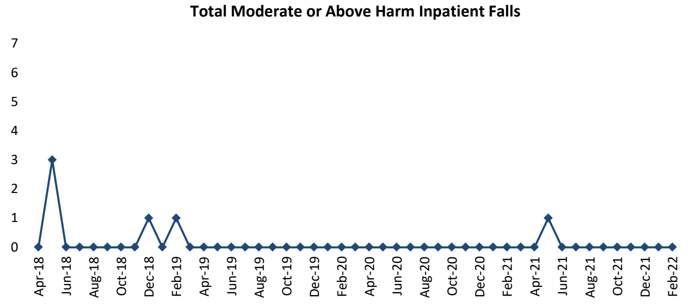
Year to date there have been nine instances of E.Coli against a year end trajectory of seven. The current rate per 100,000 bed days is 21.60. Due to a counting and coding change nationally there is a delay in publishing the national E.Coli rate.

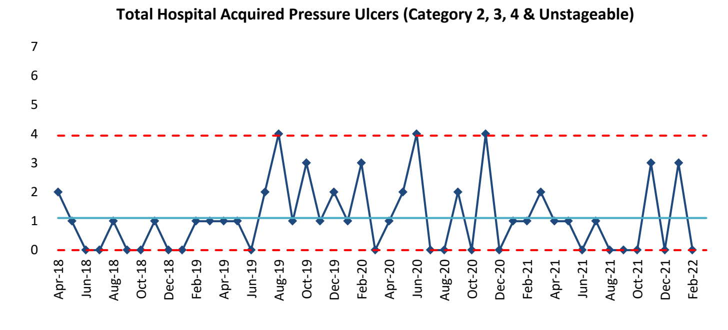
Covid-19 Nosocomial Infections

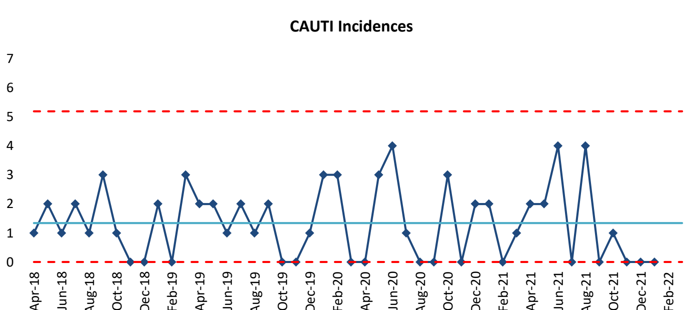
Klebsiella Rate per 100,000 Bed Days YTD

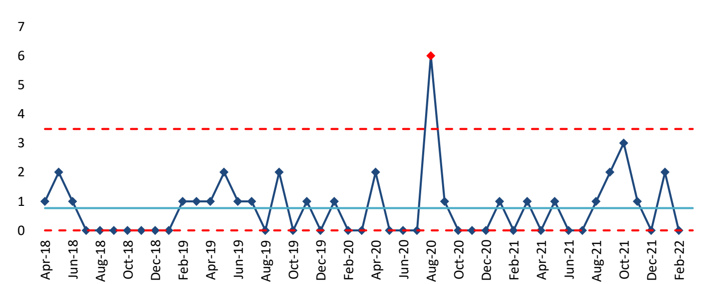
Quality of Care

Safe - Harm Free Care









Narrative

There was no falls which resulted in moderate or above harm in month.

There was zero Hospital Acquired Pressure Ulcers in month

There was zero CAUTI incidence in month

There were no VTE incidences in month

All harm measures are within normal variation.

NHS
The Walton Centre
NHS Foundation Trust

Ward Scorecard

February 2022

	Safe Staffing				Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	95.5%	94.0%	100.0%	106.1%	0	0	0	0	0	0	0	0
Caton	98.6%	100.0%	98.8%	101.2%	0	0	0	0	0	0	0	0
Chavasse	83.9%	100.0%	98.3%	100.0%	0	0	0	0	0	0	0	0
CRU	92.3%	101.2%	133.0%	98.2%	0	0	0	0	0	0	0	0
Dott	-	-	-	-	-	-	-	-	-	-	-	-
Horsley ITU	112.6%	104.8%	94.2%	100.0%	0	0	0	0	0	0	0	0
Lipton	104.0%	100.0%	94.3%	94.3%	0	0	0	0	0	0	0	0
Sherrington	94.1%	98.8%	103.2%	104.6%	0	0	0	0	0	0	0	0

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
Patient Care Income	10,015	9,071	(944)	105,370	105,966	596	115,386	116,600	1,214
Exclusions	2,124	2,121	(3)	22,998	24,765	1,767	25,122	27,017	1,895
Private Patients	2	4	2	62	30	(32)	63	32	(31)
Other Operating Income	658	755	97	6,236	6,507	271	6,942	7,149	207
Total Operating Income	**12,799**	**11,951**	**(848)**	**134,666**	**137,268**	**2,602**	**147,513**	**150,798**	**3,285**
Pay	(6,701)	(6,371)	330	(70,325)	(72,193)	(1,868)	(77,026)	(78,967)	(1,941)
Non-Pay	(3,252)	(2,497)	755	(32,335)	(30,485)	1,850	(35,638)	(34,230)	1,408
Exclusions	(2,199)	(2,208)	(9)	(23,427)	(26,206)	(2,779)	(25,573)	(28,589)	(3,016)
COVID	(77)	(65)	12	(1,351)	(953)	398	(1,428)	(1,020)	408
Total Operating Expenditure	**(12,229)**	**(11,141)**	**1,088**	**(127,438)**	**(129,837)**	**(2,399)**	**(139,665)**	**(142,806)**	**(3,141)**
EBITDA	**570**	**810**	**240**	**7,228**	**7,431**	**203**	**7,848**	**7,992**	**144**
Depreciation	(505)	(569)	(64)	(5,447)	(5,515)	(68)	(5,952)	(6,065)	(113)
Profit / Loss On Disp Of Asset	0	69	69	0	19	19	0	19	19
Interest Receivable	0	4	4	0	7	7	0	7	7
Financing Costs	(49)	(43)	6	(565)	(531)	34	(612)	(579)	33
Dividends on PDC	(128)	(163)	(35)	(1,354)	(1,375)	(21)	(1,524)	(1,500)	24
I & E Surplus / (Deficit)	**(112)**	**108**	**220**	**(138)**	**36**	**174**	**(240)**	**(126)**	**114**
I&E impact capital donations and profit/(loss) on asset disposals	**20**	**(135)**	**(155)**	**220**	**104**	**(116)**	**240**	**126**	**(114)**
I & E Surplus / (Deficit)	**(92)**	**(27)**	**65**	**82**	**140**	**58**	**0**	**(0)**	**(0)**

Due to COVID, the financial regime remains based on block funding for the full financial year and anticipated spend for the same period (based on average spend in Q3 of 2020/21). The plan for 2021/22 is break even position (submitted to HCP in November as part of the H2 planning process) in line with C&M requirements.

The current plan includes:

- Elective Recovery Fund (ERF) income and costs for the delivery of activity above the national trajectory targets;
- 'Block' system funding received for Top-up, COVID related costs, growth and CNST;
- Efficiency requirement to ensure a break-even position H1 and system efficiency of at least 2.5% in H2.

It is expected that the Healthcare Partnership (HCP) will deliver a balanced financial plan for the financial year and the Trust is continuing to work with the partnership to achieve this position.

In month 11, the Trust reported a £27k deficit position. This is a £65k favourable variance against the planned in month position of £92k deficit. The improvement in month is in the main due to £243k elective recovery funding received in relation to Jan 22 that was not previously anticipated. This was offset by a reduction in Welsh income due to their challenge on drugs and implant costs (this will be contested) and an underperformance on IoM activity. There were also savings within non pay due to a decrease in spend (against plan) on clinical supplies.

The year to date position includes £2,640k elective recovery funding (£2,086k of which was achieved in H1) against a planned position of £2,998k, £358k below plan. The Trust has not assumed any ERF income for activity in M11.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	February-22	Movement
	£'000	£'000	£'000
Intangible Assets	869	762	(107)
Tangible Assets	86,164	86,100	(64)
TOTAL NON CURRENT ASSETS	**87,033**	**86,862**	**(171)**
Inventories	1,157	1,543	386
Receivables	7,523	5,787	(1,736)
Cash at bank and in hand	35,689	41,300	5,611
TOTAL CURRENT ASSETS	**44,369**	**48,630**	**4,261**
Payables	(25,914)	(28,037)	(2,123)
Provisions	(245)	(245)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,471)	98
TOTAL CURRENT LIABILITIES	**(27,780)**	**(29,805)**	**(2,025)**
NET CURRENT ASSETS/(LIABILITIES)	**16,589**	**18,825**	**2,236**
Provisions	(701)	(672)	29
Finance Lease	(63)	(67)	(4)
Loans	(23,635)	(22,284)	1,351
TOTAL ASSETS EMPLOYED	**79,223**	**82,664**	**3,441**
Public Dividend Capital	30,513	33,918	3,405
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,799	36
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**82,664**	**3,441**

STATEMENT OF CASH FLOW - 2021/22	January-22 Actual	February-22 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(72)**	**44**	**116**
Non-Cash Flows In Operating Surplus/(Deficit)	6,779	7,670	891
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**6,707**	**7,714**	**1,007**
Increase/(Decrease) In Working Capital	387	2,006	1,619
Increase/(Decrease) In Non-Current Provisions	(29)	(29)	0
Net Cash Inflow/(Outflow) From Investing Activities	(4,112)	(4,716)	(604)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**2,953**	**4,975**	**2,022**
Net Cash Inflow/(Outflow) From Financing Activities	(1,994)	636	2,630
NET INCREASE/(DECREASE) IN CASH	**959**	**5,611**	**4,652**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**36,648**	**41,300**	**4,652**

COVID-19 expenditure:

Expenditure incurred on COVID-19 is included within the reported financial position.

In month Actual: £65k.

Year to date Actual: £962k.

COVID-19 costs are subject to independent audit if requested through NHSE/I.

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Jun-21 Actual £'000	Jul-21 Actual £'000	Aug-21 Actual £'000	Sep-21 Actual £'000	Oct-21 Actual £'000	Nov-21 Actual £'000	Dec-21 Actual £'000	Jan-22 Actual £'000	Feb-22 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	54	47	36	25	61	123	44	639
Decontamination	0	7	3	0	0	0	2	0	1	0	0	13
Agile working	0	12	1	0	0	0	0	0	0	0	0	13
Infection Control	0	0	0	0	22	4	14	3	0	(9)	0	34
Other	20	1	43	19	21	37	27	20	35	19	21	263
TOTAL	**113**	**70**	**104**	**68**	**97**	**88**	**79**	**48**	**97**	**133**	**65**	**962**

Other spend includes providing free car parking for staff, heavy duty mobile Sani-station units to be used across the trust and quarantine costs for overseas nurse recruitment.
Covid-19 related Bank spend also increased in December and January with additional costs incurred to cover staff absent due to Covid-19.

Capital

In month variance - £4,364k below plan.

Year to date variance - £6,485k below plan.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 2021/22 planning process.

Annual capital funding is now set at a HCP level (rather than using a nationally determined formula). For 21/22 allocated capital funding is £6.2m, which is approx. 50% greater than if the nationally determined formula was used.

The Trust has received an allocation of external funding in relation to Digital Aspirant and Cyber Security for IM&T innovation of £3.8m. The Trust also received £616K elective plus funding relating to the RANA project and £725k in relation to diagnostic developments.

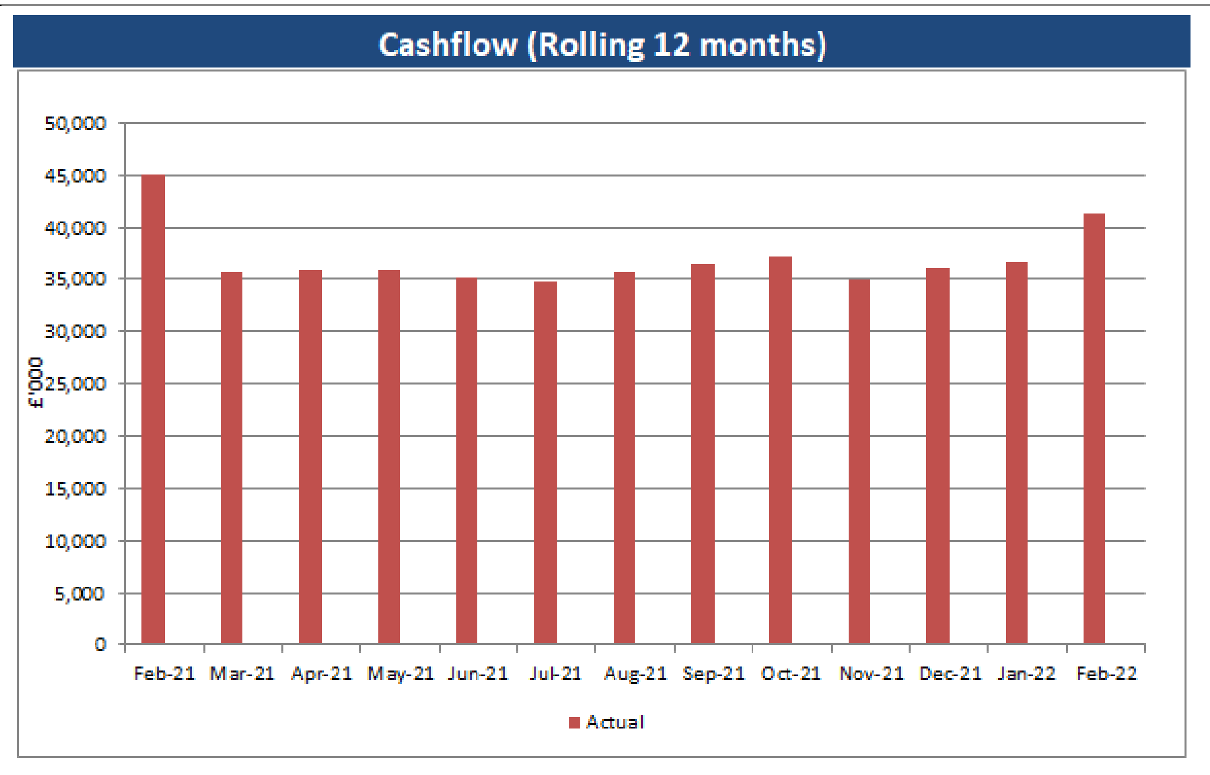
CAPITAL	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	91	28	63	1,008	837	171	1,100	935	165
Estates	214	3	211	639	7	632	850	552	298
IM&T	80	79	1	888	492	396	969	817	152
Neurology	2,349	29	2,320	3,524	179	3,345	2,349	1,673	676
Neurosurgery	2,594	70	2,524	3,891	2,169	1,722	2,594	2,248	346
Corporate	123	0	123	368	0	368	490	0	490
Capital Slippage	(455)	0	(455)	(1,695)	0	(1,695)	(2,150)	0	(2,150)
TOTAL (excl. external funding)	**4,996**	**209**	**4,787**	**8,623**	**3,684**	**4,939**	**6,202**	**6,225**	**(23)**
Donated Assets	0	87	(87)	32	119	(87)	155	119	36
Digital Aspirant	415	751	(336)	3,434	1,801	1,633	3,746	2,746	1,000
RANA	(61)	(61)	0	0	0	0	616	616	0
Cyber Security	0	0	0	0	0	0	16	16	0
Diagnostic Digital Capability Funding	0	0	0	0	0	0	699	699	0
Diagnostic Transformation Funding	0	0	0	0	0	0	26	26	0
TOTAL (incl. external funding)	**354**	**777**	**(423)**	**3,466**	**1,920**	**1,546**	**5,258**	**4,222**	**1,036**
TOTAL	**5,350**	**986**	**4,364**	**12,089**	**5,604**	**6,485**	**11,460**	**10,447**	**1,013**

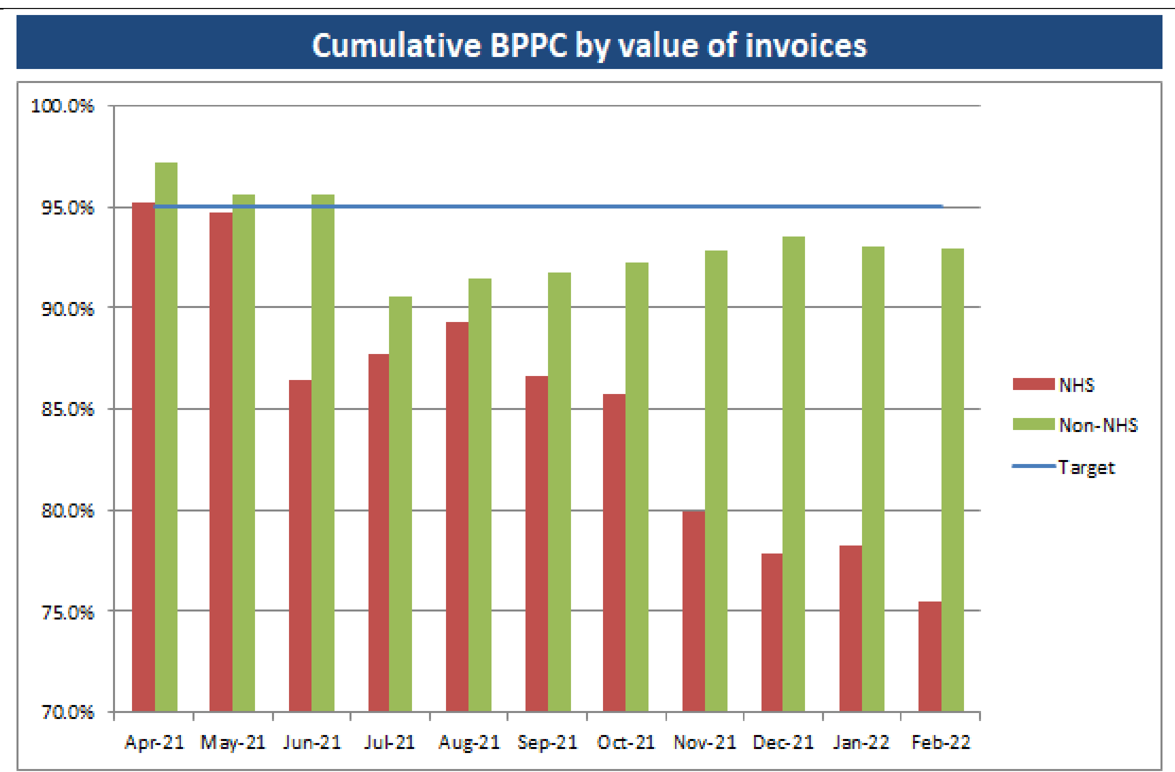
Capital spend in month is £986k.

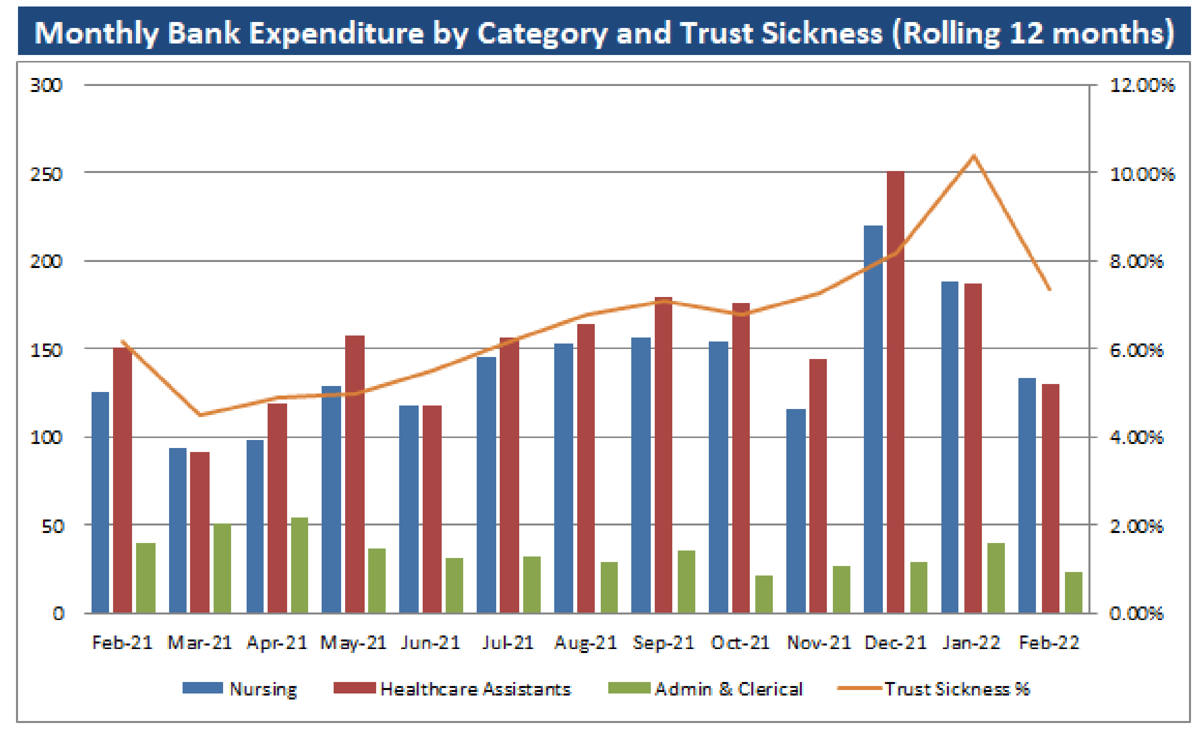
- **Heating & Pipework**: £28k – Phase 4 works;
- **IM&T:** £79k - Staffing in relation to specific projects and agile working hardware;
- **Neurology**: £29k – Second ultrasound for interventional room;
- **Neurosurgery:** - £70k – Transcranial MR guided ultrasound costs;
- **Digital Aspirant (PDC funded):** £751k;
- **RANA (PDC funded)**: £61k prior month correction.

The year-end capital forecast is £10.4m (including external funding). This is lower than plan as NHS Digital have agreed to defer £1m capital into 2022/23. It should be noted that a large amount of spend is due at the end of the financial year due to the replacement CT scanner which will be completed by the end of the financial year. A number of schemes have been brought forward from 22/23 (following prioritisation) to ensure the capital plan is delivered.

The capital forecast continues to be closely monitored so that it meets the agreed capital funding

As of the end of February: Actual Cash Balance: £41.3m. Number of days operating expenses = 105 days.		The Trust cash balance at the end of February was £41.3m. This is an increase of £4.6m compared with the end of January, due to: • An increase in non-cash flows within the operating position • An increase in inflows from financing activities (public dividend capital); • An increase in Trade Creditors The reduction of cash in March 21 was due to the reversal of the advanced block payments that had been received from commissioners during 20/21 by the Trust each month for the financial arrangements to cover the COVID-19 pandemic.

Better Payments Practice Code (BPPC):		
There is a renewed focus by NHSE/I on those Trusts that underperform against the better payments practice code standard of settling at least 95% of invoices within 30 days. Letters will be sent to provider chief executives, directors of finance and audit committee chairs to seek action plans where there is significant under-performance. In terms of contacting NHS organisations NHSE/I are looking specifically at non-NHS payments based on value.		The Trust BPPC percentage (by value) at the end of February against the target of 95.0% was: • Non NHS 93%; • NHS 75.5%; • Total 86.1%. This has seen non-NHS payments remain static and decrease in NHS payments of 2.7% since the end of January. The low % of NHS invoices paid is due to work being carried out to clear aged LUHFT invoices. The Trust BPPC percentage (by number of invoices paid) at the end of February is 86.1%. The Deputy Chief Finance Officer and Financial Accountant are reviewing the position around LUFHT invoices and will be contacting LUFHT to try and agree a resolution to improve this position.

Bank Expenditure: In month Actual: £288k. Year to date Actual: £3,825k.		Bank expenditure incurred in February was £288k, a decrease of £138k when compared to January. The in-month decrease reflects the work undertaken by the Deputy Chief Nurse on e-rostering despite high sickness levels. At the end of February, £542k bank expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis). The trusts overall sickness rate decreased from 10.38% to 7.35% in February.

Key Risks and Actions in 2021/22

As a result of the COVID-19 pandemic financial regulations changed for 2020/21 and 2021/22, with the main changes being:

- Delay of 2021/22 business planning until 2nd half of 21/22, with the finance regime of 2020/21 to continue during 2021/22;
- Payment by Results (PbR) continued suspension for the financial year and income being based on block values determined nationally based on 2020/21 Q3 levels plus 0.5% inflation for H1 and 1.16% for H2, (incorporating a 0.28% efficiency requirement for H1 and 0.82% for H2) and adjusted for the impact of CNST increases;
- System funding has been allocated to C&M HCP (Totals for H2) which has been distributed to all organisations and included within organisational plans to cover costs in relation to Top-up, COVID-19 (in relation to reasonable COVID-19 expenditure), growth and CNST;
- System level financial targets have been submitted with a forecast for the system to breakeven at the end of H2;
- An Elective Recovery Fund (ERF) came into effect in April 21 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M1-M6). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then may receive a retrospective financial penalty. The elective recovery scheme will be monitored at C&M HCP system level. The H1 plan incorporates forecast income and expenditure to deliver the trusts activity plan for H1 based on national trajectory requirements (operational and clinical teams will work to deliver these planned activity levels), further guidance has now been issued by NHSE/I increasing the trajectory threshold from 85% to 95% for M4-M6 and the Trust has under-performed against the elective recovery fund income in the plan for that period;
- For H2 elective recovery will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity, which was used in H1. The thresholds for the scheme have been recalculated so that they are on a comparable basis to the 95% threshold for the ERF in Q2. Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019/20 threshold of 89% will be able to draw down from the elective recovery fund. Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%. This will be applied to the ERF baselines for October to March which were issued in H1;
- 2021/22 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this includes an allocation of additional PDC (Digital Aspirant Funding) allocated for IM&T innovation;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

The draft financial plan for 2022/23 is currently being developed with the plan being for a 12 month period rather than 6 month financial plans which has been the case for the last 2 years. Updates on the planning exercise will be provided to BPC throughout the process.

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

RISK	COMMENT/ ACTIONS
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification was received that 2021/22 financial planning has been deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for all of 2021/22. Current national guidance states that providers will be required to achieve a breakeven position for H2. The financial framework has recently been published for 2022/23 and the Trust is now considering how the changes in regime will affects its future financial position (and what financial risks it may create), as well as what, if any, impact of the current variant of COVID will have on the future planning regime.
Efficiency requirements going forwards	The efficiency requirement of the Trust in H2 of this financial year has been set at 2.5% (in line with C&M Healthcare Partnership) and as such recurrent efficiencies will be required to be delivered in 2021/22 with work currently being undertaken to identify these. The Trust has delivered the majority of CIP non-recurrently up to M10. Work is on-going between finance and Chief Operating Officer on future CIP regime and governance. Weekly meetings are now being held with CFO, COO, deputy directors and divisional directors to discuss and assess progress on delivery of CIP schemes for 22/23 – a number of schemes have been identified and are being assessed for deliverability.
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 the changes to IPC guidance. The Trust will be carrying out risk assessments to determine the risk of reducing IPC requirements as it continues to review processes for the delivery of safe services. There is also a risk to delivery of activity as a result of staff sickness / burnout due to and following the COVID-19 pandemic and also the potential impact on services if the Trust is required to support other Trusts in the region during the anticipated winter pressures that the NHS

	will face in H2 e.g. critical care surge capacity.
The impact of excluded drugs and devices	The impact of excluded drugs and devices in previous financial years had a nil impact on the trusts surplus / (deficit) position as income and expenditure would be equally matched. For 2021/22 high cost drugs and devices are funded through a combination of block and cost and volume basis meaning that increased costs will not always be matched by income therefore potentially creating an overall cost pressure to the Trust if usage increases. Guidance for 2022/23 is being reviewed to assess whether this financial risk is likely to continue moving forward.
Access to Elective Recovery Fund	There is a risk that if the Trust is able to achieve the new ERF requirements of delivering 89% of admitted and non-admitted clock stops, whilst the wider C&M system fails to deliver, then there will be an increased cost of delivery without a corresponding increase in income. Whilst it is recognised that the achievement of these targets is imperative to reducing waiting lists and ensuring patients are treated, it must be recognised that delivery at organisational level could result in increased costs to the organisation, without associated income due to overall system under performance.

Board of Directors' Key Issues Report

Report Date: 23/3/22		**Report of:** Business Performance Committee
Date of last meeting: 22/3/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report February 2022 • Estates and Facilities Strategy Delivery Annual Update • Exit Interviews Report • People Group Update Report • Digital Aspirant NHSX Monthly Update • Board Assurance Framework • Committee Annual Effectiveness Review • Terms of Reference • Draft Operational Plan Update • Business case Brainomix • Sub-committee chair's reports - Capital Management Group - Medical Devices and Facilities Group - People Group - Staff Partnership Committee - Transformation Board
2.	**Alert**	• None
	Assurance	• Activity performance for cancer, diagnostics, activity restoration and RTT stops were all meeting plan in February. • Proportion of patients on Patient Initiated Follow Up (PIFU) (part of outpatient transformation) is in the top quartile nationally and 2nd best in the North West and expected to increase further as it is extended to further services in March. Assurance was given that patient selection is clinically-driven, to ensure patients are engaged with the process, rather than a 'blanket' or target-driven roll-out. • Theatre activity remains affected by staff sickness (looking to modify rotas to reduce impact); follow-up outpatients not attending appointments (DNAs) has increased and is being addressed through further validation of waiting lists • Staff vacancies remain moderate despite elevated turnover in some areas, in some cases caused by higher pay being offered by neighbouring trusts. • Income & Expenditure outcome was better than plan in February in the main due to lower income than plan (mainly related to Wales) which was offset by lower than planned expenditure (lower than planned activity); a break-even position is now forecast for end of year, in line with plan • The 8 principal risks within the Board Assurance Framework which fall within BPC's remit were reviewed and updated. Changes to the scoring on financial risks (financial plan and capital plan) were reduced to target levels. Cyber Security risk was

		discussed in light of heightened risks but mitigations and controls were felt to be robust.		
	Advise	• The first 3 quarterly staff Pulse Surveys (which has replaced the staff Friends & Family Test) have returned a significantly lower proportion who would recommend Walton as a place to work (range 62-68%) albeit on a low response (<10% of staff). Staff sensing discussions are planned to look for insights from this, coupled with a focus on encouraging a much higher response. • People Group overview of work including actions aimed at improving appraisal completion rates. • A review of exit interviews gave few insights, partly because the response rate was low (7-8%) as exit interviews are voluntary; MIAA are offering suggestions for improvement through a briefing note which will be received by Audit Committee • Sickness absence remains high at 7.4% (2% due to Covid) • Capital spend dipped markedly in February and now requires a significant spend of £4.8m in March to meet the full-year plan. • On-time payment to creditors remains below target (Better Payments Practice Code), markedly so for payments within NHS. Issues centre particularly on disputed and late payments to/from Liverpool University Hospitals NHS Foundation Trust. Plans in place to resolve these. • Latest 22/23 financial plan projects a break-even position but with a number of risks, including achieving a stretching activity increase, efficiency savings of 3% (of which only half is currently identified) and staff availability. • Planning underway for Cost Improvement Programmes for 2022/23 with several plans being costed • The annual effectiveness review indicated largely positive progress in improving the effectiveness of the committee over the last year. Scope for some further improvement was highlighted and agreed. An updated Terms of Reference (ToR) was recommended for Board approval which includes a streamlined membership and further increase of BPC's scope to include Equality, Diversity and Inclusion. • Updated ToRs for the Local Negotiating Committee and Staff Partnership Committee were approved • A business case to take over hosting stroke software (brain scan interpretation) used by 7 regional trusts was approved. Funding would be provided through NHSEngland. NHS Improvement. • A review of Estates and Facilities work over the last year was received. It was agreed that the resourcing of further sustainability plan work should be reviewed, including links with Aintree • The migration to NHS.net email had been implemented successfully. Digital Aspirant programme on track although resourcing remains a pressure due to sickness		
2.	Risks Identified	• Failure to spend this year's capital plan with slippage into next year when the budget is much tighter • Efficiency savings required for 2022/23 is approximately 3% of turnover, with only half of those identified to date.		
3.	Report Compiled	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Report to Trust Board
7 April 2022

Report Title	Business Performance Committee (BPC) Terms of Reference (ToR)
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To note

Level of Assurance Provided

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

Key Messages

- ToR has been refreshed following the annual committee effectiveness review
- Membership has been streamlined and quorum altered
- Equality, Diversity and Inclusion has been added to the areas of responsibility for BPC

Next Steps

- N/A

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

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
BPC	22 March 2022	K Dowson Corporate Secretary	Reviewed and proposed changes agreed

Business Performance Committee Terms of Reference

Executive Summary

1. Following the annual review of Committee Effectiveness the Terms of Reference (ToR) were refreshed and updated by the Committee and changes recommended for approval by the Board of Directors.

Proposed Changes

2. The following changes have been proposed to the ToR and are highlighted in red in the ToR (Appendix 1).

Area	Changes Made
General	General refresh of document and check against good practice for Board Committees
Purpose	Commercial and business development added to the high level overview.
Membership	Reduced to voting members with Chief Information Officer and Corporate Secretary as regular attendees. It is still intended that senior managers will be invited to attend to present regular items.
Quoracy	Quoracy remains at three voting members but the requirement for at least two Non-Executive Directors to attend has been reduced to one Non-Executive Director.
Duties	Equality, Diversity and Inclusion is added to the duties to align it with workforce, this was previously under Quality Committee. The Chief People Officer now has ED&I in their portfolio and attends BPC rather than Quality.
Other	Strategies, Duties and Groups updated to reflect the above changes and additions during the year.

Recommendation

3. To approve.

Author: Katharine Dowson, Corporate Secretary
Date: 31 March 2022

Appendix 1

BUSINESS PERFORMANCE COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Business and Performance Committee (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to provide the Board of Directors with assurance that the Trust's operational, financial and workforce activities and 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, commercial and business development, investment, procurement and digital.

Membership

7. The Committee shall be comprised of the following voting members:

   - Three Non-Executive Directors, one of whom will be the Committee Chair
   - Chief Finance Officer
   - Chief Operating Officer
   - Chief People Officer

8. The following are required to attend in a non-voting capacity:
   - Chief Information Officer
   - Corporate Secretary

9. The Committee will be deemed quorate when three voting members are present, including at least one Executive and one Non-Executive Director.

10. 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. The Chair shall have a casting vote in the event of a vote.

11. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. 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.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

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

Requirements of Membership

14. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

15. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

16. In order to fulfil its role and obtain the necessary assurance, the Committee will:

- Inform the development and provide assurance against the following strategies, associated policies, sub-strategies, action plans and annual reports:
  - Commercial & Business Development Strategy
  - Communication & Engagement Strategy
  - Data Security & Protection Toolkit
  - Digital Strategy
  - Equality, Diversity and Inclusion Strategy
  - Estates and Facilities Strategy
  - Finance and Procurement Strategy
  - Financial Plan
  - Intelligence Strategy
  - Long Term Financial Plan

- People Strategy
- Transformation Strategy

17. Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas associated with the above strategies and to also include:
    - Capital Expenditure
    - Contract Management
    - Data Quality
    - Emergency Preparedness
    - Health and Wellbeing
    - Information Governance, Data Security & Protection
    - Learning & Development
    - Occupational Health
    - Operational Performance
    - Organisational Development
    - Staff Survey Response
    - Sustainability
    - Workforce Planning

18. The Committee's general duties in the above areas will be to:

    - Provide assurance to the Board on compliance with associated legislation, national reporting and regulatory requirements and best practice

    - Consider and review relevant metrics, support the development of appropriate performance measures such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks to inform the organisation to support continual improvement

    - Oversee the delivery of any corrective action plans in areas where acceptable assurance is not yet in place

    - Assess and approve business cases in line with delegated limits for the Committee in the SoRD and SFIs; or review and make appropriate recommendations to the Board of Directors where the approval limit is above the Committee's limits

19. The Committee will also :

    - Monitor financial plans, forecasts, mitigation, Cost Improvement Plans and corrective plans including the Capital Expenditure Programmes and seek assurance on the preparation of forward planning for subsequent years

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

Data Privacy

20. The Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

21. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

22. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

23. Reports including regular assurance reports will be received from the following sub-groups:
    - Capital Management Group
    - Data Quality Group
    - Digital Systems Programme Board
    - Equality, Diversity and Inclusion Group
    - Information Governance & Security Forum
    - Local Negotiating Committee
    - Medical Devices and Facilities Group
    - People Group
    - Resilience Planning Group
    - Staff Partnership Committee
    - Transformation Group
    - Heating and Pipework Committee (time limited)

Administration of Meetings

24. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of ten meetings per year.

25. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

26. Agendas and papers will be circulated at least four working days in advance of the meeting.

27. Minutes will be circulated to members for comment as soon as is reasonably practicable.

28. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

29. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

30. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: 7 April 2022
Review Date: April 2023

Board of Directors' Key Issues Report

Report Date: 07/04/22		**Report of:** **Quality Committee**
Date of last meeting: 17/03/22		**Membership Numbers:** 15
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Medical Director's update • Integrated Performance Reports & KPI Reports • Quality Presentation by the MS ANP Lead • Quality & Clinical Strategy update • MiAA Recommendations for Annual Programme • Quality Impact Assessments • Quarterly Trust Risk Register • CQC Insight Report • Quarterly Pharmacy KPI Report • Pharmacy Review on Critical Care • In-Patient Survey Improvement Plan • Board Assurance Framework • Quality Committee Effectiveness Review & Terms of Reference • Quality Committee Cycle of Work • Health, Safety & Security Group Terms of Reference • Sub-Committee Chair's Reports
2.	**Alert**	• No alerts to report
	Assurance	• The Integrated Performance Report highlighted improvements in FFT feedback in both of the Neurology & Neurosurgery Divisions. The Neurology division has also seen improvements in tissue viability incidents. Focused work on patient falls, nutrition and hydration within both divisions is underway. There is also a continued focus on improving patient risk assessment scores. Neurosurgery teams noted the challenge of infection prevention with teams focussing on a return to the basics for infection control • Mortality figures on the RAMI have returned to the normal figures and remain low in comparison to other Trusts • Due to current over-establishment in medical training posts it has been easier for medics to attend training. It was noted that the medical turnover metric has limited value • The Advanced Nurse Practitioner Lead presented how the Multiple Sclerosis (MS) Team deliver a quality service across the six sites within the region. The

		Committee noted the positive impact the team and the services provided has on patients • BAF risks reviewed for end of year and recommended to Board for approval.		
	Advise	• The patient story highlighted the different expectations patients hold with regards to the service received. Expectations and perspectives with regards to a good quality service were discussed and it was noted that the further work in respect of “what good looks like” is underway by the Executive Team. • The Care Quality Commission (CQC) Insight Report was presented in a new format which was welcomed. The Central Alerting System (CAS) data is being verified and will be raised with CQC if it is not accurate. The Head of Risk advised that CAS alerts will now be monitored via the Clinical Services & Effectiveness Group and actions put in place to ensure alerts are closed within specified deadlines. • Pharmacy Review on Critical Care regular report update was provided, following past CQC input with regards to establishing a 7 day service. A recent Specification review on Critical Care recorded compliance with current provision. As different measures are being used, this issue is to be discussed further with the CQC and with the Critical Care Network. • The Quality Committee Effectiveness Review highlighted areas for improvement which included the quality of reports. A new board report template will be implemented on 01/04/22 to aid improvements in structure. A review of the QC cycle of business will ensure that sufficient external third party reviews are included. Committee membership to be reviewed in three months.		
2.	Risks Identified	None		
3.	Report Compiled by	Seth Crofts Acting Chair	Minutes available from:	Corporate Secretary

Report to Trust Board
7 April 2022

Report Title	Quality Committee (QC) Draft Terms of Reference (ToR)	
Executive Lead	Jan Ross, Chief Executive	
Author (s)	Katharine Dowson, Corporate Secretary	
Action Required	To note	
Level of Assurance Provided		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls
Key Messages		
• ToR has been refreshed following the annual committee effectiveness review • Quorum has been changed • Equality, Diversity and Inclusion removed and added to Business Performance Committee		
Next Steps		
• N/A		

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

Strategic Risks		
Not Applicable	Choose an item.	Choose an item.
Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development			
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	17 March 2022	K Dowson Corporate Secretary	Reviewed and proposed changes agreed

Quality Committee Draft Terms of Reference

Executive Summary

1. Following the annual review of Committee Effectiveness the Terms of Reference (ToR) were refreshed and updated by the Committee and changes recommended for approval by the Board of Directors.

Proposed Changes

2. The following changes have been proposed to the ToR and are highlighted in red in the ToR (Appendix 1).

Area	Changes Made
General	General refresh of document and check against good practice for Board Committees
Quoracy	Quoracy remains at three voting members but the requirement for at least two Non-Executive Directors to attend has been reduced to one Non-Executive Director.
Duties	Equality, Diversity and Inclusion (ED&I) has been moved to the Business Performance Committee (BPC) as this is now part of the portfolio of the Chief People Officer. This will align ED&I with workforce issues under BPC.
Other	Strategies, Duties and Groups updated to reflect the above changes and additions during the year.

Recommendation

3. To approve.

Author: Katharine Dowson, Corporate Secretary
Date: 31 March 2022

Appendix 1

QUALITY COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Quality Committee is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Quality Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Quality Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Quality Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Quality Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Quality Committee who will oversee their work.

Purpose

6. 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. It ensures that high standards of care are provided by the Trust and in particular, it ensures that adequate governance structures, processes and controls are in place throughout the Trust to:
   - Promote safety and excellence in patient care and experience
   - Identify, prioritise and manage risk arising from clinical care
   - Ensure the effective and efficient use of resources through evidence-based clinical practice
   - Ensure compliance with legal, regulatory and other obligations

Membership

7. The Committee shall be comprised of the following voting members:

   - Three Non-Executive Directors, one of whom will be the Committee Chair
   - Chief Nurse
   - Medical Director

8. The following are required to attend in a non-voting capacity:

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

9. The Quality Committee will be deemed quorate when three voting members are present, including at least one Executive and two Non-Executive Directors.

10. 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. The Chair shall have a casting vote in the event of a vote.

11. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. 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.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

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

Requirements of Membership

14. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

15. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

16. In order to fulfil its role and obtain the necessary assurance, the Quality Committee will:

- Inform the development and provide assurance against the following strategies, associated policies, sub-strategies, action plans and annual reports:
    - Quality Strategy
    - Quality Account

- Ensure that governance and assurance systems operate effectively and underpin programme delivery to include:
    - Clinical Audit
    - Clinical Care
    - Complaints, Compliments and Concerns
    - ~~Equality and Diversity~~
    - Health and Safety
    - Incident Reporting and Management
    - Infection Prevention and Control
    - Mortality and Morbidity
    - Organ Donation
    - Patient Experience
    - Safeguarding

- Oversee the Trust's arrangements for maintaining licences such as the Care Quality Commission, Human Tissue Authority, Radiation Use and Protection Regulation (IR (ME) R, ensuring compliance with standards, reviewing recommendations and monitoring of any associated action plans
- 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
- Ensure the Trust acts on learning from internal or external reports including serious incidents, other incidents, inquiries, investigations and Coroner's reports
- Monitor the principal risks assigned annually by the Board by ensuring that relevant assurances are sought with respect to the effectiveness of existing risk controls and that future actions are focused on managing risks to an acceptable level
- Monitor the management of key operational risks relevant to its remit and consider their impact on the strategic risks
- 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.

Data Privacy

17. The Quality Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

18. In conducting its business, the Quality Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

19. The Quality Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

20. Reports including regular assurance reports/meeting minutes may be received from the following sub-groups:

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

Administration of Meetings

21. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Quality Committee. There shall be at least nine meetings per year.

22. The Corporate Secretary will make arrangements to ensure that the Quality Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

23. Agendas and papers will be circulated at least four working days in advance of the meeting.

24. Minutes will be circulated to members for comment as soon as is reasonably practicable.

25. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

26. The Terms of Reference shall be reviewed annually (next review date: April 2023) and approved by the Board of Directors.

27. The Quality Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: 7 April 2022
Review date: April 2023

Report to Trust Board
7 April 2022

Report Title	Cheshire & Merseyside NHS Prevention Pledge			
Executive Lead	Andrew Nicolson Deputy Chief Executive			
Author (s)	Deputy Directors			
Action Required	To note			
Level of Assurance Provided				
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls		
Key Messages				
• To update the Board on the Trust progress with the NHS Prevention Pledge.				
Next Steps				
• The Trust will continue to work towards the commitments within the pledge.				
Related Trust Strategic Ambitions	**Impact**			
Not Applicable	Not Applicable	Choose an item.	Choose an item.	
Strategic Risks				
004 Patient Care and Experience	Choose an item.	Choose an item.		
Equality Impact Assessment Completed				
Strategy ☐	Policy ☐	Service Change ☐		
Report Development				
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**	
Not applicable				

Cheshire & Merseyside NHS Prevention Pledge

Executive Summary

1. The Prevention Pledge consists of a set of commitments whereby NHS organisations pledge support to achieve action on improving population health with a specific focus on prevention measures, for the benefit of staff, patients and the wider community.

2. A number of 'strategic core commitments' have been considered in line with commitments in the NHS Long-Term Plan, sub-regional prevention priorities and in particular the Cheshire & Merseyside Population Health Framework.

3. The strategic core commitments have been drafted to align with a range of NHS Provider Trusts, offering the opportunity for different providers to adopt the Cheshire & Merseyside Prevention Pledge.

Background and Analysis

4. In December 2021, representatives from a cross-section of departments from the Trust undertook a mapping exercise with staff from Health Equalities Group. The session was tracked through Miro Mapping software. This session was followed up with staff from HEG in early December, where initial findings were scoped out further, and aligned to the 14 Core Commitments that underpin the NHS Prevention Pledge.

5. Across January and February 2022, key findings from the mapping exercise were used in combination with the NHS Prevention Pledge audit and validation tool to develop the first iteration of the Trust's action tracker.

6. A draft action tracker was shared with HEG for further comments and redrafting in early March 2022, with a final version of the tracker submitted in late March. Please see final iteration attached.

7. The Trust have chosen some key short term commitments as a focus.

Conclusion

8. It is recognised that a lot of work was required by the Trust to reach this final action plan, a series of monthly meetings for Liverpool based Trusts have been organised to promote Place based working, the Trust will continue to work towards the pledge.

Recommendation

9. To note

Authors: Sacha Niven Deputy Medical Director
Helen Wells Deputy Chief Finance Officer
Nicky Martin Deputy Chief Nurse
Julie Riley Deputy Director of Strategy
Jane Mullin Deputy Chief People Officer
Date: 29th March 2022

Appendix 1 - Cheshire & Merseyside NHS Prevention Pledge Action Tracker

Colour Coding: Commitments actively being worked on denoted in Grey

Element	Outcome	Status	Progress	Upcoming Actions	Action Owner	Completion Date	Metric	Comment
Programme Set Up	Executive sponsor in place		Deputy CEO identified as Executive Lead	Action Tracker to be presented to Trust Board in March 2022	DCEO	01/01/22	N/A	
Programme Set Up	Working Group in place		Deputy Directors identified as working group	Monthly meetings for working group (last Tuesday in the month)	DCPO	01/02/22	Group TOR	
Programme Set Up	Prevention Pledge Plan outlining actions and completion dates		Plan created	Plan to be shared with Executive Directors	Working group (WG)	01/02/22	Agreed plan	
Programme Set Up	Governance structure established		Plan agreed with CEO	Meetings arranged to ensure progress is being made	WG	01/01/22	Agreed plan	
PP - Systems & Environmental	1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC) and making 'prevention everybody's business'.		Well-being and prevention incorporated into refreshed Trust Strategy Neurosciences Board Linked to HCP- acute, social care & community sectors all involved Refreshed Well-being strategy for staff	 To be approved at SPC/LNC	DDS DCPO	 31/03/22	Refreshed strategies and associated action plans	People sub strategy to be developed

			NED appointed as Board Wellbeing Guardian					
PP - Systems & Environmental	2. Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.		Service Transformation Team in place- staff training to support leadership & building ideas Patient experience training – specific to teams/wards Single/joint procurement portal	Continued review of projects at Transformation Board	ACO O	On going	Action plans	
PP - Systems & Environmental	3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities & deliver local priorities and prevention ambitions set out within the NHS Long Term Plan & in COVID recovery plans		Involvement in a number of place-based strategies and interventions designed at reducing inequalities in line with NHS Long Term Plan / COVID recovery	Consider prevention work in the community re head injury and helmets Work with local acute Trust re falls prevention/frailty Work with local acute Trust re back pain/injury Leading on the collaboration of pain services across North Merseyside linking in with the medicines optimisation project In line with the above	DMD DMD DDS	31/12/22	Project Milestone achievements for relevant projects, as reported to Trust Board	Neurosurgical lead identified. British cycling emailed about any stats they have- no reply as yet

				working with Sports England on improving access to exercise for patients with LTC. This is also in partnership with the Neuro Therapy Centre Work with local acute Trust re cancer patients Work with Local acute Trusts to support patients neurological care and treatment closer to home	DDS ADD ONS DDN			
PP - Systems & Environmental	4. Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.		Integrated Neurology Nurses RANA	Continue pathway work commenced in covid re stroke prevention/early presentation Develop role of AHP's in providing advice linking to other neurological care pathways	DDN	31/03/22 30/09/22	Number of patients treated via RANA pathway Number of advice session provided by AHP's	
PP - Systems & Environmental	5. Increase social value by establishing anchor practices, that positively impact on the wider determinants of health & the climate 'health' emergency, when making decisions on procurement,		Emphasis of Trust's social responsibility as an anchor institution within draft Trust strategy, for approval in 2021. Involvement in a number of	Collaborative procurement service across a number of specialist Trusts	DCFO	31/03/22		

	purchasing and through our organisation's corporate social responsibilities.		place-based strategies and interventions demonstrating the Trust's commitment to its social responsibility.	Promote the Trust as an employer to local schools Consider employing local community as a priority Active partner in the Everton Minds programme Apply for Social Value Award Participation in Liverpool Citizens Alliance Widening of the apprenticeship programme	DCPO DCPO DDS DCPO DCPO	31/03.22 31/03/22 31/03/22 31/03/22 31/03/22	Number of visits to schools over the year Monitor local recruitment Participation in programmes Success with application Involvement in alliance	
PP- Brief Intervention / MECC / Social Prescribing	6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.		MECC training package	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process	DCN	30/09/22	Number of staff trained Number of patients/clients receiving a MECC contact Number of new staff inductions that include mandatory MECC training at a basic competency level	

PP- Brief Intervention / MECC / Social Prescribing	7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building & to reduce impact on GP consultation rates, A&E attendance, hospital stays & re-admission, medication use, and social care.		Patient & family centred care steering group to inform holistic approach Nursing advice lines Enhanced triage Pathway navigators in clinical areas Best supportive care pilot with Whiston for cancer patients	In partnership with the voluntary sector supporting the implementation of the Health Coaches for patients with LTC Via the Wellbeing sub group with Liverpool City Council to consider the use of 'shinyminds' resilience app in social prescribing	DMD DCPO	30/06/22 April 2022	Length of Stay Implementation and use of app	
PP- Brief Intervention / MECC / Social Prescribing	8. Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental wellbeing.		MECC training Staff well being advocates Internal communications i.e. Walton Weekly, posters etc	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process	DCN	30/09/22	Number of staff trained/participating in training Number of patients receiving a MECC contact Number of new staff inductions that include mandatory MECC training at a basic competency level	
PP - Health & Well-being for Staff, Patients & Visitors	9.Ensure a smoke-free environment, linked to support to stop smoking for patients and staff who need		Smoke free site Smoking cessation support in place		DCPO	31/12/22	Smoke-free policy in place and actions related to policy complete	

	it							
PP - Health & Well-being for Staff, Patients & Visitors	10. Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental wellbeing		Staff well-being programme Trained MHFA across the Trust Internal communications i.e. Walton Weekly, posters etc	Review of staff experience action plan at sub board level Review staff rest facilities Respond to staff need re well being Launch of new Wellbeing Strategy Monthly wellbeing newsletter Introduction of ambassadors for the Trusts resilience app	DCP O	Quarterly 28/02/22 28/02/22 28/02/22 28/02/22	Reduction in staff absence Reduction in the number of staff leaving the Trust Improving number of staff recommend the Trust as a place to work and receive treatment Pulse Survey	
PP - Health & Well-being for Staff, Patients & Visitors	11a. Review food and drink provision across all our NHS buildings, facilities and providers in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.		New catering contract from 1st April 2022	As part of new provision to audit staff and public food provision on site to identify opportunities to further the availability of healthy food and drink	ACO O	01/04/22	Percentage of drink lines stocked which are sugar free, including energy drinks, fruit juices and milk-based drinks Percentage of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal or less per serving and don't exceed 5g fat per 100g	
PP - Health & Well-being for Staff, Patients & Visitors	11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-		All staff members provided with re-usable drink bottle Fresh water	Audit to be undertaken of current facilities on site	DCP O	31/12/22	Water points across the Trust	

	useable bottle refills.		fountains available in staff areas					
PP - Health & Well-being for Staff, Patients & Visitors	12. Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.		Some physical activity promotion to staff, including the offer of subsidised gym membership sessions and the invitation to take place in the NHS games. Aligned with initiatives at local government Charity events- Hope Mountain Hike, virtual London marathon	Audit of staff physical activity Work with MSP to promote physical activity	DCPO	31/03/22 On going On going	Proportion of staff participating in regular physical activity Wellbeing survey	
PP - Health & Well-being for Staff, Patients & Visitors	13. Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.			Paper to be produced outlining the requirements of the Prevention Concordat and the benefits to the Trust to implement the Strategy	DCPO	31/03/22	Number of staff who have participated in training provided	
PP-Governance	14. Monitor the progress of the pledge against all commitments and to publish the results of our progress at regular intervals.		Action plan	Review with Executive team	All DD	Quarterly	RAG rated action plan to be reviewed at Board	

Action Owner Key:

WG – Working Group
All DD – All Deputy Directors
DCEO – Deputy Chief Executive Officer
DMD - Deputy Medical Director
DCFO - Deputy Chief Finance Officer
DCN - Deputy Chief Nurse
DDS - Deputy Director of Strategy
DCPO - Deputy Chief People Officer
ADDONS - Acting Divisional Director of Operations Neurosurgery
DDN - Divisional Director Neurology

Report to Trust Board
7 April 2022

Report Title	Violence Prevention and Reduction Strategy		
Executive Lead	Lisa Salter Chief Nurse		
Author	Mike Duffy Head of Risk and Governance		
Action Required	To approve		
Level of Assurance Provided			
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls	
Key Messages			
• Present national requirement for adherence to violence prevention and reduction standards criteria (NHSEI)			
Next Steps			
• Implement and monitor work via Health, Safety & Security Group • To implement the Violence Prevention and Reduction Strategy contained in Appendix 1.			
Related Trust Strategic Ambitions	**Impact**		
Education, Teaching & Learning	Workforce	Choose an item.	Choose an item.
Strategic Risks			
003 Violence and Agression to Staff	Choose an item.	Choose an item.	
Equality Impact Assessment Completed			
Strategy ✓	Policy ☐	Service Change ☐	
Report Development			

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

Violence Prevention and Reduction Strategy

Executive Summary

1. The purpose of the Violence Prevention and Reduction Strategy is to set out a 3 year plan for The Walton Centre NHS Foundation Trust to address the significant risk to staff from violence and aggression. This will support staff to work in a safe and secure environment, which safeguards against abuse, aggression and violence, optimising patient care and treatment. This work is based on the national requirements to adhere to the violence prevention and reduction standard criteria (NHSEI).

Background and Analysis

2. All NHS commissioners and all providers of NHS-funded services, operating under the NHS Standard Contract should have regard to the national violence prevention and reduction standards.

3. The standards have been developed with partners from the Social Partnership Forum and its subgroups, the Workforce Issues Group and the Violence Reduction Group. The standard is managed by NHS England and NHS Improvement and was endorsed by the Social Partnership Forum on 15 December, 2020.

4. The criteria within the standards require the Trust to develop a violence prevention and reduction strategy which has been endorsed by the board. The senior management (the Chief Executive and the Board) is accountable for the violence prevention and reduction strategy and policy. A designated board-level (director) manages the violence prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).

5. The strategy (Appendix 1) also includes the approach (Plan, Do, Check, Act) for implementation and monitoring to ensure the Trust complies with the national violence prevention and reduction standards.

Conclusion

6. The Trust Board is responsible for endorsing, implementing and tracking progress of its delivery. The operational monitoring of the strategy and national violence prevention and reduction standards will be managed by the Health, Safety and Security Group.

Recommendation

To approve.

Author: Mike Duffy, Head of Risk and Governance
Date: 29 March 2022

Appendix 1

Violence Prevention and Reduction Strategy 2022 - 2025

Author and Contact details:	**Mike Duffy, Head of Risk and Governance** **Tel:** (0151 556 3084) **Email: michael.duffy2@nhs.net**	
Responsible Director:	**Lisa Salter, Chief Nurse**	
Approved by and date:	**Trust Board**	**April 2022**
Document Type:	**Strategy**	**Version 1.0**
Target Audience:	All trust employees.	
Document Approval, History/Changes	For further information contact the Governance Department on **Tel:** (0151) 556 3082	

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

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1. Introduction

The Walton Centre is a leader in the treatment and care of neurology and neurosurgery, placing the patient and their family at the heart of everything we do. As the only specialist hospital Trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services, we are proud to be rated as an ‘Outstanding’ Trust by the Care Quality Commission (CQC), and champion change throughout the field of neuroscience. Originally formed in 1992, the Trust received Foundation Trust status in 2009.

We have leading specialists and incredibly dedicated staff delivering excellent clinical outcomes for brain, spinal and neurological care both national and internationally. Teams across our site in Fazakerley, Liverpool, offer a world-class service in diagnosing and treating injuries and illnesses affecting the brain, spine and peripheral nerves and muscles, and in supporting people suffering from a wide range of long-term neurological conditions.

Due to the nature of the patients being treated at The Walton Centre, with the range of complexities and acuity of patients, the Trust has a significantly increased risk of violence. The World Health Organisation defines violence as: “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (Global status report on violence prevention 2014).

2. Violence prevention and reduction standard

All NHS commissioners and all providers of NHS-funded services, operating under the NHS Standard Contract should have regard to the national violence prevention and reduction standards.

The standards have been developed with partners from the Social Partnership Forum and its subgroups, the Workforce Issues Group and the Violence Reduction Group. The standard is managed by NHS England and NHS Improvement and was endorsed by the Social Partnership Forum on 15 December, 2020.

3. Purpose

The purpose of the Violence Prevention and Reduction Strategy is to set out a 3 year plan for The Walton Centre NHS Foundation Trust to address the significant risk to staff from violence and aggression. This will support staff to work in a safer and secure environment, which safeguards against abuse, aggression and violence, optimising patient care and treatment.

4. Duties

4.1. Trust Board

The Trust Board is responsible for endorsing, implementing and tracking progress of its delivery.

4.2. All staff

All staff are responsible for following the associated policies, procedures and risk management arrangements developed or governed by this strategy.

5. The Strategy

Leadership at all levels – Empowering leadership at all levels. Ensuring staff feel confident in making decisions and contributing to the development of risk assessments and management plans for patients with challenging behaviour.

Data driven decisions – Using data from incidents, complaints, claims, RIDDOR reporting of injuries to staff and the staff survey. This will help inform the Trust of themes, trends, issues and risks regarding violence or aggression. It will also help formulate future work plans to help mitigate the risk of violence or aggression.

Risk reduction tools – Using the data to help inform the Trust with the development of risk reduction tools. This may include equipment, protocols, procedures and policy.

Competent people – Ensuring staff receive the right training for their work environment. This will include regular reviews of data, including incidents and training sessions, to ensure the training provision is fit for purpose to meet the needs of the services and evolves with any emerging trends or threats.

Support – Providing supportive mechanisms post incident. This may include de-briefs following incidents, the LAST LAP (Looking After Staff That Look After People) initiative or more formal support such as counselling or occupational health in line with HR processes.

Monitoring – Evidencing a culture of change through reporting mechanisms, including the trusts quarterly and annual governance reports. To include all aspects of work in relation to the strategy and compliance with the national violence, prevention and reductions standards.

6. The Approach

The violence prevention and reduction strategy employs the Plan, Do Check, Act (PDCA) approach, an iterative four-step management method to validate, control and achieve continuous improvement of processes.

Plan

The Trust must review their current status against the violence prevention and reduction standards and identify their future requirements, to understand what needs to be completed and how, who will be responsible for what, and what measures will be used to judge success. This phase of the process includes developing or updating strategies, policies and plans to deliver the aims.

Do

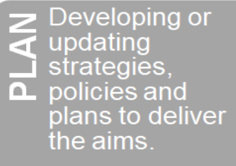
The Trust must:
• assess and manage risks
• organise and implement processes, and communicate plans to and involve staff and key stakeholders in delivery of these
• provide adequate resources and training.

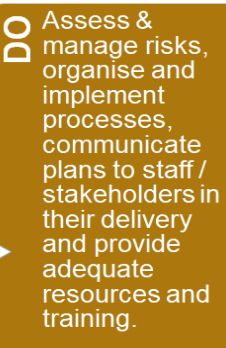
Check

The Trust must ensure that the plans are implemented successfully, assess how well the risks are controlled and determine if the aims have been achieved, i.e. via audit measures. As part of the process, the Trust should routinely assess any gaps and ensure swift corrective action. Credible, accurate and unambiguous data will assist in checking incidents of violence have fallen.

Act

The NHS organisations must review its performance to enable the senior management team to direct and inform changes to policies or plans, in response to any localised lessons learnt and incident data collected in respect of violence prevention and reduction. The NHS organisation should share critical findings with internal and external stakeholders.





7. Training

The provision of evidence based training that integrates policy into practice in line with bespoke service need is recognised. Personal Safety Training, including conflict resolution and restraint training is delivered at induction and mandatory training days for all disciplines of staff, as identified within the Trusts Training Needs Analysis. This has been accepted by the Trust. Training is regularly evaluated and reviewed to ensure it is meeting the needs of the service and responding to any emerging themes or trends.

8. References

Underpinning legislation

Employers (including NHS employers) have a general duty of care to protect staff from threats and violence at work. Five pieces of health and safety legislation cover violence at work:

• Health and Safety at Work Act 1974 (HASAWA)
• Management of Health and Safety at Work Regulations 1999
• Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR)
• Safety Representatives and Safety Committees Regulations 1977
• Health and Safety (Consultation with Employees) Regulations 1996.

8.1. Supporting policies/document

• Management of Violence and Aggression Policy
• National 'Violence prevention and reduction standard'

Board of Directors' Key Issues Report

<table>
<tr><td colspan="2">Report Date:</td><td>Report of: Neuroscience Programme Board,</td></tr>
<tr><td colspan="2">Date of last meeting:
10/03/22</td><td>Membership Numbers:
9</td></tr>
<tr><td>1.</td><td>Agenda</td><td>The Neuroscience Programme Board considered an agenda which included the following:-
GIRFT updates: Neurology
Spinal merger update
Pain Collaboration Review
MS report & update
Update from Healthcare Partnership (HCP) Transitional Board
Everton Minds update
Items for the Work Plan
Draft Terms of Reference (ToR)
Hot topics from other hospitals</td></tr>
<tr><td>2.</td><td>Alert</td><td>Spinal Update
• The full merger of Spinal services to the Walton Centre (WCFT) has been agreed. Liverpool University Hospital Foundation Trust closed to new referrals on 25/02/22 and WCFT opened to new referrals on 25/02/22. The process of validating and cleansing of both in-patient and out-patient waiting lists is underway. The business case is near to completion and will be presented to the Executive Team.</td></tr>
<tr><td></td><td>Assurance</td><td>CMRN Review
• The CRMN manager, WCFT Acting Chief Operating Officer and WCFT Acting Divisional Operations Director for Neurology are meeting to discuss the governance and infrastructure around the network to enable it to move forward and deliver its ambitions. Any updates will be provided at the next meeting.

MS Report
• The board acknowledged the detailed reports included in the papers. A summary was provided by the Co. Chair of the Cheshire and Mersey Neurological Alliance who noted that the Access to Therapies workshop was very well attended from a variety of disciplines. Key issues arising from the workshop was the need for a single point of access for those living with a neurological condition and how to engage primary care representatives.
• With regards to the Point of Diagnosis workshop, meetings have been held as to how valuable patient insight can be shared with clinicians in a manageable way. The workshop also highlighted the gap in emotional and psychological support for patients and the potential for addressing this.
• Discussions are taking place with MS Nurses in Liverpool (and possibly North Wales) with regards to a trial of the National Consensus Bladder Management Pathway</td></tr>
</table>

	Advise	**GiRFT update Neurology – RANA (Rapid Access to Neurology Assessment)** • Planning for RANA continues but it was noted that activity was low in December and January. Visibility of WCFT Neurology leads at Safety Huddles/Bed Manager meetings at LUHFT is being considered in order to highlight RANA • Planning of RANA phase 2 is in place and further communications are planned regarding the current service. All teams are supportive of the aim to maximise the service • There was currently ambulatory care in 4 of the 7 hot sites but changes in workforce reduced the figure to 3. RANA discussions to include Wrexham as a further site for ambulatory care. **Pain Collaboration Review** • It was noted that current work is focussed on the development of 3 clinical workstreams of GP education, community rehabilitation and medical prescribing/opioid reduction. Meetings are well attended with the process at the discovery phase. The aim is to ensure robust governance and assurance for this large scale and complex project. Presentations of key proposals are due at a planned workshop on 16 March with the provider collaborative. **Everton Minds update** • A brief update was provided noting that WCFT have returned metrics as to the services/clinics which could be offered by WCFT. Funding is outside of health but the Everton Programme Board does require commitment of use of the facility. • Proposals of the facility include an immersive theatre and technology area and teams are keen to incorporate WCFT gait lab and movement analysis projects Meetings have been held in order to share ideas. **Work plan** • No new projects have been put forward to be added to the work plan so the current work plan will be followed. **Terms of Reference (ToR)** • The board considered and ratified the updated ToR. Attention was drawn to the membership and how representatives from Primary Care could be encouraged to attend meetings or to submit their views. Further discussions to take place.		
3	**Risks Identified**	**Pain Collaboration** • The team are currently out to advert for the 3rd time to recruit a project manager to oversee workstreams and deliver service improvements. **Terms of Reference** • Due to the continual changes regarding Clinical Commissioning Groups/ Integrated Care Systems it was noted that the ToR will be subject to regular updates		
4.	**Report Compiled by**	Medical Director	Minutes available from:	Corporate Secretary

Report to Trust Board
7 April 2022

Report Title	Eliminating Mixed Sex Accommodation Annual Statement of Compliance	
Executive Lead	Lisa Salter Chief Nurse	
Author (s)	Lisa Salter Chief Nurse	
Action Required	To approve	
Level of Assurance Provided		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls
Key Messages		
• 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 2021 to 31 March 2022 and no mixed sex breaches have occurred. The Chief Nurse will advise the Board accordingly at the meeting on 7 April 2022 should this situation change during the remaining days of March 2021.		
Next Steps		
• To publish the annual statement of compliance.		

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

Strategic Risks		
004 Patient Care and Experience	Choose an item.	Choose an item.
Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

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

Eliminating Mixed Sex Accommodation Annual Statement of Compliance

Executive Summary

1. The Trust is required to publish an annual statement of compliance on eliminating mixed sex accommodation.

Background and Analysis

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

Conclusion

7. There were no breaches of same sex accommodation across the Trust in 2021 / 2022.

Recommendation

8. To approve publication of the annual statement in the format attached below in appendix 1.

Author: Lisa Salter, Chief Nurse
Date: 1 April 2022

Appendix 1

Eliminating Mixed Sex Accommodation
Declaration of Compliance 01/04/21 - 31/03/22

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 2021 / 2022 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
Chief Nurse
April 2022

Report to Trust Board
7 April 2022

Report Title	Revocation of Vaccination as a Condition of Deployment (VCOD) Mandate	
Executive Lead	Michael Gibney Chief People Officer	
Author (s)	John Baxter Project Lead for LAMP Testing and COVID Vaccination Programme	
Action Required	To note	
Level of Assurance Provided		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- To update the Board on the outcome of consultation to revoke the mandate for vaccination as a condition of deployment across all health and social care.
- To provide an update on staff testing provision moving forward.

Next Steps

- The Trust will continue to support staff affected by the VCOD mandate.
- The Trust will need to consider appropriate retention periods for data such as vaccination status already collected as part of the Mandatory Vaccination Programme.

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

Strategic Risks		
005 Recruitment and Retention of Staff	Choose an item.	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Not applicable			

Revocation of Vaccination as a Condition of Deployment (VCOD) Mandate

Executive Summary

1. On 31st January 2022, the government announced its intention to revoke the regulations making coronavirus (COVID-19) vaccination a condition of deployment in health and social care, subject to consultation and parliamentary process.

2. A consultation was held between 9th February 2022 and 16th February 2022 to seek views on the government's intention to revoke the vaccination as a condition of deployment policy in health and social care.

3. On 1st March 2022 the Government confirmed that the revocation of the mandatory vaccination requirement for both care homes and the wider health and social care sector would take effect on 15th March 2022.

Background and Analysis

4. In November 2021 the Government published regulations extending a mandate for VCOD to health care workers to be introduced on 1st April 2022. Following this announcement the Trust undertook work to identify staff who would be affected by the mandate and continued to promote the availability of vaccines to all staff. Drop-in sessions were also held to support staff with the Chief Executive, Medical Director and Chief Nurse in attendance.

5. On 31st January 2022 the government announced its intention to revoke the VCOD regulations subject to consultation and parliamentary process. A consultation was then held between 9th February 2022 and 16th February 2022 to seek views on the government's intention to revoke the VCOD policy in health and social care and over 90,000 responses were received to the consultation.

6. 90% of respondents supported revoking the mandate. There was some variation between different groups, with members of the public most likely to support revocation (96%) whereas 70% of managers and 78% of organisations providing health and care services supported revocation.

7. The Government published confirmation of the revocation of the mandatory Vaccination Requirement for both care homes and the wider health and social care sector on 1st March 2022 and this would take effect on 15th March 2022.

Update on Staff Testing Provision

8. The LAMP testing programme ended on 31st March 2022.

9. From 1st April 2022 staff in patient facing roles should continue to test twice weekly when asymptomatic and lateral flow device (LFD) tests will continue to be available free of charge through the gov.uk portal for NHS staff working in a patient-facing role. There is no guidance to clarify what staff groups are classed as patient facing.

10. Symptomatic NHS staff should test themselves using LFDs. LFD tests will continue to be available through the gov.uk portal for wider NHS staff in England with symptoms.

11. Staff who test positive should continue to follow the current return to work guidance. LFDs to support this guidance will continue to be available through the gov.uk portal for NHS staff in England.

12. Staff who are household contacts of a positive COVID-19 case will be able to continue to work as normal from 1st April 2022 if they remain asymptomatic and continue to test twice weekly. They will no longer be required to have a PCR test in order to return to work.

Conclusion

13. It is recognised that a lot of work was required by the Trust to plan for the mandate of VCOD and a lot of data was recorded including the vaccination status of staff members as part of this process. The mandate led to some difficulties with some staff feeling aggrieved by the mandate and work will continue to support all staff and encourage staff to receive COVID vaccinations to keep themselves, their colleagues, families and patients safe. The Trust will also need to consider appropriate retention periods for data such as vaccination status collected as part of the Mandatory Vaccination Programme.

Recommendation

14. To note

Author: John Baxter , Project Lead for LAMP Testing and COVID Vaccination Programme
Date: 30th March 2022

Report to Trust Board
7 April 2022

Report Title	Use of the Trust Seal			
Executive Lead	Jan Ross, Chief Executive			
Author (s)	Katharine Dowson, Corporate Secretary			
Action Required	To note			
Level of Assurance Provided				
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls		
Key Messages				
• The Trust Seal has not been used in 2021/22				
Next Steps				
• N/A				
Related Trust Strategic Ambitions	**Impact**			
Leadership	Not Applicable	Choose an item.	Choose an item.	
Strategic Risks				
Not Applicable	Choose an item.	Choose an item.		
Equality Impact Assessment Completed				
Strategy ☐	Policy ☐	Service Change ☐		
Report Development				
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**	
N/A				

Use of the Trust Seal

Executive Summary

1. In accordance with the Constitution and the Standing Financial Instructions, the Board should receive an annual report of the use of the Trust Seal. The Seal is used infrequently and usually in relation to the signing and sealing of legal documents relating of land and property transactions.

2. There have been no uses of the Trust Seal in 2021/22. The Trust Seal was last used on 6 September 2016.

Recommendation

3. To note.

Author: Katharine Dowson, Corporate Secretary
Date: 31 March 2022