NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 4th April 2024

Agenda and Papers

Excellence in Neuroscience

NHS
The Walton Centre
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING

Thursday 4 April 2024
Boardroom
09:30 – 13.10

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Patient Story (v)	Chief Nurse	N/A
2	09.50	Welcome and Apologies (v)	Chair	N/A
3	09.55	Declaration of Interests (v)	Chair	Note
4	10.00	Minutes and actions of meetings held on: • 1 February 2024 (d)	Chair	Approve
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive	Note
6	10.20	Substrategy Updates • Finance and Commercial Development Substrategy (d) • People Substrategy (d) • Quality Substrategy (d)	Executive Leads	Assurance
7	10.35	Board Assurance Framework Closure Report 2023/24 (d)	Chief Executive	Approve
8	10.45	Board Assurance Framework 2024/25 (d) • Principal Risks • Risk Appetite Statement	Chief Executive	Approve
COLLABORATION				
9	10.55	Joint Site Sub Committee (d) • Key Issues Report – 08 February 2024	Chair	Assurance
10	11.00	Liverpool Trusts Joint Committee • Key Issues Report – 7 March 2024 (p)	Chief Executive Officer	Assurance
INTEGRATED PERFORMANCE REPORT				
11	11.05	Integrated Performance Report (d)	Chief Executive Officer	Assurance
12	11.05	Business Performance Committee (d) • Chair's Assurance Report: 26 March 2024 • Terms of Reference	Committee Chair	Assurance Approve
13	11.15	Quality Committee (d) • Chair's Assurance Report: 21 March 2024 • Terms of Reference	Committee Chair	Assurance Approve
11:25 BREAK				
QUALITY & SAFETY				
14	11.35	Guardian of Safe Working Q3 & Q4 Report (v)	Medical Director	Assurance
WORKFORCE				

Item	Time	Item	Owner	Purpose
15	11.40	Staff Survey Results (d)	Chief People Officer	Assurance
16	12.00	Health Inequalities and Inclusion Committee (d) • Key Issues Report – 25 March 2024 • Public Sector Equality Duty & Equality Delivery System Report • Gender Pay Gap Report 2022/23	Committee Chair	Assurance
GOVERNANCE				
17	12.15	Accountability and Performance Framework (d)	Chief Executive Officer	Approve
18	12.25	Annual Board Effectiveness Evaluation (d)	Chief Executive Officer	Assurance
19	12.35	Leadership and Competency Framework for Directors (d)	Corporate Secretary	Assurance
COMMITTEE CHAIR'S ASSURANCE REPORTS				
20	12.45	Research, Innovation and Medical Education Committee • Key Issues Report – 2 April 2024 (v)	Committee Chair	Assurance
21	12.50	Remuneration Committee • Key Issues Report – 26 January 2024 (d) • Key Issues Report – 7 March 2024 (d) • Terms of Reference	Committee Chair	Assurance Approve
22	12.55	Neuroscience Programme Board (d) • Key Issues Report – 29 February 2024	Committee Chair	Assurance
23	13.00	Walton Centre Charity Committee (d) • Key Issues Report – 23 February 2024	Committee Chair	Assurance
24	13.05	Audit Committee (d) • Key Issues Report – 6 February 2024	Committee Chair	Assurance
CONSENT AGENDA				
27. Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Use of Trust Seal Report 2023/24 (d) • Eliminating Mixed Sex Accommodation: Annual Statement of Compliance (d)				
CONCLUDING BUSINESS				
28	13.10	Any Other Business (v)	Chair	Note

Date and Time of Next Meeting: 9.30am, 6 June 2024, Boardroom, The Walton Centre

Resolution – The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of business to be transacted, publicity of which would be prejudiced to the public interest.

UNCONFIRMED
Minutes of the Public Trust Board Meeting
Board Room
1 February 2024

Present:

Max Steinberg (MS)	Chair
Irene Afful (IA)	Non-Executive Director
Mike Burns (MB)	Chief Financial Officer
Clive Elliott (CE)	Non-Executive Director
Mike Gibney (MG)	Chief People Officer
Debra Lawson (DL)	Associate Non-Executive Director
Nicky Martin (NM)	Chief Nurse
Paul May (PM)	Non-Executive Director
Andy Nicolson (AN)	Medical Director/ Deputy Chief Executive
Su Rai (SR)	Deputy Chair and Senior Independent Director
Jan Ross (JR)	Chief Executive Officer
David Topliffe (DT)	Non-Executive Director
Lindsey Vlasman (LV)	Chief Operating Officer
Ray Walker (RW)	Non-Executive Director

In attendance:

Katharine Dowson (KD)	Corporate Secretary
Jennifer Ezeogu (JE)	Deputy Corporate Secretary *(for minutes)*
Justin Griffiths (JG)	Deputy Chief Digital Information Officer (*item 9 only)*
Steve Holland (SH)	Head of Estates and Facilities (*item 7 only)*
Julie Kane (JK)	Freedom to Speak Up Guardian (*item 16 only)*
Elaine Vaile (EV)	Head of Communications

Observers

Helen Adlen	Staff Governor: Non-Clinical
Amanda Chesterton	Staff Governor: Clinical
Belinda Shaw	Public Governor: Merseyside
Sally Spencer	Partnership Governor: Edge Hill University

Apologies:
N/A

1 Staff Story

1.1 The staff story was presented by a Research Nurse (ResN) regarding their experience of settling in the United Kingdom and within the Trust as an internationally recruited Nurse. The ResN noted although English was their first language, they had initially struggled to communicate effectively with colleagues and patients but had learnt to match the local culture and adopt more non-verbal cues to effectively communicate.

1.2 The ResN noted that the Trust was an inclusive place to work and offered training and support to staff in their role. Although they enjoyed their role, the ResN was unsure of their career progression as there did not seem to be enough information on career progression for Research Nurses. The ResN suggested that Research Nursing be recognised as a

specialised group with a clear career path within the Trust and the NHS to encourage more nurses to be involved in research. NM stated that there was ongoing within the Integrated Care Board (ICB) a focus on Research Nursing within the region and that once it had been established, it would be communicated to staff through the Education Manager.

1.3 The ResN highlighted that sometimes micro-aggressions might be difficult to identify hence the difficulty in reporting these but it was important to report these and ensure managers share the learning from them.

1.4 SR asked about the level of support received as an internationally recruited nurse. The ResN responded that they had received regular 1:1 meetings and support from their line manager and recognised the positive impact of the Race Network group within the Trust.

1.5 The Board expressed its thanks to the ResN for sharing their story and reemphasised its commitment to ensure that the Trust was an inclusive place to work for everyone.

The Board noted the staff story.

2 Welcome and apologies

2.1 The Chair welcomed everyone to the meeting.

3 Declaration of interest

3.1 There were no other interests declared in relation to the agenda.

4 Minutes of the meeting held on 7 December 2023

4.1 The following changes were suggested:

4.2 Paragraph 16.5 – the third sentence to be reworded to - The SFI had been drafted when Trusts had to have five-year long-term plans and a three-year plan *was being worked* on to give an idea of the Trusts CIP.

4.3 Following the completion of the amendment, the minutes of the meeting held on 7 December 2023 were approved as an accurate record of the meeting.

Action tracker

4.4 All actions for the meeting had been completed and removal agreed from the action log.

5 Chair & Chief Executive's Report

5.1 MS observed that there was an increasingly positive relationship developing between the Board and the Council of Governors (CoG) and stated that positive feedback to this effect had been received from the various Governor engagement sessions and the new bi-monthly bulletin.

5.2 MS informed that the Trust had been visited by the Pro Vice Chancellor and Vice Chancellor of Liverpool John Moores University. MS, JR, AN, NM and PM paid a useful and informative visit to Edge Hill University on 30 January 2024 and were hosted by CE, Chair of the Board of Governors at Edge Hill and Professor Sally Spencer who was also a Partnership Governor at the Trust. Discussions were held in respect of the ongoing collaboration between both organisations.

5.3 JR reported that the referendum for the government's pay offer to Consultants had been rejected and that there was a possibility of further industrial action occurring. Urgent and emergency care remained a key issue across the system and an urgent and emergency care plan was soon to be published.

5.4 JR highlighted that Nick Carleton-Bland a Consultant Neurosurgeon from the Trust had been approached by the BBC regarding questions relating to Brain Stimulation techniques and that it was a recognition of the work done in the Trust to improve links with the media.

5.5 The Board was alerted to a letter that had been received from the Integrated Care Board (ICB) regarding financial planning and the key focus areas for the region. A meeting was being scheduled between the ICB and Chief Executives in February and weekly meetings would be held by the ICB and the Chief Finance Officers to further discuss this. MB highlighted that a meeting had been scheduled with LV to review the Trust Quality Improvement Programme (QIP) and that project leads had been identified and tasked with progressing on the projects and costings. Once these had been finalised, they would be incorporated into the plan and submitted to the ICB by the deadline at the end of March 2024.

5.6 MB highlighted that, when benchmarked against other Trusts in the region for QIP the Trust ranked as number one in terms of delivery. There was an expectation from the ICB for Trusts to deliver on 100% recurrent QIP for 2024/25. JR advised that the narrative to be included in the plan should be clear on what the Trust planned to deliver if this differed to delivery required from the ICB.

5.7 NM advised that Joanne Shaw had been appointed as the Deputy Chief Nurse and that the newly appointed Assistant Chief Nurse for Neurosurgery had commenced in post. JR also informed the Board that the Trust had successfully recruited a new Chief Digital Information Officer who would sit on the Board as a non-voting member.

5.8 RW suggested that the Trust identified ways to improve staff engagement and response rates to the staff survey once the results had been released.

The Board noted the Chair and Chief Executive reports.

6 Trust Strategy Update

6.1 LV stated that good progress had been made in quarter three against the delivery of the Trust Strategy and highlighted the set priorities for quarter four.

6.2 JR stated that good progress had been made towards the delivery of the Trust Strategy and that the Trust had delivered most of the objectives identified to date. The Board was conscious that 2023/24 delivery would be slower as the Trust had delivered on many of the targets. JR highlighted to the Board the risks involved in the delivery of the plan and the mitigations in place.

6.3 RW commented that the report provided what was required and asked if the current reporting format for the Trust Strategy and Substrategies was still the right one. DT further suggested that the reporting format be revised and streamlined to include the key risks, mitigations, trends and key actions that the Board ought to be aware of regarding the delivery of the Trust Strategy and enabling Substrategies. LV responded that this would be reviewed and that a

new reporting format to be agreed by the Board would be developed to reflect the progress and key information. LV added that in future the report would be presented twice a year to Board.

ACTION: LV to review the Trust Strategy and Substrategy reporting format ahead of the next update.

The Board noted the Trust Strategy Update

7 Estates and Facilities Substrategy Update

7.1 SH highlighted that the update of the Estates and Facilities Substrategy had been to all the relevant committees and groups for scrutiny. It was noted that many of the priorities had been achieved, aside for those which were dependent on external factors.

7.2 DT commented that the Substrategy had been reviewed at the Business Performance Committee (BPC) and that the Committee was pleased with the progress made and commended the strong focus on continuing improvements to improve patient experience and cost reduction for the Trust. DT further stated that the Estates Return Information Collection (ERIC) Return had also been reviewed at BPC. The Committee had noted the progress made and the efforts put into the collation of the data. DT expressed his hope that the data collated would be used by the NHS to improve maintenance backlogs and set greater capital allocations for Trusts.

7.3 SH reported that plans were underway by NHS England (NHSE) to purchase energy through a unified procurement framework/portal to bring benefits across the system.

7.4 RW stated that it was good to see the work being done in response to the PLACE inspection and thanked all those involved. JR commended the team for their effort in the delivery of the Substrategy.

The Board noted the Estates and Facilities Substrategy Update.

8 Communications and Marketing Substrategy Update

8.1 EV highlighted that there had been a few difficulties in Q3 due to workforce pressures, industrial action and other external influences. The team was currently undergoing a refocus and a review of the main objectives of the Substrategy to focus on the key areas to be achieved with the available resources.

8.2 EV reported that the Channel 5 documentary had been successful, viewing figures on average were 175k per episode with a total of 1.5million views for the series, this was the highest rated new series on the channel for the year and the channel and producers were keen on shooting another series with the Trust.

8.3 It was highlighted that due to the success of the documentary series, there had been an increase in the number of followers across all of the Trust's social media platforms, peaking during the first episode of the series. Feedback and response rates had been positive and it had been well received by staff.

8.4 SR asked about the impact of the documentary on the Trust's profile. EV stated that it was positive and had helped raise awareness, this was exemplified by the interview by one of the Trust's Neurosurgeons at BBC as reported in the Chief Executives Report (item 5).

8.5 CE asked about the lack of clinical engagement and therefore the risk to the delivery of the strategy. EV stated that the lack of clinical engagement was due to the strikes which in turn had an impact on some of the programmes of work but that work was currently ongoing to raise awareness of the benefits of participation and improve clinical engagement.

8.6 JR stated that there had been a positive cultural shift amongst clinicians which had been driven by AN. Most staff had begun to appreciate the benefit of promoting success and had been getting more involved.

8.7 SR enquired about the rebranding process and when it was due to be finalised. JR answered that in light of the discussions had at the Board development sessions it had been agreed that the Trust would have a soft rebranding launch to standardise its colour schemes and refresh its look but that a total rebranding would be considered at a later date following discussions by the Board.

8.8 MS asked if the proposed second documentary would be clinically based, and what was the potential impact on the Trust. EV confirmed that the documentary would be clinically based and this would further help increase the Trust profile and improve staff confidence.

The Board noted the Communications and Marketing Substrategy Update.

9 Digital Substrategy Update

9.1 JR advised that the Board should be conscious of the risks identified with the Trust digital systems as identified in the external digital review. The executives had done well to manage the digital concerns and maintain oversight to date. In recognition of the Boards limited expertise in digital and to address some of the risks highlighted in the external review and staff concerns, the Trust had now successfully recruited a specialised and nationally recognised executive director for digital. The new Chief Digital Information Officer (CDIO) would maintain oversight of the Trust Digital Substrategy and the team.

9.2 JR emphasised that this meant a period of transition for the digital team and the CDIO and it would take some time for the Trust to attain the standard it had hoped for. JR further thanked MG on how well he was managing the team through this period.

9.3 DT expressed his concerns that the Board was not assured that there was enough evidence in the report to demonstrate that proper scrutiny on the follow ups and the digital risks identified from the digital review were being carried out.

JG joined the meeting to present the Digital Substrategy Update.

9.4 JG presented the progress update on the Digital Substrategy and highlighted that the delivery of the Substrategy was on target and that Q4 was predominantly focused on cybersecurity issues that needed to be addressed. Work was ongoing to harmonise the 20 unsupported software applications across the Trust, most of which were clinical. The team was working to ensure that the software was compatible before transferring them to minimise any clinical risks.

9.5 JG reported that in addition the national roll out of Multi Factor Authentication for NHS mail was scheduled to be concluded in quarter four (Q4) and that the ICE programme for pathology licensing was expected to commence in Q4. Plans were being developed with finance to understand the full scope of this programme.

9.6 CE recognised the progress made so far and stated that the Board was not fully assured that proper actions had been taken to mitigate the clinical risks and other digital risks identified. CE drew the attention of JG to the recurrent themes of dependency on infrastructure and resourcing issues with regard to the clinical risks and prioritisation of the risks. JG answered that the report represented the data as at the time of the submission of the report but that all the actions with a December/January date had since been completed. The team was now focused on completion of actions with a February/March date, there was a live digital engagement portal used to manage the data and that most of the key dependencies were due to external influences and a reduction in manpower.

9.7 JG further stated that clinical risks were discussed at the Strategic Project Management Office (SPMO) meeting. These risks were then delegated to operational leads to monitor and review clinical concerns. One of the major concerns with regard to the clinical risks was patching of services and the impact. An update on the patching schedule would be presented at the Clinical Reference Group for sign off, putting into consideration the clinical risks and the mitigations in place. NM stated that the senior nursing team also prioritised the lists and updated the IT team on this.

9.8 MS asked if CE had now been assured with the response received. CE stated that he had been assured verbally and noted that it would have been more helpful if this had been demonstrated in the report for reference and accountability.

9.9 DT proposed that an action plan be developed to maintain oversight on the recommendations. JG stated that a short-term action plan had been developed that was being worked on pending the arrival in post of the new CDIO who would focus on the long-term action plans.

9.10 RW stated that the Board relies on BPC to receive the right level assurance with regards digital and inquired if there was a mechanism to provide assurance that the short term and long-term issues were being followed up. MS suggested that this matter be referred back to BPC and assurance could then be presented at the next Board meeting that the key clinical risks identified were being followed up and prioritised through the BPC Chair's assurance report.

The Board noted the Digital Substrategy Update.

10 Board Cycle of Business 2024/25

10.1 NM noted that LV was the responsible officer for Health and Safety (H&S). RW advised that H&S would report through the Business Performance Committee in the future.

The Board approved the 2024/25 Board Cycle of Business.

11 Joint Site Sub Committee Key Issues Report

11.1 MS presented the key issues report from the Joint Site Sub Committee meeting held on 9 January 2024 and highlighted that he would be stepping down as the chair of the committee in April and Mike Eastwood would chair for a year on a rotational basis.

The Board noted the Joint Site Sub Committee Key Issues Report.

12 Liverpool Trusts Joint Committee Key Issues Report

12.1 JR highlighted that the overarching aim of the Committee was to deliver the output of the Liverpool Clinical Services Review and that update from the various Joint Site Sub Committees was received by the Committee.

12.2 RW stated that it was good to see the contribution that the Trust was making to the system and asked how best it could be demonstrated. KD stated that under the new code of governance, Trusts were now mandated to demonstrate how they contributed to the system in their annual report.

The Board noted the Liverpool Trusts Joint Committee Key Issues Report.

13 Integrated Performance Report

Noted.

14 Business Performance Committee Chair's Assurance Report

14.1 DT as Chair of the Business Performance Committee advised that there were some challenges with reducing the waiting list numbers due to industrial action and mutual aid requests.

14.2 RW requested more clarification regarding the 52-week long waiters and how the safety of the patients was being managed. LV explained that there were 80 patients on the 52-week waiting list 57 of these had been referred to the Trust via mutual aid. Approximately 20 of the 52-weeks waiters had been contacted and were currently undergoing clinical revalidation. Harm reviews were also being conducted for all the patients on the waiting lists from a clinical and administrative perspective to manage the patients efficiently and no harm had been reported so far.

14.3 JR reiterated that these were some of the risks that had resulted from the ongoing industrial action, mutual aid requests and elective recovery and that although the patients were being clinically validated, there was still a risk that they would not been seen quickly because of this.

14.4 LV stated that the divisions maintained an oversight of the data and that the team would continue to tighten up the process to ensure patent safety is prioritised. The Pre-Assessment Clinic (PAC) team maintained oversight of the data and presented updates at the weekly performance meetings.

14.5 NM advised that she also attends the weekly performance meetings to have an oversight on the risks and the impact on patients experience and also to ensure that the Board received the right level of assurance through the Quality Committee. JR asked if the Board were happy to progress with the plan as illustrated or if the Board intended to follow another approach. The Board agreed that the approach articulated was appropriate. DT added that the Executive

team should continue to manage the risks and keep the Board informed if the position worsened.

14.6 RW commended the progress made on mandatory training and asked what more could be done to improve appraisal levels. MG stated that work was ongoing to help the departments with low appraisal levels and to provide support to managers who were struggling to complete them. AN highlighted that this was also monitored by the Executive team regularly and that individual Executives had been assigned to monitor the various departments and support them.

14.7 DT reported that the preparation of 2024/25 financial plan was underway, and that the Trust was awaiting the publication of firm guidance prior to finalising the 2024/25 financial plan. DT further stated that the capital expenditure programme was reviewed by the Committee and that assurance had been provided that the 2023/24 end year spend would equal the plan. MB noted that any concerns were being raised with the ICS through individual Trust meetings.

14.8 DT advised that the Committee had also received a post-implementation review of the bed repurposing scheme which had showed excellent results across several metrics of patient experience, efficiency and cost reduction and was a great example of a successful transformation project. DT added that a follow-up plan to improve on the ideas proposed at the recent Board cyber-security development session was being developed and details of this would be presented either to Audit Committee or other Board Committees.

The Board noted Business Performance Committee Chair's Assurance Report.

15 Quality Committee Chair's Assurance Report.

15.1 IA presented the Quality Committee key issues report and highlighted that there were no alerts to be brought to the notice of the Board. The Committee had received the 2024/25 draft Quality Account priorities and these would be presented to the Council of Governors in March 2024 for final review and approval.

15.2 The Committee had also reviewed the new infection prevention and control board assurance framework which replaced the previous version which had been primarily focussed on Covid-19. The updated framework had been agreed at the Infection Prevention and Control Group along with some action points and progress would be monitored via the group and reported back to the Quality Committee.

15.3 SR enquired about the progress of the infection control action plan. NM answered that initially different action plans had been developed for different organisms, a Trust-wide proactive infection prevention action plan had now been developed to align with the education framework and would be rolled out after approval in the coming weeks.

15.4 IA stated that a new Tissue Viability Nurse had been recruited to support the delivery of a comprehensive training plan. The training had previously been successfully delivered on Lipton Ward who had since recorded 763 days without a pressure ulcer and discussions were underway to roll this out to other wards once the resource was in place.

15.5 A review of the roll out of the 24/7 Thrombectomy service update had been undertaken which identified a number of issues and significant challenges faced by the service. No quality

concerns were raised and there would be a review of how the service would be managed going forward with regards to the workforce and operational issues.

15.6 DT asked for clarification on the Thrombectomy service and for an update on the new plan in place for the registrars. AN stated that the new plan had been presented to the registrars and an update on the service review was also presented to the Executive team. The service now had SMART Nurses in post to coordinate activity and reduce the work for the registrars on call but there were still some issues with the safe working of registrars. Discussions were underway with regards to a long term and short-term plan on how to best manage the service.

15.7 PM stated that there was a national challenge on capacity within the Thrombectomy services and provision of 24/7 service. Although the Trust had issues yet to be resolved, it was still ahead of the game and performed better than other Trusts in the region based on the national figures.

15.8 IA advised that the Trust was soon to commence the Theatres Refurbishment Project and in light of the potential impact on the quality of care, a working group had been formed to support the implementation of the project and monitor the impact of the refurbishment programme with any quality concerns escalated back to the Quality Committee.

15.9 SR asked about the ratings from the CARE reviews and the impact of the downgrading of some of the wards after the exercise. NM responded that the downgrade was mostly in relation to safeguarding knowledge and medication storage as some of the staff were new in post. The safeguarding matron had now delivered an education session for the new staff.

15.10 JR stated that the CARE Reviews results provided assurance around the process and that the changes in status of wards support this, she was pleased to see they had action plans in place to ensure that their ratings were improved upon.

15.11 RW suggested that within the IPR there was a need for more clarity and narrative to be included on some areas for better understanding. LV stated that BPC had also discussed this and that it had been agreed that a front sheet with narrative was included for the Committee and this could be replicated for the report received at the Quality Committee.

ACTION: LV to include more narrative on the IPR for the committees and the version that comes to the Board.

15.12 KD alerted the Board to consider what level of detail needed to be included in the report for the Board.

The Board noted the Quality Committee Chair's Assurance Report.

16 Freedom to Speak Up Guardian Report

16.1 JK highlighted that 14 concerns had been raised during quarter two and quarter three and no anonymous concerns had been raised.

16.2 JK reported that Speak up Month was a success, there had been an increase in the number of staff that had expressed their interest in becoming Freedom to Speak Up (FTSU) Champions. The FTSU reflection tool had been completed and an action plan developed to monitor progress. Model two and three of the Speak Up eLearning had been launched.

Although it was not mandatory, managers and senior staff were being encouraged to complete it.

16.3 CE asked if there were any areas of concerns and specific themes. JK stated that there were no arears of concerns or hot spots and that staff spoke up from every department.

16.7 NM advised that focus was now to be put in areas where staff had not raised any concerns to see if there were any themes and trends and also improve visibility of the FTSU platforms. MG stated that exit interviews had been held and had been helpful in gathering data and that there were no prevalent themes and trends.

16.8 SR commented that it was good to see that staff were utilising all the reporting channels available in the Trust and were not directly reporting to the CQC which had occasionally happened in the past.

The Board noted the Freedom to Speak Up Guardian Report.

17 Trust Wide Mortality Report: Learning from Deaths Q3

17.1 AN highlighted the changes put in place in relation to the reporting and reviewing of inpatient deaths within the Trust.

17.2 SR enquired if there was anything the Board could learn from the report about patients with protected characteristics. AN replied that the data on patients from the BAME group had been reviewed and there no disproportionate effects or trends found. Cases were always reviewed on an Individual basis. AN further stated that there was a separate reporting process for reviewing patients with learning disabilities.

17.3 RW suggested that there was a need to understand the Trust patient population and benchmark these against the mortality and morbidity data to get a clearer picture. AN replied that this was what the mortality data in the IPR described as it provides the expected mortality rate for the Trust. RW asked that this was included in the annual report and also that the number of patients with a Do Not Attempt Cardiopulmonary Resuscitation (DNAR) in place was also highlighted.

ACTION: AN to include in a benchmark of the Trust population data and data from patients with DNAR in the annual report.

The Board noted the Trust Wide Mortality Report: Learning from Deaths Q3.

18. Research, Innovation and Medical Education Committee Key Issues Report

18.1 PM presented the main areas of assurance for the meeting held on 19 December 2023 and highlighted that the Committee approved the Library and Knowledge Services Strategy for 2024 to 2026 and noted that an application would be submitted to the Committee from the University of Liverpool to form a Neurosciences Centre and then build on this to work towards a Neurosciences Department.

The Board noted the Research, Innovation and Medical Education Committee Key Issues Report.

19 Remuneration Committee Key Issues Report

19.1 MS advised that the Committee received an update on the outcome of the appointment of the Chief Digital Information Officer.

The Board noted the Remuneration Committee Key Issues Report.

20 Consent Agenda

20.1 The Board noted the following papers submitted on the Consent Agenda which had been reviewed through the Board Committees:

- **Estates Return Information Collection (ERIC) Return**

21 Any Other Business

21.1 There was no other business to be discussed.

There being no further business the meeting closed at 12:10

Date and time of next meeting - Thursday 4th April 2024 at 09:30 Boardroom

Trust Board Attendance 2023-24								
Members:	Apr	May	Jun	Jul	Sept	Oct	Dec	Feb
Max Steinberg	A	✓	✓	✓	✓	✓	✓	✓
Irene Afful	✓	A	✓	✓	✓	✓	✓	✓
Mike Burns	✓	✓	✓	✓	✓	✓	✓	✓
Clive Elliott							✓	✓
Mike Gibney	✓	✓	✓	✓	✓	✓	✓	✓
Debra Lawson					✓	✓	A	✓
Nicky Martin					✓	✓	✓	✓
Paul May	✓	✓	✓	✓	✓	A	✓	✓
Andy Nicolson	✓	✓	✓	✓	A	✓	✓	✓
Su Rai	✓	✓	✓	✓	✓	✓	✓	✓
Jan Ross	✓	A	✓	✓	✓	✓	✓	✓
David Topliffe	✓	✓	✓	✓	✓	✓	A	✓
Lindsey Vlasman	✓	✓	✓	✓	✓	✓	✓	✓
Ray Walker	✓	✓	✓	✓	A	✓	✓	✓

PUBLIC TRUST BOARD
Action Log
April 2024

	Complete & for removal
	In progress
	Overdue

Open Actions

Date	Item Ref	Name of Item and Description	Action Owner	Update	Deadline	Status
01/02/2024	Item 15 Para 15.11	**Quality Committee Chair's Assurance Report** Include more narrative on the IPR for the committees and the version that comes to the Board.	LV	More narratives have been included in the IPR report to Board and relevant Committees.	April 2024	

Actions for future meetings

Date	Item Ref	Name of Item and Description	Action Owner	Update	Deadline	
01/06/2023	Item 6	**Charity Substrategy Update** Charity Committee impact statement report to be brought to the Board at the end of the 2023/24 financial year highlighting the achievements and projects approved by the Charity Committee within the year against the focus areas.	MB	To be presented at the April Charity Committee meeting.	~~April 2024~~ June 2024	
01/06/2023	Item 12	**Board and Committee Reporting Schedule** Report on the effectiveness and impact of the revised Board and Committee reporting schedule.	KD	Deferred to June to follow annual board committee effectiveness reviews.	~~April 2024~~ June 2024	
07/12/2023	Item 15 Para 15.3	**Freedom to Speak Up Reflection Tool** Update Report on the implementation of the Freedom to Speak Up Reflection and Planning Tool	NM		June 2024	

01/02/2024	Item 6 Para 6.3	**Trust Strategy Update** Review Trust Strategy and Substrategy reporting format ahead of the next update	LV		June 2024	
01/02/2024	Item 17 Para 17.3	**Trust Wide Mortality Report: Learning from Deaths Q3.** Include a benchmark of the Trust population data and data from patients with do not actively resuscitate orders in place in the annual report	AN		June 2024	

The Walton Centre
NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Chief Executive's Report
Executive Lead	Jan Ross, Chief Executive
Author (s)	Jan Ross, Chief Executive
Action Required	To note

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

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

Key Messages

- Industrial action as well as the theatre improvement work is a key challenge for the delivery of operational performance, regionally Urgent and Emergency care remains a key challenge and the Walton centre participated in a recent multi-agency discharge event (MADE).
- Collaboration continues through Cheshire & Merseyside Acute and Specialist Providers Trusts
- The Walton Centre is committed to rolling out Martha's law and becoming a pilot site for the first 100 hospitals to implement this initiative

Next Steps

This paper is intended for information purposes

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Chief Executive's Report

Industrial Action

1. The focus remains on industrial action which has dominated the early part of this year. In relation to the consultant offer, a digital referendum will take place between 14 March and 3 April 2024. An announcement is anticipated soon after this date.

2. The junior doctor industrial action re-ballot has closed, with 98% of those who voted being in favour of further industrial action. This was above the threshold of 50% of those eligible voting in favour. No dates have been announced for further action as yet.

3. The Specialist, Associate Specialist and Speciality Doctors (SAS) referendum on the pay offer was rejected by a majority of 62%. A survey has been circulated to members to ascertain the issues which closed on 7 March 2024.

Cheshire & Merseyside (C&M) Acute and Specialist Trusts (CMAST)

4. The CMAST Leadership Board has met twice since the last Board meeting. In February the Leadership Board received an update from the Integrated Care Board (ICB) about the in year, financial priorities where it was indicated that contact would be made with a number of Trusts in the week ahead to ensure that support was in place to maximise delivery of this year's financial plan. The system's aim is to retain control of its own financial position and mitigations to financial risk, a view which was endorsed by the Leadership Board. Further discussions included current finance assumptions for 2024/25 with a priority being to secure a shared view on the delivery of recurrent cost improvement programmes so as to address the system's underlying deficit. The Board endorsed a system focus on the top three to five factors that had greatest potential to reduce cost, supporting transformation, while improving system flow.

5. The Leadership Board considered system Laboratory Information System (LIMS) procurement and those Boards who would be contract holders (not including The Walton Centre) had been asked plan for a Board decision in March. The Board was provided with an update on the work of the Children and Young People's (CYP) Alliance. The Board reflected upon the impact of delayed access to CYP services including in dental, the need to prioritise the well-being of children and young people and the potential for this to act as prevention when it came to future demand for adult medicine. Wider health inequalities were also discussed which could now be seen presenting as problems in many of the region's young mothers. The Leadership Board was assured by the focus on this agenda at the recently established Integrated Care Board (ICB) CYP Committee.

6. A discussion also took place on the impact of pressures in hospital emergency departments, the impact on paramedic crews and vehicle's availability and response times and the need for action with relation to non-criteria to reside. A small group of Chief Executives (CEO) agreed to discuss the best way to make progress on these interlinked issues within C&M. This discussion continued at the March meeting and the intention to prioritise health and care prevention funding was emphasised.

7. In March the focus of discussions was the review of programme delivery for 2023/4 and projected year end milestones. Significant progress was reported and acknowledged

across all programmes. The Board also noted the planned closure of the CMAST workforce programme and intentions for the development of other CMAST programme commitments and the delivery approach for 2024/5. It is expected that a draft Annual Plan will be discussed by the Leadership Board from May onwards before sharing with the ICB.

Cheshire & Merseyside Integrated Care Board Update

Elective Recovery and Transformation Programme

Waiting times reduction

8. As of 20 February 2024, C&M had 4,640 patients waiting over 65 weeks for treatment. This is a reduction from the previous month of 5,358.The national target is to eliminate 65 week waits by March 2024, which would require 9,569 patients to be treated by then (15,376 in January 2024). However, there are significant pressures on the system currently, including more potential industrial action which makes clearance of these patients challenging.

9. There are still a small number of 78 week waits to clear, which includes allowable exceptions relating to patient choice and clinical complexity. The system is working hard to clear these by the end of March 2024. The "alternative choice" programme has been praised by the national team as exemplar, and the protocols and processes have been shared with other systems both within the NW and nationally.

Theatres

10. Four of the Cheshire & Merseyside trusts are achieving the national target of 85% utilisation for theatres, three trusts are very close at over 81%, however there are three trusts that require additional support. This support is being offered through the theatre programme team and will include deep dives into the opportunities for improvement, support around booking and scheduling, and data quality input.

11. The Theatre Academy training programme has been shortlisted for a national award based on the improvements to the system performance. C&M have achieved 10% in-session theatre utilisation within that cohort.

Clinical Pathways

12. This programme continues to focus on orthopaedics, dermatology, ENT, gynaecology and cardiology specialities and the following highlights were reported:

- Five additional Chester Orthopaedic surgeons commenced operating lists at Clatterbridge Elective Hub in January 2024 for Chester patients
- Teledermatology implementation is currently at 76% across Cheshire and Merseyside as of February 2024. A business case is being drafted to secure future funding for teledermatology, whilst a full procurement process is due to begin.
- Following a planned implementation session with the gynaecology network leadership in November, a 12-month forward plan and provider briefing has been agreed with 'Phase 1' trust visits expected to start shortly and an immediate offer to providers to support on-site with waiting list reduction (focusing on presenting conditions) and mapping of 'as is' pathways
- As part of the national Further Faster programme, ENT has been agreed as a priority area and network leadership have agreed initiatives to the end of March 2024.

Diagnostic Programme

13. December Figures showed:
    - 97,934 tests performed in December – 6% higher than forecast and 8% over plan
    - 83% of patients have been waiting 6 weeks or less (1% decrease since last month)
    - ICS ranking 7th out of 42 ICSs (compared to 12th in November 2023)
    - 11,017 patients have waited 6 weeks or more (reduction of 20 since November)
    - Total number of patients waiting has reduced to 69,206 (was 71,808 in November)

Radiology

14. **Waiting List Recovery** – Trusts are continuing to support each other with long waiters. The biggest pressure is MRI performance at East Cheshire, which was at 36.9% at the end of this month. The Trust have identified 247 patients who are willing to travel to Paddington Community Diagnostic Centre (CDC).

15. **Artificial Intelligence (IA) for Chest X-Rays** – Confirmed supplier selected. To be transferred from the ICS to Clatterbridge before year end.

16. **Intelligent Data** – New focused imaging reports for Cardiac CT, Cardiac MRI, CT Colon, and nuclear medicine are ready to launch. All reports set to be published in February.

17. **Radiology Reporting Collaborative** - Stakeholders sent a pilot report for comment. This initiative looks at how reporting can be carried out collaboratively by NHS Staff rather than outsourced.

18. **Diagnostic IT Network** - Routing work to fully connect the first sites (St Helens and Whiston) was successful and data migration testing is further along than anticipated.

19. **Cyber resilience** - A business case has been written for an immutability solution, outlining detailed risks around the current architecture, and costs and benefits of implementation. The cyber resiliency risks identified have been raised on the regional Digital Design Authority and Chief Information Officer's calls, and two third parties have presented their solutions.

20. **Community Diagnostic Centres (CDCs)** - Halton Shopping City's formal opening took place on 15 Feb 2024. Additional international recruitment (funded through NHS England) being commenced for histopathology, endoscopy and respiratory services.

Collaboration

Efficiency at Scale

21. **Medicines Optimisation -** 2024/25 planning preparation continues with the medicines optimisation workstream attending the Place Associate Directors of Finance meeting and procurement planning workshop taking place in February 2024. In December 2023 medicines optimisation reported year to date savings of £13.7million against a full year target of £17.5million and a stretch 2023/24 forecasted position of £18.3million. Providers are working collectively with the ICB, and specialised commissioners to develop a single system business case for high-cost drugs and homecare. A steering group and task and finish groups have been established to progress the improvement plan with regard to the Valproate patient safety alert. A briefing has been issued to all CEOs.

22. **Finance and Legal** - Work continues on the potential development of a single financial ledger

vision and strategy which can then be used to develop a full business case. A meeting to explore the funding options is scheduled. The Liverpool legal collaboration between Liverpool University Hospitals NHS Foundation Trust, Liverpool Women's NHS Foundation Trust (FT) (LWH) and Liverpool Heart and Chest Hospital NHS FT (LHCH) and remains on track for an April 2024 implementation date. C&M continues to support the national workstream looking at additional indemnity insurances and discussions are taking place with the regional NHSE team.

23. **Procurement** - Meetings have been arranged with key stakeholders, in digital and estates, for a deep dive procurement opportunities assessment which is due to be concluded in March 2024. Eleven C&M providers have now signed up to national energy contract with CCS and £8million plus estimated savings have been identified from April 2025. An extension has been supported by CCS for the remaining trusts to complete any necessary data analysis and internal approval processes as appropriate.

Workforce

Development of Band 6 Ward & Department Nurse Roles

24. The Development Toolkit pilot scheme was launched on 27th November at three trusts in Cheshire & Merseyside: The Walton Centre NHS FT, Alder Hey Children's NHS FT and Warrington and Halton Teaching Hospitals NHS FT. In total, 29 Nurses enrolled onto the pilot scheme which will conclude on 1st March after 14 weeks. The working group met in January to agree the key metrics that will be used to evaluate the success of the toolkit and evaluation is ongoing with pilot scheme participants

Allied Health Professionals (AHP) Faculty

25. Targeted placement expansion funding was awarded for the Occupational Therapist and Physiotherapist practice educator project. Project management has commenced, and a project plan is currently being developed, alongside surveys and key activities at two C&M trusts. Resource for AHP career conversations has been developed and circulated for feedback prior to launching further. Three new project leads are now in post for AHP Preceptorship, Educator Career Framework and Enhanced, Advanced and Consultant Practice Insights Report work.

Elective Recovery Workforce

26. The workforce planning piece concluded at the end of December and the outputs of this work were presented to the Workforce Programme Board. The following areas will be taken forward via the Clinical Pathways Programme for further consideration and implementation: GP with special interests, establishment of a Memorandum of Understanding for the Elective Recovery hub and Advanced Practitioners. The Elective Recovery Workforce Enabling Group will be formally closed from February recognising that key workstreams have come to a conclusion and the implementation work will be taken forward via alternative groups.

Trust Update

Sutcliffe Kerr Lecture 2024

27. The annual Sutcliffe Kerr Lecture took place on 13 March at the Spine, Paddington Village, Liverpool chaired by Dr Rhys Davies, Clinical Director Research Innovation and Medical Education & Consultant Neurologist. The afternoon agenda focused on Medical Education and the NHS Long Term Workforce Plan. Speakers from both the University of Liverpool

and NHSE outlined the scale of the opportunities and challenges for both undergraduates and post graduate medicine.

28. The evening session focused on clinical neuroscience research with notable international contributions from Professor Jakob Christensen, Consultant Neurologist Aarhus University Hospital, Denmark in the field of epilepsy; and Professor Elena Moro, President Elect EAN & Neurologist, CHU Grenoble, France on the history of DBS for Movement Disorders. There were additional contributions from those active in research at the Walton Centre.

29. Planning has already begun to integrate the Sutcliffe Kerr Lecture 2025 into the wider festival of neuroscience to be hosted in Liverpool in 2024.

Neuro-oncology Meeting

30. Professor Tim Maughan, Professor of Oncology at University of Liverpool met with the neuro-oncology clinical research team together with Dr Nicolson and Professor May, to discuss the strategy for cancer research in the region with brain cancer being a key focus for translational research.

Starters & Leavers

31. Two Consultant Interventional Neuroradiologists have been appointed – Dr Rukhtam Saqib and Dr Mohammed Altibi.

32. The new Deputy Chief Nurse Joanne Shaw starts in post on Tuesday 2 April 2025. The new Divisional Director for Neurosurgery Ellis Hayes also starts next week.

Trust Strategy

33. Dissemination of the trust strategy continues to progress with two events planned in May working with the MS Society and the Neuro Alliance patient groups.

34. The trust has been awarded the contract for the provision of MR-guided Laser Interstitial Thermal Therapy (MRgLITT) for treatment of epileptogenic zones for adults with refractory focal epilepsy. The divisions are now finalising the original business case and planning for the implementation of the service.

Estates & Facilities

35. Phase 1 of the theatre refurbishment project has commenced successfully with no issues to report. The project management team have been working closely with the clinical teams to ensure that patient safety is not compromised. A weekly operational meeting is held in theatres and a monthly group is held chaired by the Chief Operating Officer.

Business as Usual

Quality

36. On 21 February NHS England announced that the first phase of the introduction of Martha's Rule will be implemented in the NHS from April 2024. Once fully implemented, patients, families, carers, and staff will have round the clock access to find to a rapid review from a separate care team if they are worried about a person's condition. Martha Mills died in 2021 after developing sepsis in hospital, where she was admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. In response to this and other cases related to the

management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule' to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon. The Walton Centre is committed to rolling out Martha's law and becoming a pilot site for the first 100 hospitals to implement this initiative. Clare Moore from the Quality and Safety Improvement Team team is supporting the implementation plan.

37. Sheila Shepley, Nurse Clinician in North Wales has been awarded the Excellence in Epilepsy Award 2024 from the ILAE British Branch Council, in recognition of her outstanding work in the field of epilepsy.

38. The trust has been shortlisted for Student Nurse Hospital Placement of the Year, Nursing Times awards. The trust will be represented by a team of nurses on the 26 April 2024.

Finance

39. Financial performance for February and year to date is above the plan and also above the latest forecast recently submitted to the ICB. The Trust delivered a surplus in month of £682k. Year to date the Trust is showing a £6.7m surplus (£0.3m ahead of the submitted re-forecast). The full year forecast is a £7.3m surplus (compared to an original plan of a £4.1m surplus) which is £0.4m above the reforecast submitted to the ICS.

40. Capital is underspend year to date (£0.7m below plan) though in month there was an overspend against plan by £1.2m, driven in the main by the air handling units scheme and the fluoroscopy equipment. The Cost Improvement Plan (CIP) has delivered in full year to date (£7.0m), however 82% has been delivered recurrently (when the ICS had informed all providers that 100% needed to be delivered).

41. The current Cheshire and Merseyside (C&M) financial position at month 10 (January) is a £79.8m deficit against a planned deficit position of £22.1m (£57.8m adverse to plan). The recent industrial action added £22.7m of pressures to the overall financial position (of which there was national funding of £18.0m to cover this). The deficit is driven by several factors including industrial action, prescribing pressures and continuing healthcare packages (CHC).

42. Formal planning guidance is still awaited from NHSE although (as noted previously) some top level guidance had been circulated. Further draft plans were submitted to the ICS on 14th March, and the Trust submitted an updated plan (to that presented at board) that was circulated to board members. Final plans are due to be submitted in late April to the ICS with final submission from the ICS to NHSE expected on 2nd May.

Performance

43. Performance remains on track for cancers and diagnostics. All the long waiting patients have now been completed for 104 weeks and 78 weeks. The Trust is now focusing on patients who have waited 65 weeks, all patients within this category need to have been seen by March 2024, the Walton Centre will have completed this trajectory. The focus will then continue to be on 52 weeks, which we have seen an increase in due to mutual aid.

44. Mutual aid requests continue via the Digital Mutual Aid Systems. Requests have been received for spinal support from Robert Jones and Agnes Hunt Hospital, University Hospital of North Midlands NHS Trust, Salford Royal Hospital and Nottingham University Hospitals NHS Trust; both the clinical and operational teams are working through these requests.

45. The new planning guidance will not be published until the new calendar year. The priorities and objectives set out in 2023/24 planning guidance and the published recovery plans on urgent and emergency care, primary care access, and elective and cancer care will not fundamentally change. The deadline for the final operational plan will be 2 May 2024.

46. Urgent and Emergency Care services (UEC) remain under immense pressure to achieve the 76% ED target for patients to be seen in 4 hours. March has been a challenging month for all trusts to achieve this and The Walton Centre have supported by holding on to patients, who require transfer back to other trusts.

Recommendation

To note

Author: Jan Ross, Chief Executive Officer

Date: 27 March 2024

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Finance and Commercial Development Substrategy Q3 and Q4 2023/24 Progress Update
Executive Lead	Mike Burns, Chief Finance officer
Author (s)	Andy Green , Deputy Chief Finance Officer Mike Burns, Chief Finance Officer
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- The Finance and Commercial 3-year Substrategy was approved in July 2023;
- The update for Q3 and Q4 shows that progress is being made across most areas.

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

- Note progress and any feedback;
- Continue to progress the objectives of the Finance & Commercial Development Substrategy.

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
All Applicable	Finance	Compliance	Quality

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

003 System Finance	007 Capital Investment	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**
Business Performance Committee (BPC)	26.09.23	Mike Burns - CFO	
Board	05.10.23	Mike Burns - CFO	
BPC	26.03.24	Mike Burns - CFO	

Finance and Commercial Development Substrategy Q3 and Q4 2023/24 Progress Update

Executive Summary

1. The Finance and Commercial Sub-strategy was approved in July 2023. It covers a 3-year time period to support the overall Trust Strategy.

2. The report outlines progress against quarters 3 and 4 2023/24 objectives and

3. Quarter 1 2024/25 objectives

Background and Analysis

4. The Finance and Commercial Sub-strategy vision is 'To maximise use of resources, improve productivity and develop market opportunities to deliver best value for the Trust, the public and the wider system.'

5. This mission is to be achieved through 4 elements:
   - Maintaining and improving financial performance;
   - Focusing on improving productivity within the organisation;
   - Maximise our opportunities in procuring capital, goods, and services; and
   - Assessing the market data to understand and develop areas of opportunity.

6. The programme of work spans across 10 separate areas (noted in the report) and effectively sets out the delivery plan for the Finance Department over the next 3 years. Underpinning the strategy is a detailed document which outlines by year when the objectives are to be achieved. This also includes elements of the objectives by quarter so there is a clear plan for delivery by the Finance Team.

Conclusion

7. There has been good progress on the delivery of objectives for quarters 1 to 4 2023/24 of the finance and commercial development sub-strategy. The key will be to continue to deliver and collaborate with other areas such as digital and informatics, who are a key enabler in helping to deliver the finance and commercial sub-strategy.

Recommendation

8. To note progress to date and quarter 1 2024/25 objectives.

Author: Andy Green
Date: 26th March 2024

Executive Summary

Following approval of the enabling Finance and Commercial Development Substrategy in July 2023, the Finance team have worked collaboratively to develop an underpinning framework to ensure delivery of the set objectives described within the overarching Trust Strategy.

The following information demonstrates the objectives agreed for delivery in Q1-Q4 2023/24 and those set for delivery in Q1 2024/25

Finance and Commercial Development Substrategy

The Walton Centre
NHS Foundation Trust

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Finance and Commercial Development – Vision, Mission and Programme of Works

Finance & Commercial Development Sub-Strategy

Vision

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

Mission – We will achieve this through

- Maintaining and improving financial performance;
- Focusing on improving productivity within the organisation;
- Maximise our opportunities in procuring capital, goods and services;
- Assessing the market data to understand and develop areas of opportunity.

The programmes of work will include:

- Financial Housekeeping and Key Messaging
- Financial and Operational Planning
- Business Insight
- Patient Level Information / Service Line Reporting
- Regional and Local Collaboration
- Efficiency and Productivity in the use of resources
- Improving profitability of R&D and non-patient income
- Digitalisation and process re-design
- Ensuring best value for Trust expenditure
- Capital Investment

Finance and Commercial Development Sub-strategy Q3-Q4

The Walton Centre NHS Foundation Trust

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Q3&4 Objectives	Q3&4 Progress Update
Financial Housekeeping and Key Messaging • Ensure that staff have a basic knowledge of the key financial processes and controls. • Deliver a sustained improvement in Better Payment Practice Code (BPPC) leading towards the 95% national standard. • Deliver the key actions and improvements within the HFMA Financial Sustainability framework to improve scores in any future review. • Automate and provide access to most requested Finance FOI questions to cut down on responses required.	**Financial Housekeeping and Key Messaging** • Financial Management training pack complete, training is due to be rolled out from April onwards. • Finance Training provided for Governors, Business Planning process training provided for Governors, QIP, Capital training provided to operational teams. • The Trust BPPC by number of invoices paid is currently 90.0% in February 2024 (90.1% September 2023) and by value of invoices paid is 92.4% (89.8% September 2023). The Trust continues to follow the action plan put in place to improve BPPC performance (Target Y1 90%). • System controls and Budgetary controls reviews have been undertaken by MIAA and we are awaiting the outcome, early indications are that both will receive substantial assurance.
Financial and Operational Planning • Put in place systems to monitor activity performance against Elective Recovery Targets. • Develop capacity model to match demand with supply (consultants, theatres and beds) to model backlog wait clearance and increased referrals. • Create a clear planning timetable for the 2024/25 planning round resulting in the production of a business plan for approval by the Board in April 2024 and subsequent planning years. • Development of a medium-term financial plan for submission to the ICS.	**Financial and Operational Planning** • Elective recovery funding detail has now been provided by both NHSE and ICS and gives the trust a greater indication of how the trust is financially performing against expected targets. • A monthly reconciliation of Trust performance is carried out against the threshold targets and discussed on a regular basis at the weekly Finance and Operational performance meetings. • 2024/25 planning paper presented and approved at Executive team meeting, this has been forwarded to Operational and Finance leads for information on the agreed planning process. • The Trust has currently submitted all 2024/25 planning returns in line with the national timescales. • As part of the 2024/25 planning process the Finance Team have set up a planning model that will allow Trust Finances to be modelled over a 3-year period with a with a set of standard assumptions and scenarios
Business Insight • Review approach to population health taken by ICS and providers. • Engage with divisions/Executive team to agree a programme of service line reviews to be conducted over the next 12 months.	**Business Insight** • Specialist commissioned services are being delegated to ICSs in 2024/25 on a population basis and the Trust is working with commissioners to understand the full impact and any potential risk of this change.




Finance and Commercial Development Sub-strategy Q3-Q4

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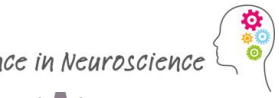
Q3&4 Objectives	Q3&4 Progress Update
Business Insight (Continued) • Use data packs to conduct service line review and identify areas for service improvement and waste reduction. • Divisions to finalise outcome from individual service line reviews, together with recommendations for next steps. • Test zero based budgeting as a way of identifying efficiencies.	**Business Insight (Continued)** • Service Line reviews discussed with operational teams around provision of service line information for satellite clinics, rehabilitation, critical care and radiology. • Continued review of services is ongoing with support from the e-Roster team involving the rolling out of WTE reviews service by service. • In year use of budgets to identify below budget contracts to be used as in year service improvements saving.
Patient Level Information / Service Line Reporting • Production and submission of the annual National Cost Collection (NCC) return to NHS England. • Reporting and Governance of NCC submission, PLICs and Service Line Reporting. • Develop a plan to roll out PLICS to service lines in support of the service line review process (as part of 'business insight').	**Patient Level Information / Service Line Reporting** • NCC was submitted in early December in line with the National revised costing timetable. • The NCC return was signed off at Trust Board prior to submission in line with guidance issued on the governance requirements. • Now NCC has been submitted, focus will shift to creating Service Line Reporting model to utilise across the Trust. • Work is ongoing with the informatics team regarding automation of the relevant feeds for Service Line Reporting.
Regional and Local Collaboration • Work with operations colleagues on the data and information in the Trust to develop any further NHS market opportunities.	**Regional and Local Collaboration** • Weekly Operations and Finance Group set up and regularly reviews performance data to review improvements / opportunities. Given the demand for mutual aid, NHS market opportunities will be looked at in the next 6 months.
Efficiency and Productivity in the use of resources • Work with service transformation team to develop a programme of continuous improvement activities which will be in line with the organisational strategy.	**Efficiency and Productivity in the use of resources** • Details of new efficiency and productivity programmes for 2024/25 currently discussed in CIP meetings. • Attendance at the monthly SPMO committee meeting discussing ongoing projects of work being carried out across the Trust and how finance can support, including Outpatient, Theatre and bed utilisation.



Finance and Commercial Development Sub-strategy Q3-Q4

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Q3&4 Objectives	Q3&4 Progress Update
Improving profitability of R&D and non-patient income • Conduct a review of each line of non-patient related income comparing pre/post covid position and identify what can be done to restore remaining income or replace with new trading activities. • Create standard costing templates for trading activities (including R&D activities). • Update Private Patient Tariffs to standardise and to reflect present day costs.	**Improving profitability of R&D and non-patient income** • Initial model Service Level Agreement has been designed by Finance to ensure that all contracts are standardised and generating the correct level of income for the specific services that are supplied / purchased. • Non patient related income is now in place on the individual budget statements for the service that generates the income
Digitalisation and process re-design • Implementation of Robotic Process Automation (RPA) on task that can be utilised through the finance team. • Stronger links with the IT Strategy to understand future projects and any funding that is available.	**Digitalisation and process re-design** • RPA implementation and training is currently being undertaken within the IM&T team, now the current ledger system is going to be in place for the next 3 years the use of RPA within finance is being investigated with various process mapping meetings having taken place. • A new Digital Officer is starting at the Trust in May so further work will be undertaken once in post, the finance team liaise and link in with the requirements of both teams on an informal basis, which can be formalised post review.
Ensuring best value for Trust expenditure • Begin to work towards Zero based budgeting, beginning with small discrete departments to enable team to develop processes and standard practices. • Develop and embed our approach to PLICS, using the data available to highlight potential areas of inefficiency and focus.	**Ensuring best value for Trust expenditure** • NCC has been submitted, focus will shift to creating Service Line Reporting model to utilise across the Trust. • Work is ongoing with the informatics team regarding automation of the relevant feeds for Service Line Reporting. • Work to begin on zero based budgets within small discrete departments within the Trust.
Capital Investment • Strengthen the process for identifying capital investments to assist with planning. • Identify capital assets where the useful life can be extended.	**Capital Investment** • Given the current limitations on access to capital, the Trust has started to utilise a risk-based approach to capital investment through a risk register. • Finance is also reviewing any access to further capital 'pots' e.g. IFRS 16 opportunities.

Finance and Commercial Development Sub-strategy Q3-Q4

The Walton Centre
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Q3&4 Objectives	Q3&4 Progress Update
	Capital Investment (Continued) • Finance department reviewing 3-year capital plan with operational / clinical colleagues to understand / manage the demand for capital investment in future years. • Priority group has been set up to include CFO, COO, DMD and DCFO. This group makes decisions as phasing / timing of capital investments changes to manage within the envelopes set.

Finance and Commercial Development Sub-strategy Q3-Q4

The Walton Centre NHS Foundation Trust

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Q3&4 Objectives – Risks to Delivery / Further work required

Financial Housekeeping

FOI request template still in progress to design easy-to-read document to enable quicker FOI access.

Business Insight

- Use data packs to conduct service line review and identify areas for service improvement and waste reduction.
- *Further work required although discussions are taking place in specific service lines (Outreach Neurology Clinics, Rehabilitation, and Critical Care).*

Patient Level Information / Service Line Reporting

- Reporting and Governance of the National Cost Collection (NCC) submission, PLICs and Service Line Reporting.
- *NCC submitted early December within the revised timescales set by the national team, timetable and automation for the rollout of Service Line Reporting to be put in place. Automation processes for informatics on the information feeds to the system.*

Regional and Local Collaboration

- Work with operations colleagues on the data and information in the Trust to develop any further NHS market opportunities, such as assessing work sent to the independent sector providers with the aim of repatriating work to the Trust.
- *Various pieces of work are ongoing and reported into the Operational and Finance weekly meetings update, will need to be planned and formalised in specific areas of work reported to the Executive Team moving forwards.*

Digitalisation and process re-design

- Stronger links with the IT Strategy to understand future projects and any funding that is available.
- *A new Digital Officer is starting at the Trust in May so further work will be undertaken once in post, the finance team liaise and link in with the requirements of both teams on an informal basis, which can be formalised post review.*

Ensuring best value for Trust expenditure

- Develop and embed our approach to PLICS, using the data available to highlight potential areas of inefficiency and focus.
- *NCC submitted early December within the revised timescales set by the national team, timetable and automation for the rollout of Service Line Reporting to be put in place. Automation processes for informatics on the information feeds to the system.*

Finance and Commercial Development Sub-strategy Q3-Q4

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Q1 2024/25 Objectives
Regional and Local Collaboration • Present a minimum breakeven plan and deliver against this in the financial year. • Work with Efficiency at Scale Programme to deliver any collaborative opportunities across Cheshire & Merseyside. **Ensuring best value for Trust expenditure** • Develop and embed our approach to PLICS, using the data available to highlight potential areas of inefficiency and focus. **Capital Investment** • Strengthen the process for identifying capital investments to assist with planning. • Identify the capital budget allocations for IT, backlog maintenance, equipment replacement, minor estates work and strategic schemes.

Any questions?

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	People Substrategy Annual Review 2023/24
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Rachel Saunderson, Innovation Manager Jane Mullin, Deputy Chief People Officer Liz Doherty, Medical Education Development Manager Zoe Kershaw, Senior Education Manager Gemma Nanson, Head of Neuroscience Research Centre
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Annual Review of the People Substrategy objectives for 2023/24
- Significant progress has been made across all five strategic objectives
- Continues to be a challenging area of work across all objectives as the environment within which the Trust operates has not improved since the launch of the Substrategy

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

- Activity to continue to achieve deliverables identified for 2024/25 through the strategic implementation and assessment delivery plans

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
People	Workforce	Quality	Equality

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

004 Leadership Development	010 Innovative Culture	008 Medical Education Strategy

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**
Health Inequalities and Inclusion Committee	25/03/24	Mike Gibney Chief People Officer	Report was noted.
Business Performance Committee	26/03/24	Mike Gibney Chief People Officer	Report was noted. Update to be shared with RIME Committee.

People Substrategy Annual Review 2023/24

Executive Summary

1. In line with the launch of the Trust Strategy 2022-25, the People Substrategy was approved by the Trust Board in February 2023 as one of the seven enabling strategies. The overarching aim of the Substrategy is to ensure a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background. The report provides an overview of the progress made for 2023/24 and 2024/25 objectives.

Background and Analysis

2. The People Substrategy was approved by the Trust Board in February 2023 and consists of five overarching objectives in line with the organisation's strategic ambitions:
    - **Education Training and Learning Objective:** *To provide the right systems, processes and environment to enable our workforce to be as efficient and effective as they can be in delivering high quality care to patients. To invest in education and training to ensure we deliver the highest calibre of healthcare staff for future NHS patients.*
    - **Leadership Objective:** *To provide a compassionate and inclusive work environment where all of our staff including those working in an agile way and those in the community delivering care closer to the patients' home, are equally motivated, engaged, valued and share the same vision.*
    - **Research and Innovation Objective:** *To lead, educate and train, embedding research and innovative approaches to deliver changes across the health economy.*
    - **Collaboration Objective:** *To adopt new ways of working to create a place that recruits, retains and supports an efficient, resilient and productive workforce delivering excellence in healthcare.*
    - **Social Responsibility Objective***: To recognise the importance of excellence in staff wellbeing, and to embed a high performing culture based upon our Walton Way values and standards of behaviour.*

3. The delivery of the above is underpinned by six strategic implementation plans:
    - Health and Wellbeing
    - Staff Experience
    - Medical Education
    - Innovation
    - Research
    - Training and Development

4. **Appendices 1-5** provide an overview of the key achievements for 2023/24 and associated items for escalation, as well as 2024/25 objectives and risks to delivery.

5. The strategy also has three assessment delivery plans:
    - Social Value Framework – This will be developed in line with the Trust's applications for its Social Value Award and Health Quality Mark accreditations. 2023/24 non-recurrent Trust funds have been secured in support of the accreditation process which will be undertaken following the Trust's first Corporate Social Value Contribution report due in April 2024.
    - Prevention Pledge Action Plan - The Action Plan and 2023/24 Annual Report will be reported into the Cheshire and Merseyside Community of Practice in April 2024 with

internal assurance provided though the April 2024 Anchor Institution Group and subsequent Health Inequalities and Inclusion Committee.

- Investors in People Action Plan - The Trust undertook its Investors in People reaccreditation assessment in June-November 2023 the outcome from which was that Gold award status was maintained for the 'we invest in people' and 'we invest in wellbeing' standards. A Task and Finish Group has been established to ensure delivery of the 2024/25 Action Plan which is chaired by the Chief People Officer. The Group will meet on a bi-monthly basis and feed into the Trust's People Group. The first meeting is being held on the 22 March 2024.

Conclusion

6. The Trust's People Substrategy was approved by the Trust Board in February 2023. An annual review for 2023/24 demonstrates the significant progress made across all areas as well as the objectives identified for 2024/25.

7. The environment within which the Trust operates has remained challenging since the launch of this Substrategy e.g. Continuing industrial action, transition emerging from COVID, consolidation of services. The cost-of-living crisis is still intense resulting in labour market conditions that combine skill shortages with increasing pay. Further, there continues to be fragmentation in the nationally negotiated terms and conditions (Agenda for Change) which has resulted in the salary variation within the local health economy.

8. The NHS Long Term Workforce Plan's primary object is to increase the workforce by around 1 million over a 15-year period with a focus upon training (notably apprenticeships), recruitment (with a focus on culture) and reform (with an emphasis upon new roles such as nurse apprenticeships). It is important for Committee to note that these aspirations absolutely align with the Trust's local Substrategy.

Recommendation

9. Trust Board is asked to note 2023/24 achievements and to support the progress of the work identified in the underpinning strategic implementation and assessment delivery plans for 2024/25.

Author: Rachel Saunderson
Date: 13/03/24

Appendix 1 – Health and Wellbeing and Staff Experience Annual Review 2023/24
Appendix 2 – Medical Education Annual Review 2023/24
Appendix 3 – Innovation Annual Review 2023/24
Appendix 4 – Research Annual Review 2023/24
Appendix 5 – Training and Development Annual Review 2023/24

People Substrategy 2023/24 Annual Review – Health and Wellbeing & Staff Experience

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

2023/24 Achievements

- Trust maintained Gold award status for Investors in People and 'we invest in people' and 'we invest in wellbeing' standards
- Walton Centre succession planning model and process agreed
- Review of employee of the month and long service award process
- Participants increased in Q4 Pulse Survey
- Wellbeing hub opened in April 2023
- Transfer of administration and clerical bank staff to NHSP completed
- Armed Forces Covenant (Employee Recognition scheme) silver award achieved
- Maintained Investors in People Gold for People and Wellbeing standards
- Well-being dashboard devised
- Sickness audits introduced
- Inclusive consciousness training rolled out across the Trust
- Anti-Racism statement approved by Board
- Navajo kitemark reaccreditation
- Veterans staff network established

Items for Escalation

- Implication of NHSE Long Term Workforce Plan

2024/25 Objectives

- Review of Occupational Health Services
- Build wellbeing team within departments
- Train additional Mental Health First Aiders
- Review of payroll contract
- Increase uptake of national staff survey
- Implement Investors in People 2023/24 Assessment Action Plan
- Review of ED&I strategy

Risks to delivery

- On-going industrial action
- Staffing pressures and associated risks i.e. sickness absence, recruitment, retention

People Sub-Strategy 2023/24 Annual Review – Medical Education

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

2023/24 Achievements

- Undergraduate medical student experience remains excellent with consistent green outliers on rotational evaluation reports.
- Induction and Statutory and Mandatory training reviews
    - Development of web-based repository for Junior Doctor handbook
    - Engagement with Lead Employer and regional streamlining of mandatory training project.
- First cohort for the Research funded student bursary placement started in 2023. Core group of consultant contributors established and a catalogue of projects being collated
- New external appointments made by Trust consultants to Higher Education Institutes/NHS England senior education roles: UoL SoM Year 1 Neurology Lead & SoM Neuro Oncology Specialty Lead, NHS England Training Programme Director for Neurosurgical Online Learning and Edge Hill University SoM, WCFT placement Year Four Module Lead
- Establishing external educational courses in Neurosurgery masterclasses and Headache workshops
- Named Executive Lead for Medical Education transferred from Chief People Officer
- Appointment of Educational Appraisal Lead. Development of guidance for consultants involved with educational appraisal mapped to GMC standards. Improved engagement with consultants via presentation at Clinical Senate
- Inhouse Educator Programme funded by Postgraduate Medical Education Post-Covid Recovery .
- Embedding of Specialty and Associate Specialist (SAS) and International Medical Graduate (IMG) Lead roles, award of NHS England (non-recurrent) funding bid to support IMG Lead and enhanced IMG induction.
- Clinical Attachment Policy going through approval stages.
- Communication taking place with regard to an overseas clinical observership partnership

Items for Escalation

- Effectiveness of Junior Doctor Forum – Attendance has been low and absence of Guardian of Safe Working (sickness) has meant limited engagement with junior doctors and insight to junior doctor issues, experience etc… Interim Guardian of Safe Working now in post
- Support for new and ad hoc medical education work, e.g. courses and events, has been challenging with a reduced administrative team
- Dedicated finance support for Medical Education is needed to provide robust oversight of recurrent and non-recurrent income and funding

People Substrategy 2023/24 Annual Review – Medical Education

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

2024/25 Objectives

1. Continue to maintain a high-quality learning environment for postgraduate and undergraduate medical learners
2. Encourage quality improvement projects by Medical Education team to support continuous learning and improvement
3. Continue to nurture relationships and collaborations with NHS England education stakeholders, academic institutions and other partners
4. Support Medical Director in developing the strategic direction for Medical Education
5. Have an effective medical education clinical faculty, underpinned by an appropriately resourced administrative team
6. Continue to explore new opportunities for growing trusts academic networks and offer outside of formal training programmes
7. Key contributor for the 2025 British Neuroscience Association (BNA) Festival of Neuroscience (with Liverpool Neuroscience Group) Walton supporting fringe festival and public engagement programme.

Risks to delivery

- Staffing capacity – consultant job plans, education office administration
- Retaining specialist Medical Education knowledge
- Ongoing medical staff industrial action affecting trust level activity – impact upon productivity, culture and workplace satisfaction
- National Neurology training programme change and demands of local thrombectomy service impacting local trainee experience
- Shortage of doctors employed at a junior level and effect upon provision of service

People Substrategy 2023/24 Annual Review - Innovation

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

2023/24 Achievements

- Completion of Investor in Innovations (ISO standards) self-assessment element (March 2024)
- Progressing against all 14 Prevention Pledge Core Commitments with substantial progress made in the areas of wellbeing, early intervention, social value and corporate social responsibility
- Implementation of the C&M Social Value TOMs portal
- First C&M ICB Anchor Institution Charter submission and Assembly held in July 2023
- Launched the Access to Exercise and Wellbeing Programme
- NHSE funding secured to support next development phase of the Headache Chatbot innovation due for completion Q3 2024/25
- NIHR funding secured to enable second viability and feasibility study for VERA for its use in a community setting – evaluation due to complete in June 2025
- Trust Non-recurrent funding secured to support the next phase of the technology development for VERA
- First proof of concept/prototype developed for CHAT innovation (March 2024)
- Initial pilot of Circada Lighting System trial on ITU completed
- First order accepted for the Spinal Improvement Programme
- First Liverpool Citizens Listening Campaign launched with second round of listening being undertaken. Ongoing engagement with local elective members and recruitment of member organisations working toward Founding Assembly

Items for Escalation

- To establish minimum staffing requirement for Innovation function in line with ISO standard - business case for an Innovation Officer and Clinical Lead for Neurosurgery Division endorsed by the Hospital Management Group and supported by the Executive Team. Due to financial constraints the posts have been put on the 20224/25 pressures list.

People Substrategy 2023/24 Annual Review - Innovation

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

2024/25 Objectives

- Agree and Implement Investor in Innovations (ISO standards) Action Plan
- Trust's first Corporate Social Value Annual Report
- Achieve Social Value Award and Health Quality Mark accreditation
- Launch Liverpool Citizens as a founding Chapter and first local priority Campaign
- Deliver against 14 Prevention Pledge Core Commitments
- Undertake second C&M ICB Anchor Institution Charter Submission and Assembly in July 2024
- Complete development phase 2b of the Headache Chatbot innovation and explore scaling capacity into the NHS App
- VERA Community Setting viability and feasibility study to be undertaken
- VERA technology to be developed to enable implementation on CRU and to support the community setting research study
- CHAT innovation MVP to be developed with first research study undertaken
- Roll out of Spinal Improvement Programme model to other MedTech partners
- Liverpool Citizens matured to Founding status with local campaigns being undertaken

Risks to delivery

- Minimum staffing requirement for Innovation function in line with ISO standard to be established in line with business case on 2024/25 pressures list.
- Staff/innovation champions capacity to progress innovation initiatives against daily pressures
- Staff having protected time to develop innovations

People Substrategy 2023/24 Annual Review - Research

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

2023/24 Achievements

- Financial Management – There has also been significant work on improving clarity around financial flow and remuneration arrangements for research. This has seen a marked improvement in the financial performance of the NRC for financial year 2023/24; which is no longer operating in deficit for this financial year

- Quality - There has been strong focus on improvement of the quality of research delivered in the NRC:
  - A Research Quality Manager was appointed and started in Feb 2024
  - A specific Research Quality Sub-group was created as the primary mechanism by which the Research Group (Sponsorship and Governance) gains assurance of delivery of research projects to the highest standards of research and clinical governance ensuring that quality and safety considerations are embedded throughout the Trust. The Research Quality Subgroup has oversight of the Quality Management System to provide scrutiny of the outcomes of these systems and processes in relation to quality to promote a culture of continual quality improvement
  - The Research Quality Sub-Group has developed and is implementing the Quality Improvement plan, which addresses the previous findings from MHRA inspections in 2010 and 2016, as well as other external audits
  - The Research Quality Sub-group is also leading on the NRC becoming compliant with International Organisation for Standardisation (ISO) for Quality Management System (ISO9001). ISO accreditation will provide clear evidence to both internal and external stakeholders of the Trust's commitment towards quality and provide confidence in our ability to deliver clinical research and build commercial activity. The first gap analysis visit took place in Feb 2024.

- Communications - A research specific communication plan, with the aim of increasing visibility of research at the Trust has been developed in conjunction with the communications team.

- Collaborations - There has been a clear commitment between the University of Liverpool and the Trust to create a Neuroscience Centre within the University, this will include the creation of a number of clinical academic posts. The business case for centre has been drafted and currently being reviewed by all parties.

Items for Escalation

- None of note.

People Substrategy 2023/24 Annual Review - Research

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

2024/25 Objectives

- Financial Management
  - Although financial year 2023/24 saw an improvement in financial performance of the NRC, this was is in large part due to the improved recovery of financial claims for activities undertaken in other financial years. The commercial portfolio of the NRC still needs to be rebuilt to see a sustained financial performance.
  - Implement new financial management policy to incentivise individuals to undertake commercial research
- Quality
  - To become compliant with the ISO9001 standard for quality management systems
- Collaborations
  - Continue collaboration with University of Liverpool to see the creation of Neuroscience Centre and a clear strategy for joint working between the two institutions
- Strategy
  - Financial year 2024/25 should see the release of a research specific SORT tool to understand an organisation readiness for research. The results from the SORT tool, as well as the joint working strategy, will be used to developed a further detailed strategic implementation to embed patient focused research across the Trust
- Communications
  - Create a 'consent for consent' database so that we can improve visibility of research at the Trust and improve our recruitment to time and targets rates for clinical trials

Risks to delivery

- With support of the Research Accountant, the Head of NRC is developing a clear financial management policy for research, which will see incentives for participation in commercial research. However, this need to work with the financial reporting constraints of NHS finance control. This financial management plan is due at the Research Group for approval in March 2024.
- Communication plan due for approval at the March 2024 Research Group

People Substrategy 2023/24 Annual Review – Training & Development

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

2023/24 Achievements

- Successful pre-employment programme ran from September – November, with a number of participants gaining permanent employment at The Walton Centre on completion of the course
- Recruitment process started to "top-up" x3 existing Nurse Associates to Registered Nurses via the apprenticeship route (commencing on programme June 24)
- Public sector apprenticeship target - 10 new starts
- Business case agreed to recruit an apprentice Operating Department Practitioner on a rolling basis (commencing September 2024)
- Both Personal Safety Training and Moving and Handling Training compliance increased from 61% in April 2023, to 81% as of February 2024.

Items for Escalation

- Delay to Building Rapport re-launch in 23/24 due to staff sickness

2024/25 Objectives

- Re-launch Building Rapport Programme in Q3
- Increase apprentice uptake of existing and new recruits by progressing a Trust-wide 'apprenticeships first' ethos - 6 new starts planned Q1
- Workplace Safari to be held July 2024
- Trust participation in NHSE "Experience of the Workplace" Programme
- Development of Internships and T-Levels

Risks to delivery

- Managers' awareness of apprenticeships / willingness to recruit apprentices
- Fluctuating appraisal compliance

The Walton Centre NHS Foundation Trust

Report to Board
4 March 2024

Report Title	Quality Substrategy Update
Executive Lead	Nicola Martin, Chief Nurse
Author (s)	Nicola Martin, Chief Nurse
Action Required	To note

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

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

Key Messages

- The Report highlights: -
- Q3 Achievements and Highlights
- Q4 Objectives and initial progress
- Items for escalation
- Key progress Metrics

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

- Plan away morning with divisions and corporate team to develop 24/25 plan.
- Progress with Q4 objectives.

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ✓	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	March 24	Nicola Martin, Chief Nurse	Noted.

Quality Substrategy Update 2023-24

Executive Summary

1. The purpose of this report is to provide Trust Board with progress of delivery for the Quality Substrategy for Quarter three and objectives planned for Quarter four.

Progress Summary

2. Following the approval of the enabling Quality Substrategy in July 2023, the Divisional, Nursing and Quality Improvement teams have worked collaboratively to develop an underpinning delivery plan to ensure set milestones are agreed for each quarter.

3. This report demonstrates the progress made against objectives agreed for delivery in Q3 and planned objectives for Q4 of 2023/24. The report also highlights key risks to delivery and escalation highlighted.

4. Work is ongoing with the Business Intelligence team to put into operation a dashboard for those KPIs which can be measured i.e. Reduction in patient harms and which of the KPIs that lend themselves to such an approach.

5. A Quality Substrategy event will take place in April to agree 24/25 delivery plan.

Conclusion

6. Good progress is demonstrated against the key priorities for Q3 2023-24, and further key priorities set for Q4 2023-24.

Recommendation

- To note

Author: Nicola Martin, Chief Nurse
Date: 26/03/24

NHS
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NHS Foundation Trust

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Executive Summary

Following approval of the enabling Quality sub strategy in July 2023, the Senior nursing team and Quality Improvement team have worked collaboratively to develop an underpinning framework to ensure delivery of the set objectives described within the overarching Trust Strategy.

The following information demonstrates the objectives agreed for delivery in Quarters 3 of 2023/24 and those set for delivery in Q4.

Quality Sub strategy Q3

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Q3 Objectives	Q3 Progress Update
• To have implemented 'you said, we did' signage	• Completed and in place.
• To have demonstrated patient outcomes at 6 months post MRgFUS implementation	• Completed and outcomes presented to NHSE 6 months post implementation.
• Have completed mini place and improved compliance compared with the last PLACE assessment	• Completed and improved, full PLACE audit has been carried out Nov 23 and await results. Top 2nd Trust for best food.
• Delivered x3 QI study day sessions	• Completed, and continues every month
• Will have QI ward boards on all wards and operational areas	• Rolled out and completed, monitored via SPMO.
• Established ad renewed PFCC working Group with clear lines of accountability	• In place, embedded and reports to PFEG
• Completed Sepsis QI programme	• IT solution completed but issues reported so waiting amendments.
• Learning Disability Gap analysis	• Completed, nurse recruited and should start Q4, action plan to be developed and monitored via Safeguarding Committee.
• Source solution to improve FFT response rate	• Funded, currently working with the development team.
• To have evaluated and realised benefits from introducing e roster in theatres	• In progress, out of hours staffing gap identified and added to risk register.
• To have implemented text messages reminders for patient appointments	• Go live 11/3/24




Quality Sub strategy Q3

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Q3 Objectives	Q3 Progress Update
• Continue to improve RANA utilisation	• Continued progress
• progress bid for LITT services	• Bid successful.
• 15 senior leaders to have commenced levels 3,4,and 5 PSIRF training	• Completed and further dates obtained for 2024
• To have rolled out e-consent to all spinal patients	• Completed
• To have established e forms ad Quick question to optimise healthcare information for patients	• E-forms now established; integration ongoing
• To launch the Quality and Sustainable improvement team vision and ambitions	• Launched as part of the QSIT day and attended by regional colleagues
• Secure funding to progress awake craniotomy	• Funding secured, await roll out plan from division
• Engage with lived experience panel	• Engaged and established an external lived experience panel
• Invest in reusable theatre hats to aid patient safety and environmental sustainability	• Invested and roll out pending
• Improve patient and family areas on Caton ward and Chavasse ward	• Secured charitable funding and progressing
• Launch ‘gloves off’ campaign	• Commenced October 2023 in ITU, Roll out to rest of the organisation Q4
• Launch ‘noise at night’ campaign	• Commenced W/C 13/11/23, Noise at night patient packs now completed.
• Culture review in ITU	• Feedback commenced, action plan in progress.

Quality Sub strategy Q3

The Walton Centre
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Key Prog. Metrics	Baseline	Q3 23/24	
• Reduction in catheter associated infections	Baseline total 35 in 22/23	Total YTD 21 (March 24)	
• Reduction in Category 2 pressure ulcers	Baseline total of 25 in 22/23	Total YTD 18 (Feb 24)	
• Increase in FFT Response Rate	50%	70%	





Quality Sub strategy Q4

The Walton Centre NHS Foundation Trust

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Q4 Objectives	Q4 Progress Update
• Roll out of gloves off Campaign across ward areas	• Commenced
• Scope options for sensory room to support our patients with Learning Disability +\- Autism	• Commenced
• Roll out new ITU Patient Diaries	• At printers
• Roll out Martha's Law	• On Plan for 1st April
• Commence Planning and Scoping of Patient Experience Hub at the Hospital main entrance	• Awaiting costings
• New protocol for usage of MITTs and MITTs leaflet	• Completed at printing
• Roll our role of Patient Safety Specialist Role	• Ongoing
• Approval of ODP Apprenticeship	• In recruitment process
• Approval of 3 Nurse Associates to be supported to complete Registered nurse Training	• Recruitment process

Quality Sub strategy

The Walton Centre
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Quality Sub Strategy, items for escalation and risks in delivery.

Items for escalation

Still no progress with Quality Sub Strategy Dashboards due to BI capacity.

Still concerns re engagement, plan is to complete an away day in April for 24/25 Sub strategy plan

Risks	Actions / Mitigations	Owner / Lead	Anticipated End Date






Any questions?

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	**Board Assurance Framework (BAF) 2023/24 Closure Report**
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- The end of year review for 2023/24 for the BAF has taken place with Executive Leads and through the Board Committees
- All risks and associated actions have been updated
- There are no proposed changes to risk scores or risk appetites.

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

N/A

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

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

All Risks	All Risks	All Risks

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	6 March 2024	K Dowson Corporate Secretary	All risks reviewed by Executives and agreed
Quality Committee	21 March 2024	K Dowson Corporate Secretary	Reviewed and commented on the risks assigned to the Committee.
Health Inequalities & Inclusion Committee	25 March 2024	K Dowson Corporate Secretary	Reviewed and commented on the risk assigned to the Committee. No changes proposed.
Business Performance Committee	26 March 2024	K Dowson Corporate Secretary	
RIME Committee	2 April 2024	K Dowson Corporate Secretary	Comments to be advised verbally to Board due to timing of meetings.

Board Assurance Framework (BAF) 2023/24 Closure Report

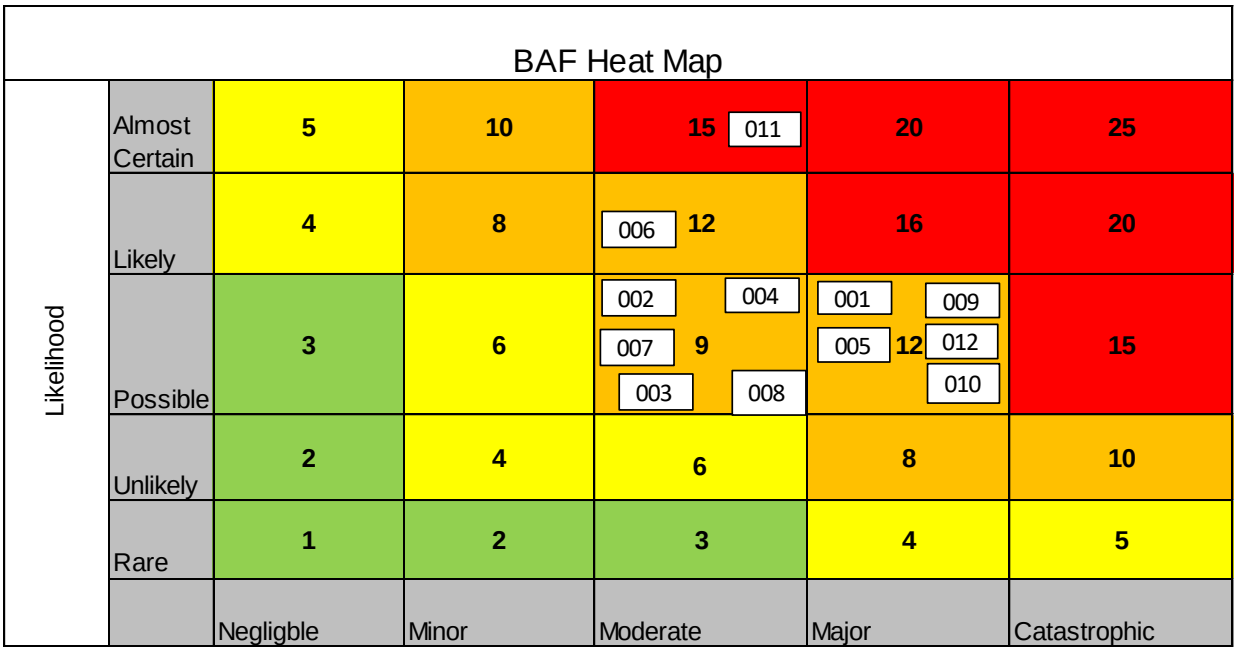
Executive Summary

1. This paper summarises the detailed current position against the twelve strategic risks approved at Board on 6 April 2023. The initial, current and target scoring and risk appetites were all reviewed at this meeting. Each has been reviewed through the assigned Board Committees three times during the year.

2. There were no changes proposed at this review to risk scoring, appetite or descriptors as this was the end of year report. The new principal risks for 2024/25 will be approved at the same Board meeting and will reflect comments made regarding the ongoing appropriateness of the principal risks.

3. The Heat Map below illustrates the current scoring position for BAF risks. As there are no changes proposed to risk scoring, no direction of travel arrows are shown.

Diagram 1 – Heat Map



Background and Analysis

4. There are twelve principal risks identified on the BAF which align to the Trust Strategy 2022-25. All the BAF risks have been reviewed in detail and updated by the appropriate Executive Lead and reviewed by the Executive Team and Board Committees. Changes to the BAF risks are marked in red or through strike through on each BAF risk and are included in the appendices to this paper.

5. The strategic ambitions which form the strategic objectives for the Trust are:
   - **Education, training and learning** - Leading the way in neurosciences education and training
   - **Research and Innovation** - Delivering high-quality clinical neuroscience research, in collaboration with universities and commercial partners

- **Leadership** - Developing the right people with the right skills and values to enable sustainable delivery of health services
- **Collaboration** - Clinical and non-clinical collaborations across and beyond the ICS, building on existing relationships and services
- **Social Responsibility** - Supporting our local communities and providing services for patients within and beyond Cheshire and Merseyside

6. These ambitions are supported by seven enabling Substrategies which are regularly reviewed by the Board. The Substrategies are: Quality, People, Digital, Estates, Facilities & Sustainability, Finance & Commercial Development, Communications & Marketing and Charity.

7. The BAF aligns principal risks, key controls, risk appetite and assurances to the Trust's strategic ambitions, 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.

8. 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
   - Describes the Board's agreed risk tolerance through the agreement of a risk appetite for each risk
   - Provides critical supporting evidence for the production of the Annual Governance Statement.

9. The BAF risks were assigned to Board Committees to review and provide assurance and this took place during March and April 2024.

Changes

10. A number of actions are in place for each BAF risk to address the gaps in controls or assurances identified. These have been updated and completed actions marked as such.

11. Following the agreement by the Board to reduce the number of public Board meetings the BAF reporting schedule has moved from quarterly to three times per year. Executives reviewed the BAF at meetings in July this year (August from 2024), December and March with Committees reviewing in July, November and March/April.

12. A summary of the current risk scores and risk appetites are in Table 1. The previous risk score from 2022/23 has been included where the new risk was clearly aligned to previous strategic risks. The risk descriptors which define the scoring of the risks and the risk appetite are included at Appendix 1. There are no proposed changes to the risk scoring of any of the risks.

13. The Board established its Risk Appetite Statement for 2023/24 at the April Board meeting. There is variation in the risk appetite assigned to each risk across the BAF. This reflects that these risks are linked to the strategy for the Trust which is focused on opportunities as well as risks and therefore the Trust may need to consider taking more risks to achieve these ambitious objectives. There are no proposed to changes to risk appetite this quarter.

Table 1

Risk ID	Risk Appetite	Title	Q4 22/23	1 23/24	2 23/24	3 23/24
001	**Cautious**	**Quality Patient Care** Impact on patient outcomes and experience	**12**	**12**	**12**	
002	**Open**	**Collaborative Pathways** Inability to develop further regional care pathways	**9**	**9**	**9**	
003	**Open**	**System Finance** Inability to deliver financial plan for year	**6**	**9**	**9**	
004	**Cautious**	**Operational Performance** Inability to deliver the operational plan	**9**	**9**	**9**	
005	**Open**	**Leadership Development** Inability to attract, retain and develop sufficient numbers of qualified staff	**12**	**12**	**12**	
006	**Open**	**Prevention and Inequalities** Inability to improve equitable access to services	**12**	**12**	**12**	
007	**Moderate**	**Capital Funding** Inability to secure capital funding to maintain the estate to support patient needs	**9**	**9**	**9**	
008	**Open**	**Medical Education Strategy** Inability to deliver a national training offer		**9**	**9**	
009	**Open**	**Research and Development** Inability to develop and attract world class staff	**12**	**12**	**12**	
010	**Adventurous**	**Innovative Culture** Inability to grow an innovative culture	**12**	**12**	**12**	
011	**Averse**	**Cyber Security** Inability to prevent Cyber Crime	**15**	**15**	**15**	
012	**Moderate**	**Digital** Inability to deliver the Digital Substrategy ambitions		**12**	**12**	

14. There was a focus through 2022/23 on ensuring that there were clearly linked operational risks that align to the strategic risks and these are now in place and are reviewed regularly. New or revised risks are shown in red font and those that have been downgraded or removed are shown as strikethrough. Where risks have been closed or reviewed and the score has dropped below 12 these are shown as crossed out.

15. Only those operational risks scoring 12 or above would normally be shown on the BAF and this means that there are no linked operational risks for BAF008 or BAF010 included on the BAF. Where there are a larger number of linked operational risks such as for BAF001 Quality of Care only the current highest scoring riskswill be shown.

Conclusion

16. The new BAF articulates the principal risks to the achievement of the strategic ambitions of the Trust. The Board are asked to consider the control and assurance gaps and identify any further actions required or additional assurances that are required.

Recommendation

17. To approve the closure of the BAF

Author: Katharine Dowson
Date: 28 March 2024

Board Assurance Framework Glossary

ADO	Associate Director of Operations
AI	Artificial Intelligence
ANTT	Aseptic non-touch technique
BMA	British Medical Association
BPC	Business and Performance Committee
C&M	Cheshire and Merseyside
CDRD	Clinical Director of Research & Development
CEO	Chief Executive Officer
(D)CFO	(Deputy) Chief Finance Officer
CIP	Cost Improvement Plan
CMAST	Cheshire & Merseyside Acute and Strategic Trusts (Provider Collaborative)
(D)CN	(Deputy) Chief Nurse
COO	Chief Operations Officer
(D)CPO	(Deputy) Chief People Officer
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRN	Clinical Research Nurse
DHSC	Department of Health and Social Care
DMA	Digital Maturity Assessment
DME	Director of Medical Education
EPR	Electronic Patient Record
ERIC	Estates Returns Information Collection
ERF	Elective Recovery Fund
FoSH	Federation of Specialist Hospitals
FFT	Friends and Family Test
GDPR	General Data Protection Regulations
GMC	General Medical Council
HEE(NW)	Health Education England (North West)
HFAI	Health Facility Acquired Infection
HFMA	Healthcare Financial Management Association
HiMSS	Healthcare Information and Management System (Digital Maturity Model)
HMG	Hospital Management Group
ICB	Integrated Care Board
IM	Innovation Manager
ICO	Information Commissioners Office
ICS	Integrated Care System (Cheshire & Merseyside)
IG	Information Governance
IT	Information Technology
IOM	Isle of Man
IPC	Infection Prevention and Control
IPR	Integrated Performance Report

ITU	Intensive Therapy Unit
KPI	Key Performance Indicator
LoA	Letter of Authority
LHP	Liverpool Health Procurement
LUHFT	Liverpool University Hospitals Foundation Trust
MD	Medical Director
MHRA	Medicines and Healthcare Products Regulatory Agency
MIAA	Mersey Internal Audit Agency (Internal Auditors)
MSSA	Methicillin-sensitive Staphylococcus Aureus
MoU	Memorandum of Understanding
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning Score
NHSE	NHS England
NHSP	NHS Providers
NICE	The National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NRC	Neuroscience Research Centre
NWC	North West Coast (Innovation Agency)
RAG	Red-Amber-Green (scoring)
RCA	Root Cause Analysis (Investigatory Technique)
RN	Registered Nurse
QIP	Quality Improvement Programme
QPSG	Quality and Patient Safety Group
RIME	Research, Innovation and Medical Education (Committee)
SFI	Standing Financial Instruction
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SORD	Scheme of Reservation and Delegation
SPA	Supporting Professional Activities
SPARK	Single Point of Access to Research and Knowledge
SPMO	Strategic Project Management Office
SRO	Senior Responsible Officer
TEL	Training, Education and Learning
TOMs	Themes, Outcomes, Measure
UoL	University of Liverpool
WCFT	The Walton Centre NHS Foundation Trust

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

Risk ID: 001	Date risk identified April 2023	Date of last review:	December 2023
Risk Title: Quality Patient Care If the Trust does not deliver high quality care for all patients then this will lead to adverse clinical outcomes for patient and a deterioration of the patient, staff and family experience which may impact on the reputation of the Trust.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 12 Safe Care and Treatment
		Ambition:	Quality of Care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks (15+ or new risks only)		
1048	If there is not adequate resource within the Neuromodulation Service to provide pump clinic and theatre cover then there will be a risk to patient safety due to pumps not being programmed, which could result in serious harm to patients.	16
1063	If elective cases overrun and result in the pausing of the emergency list there is a risk that the theatre will not be able to provide emergency care for patients	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	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor outcomes for patients - Poor patient and family experience /increase in complaints - Reputational damage - Increased incidents - Increased morbidity and mortality - Quality standards not met - Lower CQC rating - Lower staff morale - More difficult to recruit workforce - Increased staff turnover - Widening of health inequalities - Worsening staff and patient survey results - Worsening Friends and Family Test results - Increase in clinical claims - Reduced CQC regulatory compliance	- Number of complaints/concerns received with enhanced analysis into themes and trends. - Zero Never Events in 2020/21, two in 2021/22, zero in 2022/23, one in 2023/24 to date. - Mortality rates - Staff vacancy rates (nursing currently at 6%) - Staff retention – turnover figures - Annual CQC Inpatient survey - Integrated Performance Report – Quality metrics in place - Friends and Family Test, reduced response rate in outpatients - Incident Numbers - CARES Assessments in place 6-12 monthly - Actions following RCAs - Improved MUST Performance at 12 hours - Number of Serious Incidents - Freedom to speak up concerns - Staff survey
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. New Quality Substrategy approved May 2023 2. IPC BAF reviewed at Quality Committee quarterly – January 2024 3. Ward Accreditation Programme (CARES) in place for 2023/24 4. Implementation of Tendable Audit System for ward-based Quality metrics from 2022/23. Now to be rolled out across ITU and Theatres. 5. Board Walkabout Programme – reporting to Quality Committee 6. NICE Exception Report 7. CQC Mock Inspections 2024 ~~– May 2022~~ 8. Specialist Nurse Support in place e.g. tissue viability and IPC 9. Patient and Family Centered Framework in place – relaunched January 2023 10. ~~HCAI plan for 2022-23 approved by Board June 2022~~ IPC Board Assurance Framework reviewed three times per year by Quality Committee and reported to Board 11. Pulse Survey reflecting staff morale 12. ANTT Training for nurses complete and established as a quality priority for 2023/24. Medical courses now underway 13. 'Call for Concern' campaign re launched Jan 2024 14. Neuropsychology specialist nursing team 15. PLACE Inspections ~~mini review June 2023 – reporting to BPC~~ 16. Patient Safety Incident Reporting Framework implemented from 1 September 2023 17. Safe care and Health roster 18. Patient safety partners now recruited 19. Service reviews taking place across each specialist nursing team 20. External patient engagement events 21. SWAN Nurse appointed to be launched Feb 2024 22. Quality Priorities agreed for 2024/25 23. Quality Patient and Safety Group relaunched in February 2024 to bring together all quality issues in one meeting with a multidisciplinary membership 24. Currently out to recruitment for a Learning Disability+/- Autism trained nurse 25. Martha's Rule to be launched April 24 26. Gloves off campaign launched Dec 23 27. Nurse competencies in process of being updated	1. ~~Timely completion and reporting of NICE exception reports~~ 2. Theatre utilisation programme not achieving its objectives as planned Assessment criteria against Patient and Family Centered Plan (6 Steps) 3. ~~ANTT Training for medics,~~ 4. Sepsis audits to include all relevant patients 5. ~~Limited~~ Slow progress on agreed End of Life Framework with LUHFT 6. Peer review plan requires roll out 7. Robust process for CQuINs 8. Response rate for Friends and Family Test – digital solution to be implemented following approval of business case, January 2024 ~~explored~~ 9. Review of all nursing documentation to allow the delivery of the Digital Substrategy and to ensure is in line with NMC Code of Conduct 10. Safeguarding training compliance - All levels 11. IT System 12. Learning Disability improvement standards, only compliant with 13 of the standards 13. Appraisals 14. E learning package for ANTT training for medics, face to face sessions provided but attendance insufficient

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 review Patient Safety Incident Reporting Group Quality and Patient Safety Group (QPSG) Tendable Quality Audits ~~Balance Score Cards – monthly review~~ Hospital Management Group – bi-monthly review Hand Hygiene Audits – monthly review Staff and Patient stories to Board at each meeting Infection Prevention and Control Group – monthly review **Level 2** Integrated Performance Report Quality metrics – Quality Committee – bi-monthly Quarterly reports from Clinical Governance Team (incidents & risks, Patient Experience Team, Pharmacy, Pathology, Tissue Viability, Mortality and Morbidity) – Quality Committee and QPSG IPC Annual Report to Board – June 2023 Safeguarding Annual Report to Board – July 2023 Annual Clinical Governance Report 2022/23 to Quality Committee – May 2023 Medicines Management Annual Report to Board – July 2023 ~~Quality Strategy Progress Report to Quality Committee – Sept 2022~~ Visibility and Walkabout update quarterly report to Quality Committee Quality Account to Board - June 2023 Ward Accreditation and Tendable Annual report to Quality Committee – September 2023 Update on NICE assessment, including those outstanding quarterly, reported to Quality Committee IPC BAF Jan 24 **Level 3** CQC Inspection Report 2019 Quarterly reporting to CQC Relationship Manager Review meetings with Commissioners – Quarterly National Inpatient Survey Results – published September 2023 CQC Mental Health Inspection – December 2020 CQC Interventional Radiology Inspection – published December 2021 Getting it Right First Time (GIRFT) reports Investors in People Gold Award 2020 (reaccredited 2023~~1~~) Anaesthesia Clinical Services Accreditation (ACSA) visit 2022 Report following visit to check compliance with Human Tissue Act (~~March 2023)~~ January 2024 Trauma Audit and Research Network (TARN) peer review – February 2023~~4~~	1. End of Life Care Strategy (available from February 2023) 2. Quality Impact Assessments e-system now in place, only one completed to date 3. ~~Most recent PLACE assessment highlighted areas for improvement in food service and environment.~~ 4. Impact of Clinical Audits understood and changes made as a result reported to Quality Committee

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Review process for gaining assurance for End of Life Care. New group established. UPDATE Verbal update on progress received at Quality Committee in November 2022, Clinical Effectiveness Group to monitor with Annual Report to Quality Committee. Identify qualitative indicators to fit in with SWAN model. UPDATE Dec 2023: Business case approved but Committee is consistently cancelled, to escalate to LUHFT as unable to give assurance re progress against strategy. UPDATE March 2024: Group met in Feb 2024, operational groups re-established and SWAN nurse now commenced in post	MD	~~September 2022~~ ~~October 2022~~ ~~March 2023~~ August 2024	In progress
2	New Quality Substrategy to be written and ratified by Quality Committee. May Board	CN	~~February 2023~~ April 2023	~~In progress~~ Complete
3	Working groups set up to assess the Trust against the six steps in Patient and Family Centred Care and identify improvements. First two steps to be assessed initially.	CN	June 2023	~~New Action~~ Complete
4	Peer audits to be completed on wards on the fundamentals of care. This is now business as usual.	CN	June 2023	~~New Action~~ In progress Complete
5	Delivery plan to fulfil the Quality Substrategy. UPDATE Dec 2023: Lack of engagement from Divisions, escalated to COO	CN	July 2023	~~New Action~~ Complete
6	Options for investment in electronic Friends and Family Test to be explored. Business Case approved January 2024	CN	January 2024	~~New Action~~ Complete
7	IT amendments required in order to monitor Trust progress against Sepsis compliance	CN	March 2024	~~New Action~~ In progress
8	Explore options of e-learning package for doctors training of ANTT, still taking place	~~CN/~~MD	~~November 2023~~ April 2024	~~New Action~~ In progress
9	Nursing review of all patient care forms for digital team and prioritisation plan required.	CN	April 2024	New Action

Risk ID: 002	Date risk identified	April 2022 (*updated April 2023*)	Date of last review:	December 2023
Risk Title: Collaborative Pathways If the Trust does not succeed in developing and leading well led high quality standardised regional care pathways and networks with system partners that meet patient needs, then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable patient care which addresses health inequalities in our population.			**Date of next review:**	April 2024
			CQC Regulation:	Regulation 17 Good Governance
			Ambition:	Collaboration
			Assurance Committee:	**Quality Committee**
			Lead Executive:	Medical Director

Underlying Operational Risks				**Consequence**	**Likelihood**	**Rating**
838	If the Trust pain service cannot recruit to consultant vacancies, then the Trust's pain service provision may not be able to meet demand and this will make the Trust's offer to deliver a regional pain network less robust.	12	**Initial**	**Moderate** 3	**Possible** 3	9
			Current	**Moderate** 3	**Possible** 3	9
			Target	**Moderate** 3	**Unlikely** 2	6
Risk Appetite	**Open**					

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Equality of care for patients due to variation in system delivery and capacity - Potential for increased morbidity and mortality rates - Patient safety incidents - Patient outcomes worsen - Length of stay increases - Resource impact of excess unnecessary investigations - Sustainability of Trust - Inadequate funding to support development and growth in line with strategic ambition - Deterioration of patient and family experience - Increase in long waiters	- Immature system governance, new people and new ways of working create uncertainty in the system in conjunction with ongoing streamlining of regional bodies - Regional governance arrangements determined at national/ regional level - System governance arrangements still embedding and emerging with further structural change to staffing taking place - New commissioning arrangements not yet fully known although roadmap to specialist commissioning now published - Unwarranted variation in services - Health inequalities between different postcodes - Pressure on staff resources to develop new pathways and capacity regionally to support and drive change - Vacancies in Trust's own services reflect challenges to recruit in certain specialities across the system - 24/7 Thrombectomy service for region is hosted by the Walton Centre - RANA service established 2022 to support emergency department flow, referrals continuing to increase

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 Strategy 2022-25 approved 2. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place-based partnerships and Provider Collaborative 3. Host of C&M Rehabilitation and Critical Care Networks and Neuroscience Programme Board 4. Successful delivery of regional services: Neurology / Neurosurgery / Thrombectomy/ Spinal Surgery 5. Existing relationships with partner organisations through current neurology / neurosurgery model 6. Existing relationships ongoing with Specialised Commissioning through ongoing transitional period (2023/24) 7. Engagement with other specialist trusts both at local and national level 8. Communications and Engagement Substrategy 2022-25 9. Nursing Times Award for Brain Tumour Optimisation Programme, being rolled out to other Trusts to standardise pathway 10. Trust Medical Director appointed to be lead clinician in ICS on development of pain pathways 11. Aintree Site Committee established with LUHFT to progress the Liverpool Services Clinical Review clinical priorities and investigate potential collaborations with delegated authority from the Board. 12. Priorities for the Aintree Site Sub-Committee agreed as imaging, emergency clinical pathways and estates and digital. 13. C&M Forward Plan 2022-28 includes Neurosciences, Epilepsy and Stroke as focus areas	1. Profile of Trust and communication of specialist offer 2. Promotion of success of current regional services 3. Perception of specialist Trust's ability to deliver system-wide services 4. Some of Walton Centre patient population lies outside ICS (C&M) and therefore does not align with population basis for commissioning / funding allocations 5. Engagement with other providers can be challenging to promote new ways of working 6. Ability to meet widened criteria for thrombectomy - model of care needs review. 7. Capacity to lead on regional pain services and develop a collaborative solution.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Weekly C&M ICS CEO meeting Regular ICS Chair meetings	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR.

Level 2 Monthly reporting to Board on ICS development and development of strategy, processes and systems and also of operationalisation of 24/7 Thrombectomy and spinal surgery Monthly Chair and CEO reports to Board Project update e.g. Spinal Services to Executive Directors meeting on a regular basis Clinical Effectiveness and Services Group monthly meeting reviews and reports to Quality Committee through Chair's assurance report Regional Thrombectomy Meeting Spinal Provider Board with LUHFT Project Boards with partners e.g. Pain Collaborative ICB Transformation Board oversight of network boards Complex Rehabilitation Board 6 monthly updates to Executive regarding pain collaborative work Benefits Realisation Paper on Thrombectomy to Executives Sept 2023 **Level 3** GIRFT reviews of specialist services e.g. spinal, cranial neurosurgery, neurology monitored through Neurosciences Network Programme Board Regional neuroscience services monitored through Neurosciences Network Programme Board Nursing Times Award 2022 for Brain Tumour Optimisation Programme Shortlisted for HSJ Trust of the Year 2023	3. Lack of clarity on future of specialist commissioning – NHSE have published a roadmap for proposed services for delegation to the ICS from April 2023. MD and CEO involved in regional and national discussions regarding proposals. 4. Outcomes dependent on other statutory bodies 5. Comprehensive stakeholder engagement 6. System oversight of networks – currently under review 7. Consultant vacancies in Pain Service

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Participation in review of Complex Rehabilitation Network – led by Liverpool Clinical Commissioning Group UPDATE: Review has been replaced by Implementation of the NICHE report by ICB. Project Manager for this is not in work currently so the Trust is planning to take a paper to the ICB in March 2023 on how to improve patient flow in the system. UPDATE: Spec Comm agreed ~~exploring some~~ short-term support to conduct a review~~. No current timescales. Paper going to Rehab Network meeting on 16 October.~~ Review lead appointed by NHS England 5 March 2024.	MD	~~September 2022~~ ~~January 2023~~ tbc	Delayed
2	Benefits realisation analysis of 24/7 Thrombectomy UPDATE Executives to review in September, review required further work. UPDATE ~~Planned for June 2023~~	COO	~~September 22~~ ~~October 2022~~ ~~March 2023~~ ~~July 2023~~ September 2023	~~Not yet started~~ ~~In progress~~ Complete
3	Benefits realisation analysis of delivery of regional spinal services. Delayed due to addition of additional long waiters from LUHFT. UPDATE: to review 6-12 months after last referral. UPDATE deferred as no capacity in Neurosurgery to deliver this piece of work currently. Finance to review financial position initially.	MD	~~December 2022~~ ~~September 2023~~ March 2024	~~Not yet started~~ In progress
4	Leading Pain Collaborative Working Group review of regional services and equity of access. UPDATE: MD now clinical lead for ICS for pain management pathways. Next step to contract regional Medical Directors to ascertain the current position of regional pain services	MD	~~December 2022~~ ~~April 2023~~ July 2023	In progress
5	Appropriate linked operational risks are to be developed and entered onto risk register with risk manager UPDATE: 1 new linked risk added, one new risk in process of being added on.	MD	March 2023	~~In progress~~ Complete
6	Develop a workplan to be agreed by the Board for the Aintree Site Joint Committee for initial focus to develop further collaborative services.	MD	June 2023	~~New Action~~ Complete
7	Staff Engagement and options for nursing workforce model to deliver Thrombectomy to be taken to Execs for agreement. Trial proposed with LUHFT using their stroke nurses to coordinate care.	COO	December 2023 tbc	New Action
8	Head Injuries pathway to be reviewed for patients attending Aintree A&E by Joint Site Sub-Committee.	MD	January 2024	~~New Action~~ Complete
9	Pathway for MRI for ventilated patients with LUHFT to be agreed.	MD	December 2023	~~New Action~~ Complete
10	Link with ICS Clinical Pathways Programme to coordinate a review of pain services. Original business case to be updated while awaiting outcome from ICS.	MD	February 2024	~~New Action~~ Complete

Risk ID:	003	Date risk identified	April 2023	Date of last review:	Date of next review:
Risk Title: System & Finance If the Trust does not deliver its financial plan for 2023-24 the Trust's standing and influence in the system will be diminished and this may result in less resource and opportunities in the future for the Trust to grow and meet it strategic ambitions.				**Date of next review:**	April 2024
				CQC Regulation:	Regulation 17 Good Governance
				Ambition:	Collaboration
				Assurance Committee:	**Business Performance Committee**
				Lead Executive:	Chief Finance Officer

Operational Risks		
135	If SLA and contracts management cannot be maintained, then there is a Risk to financial control and service provision.	~~12~~ 16
934	If 2023/24 elective weighted activity trajectories are not delivered there is a risk that income may be retrieved from the base contract (for Specialist Commissioners). Weighted activity levels may not reach required levels to receive associated Aligned Payment Incentive Contract (API). This would put delivery of the 2023/24 financial plan at risk as receipt of API income is assumed within the financial plan.	16
948	If the specialised commissioning element of income transfers to Population based commissioning as planned, then there is a risk of this leading to reduced funding allocations for the Trust.	12
Risk Appetite	**Open**	

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

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of decision-making responsibilities / influence as move to system based working and financial targets with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance and finance - Loss of autonomy as the approach to finance is defined by ICS through its finance strategy - Potential deterioration of the Trust's financial position through funding / tariff changes - Change in funding provision for specialist services - Increased complexity to approaches with different tariff systems (Wales and Isle of Man) - Move of commissioning from NHSE Specialised Commissioning to ICS may lead to a lack of local service knowledge around commissioning of services - Equity of access to care for patients - Inadequate funding to support development and growth in line with strategic ambition - Reputational impact if outlier within the system due to financial performance - Prioritisation of Neurosciences funding by ICS compared to other funding priorities - ~~Closure of theatres for refurbishment will impact activity~~	- Developing system governance, new people and new ways of working create uncertainty in the system - Regional governance arrangements determined at national/ regional level from 1 July 2022 - Development of Provider Collaborative Model arrangements underway - Work is on-going regarding the delegation of specialist service commissioning budgets to the ICB. This is now delayed until 2024/25. - Requirement to meet system financial targets - Liverpool Providers Clinical Review recommendations - Larger acute trusts with underlying structural deficits in the ICS - Trust basis for funding based on historical local tariffs and disproportionate costs of delivery may not be taken into account for services leaving Trust with a financial gap - Shortfall in recurrent element of programme - Delivery of elective recovery in line with plan - Financial monitoring and reporting - ICS finance strategy development which will lead to more financial controls, especially for poor performing trusts - Expenditure Controls agreed September 2023

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. Revised Trust Strategy 2022-25 approved 2. Communication and Engagement Substrategy 2022-25 3. Finance and Commercial Development Substrategy 2022-25 4. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place based partnerships and Provider Collaborative 5. Host of C&M Rehabilitation and Critical Care and Major Trauma Networks and Neuroscience Programme Board 6. Existing relationships ongoing with Specialised Commissioning through the transitional period (2023/24) 7. Trust has fed back on consultations to changes in commissioning 8. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) and through FoSH Finance Group which is reviewing impact of the new financial framework on the system and engaging with the wider system on potential changes 9. Tight management of financial position to ensure end of year position achieved and efficiency targets met 10. Healthcare Procurement Liverpool (HPL) established to improve efficiencies, provide value for money, resilience and quality – business case under development to expand to Liverpool Place. 11. Provider Selection Regime for procurement of healthcare services introduced with Health and Care Act 2022 12. 2023/24 financial planning cycle complete 13. Counting and coding changes for activity accepted by NHSE for theatre downtime during Air Handling Unit replacement. 14. Regular reviews of QIP performance and future plans with senior leaders. 15. Liverpool Place finance Group established 2024 16. Confirmation of specialised commissioning payments up to M6 based on activity plan.	1. Profile of Trust and communication of specialist offer 2. Perception of specialist Trusts 3. A significant proportion of the Walton Centre patient population lies outside C&M, therefore does not align with population basis for commissioning / funding allocations 4. Regional governance arrangements potentially result in greater influence for larger providers ~~5. Review of stakeholder analysis~~ 6. ICS funding priorities not yet confirmed 7. Trust does not currently have a medium-term financial plan (3-5 years) to determine future sustainability. 8. Sufficient contract management resource in divisions to review contracts and SLAs 9. Impact of industrial action on challenging activity levels for 2023/24 10. Confirmation of income under PBR is not confirmed until end of quarter due to system alignment 11. Still awaiting confirmation of ICB API payments to date. This will be a continued risk under the proposed payment scheme for 2024/25, under which new targets will be issued.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Weekly C&M ICS CEO meeting Regular ICS Chair meetings Regular C&M ICS Directors of Finance planning meetings Provider Collaborative (CMAST) meetings with CEO/ Chair Weekly Finance, Operational and Performance Meetings New Executive led Finance, Performance and Environment meeting established March 2024 **Level 2** Monthly Chair and CEO reports to Board Monthly reporting to Board on ICS development and development of strategy, processes and systems Regular review of operational risks at Board level and on-going review of mitigations Review of financial position and CIP at every Board and ongoing monitoring through financial controls and processes with closer review at monthly meetings Risks review by FoSH Detailed review of financial performance at bimonthly Business Performance Committee Service Level Agreements and contract register reported quarterly to Executive meeting **Level 3** External Audit of Annual Accounts and going concern considerations Internal Audit of financial processes and control systems including HPL ICS triangulation benchmarking C&M providers across finance, performance and workforce National Financial sustainability report completed by internal auditors	1. Measurement of the impact of the influence of The Trust and FoSH 2. Lack of clarity on future of specialist commissioning 3. Outcomes dependent on other statutory bodies 4. Financial plan could change due to system pressures and the Trust may be asked to deliver more. 5. Recurrent 5% QIP required which is higher than ever previously achieved.

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with the ICS on system development and engage through regional roles in ICS.	ALL	Ongoing	In progress
2	Continue to work with FoSH and specialist commissioners to deliver the specialist commissioning roadmap	CEO/CFO	Ongoing	In progress
3	Continue to work collaboratively across the ICS and offer mutual aid as appropriate	COO	Ongoing	In progress
4	Develop a medium-term plan based on anticipated changes to the tariff and other assumptions to understand longer term financial risks for the Trust, support strategic planning and identify the timing of financial gaps and efficiencies.	CFO	~~March 2023~~ ~~Tbc~~ ~~September~~ December 2023	~~New Action~~ In progress Complete
5	ICS to develop a three year financial plan 2024-2027 to ~~e~~review ongoing financial sustainability and actions required to close the gap. This has been completed but not yet shared with Trusts. ~~The Trust is developing a one year plan initially (November) and will then draft a three year plan.~~ One year plan submitted November 2023. Three year plan in development.	CFO	~~September~~ November 2023	~~New Action~~ In progress
	Develop a new Finance and Commercial Development Substrategy	CFO	April 2023	~~New Action~~ Complete
6	Implement the recommendations from the HFMA Sustainability Report regarding CIP processes	CFO	July 2023	~~New Action~~ In progress

Risk 004	Date risk identified April 2023	Date of last review:	December 2023
Risk Title: Operational Performance If the Trust does not deliver its agreed weighted (based on 2019/20) levels of activity, then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	Leadership
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Operating Officer

Linked Operational Risks (15+ or new risks only)				Consequence	Likelihood	Rating
43	If current capacity constraints and service / pathway inefficiencies continue then there is risk of a deterioration of Trust performance against national access standards and waiting times, patient experience indicators and staff satisfaction.	~~12~~ 16	Initial	Major	Possible	
				4	3	12
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	Current	Moderate	Possible	
				3	3	9
971	If current demand and capacity restraints within the WCFT Pain Service and regionally continue, there is a risk of the Pain Service not being able to successfully fulfil the function and requirements that it is commissioned for.	~~16~~ 15	Target	Minor	Unlikely	
				2	2	4
Risk Appetite		**Cautious**				

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Patients will wait longer for 1st and follow up appointments – which could result in harm or lead to poor patient experience. - Referral to treatment standard (RTT) / average wait pilot standard will not be met. - Cancer standards will not be met. - Diagnostic standards will not be met. - +52 week wait standard will not met - Financial sanctions for not meeting targets to receive Elective Recovery Fund allocation - Reputational impact - If ERF not received, impact on system finances as well as Trust finances may worsen reputation in ICS	- Average Wait Performance - Overdue Follow up waiting list in Neurology - Reduction in overall activity due to the impact of Covid-19 - IPC pathway control for electives - Increasing waiting list size - Volume of 52-week waiters - Increase in long waiters following the transfer of spinal patients now levelling off and 78 week waiters are now at zero - Good performance against trajectories – meeting ERF targets - Impact of further Covid variants on patient numbers, IPC requirements and staff sickness - Vacancies particularly in specialist roles and in nursing - Cancelled operational activity - Delay in patients awaiting external beds - Uncertainty regarding potential industrial action from trade unions

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. ~~COVID-19 Recovery Plan Phase 3~~ Elective Recovery Plan. 2. Performance Dashboard in real-time 3. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 4. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 5. Submission of Recovery and Restoration plans for 2022/23 6. Stretch recovery target set for 104% of 2019/20 activity 7. Daily COO-led performance catch up which focuses on performance targets and addressing issues that may impact on delivery such as operating list cancellations 8. Divisional recovery plans 9. +52 week recovery plan through to April 2024 10. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners. 11. All 52-week plus waiters have been clinically reviewed and validated 12. Rapid Access Neurological Assessment (RANA) supporting system partners 13. Staff wellbeing programme 14. Regular meetings with specialist commissioners and partners re Thrombectomy to escalate ~~initial~~ issues e.g. ambulance response times 15. Waiting List Initiatives and additional hours worked over contracted 16. Business continuity plans being reviewed for industrial action 17. New performance guidance released January 2023~~-~~4 18. Implementation Plan and Theatres Refurbishment Steering Group in place to mitigate risks from capital works 2023-27	1. ~~Covid-19 Recovery Plan~~ Elective Recovery Plan. based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviours / compliance. 2. Reliance on other organisations capacity to provide services 3. Industrial action started in December 2022 and remains ongoing despite the agreement of a settlement by some unions 4. Lack of clarity regarding referral to treatment future targets 5. Impact of mutual support work not fully known. 6. Implementation of Patient Initiated Digital Mutual Aid System (PIDMAS) November 2023 may worsen RTT position. 7. EPRR arrangements judged as non-compliant by system (November 2023) 8. .

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily performance review with Divisions Weekly monitoring of performance of RTT and long waits ~~– improvement in 52 and 104 week waits~~ Weekly Finance and Performance Meeting	1. Thrombectomy demands on staff rotas 2. Transfer of Thrombectomy patients to and from the Trust in a timely manner ~~3. Sickness of critical staff~~ 4. Recruitment and retention of key staff and succession planning

Divisional Performance Management Review Meetings – quarterly Daily monitoring of critical staff absences at Huddle Live monitoring of performance dashboard **Level 2** Activity reported monthly in Integrated Performance Report (IPR) to Trust Board Workforce metrics on turnover, vacancies and staff sickness reported bi-monthly in IPR to Board and Business Performance Committee New Finance and Performance Executive led Committee established **Level 3** Meetings with Commissioners – monthly Internal Audit review of Waiting List Management - April 2022 System review of 52+ week waiters – April 2022 Check and challenge sessions with ICS on operational and workforce plans	5. Challenging follow up outpatients target, to reduce by 25% 6. Challenging activity plan set for 2023/24

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Implementation of ~~Covid-19~~ Elective Recovery Plan to increase activity – plan is in progress and progress monitored through BPC.	COO	~~Sept 2022~~ ~~March 2023~~ April 2024	In progress
2	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue. NHSI pilot ongoing. UPDATE: No further update and not included in new guidance released January 2023. Focus remains on long waits, cancer performance and diagnostic performance.	COO	~~March 2022~~ ~~March 2023~~ tbc	Pilot Extended
3	Job Planning for new spinal consultants for 2022/23	MD	September 2023	~~On track~~ Complete
4	Overdue follow up waiting list is to be monitored by the division by undertaking a validation exercise and a review of the patients to determine which patients can be moved over to PIFU. Dedicated project manager in post from May 2022 Update of progress was presented to the executive team in October 2022/ April 2023 and to BPC November 2022/ April 2023. Update Nov 2023: work has been hindered by diversion of resource to industrial action planning. Update March 2024: Plans to recommence this work with a revised proposal being developed.	COO	~~November 2022~~ ~~April 2023~~ ~~September 2023~~ March 2024	Ongoing
5	Thrombectomy working group to review at 6 month point to address any ongoing issues and report to Executives – UPDATE paper to executives in September 2022- requires further work. Due in June 2023.	COO	~~June 2022~~ ~~July 2022~~ ~~September 2022~~ ~~March 2023~~ ~~July 2023~~	~~On track~~ In progress
6	Following Benefits Analysis Review Thrombectomy next steps business case to be presented to Execs in December 2023	CPO	December 2023	~~New Action~~ Complete

Risk ID: 005	Date risk identified	April 2022 *(revised April 2023)*	Date of last review:	December 2023
Risk Title: Leadership Development If the Trust does not provide the right culture, environment or opportunities for staff to develop, learn and progress the organisation will not have well led services or experienced staff. This will reduce the Trust's ability to provide well led, high quality services and this could lead to poor staff experience, higher vacancy rates and the requirement for additional resource to recruit and train new staff.			Date of next review:	April 2024
			CQC Regulation:	Regulation 18 Staffing
			Ambition:	Leadership
			Assurance Committee:	Business Performance Committee
			Lead Executive:	Chief People Officer

Linked operational risks				Consequence	Likelihood	Rating
~~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 patient care, patient safety, the achievement of CQC standards and regulatory requirements.~~	~~12 8~~	Initial	Major 4	Likely 4	16
			Current	Major 4	Possible 3	12
			Target	Major 4	Possible 3	12
Risk Appetite		**Open**				

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Reduced staff morale - Staff Turnover increases - Gaps in workforce will include hard to fill specialist roles - Costs of recruitment and training - Business continuity - Reputational damage - Sickness increases if vacancies increase - Staff capacity to attend training and development and complete annual appraisals	- Staff Turnover - Vacancy Levels - Sickness Absence - Statutory and Mandatory Training metrics - Quarterly Pulse Survey results - Feedback from staff engagement sessions - Appraisal Rates - Lack of engagement with national development opportunities - Staff Survey responses - Study Leave take up
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Mandatory Training Annual Cycle – now includes Oliver McGowan training for all staff 2. People Substrategy 2022-25 3. Regional Workforce Plan 4. Health and Wellbeing Strategy approved June 2022 5. Wellbeing Guardian in post 6. Staff Survey /Action Plan 7. Partnership working with universities to recruit newly qualified staff 8. Regional collaborations e.g. International Recruitment 9. WCFT Health and Wellbeing Programme 10. National Nursing Bursary – 2020/21 11. Hybrid training models developed to enable ongoing delivery of training with social distancing 12. Monthly deputy's engagement sessions 13. Annual Training Needs Analysis 14. E-rostering 15. Senior Leadership Team meetings held in Neurology and Neurosurgery 16. Aspiring ward manager programme started 2022 17. Building rapport for managers programme relaunched September 2022 and repeated annually 18. Triumvirate leads development programme to start early 2023 – restarted September 2023 through AQuA 19. Investors in People Action Plan 20. Mental Health First Aiders – support and training programme 21. New People Substrategy 2022-25 approved at Board February 2023 22. Catch up programme for Deputies who did not complete first cohort 23. Listening activities in place i.e. Join Jan, TEA engagement sessions, NED/Executive walkrounds. 24. Sickness Controls Internal Audit demonstrated good processes and policy in place. Rolling programme of sickness controls internal audit. 25. Civility training Programme completed ~~in place for all staff groups~~ 26. Building a Culture of Conscious Inclusion. Train the trainer programme started Autumn 2023. 27. Succession Planning process established 2023 28. Back to Floor programme for Execs completed 2023/24.	1. Sickness levels ~~including Covid~~ leading to pressures on workforce to cover and training and development can be seen as lower priority 2. Celebrating successful development outcomes 3. Consistent development offer for bands 2 to 4, particularly use of apprenticeships 4. Consistent national shortage in some staff groups e.g. ODP, IT, nurses 5. Lack of consistency across system in application of Agenda for Change staff pay bands 6. Inconsistent application of return to work interview processes highlighted in internal audit sickness controls audit despite completion of recommendations

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 W~~orkforce control Panel – weekly	1. Delivery of National People Plan

Staff training and development reports sent monthly to mangers Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events Staff Support sessions provided by NOSS as and when required HR\Finance\Nursing Vacancy renew meetings **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC (linked to People Plan) Quarterly Staff Pulse Survey Workforce report to People Group **Level 3** Outcomes of Staff Survey 2023. Investors in People Accreditation 2022~~2~~3 – Gold Status Investors in People Wellbeing Award 2022~~2~~3 – Gold Status Exit Interviews Review MIAA April 2022 Flexible working MIAA Review 2022 Sickness Controls MIAA Review April 2023 Shortlisted for Investors in People national Health and Wellbeing Award 2023	2. ~~Adherence to sickness processes in some areas as evidenced in MIAA internal audit report on return to work processes. Action plan in response to internal audit review April 2023 due to be completed by October 2023.~~

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Deliver a leadership development programme with AQuA for divisional management. UPDATE: Agreed triumvirate training from early 2023 (dates being sought) with Action Learning Sets to follow. Launched February 2023 due to complete June 2023 Update May 2023: Two people left so programme paused, new dates have been set. September 2023: Programme restarted, due to complete January 2024. Due to changes in senior leadership agreed to restart in April 2024.	CPO	~~September 2022~~ ~~Feb/Jun/Oct2023~~ ~~January 2024~~ July 2024	In Progress
2	Roll out of new Exit Interviews Process for Leavers	CPO	April 2023	~~New Action~~ Complete
3	Succession Planning Tool for Business Critical Roles to be completed as part of 2023/24 business planning process. Update May 2023: Launched with managers who are now producing plans by 30 June, verbal report to BPC by November 2023. End of year report due to BPC in March 2024, full compliance with completion of reviews remains an issue.	CPO	~~April 2023~~ ~~July 2023~~ ~~November 2023~~ March 2024	~~New Action~~ In progress
4	In some areas where healthroster has been implemented sickness processes are not being followed consistently therefore action plan in place to address recommendations in internal audit report (April 2023). Quarterly audits to be reestablished and completed.	CPO	September 2023	New Action
5	Middle Managers Training to be developed focused on setting culture, values and behaviours to be completed. March 2023: Reviewed following IiP feedback. Values driven leaders programme to be developed by June and start delivery by September.	CPO	~~December 2023~~ September 2024	~~New Action~~ In progress
6	Preparation for three yearly Investors in People and Health and Wellbeing standards.	CPO	November 2023	New Action
7	Develop back to the floor programme for Executive Directors.	CPO	~~September 2023~~ January 2024	~~New Action~~ ~~In progress~~ Complete
8	Develop a training offer for bands 2-4.	CPO	September 2024	New Action

Risk ID: 006	Date risk identified April 2022	Date of last review:	December 2023
Risk Title: Prevention and Inequalities If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Social Value: Supporting local communities and staff
		Assurance Committee:	Health Inequalities & Inclusion Committee
		Lead Executive:	~~Chief Executive~~ Chief People Officer

Linked Operational Risks				Consequence	Likelihood	Rating
	None scoring 12 or above.		Initial	Major 4	Possible 3	12
			Current	Moderate 3	Likely 4	12
			Target	Moderate 3	Unlikely 2	6
Risk Appetite	**Open**					

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor patient outcomes - Deteriorating staff morale and wellbeing - Unable to retain staff - Reputation of Trust - Financial cost of staff leaving - Loss of goodwill and staff engagement - Fluctuating capacity and disruption to services - Failure to adapt to the changing health needs of the population - Failure to achieve duty to improve population health outcomes - Increasing pressure on services due to increasing acuity of patients - Loss of trust with local communities - Increase in violence and aggression towards staff - Inequitable patient waits for treatment - Delivery of the recommendations in the Marmot Review	- Variance in outcomes for different socio-economic groups and those with protected characteristics - Aging Population - Deprivation Indices - Staff Survey Results - Incident Reporting - Vacancy/ turnover/ retention rates - Increase in long term sickness - Violence and Aggression incidents - Mandatory and Statutory Training compliance - Increasing waiting times for treatment following Covid-19 - Cost of Living Increasing in work poverty - Industrial Action
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Health and Wellbeing Strategy – approved June 2022 2. Health and Wellbeing programme 3. NHS Prevention Pledge adoption and action plan 4. Violence and Aggression Strategy - approved April 2022 5. Trust signed up to the C&M Health and Care Partnership Social Value Charter – May 2022 6. Trust signed up to the C&M Health and Care Partnership Anchor Institution Charter – June 2022 7. Founder member of Liverpool Citizens 8. Weekly operational monitoring of waiting list 9. People Substrategy 2022-25 approved at Trust Board in February 2023 10. Wellbeing Guardian 11. Member of the Everton Minds Partnership Committee 12. Trust Sustainability Plan 2022-25 in line with the C&M Integrated Care System Green Plan 2022 13. Review of performance data against indices of deprivation completed 2022 14. NHSE CORE20PLUS5 Ambassador Programme lead identified. 15. Violence and Aggression Lead in post. 16. NHS C&M Prevention Pledge - 12 of 14 priorities being delivered against 17. Health Inequalities and Inclusion Board Committee established 18. New ED&I lead in place 19. Executive Lead for Health Inequalities confirmed as Chief People Officer	1. Health Inequalities and patient access strategic plan 2. National issue with complex long-standing causes that cannot be easily turned around 3. Liverpool population recognised as area of high deprivation 4. Strategic plan for health inequalities 5. Development of health inequalities performance data 6. Move to population-based commissioning may reduce funding available for some geographical areas 7. Two of 14 HS C&M Prevention Pledge priorities cannot be progressed by any Trusts due to third party issues.
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Health, Safety and Security Group – quarterly review of Violence and Aggression data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – every two months Violence and Aggression Group – every two months People Group – every two months Anchor Institution Group – quarterly **Level 2** Quality IPR – Quality Committee – monthly Workforce IPR – BPC – monthly	1. Agreed KPIs for measuring patient access and outcomes against deprivation index 2. As only neuroscience provider Walton Centre will have a high proportion of highly complex patients with associated behavioural challenges ~~3. Limited ED&I reporting to Board/Committees since ED&I lead left~~

Board oversight of progress against NHS Prevention Pledge Quarterly Pulse Survey Staff Partnership Group with Trade Unions Health Equalities report into Health Inequalities and Inclusion Committee Bi-annual update on Violence and Aggression work to Board **Level 3** Annual Staff Survey results CQC Inspection Report 2019 Investors in People - Gold accreditation for 'we invest in wellbeing' standard - annual reaccreditation received in ~~June 2022~~ December 2023 Investors in People Gold accreditation for 'we invest in people' standard - ~~annual reaccreditation received in January~~ maintained in December 2023. Veteran Accreditation achieved 2022 Silver Employee Recognition Scheme for Armed Forces achieved 2023.	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	To work with partners to establish a Citizen's Panel for Liverpool UPDATE pre-founding assembly 30 November 2022. Launch March 2023 February 2023 Update: Founding Assembly delayed until September 2023 to enable member organisation recruitment target to be achieved. Trust ED&I Leads identified to support engagement work. September 2023 Update: Founding launch deferred until spring 2024. Three workstreams have been established to support the Alliance progress to Founding stage. February 2023 Update: First listening campaign undertaken member organisations. Initial themes identified. Further listening being undertaken to identify testimony to progress to action/campaign. Actions being undertaken to progress from pre-founding to founding status to achieve thresholds for member organisations, investment and training. In the process of agreeing Chapter workplan for 2024.	CPO	~~October 2022~~ ~~March 2023~~ ~~Sept 2023~~ ~~May 2024~~ November 2024	In progress
2	To implement the Violence and Aggression Strategy. UPDATE: Report to Board April 2023 following new Lead arriving in post.	CN	April 2023	~~In progress~~ Complete
3	To implement the Health and Wellbeing Strategy. UPDATE: Health and Wellbeing Dashboard for monitoring agreed at BPC January 2023	CPO	April 2023	~~In progress~~ Complete
4	To achieve C&M Health and Care Partnership Social Value Award. February 2023 Update: The Trust has signed up as an early adopter site for the C&M ICB TOMs Framework which is a consistent set of metrics to measure social value activity. September 2023 Update: Key leads populating the portal over Q3 and Q4 of 2023/24 to provide baseline data to support application for Social Value Award in April 2024.	CPO	~~November 2022~~ ~~May 2023~~ ~~October 2023~~ April 2024	In progress
5	To achieve Social Value Business Quality Mark Level September Update: As per Action 4	CPO	~~November 2022~~ ~~May 2023~~ ~~December 2023~~ April 2024	In progress
6	To achieve Social Value Business Quality Mark. Level 2 can only be completed twelve months after Level 1 achieved as focuses on auditing the first year's activity of the pledges.	CPO	~~November 2023~~ ~~May 2024~~ May 2025	~~New Risk~~ In progress
7	To deliver against the 14 identified priority C&M NHS Prevention Pledge outcomes February 2023. Report to Board May 2023 12 of 14 achieved, remaining 2 will be challenging to achieve without third party lead and roll out of delayed mental health concordant, so action closed as partially complete.	CPO	~~December 2022~~ ~~March 2023~~ March 2024	~~New Risk~~ ~~In progress~~ Complete
8	To achieve NHS Veteran Accreditation (Silver Level) February 2023 Update: The Trust has signed the Arms forces Covenant and achieved bronze level. Working towards Silver accreditation. May 2023 Update: Reservist and Mobilisation Policy approved and on intranet.	CPO	June 2023	New Action Complete
9	To achieve LCR Fair Employment Charter Accreditation. February 2023 Update: The Trust has achieved aspiring status and is progressing towards accreditation. Update February 2024: no further update has been received from Liverpool City Region	CPO	~~December 2023~~ tbc	~~In progress~~ On hold
10	Develop further operational risks in regard to health inequalities and staff wellbeing that impact the strategic risk and add to Trust wide risk register.	CPO	~~November 2022~~ March 2023	~~New Risk~~ ~~In progress~~ Complete
11	Development of strategic plan for health inequalities work. May 2023 Update: awaiting NHS England guidance statement on Health Inequalities in order to agree strategic approach (to be published this summer). Statement on information on health inequalities published November 2023 and presented to HIIC March 2024.	~~CEO~~ CPO	~~March 2023~~ ~~March 2024~~ June 2024	~~In progress~~ ~~On Hold~~ In progress
12	Further development of performance indicators for health inequalities in divisions May 2023 Update: Review of other IPRs completed, work being progressed as part of outpatients transformation as focus is on non-attendance. Update March 2024: DrDoctor implemented in February 2024 which will create a profile for all patients to target patients who do not attend, this will include reminders of appointments and self-scheduling of appointments.	COO	~~February 2023~~ March 2024	In progress
13	Deliver services to people living with dementia, their families and the wider community closer to home and to hard-to-reach communities through the Everton in the Community Health Zone Development. Update February 2023: Initial scoping of the Trust's potential service offer undertaken. Updated Memorandum of Understanding signed off. Building due to start in 2025	CPO/IM	~~March 2024~~ March 2026	New Action
14	Expand exercise and wellbeing services tailored for people who have a neurological condition, into the community through the Access to Exercise and Wellbeing Programme. 3 year lottery funding secured to support the project. September 2023 Update: Referral portal on NTC website has gone live enabling patients and healthcare professionals to refer into the service. Engagement sessions being held with Specialist Nurses and Therapies teams to launch the service and comms being developed to raise awareness. February 2023 Update: The Brain Charity has joined as a programme partner following their gym development. Further funding being sought from Community National Lottery funding to expand the service into North Wales. Two Walton patient representatives have been identified to join the Steering Group.	CPO/IM	March 2026	~~New Action~~ Ongoing
15	Real Living Wage Organisation February 2023 Update: Trust aspires to be a real living wage organisation. Discussions being held regarding a whole system approach being taken. May 2023 Update: Achieved as new pay settlement brings lowest band above threshold	CPO	March 2023	~~New Action~~ Complete

16	Review of SBAC February 2023 Update: Potential widen remit to include health inequalities, social value and ED&I. Briefing taken to Executive Team Meeting in January 2023 and consultation with SBAC members in progress.	CS	April 2023	~~New Action~~ Complete

Risk ID: 007	Date risk identified April 2022	Date of last review:	December 2023
Risk Title: Capital Investment If the Trust does not maximise its opportunities to acquire capital funding, then it may not have enough resource to deliver its estates and wider strategies and provide a fit for purpose environment for staff and patients leading to poor staff morale, poor patient experience and the risk of increased backlog maintenance		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	Value for Money
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Finance Officer

Linked Operational Risks		
323	Aging Theatre air handling units (AHU) are performing at below the recommended level of air changes per hour in five theatres. If the AHU fail, the department would be unable to run a Theatre list resulting in cancelled operations and impacting patient experience.	12
220	If the theatre lights fail and repairs cannot be conducted/ completed there is a risk that the theatre will be unusable for surgery and if flaking paint falls from the theatre lights there is a risk that this could contaminate the sterile area during surgery.	~~16~~ 12
~~1026~~	~~If a surgical microscope were to develop a fault and require repair then we would not have a spare microscope to replace it in the operating theatre. This would result in a theatre not being able to conduct procedures that require a microscope and also impact patient care and safety.~~	~~16~~
Risk Appetite	**Moderate**	

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where are we failing to put controls/systems in place?
1. Capital Management Groups reviews specific capital risks and all capital business cases – Executive Chair 2. Capital Risk Register 3. SFIs/SORD have appropriate approval levels for capital expenditure so CFO / COO are sighted on expenditure 4. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc. 5. Executive led capital prioritisation with operational finance and clinical staff 6. Monthly reporting of capital expenditure to Board 7. Estates, Facilities and Sustainability Substrategy approved by Board March 2023 8. Operational Plan ~~submitted~~ for 2023-24 complete 9. Revenue and Capital budgets - Ongoing 10. Costed Backlog Maintenance Register and Programme - updated May 2022 11. Estates related policies • Electrical Safety Policy: 2021-2023 • Water Management Policy: 2021-2024 • Fire Safety Policy: 2019-2022 • Control and Management of Contractors: 2021-2024 • Health & Safety Policy: 2022-25 12. Contractual agreements with specialist contractors 13. Water Management Action Plan inc. Legionella actions 14. Premises Assurance Model – completed 2021 15. Heating replacement scheme Phase 5 started 16. Sustainability Plan in place and Sustainability Lead ~~appointed in April 2023~~ now in post 17. Mutual aid agreed for theatre use during refurbishment project with LUHFT 18. Radiology Reconfiguration proposal case worked up and ready – pending opportunities for funding	1. Further work on capital risk register to ensure estates risks recognised 2. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend 3. Some capital items are not specified in detail and therefore there is an ability for teams to substitute items in year which means capital spend is difficult to prioritise 4. Limitations of ICS approach to capital allocations 5. Reliance on specific items which cause delays if not available 6. Priorities may change in year which may lead to pressures against the plan 7. Market prices may differ from estimates once equipment is purchased 8. Clarity of how future revenue costs associated with capital and digital investment will be funded in the long term. 9. High levels of inflation are increasing capital costs 10. ~~Policies require review to ensure that they are reflective of current legislation~~ 11. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 12. System capital management leaves little flexibility for Trust to invest surplus cash 13. Programme for Pipework replacement incomplete 14. The national Premises Assurance Model (PAM) outcomes 15. Service Level Agreement (SLA) with LUFHT due review 16. ~~Impact of IFRS16 accounting regulations on CRL, regarding treatment of leases from 2022/23 financial year, is not yet clear and could affect capital allocation~~ 17. Substantial waiting times for certain components/goods since Covid. 18. SLA with LUFHT last reviewed in 2016. 19. Electrical Policy listed in key controls is overdue for review. (Review is completed but not yet published).

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular reforecasting of capital position and discussion at Capital Management Group Daily Safety Huddle Water Safety Group – reporting into IPC Committee Health & Safety Group Contract review meetings with LUHFT – monthly ~~Heating and Pipework Project Board – monthly~~ Medical Devices, Estates and Facilities Group (6 per year) Theatres Refurbishment Group established January 2024 **Level 2** Capital Programme approved by Trust Board Working group to review capital prioritisation programme Monthly updates received by BPC and Trust Board on capital BPC and Board approve higher value business cases as per SORD Estates Strategy monitored by BPC and updates received Mini PLACE assessment July 2023 **Level 3** 6 Facet Survey – updated May 2022 CQC Inspection Report Aug 2019 Fire Brigade post-incident review of Fire Processes - 2019 Annual ERIC Returns – Submitted June 2022 Reinforced Aerated Autoclaved Concrete (RAAC) review 2021 Premises Assurance Model (PAM) Assessment 2021 PLACE Assessment 2022	1. Allocations are system based from ICS so no longer freedom to generate surplus to spend on capital priorities 2. Timeliness of national/ system decisions of additional/one-off allocations of capital reduces the time in which it can be spent as cannot be carried forward into future years 3. Limited LUHFT planned maintenance/KPI reporting in place 4. Lack of reporting of sustainability data / KPIs. Sustainability lead is now in post and will develop these. ~~post now approved to lead this work. Now appointed to start in summer.~~ ~~5. Proposals for replacement of air handling units for Theatres 1-5 is being worked up – currently costs unknown~~ 6. Risk of failing to spend full budget in year due to delays in goods arriving and operational pressures 7. PLACE Assessment identified areas where Trust is performing below peers.

	Corrective Actions: **To address gaps in control and gaps in assurance**	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Internal desk top review of SLA with LUHFT before discussions with LUHFT. UPDATE delayed due to resource available. September 2023: This is now being reviewed as part of the Aintree Site Joint Site Sub-Committee Estates and Facilities workstream.	COO/CFO	~~September 2022~~ ~~February 2023~~ ~~September 2023~~ January 2024	In Progress
2	Work with NW specialist trusts on QIP work, to consider wider solutions for hard and soft FM. This work continues to progress with Soft Facilities Management Services being tackled in 1st wave. Since agreeing new contract with ISS this action is no longer relevant to be closed.	COO	March 2023	Delayed
3	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring with LUHFT via monthly meetings. Estates are currently reviewing resource and cost impacts in advance of recommendation. UPDATE: ~~March 2023 Lack of resource to progress this.~~ Update May 2023: Business case for Estates and Finance restructure to be submitted for approval to keep service in house September 2023: This is now being reviewed as part of the Aintree Site Joint Site Sub-Committee Estates and Facilities workstream.	COO	~~September 2022~~ ~~August 2023~~ January 2024	In Progress ~~Delayed~~
4	WC Estates Strategy to be incorporated into wider "system" strategy currently being led by LUHFT.E&F Substrategy approved by Walton Centre Board in March 2023. Update May 2023: Aintree Site Strategy in place but currently no plans in place for an ICS system strategy so action closed.	COO	~~September 2022~~ ~~March 2023~~ May 2023	In Progress
5	Ongoing monitoring of Phase 5 Heating and Pipework Programme. Due to start in June 2022.	COO	March 2023	~~Ongoing~~ Complete
6	Award of contract for upgrade works to Theatres 1-5 due to non-compliant Air Handling Units. Estates Working with procurement to adopt best solution. ~~UPDATE January 2023: Executive team to review impact of the air handling unit work by April 2023~~. Update May 2023: Paper approved for pre-construction phase and permission to proceed to full tender stage. Update September 2023: Contractor award due early October. Following this, contract award paper to be developed. January 2024 paper to board to progress with the first phase of the project phase 1 which covers theatres 4&5 and is due to commenced 15 February 2024.	COO	~~January 2023~~ ~~July 2023~~ January 2024	~~In progress~~ Complete
7	Proposals ready "on the shelf" for any additional capital funds that may become available in year based on Trust's priority criteria. Radiology / fluoroscopy business Case developed and hase been submitted in January 2024 for Transformation Investment Funding (TIF) capital funding.	CFO	~~September~~ December 2023	~~New Action~~ Complete

Risk ID: 008	Date risk identified: April 2023	Date of last review:	December 2023
Risk Title: Medical Education Offer If the Trust does not effectively manage the increase in demand regionally and nationally for its Medical Education offer, then the Trust will not meet its strategic ambition to offer a national medical education training programme in Neurosciences.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Medical Director

Linked Operational Risks		Consequence	Likelihood	Rating
	None scoring over 12	**Initial** Major	Likely	
		3	4	12
		Current Moderate	Possible	
		3	3	9
		Target Minor	Unlikely	
		3	2	6
Risk Appetite	**Open**			

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• Failure to achieve key strand of Trust's Strategic ambition as leading in education. • Inability to grow beyond current student / trainee establishment numbers and risk current and future HEE/DHSC income streams for medical education • Failure to build on Trust's external reputation as centre of academic excellence and subsequent ability to attract highest calibre undergraduate and postgraduate medics • Failure to take advantage of opportunity to grow education offerings outside of HEE training programmes • Challenges in attracting medical staff with a specialist interest in medical education • No obvious trajectory for developing future educationalists • Failure to invest in new and emerging means of delivering education through technology enhanced learning. • Failure to consider alternative and new professional roles in the delivery of medical education.	• Difficulties recruiting to internal lead educator roles • Limited capacity within current physical resource as it is presently utilised • Challenge in managing competing pressures of clinical service delivery and dedicated student support/supervision time. • Human resource capacity limited with regards to hosting elective/observer programmes, numbers capped due to capacity of clinical supervisors • Formal plan not yet in place to deliver national programme, activity has been ad hoc. • Technology Enhanced Learning programme in its infancy, infrastructure to be established to support implementation / expansion • Growth in interest from medical schools in North West /North Wales and pressure to lead on delivery of Neuroscience medical education for programmes in addition to University of Liverpool – competition for WCFT resource. • Growth in international medical graduates and locally employed doctors beneath Consultant requiring educational/training and pastoral support

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 Group and clear reporting line to the Board of Directors via to Research, Innovation and Medical Education (RIME) Committee 2. Lead educator roles established with Director of Medical Education (DME) engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and meets at least bi-monthly. Clinical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed 6. SOPs have been created to standardise and assure processes 7. New structure for delivery of education was consolidated in 2021 8. Consultants are now formally recognised for undergraduate educational supervision and remunerated through job planned activities 9. Education Clinical Fellows and other education leads (consultant) roles embedded – Education Appraisal Lead, Student Research Projects, provide a diffused, sustainable network of educational support. ~~10.~~ Trust educators being supported to apply for honorary clinical appointments with University of Liverpool. ~~DME awarded Honorary Associate Professorial title (December 2022)~~ 11. Guardian of safe working quarterly report to Board 12. Deputy Director of Medical Education and Educational Assessment Leads in place 13. Membership of University Hospitals Association achieved 2023 14. People Substrategy 2022-25 in place including Medical Education 15. Edge Hill new cohort of medical students to start from June 2024.	1. Plan for a national programme of Walton branded medical education training events is not currently in place although there has been delivery of three national training events organised through Trust consultants 2. Assessment of resource required to develop and deliver national offer in terms of infrastructure, staffing, marketing needs to be undertaken 3. Workforce planning has to consider impact of AI and how doctors future roles/education needs will change 4. Plans to manage increased medical student numbers and implications of NHS Long-term Plan are being led by regional workforce leads 5. Medical Education staffing to deliver strategic objectives 6. Professional and pastoral support for trust employed specialty and associate specialist, international medical graduates and locally employed doctors needs to be strengthened

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 Group • Medical Education Action Plan • Medical Undergraduate Working Group • Junior Doctor Forum (held alongside Guardian of Safe Working)	1. Support from key strategic partners for national programme. 2. Governance for development of a national offer still to be developed and agreed. 3. Infrastructure is limited to support new and emerging work streams e.g. TEL and simulation

• SAS / LED Forum (including international medical graduate reps) **Level 2** • Medical Education Quarterly and Annual Reports to RIME Committee • HEENW Annual Education Return Board report • End of Placement Feedback – Undergraduate • Placement Exit Survey – Postgraduate • Six monthly updates to RIME Committee **Level 3** • GMC National Training Survey – Postgraduate Trainee and Trainer • UoL Clinical Undergraduate placement RAG reports • Annual Education Self Assessment Report - UoL • Annual Education Self-Assessment Report – HEENW • University Hospital Status October 2022 / Membership of University Hospitals Association • ~~# Trust staff with honorary clinical appointments~~ • ~~# Trust staff with GMC Trainer Recognition~~	4. Coordination and management of medical elective and observer placements based on historic admin process, no data to evaluate satisfaction or quality

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Review governance and financial costing of ~~foreign~~ student electives from overseas students and observers to support the national offering. Update September 2023: Task and finish group to be established to complete this action. Update Feb 2024: To be discussed in Medical Education Group at request of DME.	MD	~~May 2023~~ March 2024	In progress
2	Development of a policy on external Clinical Attachments for undergraduate and postgraduate learners Update September 2023: Policy complete, currently being reviewed through governance processes – due to RIME December 2023. Update Feb 2024: policy still to be approved.	MD	~~September 2023~~ ~~December 2023~~ June 2024	~~New Action~~ In progress.
3	Review resource required for Education Supervision if offer widened to other medical schools and demand increases Update September 2023: Financial case in developed to define financial need for supervision from income generated by medical students. Complete – this is part of business as usual activity	MD	~~August 2023~~ ~~December 2023~~	~~New Action~~ ~~In progress.~~ Complete
4	Engagement with strategic partners i.e. NHSE NW, C&M ICS, regarding national medical school expansion, contribute to regional discussion Update September 2023: Ongoing, need to agree target figures to fulfil requirements on long-term plan. Visits to Edge Hill and from UoL January 2024.	MD	~~September 2023~~ Ongoing	~~New Action~~ In progress
6	Review of Med Ed/ Training team ongoing (led by Senior Training Manager).	CPO	September 2024	New Action
5	Medical Education Strategic Implementation Plan to be developed and approved by RIME. Complete as part of People Substrategy.	CPO	September 2023	~~New Action~~ Complete

Risk ID: 009	Date risk identified: April 2023	Date of last review:	December 2023
Risk Title: Research and Development If the Trust does not develop a sustainable business model and strategy for research it will not attract the right staff or the research projects necessary for the Trust to become a world-class centre for Neurosciences and innovation		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Innovation and Research
		Assurance Committee:	Research, Innovation & Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks		
983	If the QMS does not function correctly, then there is a risk of non-compliance with the clinical trial directive and good clinical practice. This could cause issues with the reliability of the data or even cause patient harm. This could impact on the Trust's reputation and result in a loss of income.	12
938	938 - If a clearly defined financial management plan which outlines the principles underlying the costing and management of clinical research income, is not implemented within the Trust, then there is a financial risk as a result of activity not being costed accurately There is also a risk that individuals could become disincentivised to undertake research, if there is no clarity on how income will be dispersed / reimbursed.	9
Risk Appetite	**Open**	

	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

- Unable to recruit and retain the most ambitious clinical staff
- Unable to meet the Clinical Research Network targets
- Negative impact to Trust's reputation and ability to attract commercial sponsors
- Failure to attract the right research projects
- Unable to secure sufficient grant-based funding
- 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
- Financial model becomes unsustainable and unable to balance income streams, notably commercial income
- Inability to secure sufficient grant-based funding
- ~~Ineffective development of the research strategy, through a lack of awareness and mitigation of external macro-environmental influences and pressures~~

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

- ~~20 studies have been declined in the past two years (increase from 10)~~
- ~~29 studies in backlog which currently cannot be opened (consistent with 27 in 2022)~~
- ~~Ability to recruit consultants with research interests~~
- ~~Failure to recruit to trials~~
- ~~Unable to meet timelines for setting up studies~~
- ~~Delays in meeting recruitment targets~~
- ~~Not enough consultants who are engaged and interested in research studies and the potential benefits~~
- Unable to meet timelines for setting up studies
  - 2023/24 – current average for opening a study was 267 days compared to 225 days in 2022/23. However, the backlog of studies has now been decreased
- 2023/24, 28 studies have been opened, compared to 22 in 2022/23
- Failure to recruit to trials
  - 2023/24, 4 out of 11 open commercial studies have met or are currently meeting their recruitment targets.
- Delays in meeting recruitment targets:
  - In 2023/24 – average time to recruit the first patient into a trial is 47days – this is down from 76 days in 2022/23
  - 18 studies that have opened in 2023/24 that have yet to recruit a patient (or report their recruitment).
- Ability to recruit consultants with research interests
- Not enough consultants who are engaged and interested in research studies and the potential benefits. In 2023/24, 11 studies have been sent by CRN for 'Expression of Interest' with only 3 positive responses.

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

1. Research and Development Strategy 2019/24 (under review)
2. Defined audit plan for current financial year in place ~~CAPA (Corrective Actions Preventative Actions)~~
3. External peer review of WCFT protocols, sponsor studies in 2020
4. New partnerships with universities, other trusts and system level collaborations
5. Charitable funds allocation for research (recurring)
6. GCP (Good Clinical Practice) training for research active staff monitored
7. Portfolio meetings to review each trial offer
8. ~~'Rebooted'~~ Liverpool Health Partners including the Joint Research Office with agreed standardised reporting
9. Research contracts now in Edge database
10. Key Performance Indicators for research in place
11. University Hospital Status and membership of Associate Research Groups and Research and Development Directors University Hospitals Association Groups
12. SOP for feasibility study process in place
13. Quality Manager for Research (starts early ~~January~~ 2024)
14. Quality Improvement Plan for Research.

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

1. Implications of the NRC redesign upon the development/ implementation of strategic objectives. ~~Current R&D governance model unable to deliver research on a bigger scale~~. Benefits realisation of changes to NRC model have identified 4 areas which still require work:
   - Interdependencies between R&D department and delivery team need to be streamlined to avoid unnecessary delays to the start of studies
   - Needs to be a more proactive approach to workforce planning and to the recruitment of studies and resolution of barriers to recruitment
   - Further engagement to improve relationships with research active clinicians
   - Active horizon scanning for research opportunities
2. Clarity of purpose and roles in the emerging system infrastructure
3. ~~Income generation model approved but contracts to be negotiated~~
4. Review/development of principles for time dedicated to research
5. Prioritisation framework
6. Engagement with wider consultant body
7. Principal Investigators Training Plan
8. No specific strategy for research; current strategy ends in 2024.
9. Gap analysis has identified a number of Standard Operating Procedures (SOPs) are out of date and need an overhaul and testing of processes
10. Communications Plan for Research.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Principal Investigators Forum • Sponsorship & Governance Oversight Group • Research Capability Funding Group • GCP record • Monthly portfolio meeting to identify financial benefits or disbenefits of each trial • Quality Management Meeting **Level 2** • Research updates to RIME Committee • RIME Committee Chair's Key Issues Report to Board of Directors • Benefits Realisation of investment in NRC to HMG in February 2024 **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019 • Kings College external review of NRC 2020	1. Organisational change and service redesign still in implementation phase, impact to be assessed 2. Standard Operating Procedure required for the setup of studies to ensure consistency 3. Expression of interest process does not chase responses where no interest 4. Time to explore quality issues with research projects 5. Understanding of ideal research portfolio mix for trials 6. Full understanding of money flows in and out of NRC 7. Principal Investigators Forum is not meeting regularly as attendance is poor. 8. External accreditation of Quality Assurance Systems 9. Finance Management Plan, principles agreed but final plan needs to be signed off.

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Head of NRC to support with a review of governance practices including audit action plans and developing the administrative capabilities to support research on a bigger scale. UPDATE: Complete except administrative support – pending HR process	CDRD	~~Apr/Aug/Nov 2022~~ ~~February 2023~~ March 2023	~~On track~~ ~~In progress~~ Complete
2	Strengthen links and collaborate with key local research partners such as universities to clarify NRC place in external local system. UPDATE: LHP disbanded, system change has delayed progress. Closed as action as engagement is ongoing.	CDRD	~~Oct/Dec 2022~~ April 2023	~~In progress~~ Complete
3	Develop plan to promote research agenda with patients, carers and staff. UPDATE: To review at RIME March 2023. Further work required to understand finances. Update September 2023: Communications plan being developed. March 2024: Drafted and going to Research Governance Group in March for sign off.	Head of NRC	~~Jan/Mar/Dec 2023~~ June 2024	In progress
4	Develop SPAs framework for research activity using medical education model. Update September 2023: work is ongoing. Update March 2024: This will form part of the research Strategic Implementation Plan.	CDRD	~~Jan/Jun/Sep 2023~~ ~~January 2024~~ September 2024	In progress
5	Develop R&D operational risks impacting the strategic risk and add to Trustwide risk register. UPDATE: In process of being finalised.	CPO	~~November 2022~~ February 2023	~~New Action~~ ~~In progress~~ Complete
6	Requirement to understand internally and externally managed research financial flows in and out of the Trust. Update Sept 2023: Internal flows are understood and progress made to identify and process invoices appropriately. External flows require further work. Update March 2024: Financial Management Plan drafted, in the process of being approved.	~~CFO~~ CFO	~~March 2023~~ ~~October 2023~~ ~~March 2024~~ April 2024	~~New Action~~ In progress
7	Research KPIs to be developed.	CPO	November 2023	~~New Action~~ Closed
8	Quality meeting to be established as a subgroup of the Research and Sponsorship Group	CPO	November 2023	New Action Closed
9	Shared set of research priorities to be developed with UoL to underpin the new research partnership. Update September 2023: 2-day meeting with UoL 30/31 October took place with shared agenda and ambition agreed.	CPO	~~July 2023~~ November 2023	~~New Action~~ Complete
10	Invest in joint research posts with UoL. Update September 2023: Investment agreed, governance to be agreed through a MoU. Update March 2024: MoU drafted with plans to launch publicly in March 2024. Funding secured. Posts to be agreed in 2025/26.	CPO	~~November 2023~~ ~~December 2023~~ March 2024	~~New Action~~ In progress
11	Achieve QMS external accreditation ISO9001. Update September 2023: Supplier selected to support process. To be taken forward by new Quality Manager (from January 2024) with action plan to be in place from February 2024. Update March 2024:Visit in February and a full action plan is now being developed. September deadline remains realistic.	CPO	September 2024	~~New Action~~ In progress
12	Develop a Strategic Implementation Plan for Research and Development. Update September 2023:Included in People Substrategy	CPO	October 2023	~~New Action~~ Closed
13	Review had identified that all SOPs need reviewing and putting into new templates, some SOPs will need to be redone.	Head of NRC	September 2024	New Action

Risk ID: 010	Date risk identified: April 2023	Date of last review:	December 2023
Risk Title: Innovative Culture If the Trust does not develop a culture where staff are able to innovate, develop solutions and put patient care first then it will not attract external funding and the right staff to support the ambitions of the Trust.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief Executive

Linked Operational Risks		
~~989~~	~~If there is insufficient knowledge at Board/senior management level to lead and develop the organisation's innovation agenda this would restrict the Trust's ability to deliver on its innovation ambition due to a limited level of maturity and lack of innovative culture~~	~~12~~ 9
Risk Appetite	**Adventurous**	

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

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Not continuing to be at the forefront of innovative neurosciences treatment to improve patient care - Inability to retain or attract clinical staff if unable to fulfil their innovation ambitions - Insufficient workplace capacity and resourcing to ensure innovative practices, treatments and boundary scanning - Risk aversion and complacency - Innovations will not be fully implemented, acknowledged and celebrated - Reputational impact - External scrutiny e.g. CQC well led	- National Staff Survey ~~2022~~ themes; wellbeing, development and reward and recognition - Limited understanding of culture and sub-cultures in Trust - Lack of staff and leadership engagement - Insufficient succession planning or development opportunities in innovation

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Innovation Strategic Implementation Plan 2022-25 approved by RIME Committee in December 2022 2. Innovation Pipeline review completed November 2022. 3. Innovation Group Terms of Reference approved by RIME Committee in December 2022. First meeting in March 2023 4. Innovation Lead in post 5. Investors in People Gold accreditation for 'we invest in wellbeing' standard - reaccreditation received in December 2023 6. Investors in People Gold accreditation for 'we invest in people' standard - annual reaccreditation assessment maintained in December 2023 ~~full three yearly reaccreditation due~~ November 2023 7. Pulse and National Staff Surveys 8. Staff 'TEA' (talk, engage, action) sessions with Executive Team 2023 9. 'Join Jan' bi-monthly staff engagement sessions with CEO 10. Board Effectiveness Review April 2023 included responses from staff about innovation 11. Financial and Commercial Substrategy approved by Board April 2023 12. Project Management Office now established 13. Innovation Communications plan in place and implementation started 14. Staff engagement sessions held with patient engagement sessions to follow in October 2023 and open innovation sessions to commence at the end of September 2023 15. Patient representatives identified for the majority of innovation project groups and Patient Forum being established. 16. Horizon Scanning Development Session held with Board and Senior Managers June 2023.	1. Clinical and corporate divisional engagement of; internal initiatives, spread and adoption of external innovations and address risk aversion 2. Workforce capacity to have time to develop and implement initiatives 3. Competitor Analysis to be completed 4. Ongoing resource for permanent staffing for innovation

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

• RIME Committee Chair's Report to Trust Board and Council of Governors • Executive Team approval of innovation business cases • Trust Board and HMG endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • Member of LHP SPARK Innovation Forum • Innovation cited in CQC Inspection report 2019	10. Consistent legal processes/ advice for more common realisation working arrangements

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Benchmarking assessment of innovation function via Investors in Innovations Standard aligned to ISO 56002 Innovation Management System – international industry standard. Update September 2023: 7 of 8 self-assessment submissions made with feedback received from the panel. Update February 2024: 8 of 8 self-assessment initial submissions made and panel feedback sessions held. Final submissions by end of March 2024 with panel presentation in April 2024. Stakeholder evaluation process to be undertaken by April 2024.	CPO	~~June 2022~~ ~~Tbc~~ ~~May 2023~~ ~~September 2023~~ ~~February 2024~~ April 2024	In progress
2	Develop innovation communication plan in line with Innovation Implementation Plan 2022-25	CPO	~~September 2022~~ ~~January2023~~ ~~February 2023~~ ~~April 2023~~ June 2023	Complete
3	Develop Innovation Risk Register Update November 2022: Meeting held with the Head of Risk further to which risk register is in development. Innovation operational risks to be identified in place of departmental risk register. Update February 2023: Innovation operational risks identified, agreed. Will be entered onto Datix system and included in the Trust's Operational Risk register therefore departmental risk register not required.	CPO	~~September 2022~~ ~~December 2022~~ March 2023	~~In progress~~ Complete
4	Five Year Workforce Plan Update November 2022: Annual review for 2022/23 undertaken and NHS England submission returned April 2023	CPO	~~December 2022~~ April 2023	~~In progress~~ ~~Ongoing~~ Complete
5	Single project management office established. Update November 2022: paper taken to Executive Team meeting on 14/11/22 on proposed model. Update February 2023: Consultation undertaken to create one strategic project management Office first shadow meeting 13 Feb 23.	ADO	~~December 2022~~ ~~January 2023~~ April 2023	~~In progress~~ Complete
6	Spinal Improvement Programme income generation model contracts to be finalised. Update January 2022: COVID added > 1 year delay due to resourcing and project complexities limiting progress. Contracting in progress. Update November 2022: Significant rewrite of contract required. Review of feasibility and capacity within the Neurosurgical division being undertaken due to staff changes. Update May 2023: Proposal taken to Executive Team to approve trial in Neurosurgery. Update September 2023: Pilot complete and contract signed. Evaluation of pilot now underway. Update February 2024: Pilot phase deemed a success, first reports sent to first customer (Medtronic). Contract signed. New action (11). SIP to be rolled out to three other customers from April 2024.	CPO	~~October 2020~~ ~~March 2021~~ ~~August 2021~~ ~~October 2021~~ ~~February 2022~~ ~~June 2022~~ ~~September 2022~~ ~~December 2022~~ ~~March 2023~~ ~~June 2023~~ December 2023	~~Delayed due to COVID~~ ~~On track~~ ~~In progress~~ Complete
7	Innovation included within the staff engagement surveys. Update November 2022: Review of outcomes from the relevant sections of the national NHS Staff Survey to be undertaken when received in March 2023. Update May 2023: Agreed to early to include in surveys – action closed. Relevant sections of current responses to be reviewed through innovation lens.	CPO	~~September 2022~~ ~~March 2023~~ June 2023	~~In progress~~ Complete
8	Competitor analysis to be initiated and presented to Trust Board Update November 2022: Competitor analysis being undertaken as part of the Commercial Substrategy Update February 2023: Finance and Commercial Substrategy due to go to Trust Board for approval in March 2023.	CFO	~~TBC~~ ~~(due to COVID-19)~~ ~~July 2022~~ ~~February 2023~~ March 2023	~~On hold~~ ~~Delayed due to COVID~~ ~~In progress~~ Complete
9	Development of Financial and Commercial Substrategy Update February 2023: Finance and Commercial Sub-strategy due to go to Trust Board for approval in March 2023.	CFO	~~November 2022~~ ~~February 2023~~ March 2023	~~In progress~~ Complete
10	Development of business case for minimum resource requirement for a sustainable innovation function. Due to Executives for agreement in November. Update February 2024: business case was endorsed by Hospital Management Group and supported by the Executive Team however, due to funding requirement was added to pressures list for 2024/25.	CFO	~~November 2023~~ ~~September 2024~~ June 2024	~~New Action~~ On hold
11	Spinal Improvement Programme Research. Plan to be developed for use of data to drive research.	CPO	September 2024	New Action

Risk ID: 011	Date risk identified: April 2020	Date of last review:	February 24
Risk Title: Cyber Security If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee (Audit)
		Lead Executive:	Chief Finance Officer (SIRO)

Linked operational Risks		
686	If the Trust encounters a cyber security incident, then there is risk of potential data breaches or malware attack.	12
684	If the Trust doesn't provide adequate security for hardware and clinical devices, then there is a risk of a potential cyber incident due to open public access.	12
685	If the appropriate Trust controls with regards to data are not adhered too, there is an increased risk of a data breach.	12
Risk Appetite	**Averse**	

	Consequence	Likelihood	Rating
	Major	Almost Certain	
Initial	4	5	20
	Moderate	Almost Certain	
Current	3	5	15
	Minor	Likely	
Target	2	4	8

Key Impact or Consequence

- Loss of operational capability and clinical disruption or a ransom which could have a significant impact on patient care
- 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?

NHS Cyber Alerts

Year	2024	2023	2022
Insecure Software	23	225	251
Vulnerability	2	4	33
Attack methodology		3	5

- **2 High Severity Feb 2024**
- **12 High Cyber alerts 2023**
- **14 High Cyber Alerts 2022**

- Cyber security attacks remain an issue, and ongoing high resource work is required to keep up to date
- Heightened Cyber level due to current world conflicts.

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 on an ongoing basis
2. Security Information and Event Management (SIEM) monitors all live systems
3. Vulnerability Protection across Server Fleet
4. Hard drive encryption (Laptops)
5. Endpoint Encryption on all computers to prevent local distribution of malware
6. 2 factor Authentication on Server Rooms
7. Swipe Access for staff areas
8. Smart water protection on all devices
9. Asset register and inventory in place
10. ~~10.~~ ISO27001 Accreditation process –accreditation passed Feb 2024 with no recommendations ~~3 yearly with annual checks. Full accreditation passed April 2023~~
11. Informatic Skills Development Accreditation Level 1
12. HIMMS Level 5
13. Data Security and Protection Toolkit
14. Member of the Cheshire and Mersey Cyber Security Group
15. CareCERT Processing on a regular basis
16. Network groups for IG - Radiology etc.
17. Proactive monitoring of national cyber alert status
18. Daily National update Advance
19. NHS Mail – National mail protection
20. ~~20.~~ Backups – Transition to immutable "offline" backups ~~to protect against Ransomware attacks Q2/3 23~~
21. Datacentre – Currently upgrading to latest VMware platform to continue to receive critical security updates
22. SQL – Migration of SQL instances underway to the latest supported Microsoft SQL platform to continue to receive critical security updates
23. Alerts and communications plan in place to educate and remind staff about IT security
24. Updated version of Antivirus in place
25. Board of Directors completed Cyber Security training ~~Nov 22~~ Jan 24.
26. Digital Substrategy approved at Board in March 2023
27. McKinsey digital maturity assessment completed, with peer review, approved at Board and submitted May 2023.
28. Adoption of national NHS Cyber Security Strategy 2023-2030

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
3. Increased activity due to geo-political events
4. Legacy servers are still being migrated into the new Datacentre.
5. ~~Some recommendations from MIAA Cyber Security Internal Audit will continue to be implemented throughout 2023/24 as legacy servers are moved into new Datacentre.~~ Two recommendations for Cyber Security 2020/21 review remain only partially implemented as require finalisation of movement of legacy servers into new Datacentre.
6. Number of legacy systems and therefore unsupported Software including a legacy operating system which is being migrated as application become latest OS compliant. (Remedial protection in place)

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Review of CareCERTs – Weekly (Technical Infrastructure Group) Monthly Information Governance and Security Forum Meetings **Level 2** Monthly report from Information Governance and Security Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - reports to Audit and Trust Board Annual Cyber Plan to Audit Committee IG Data Security & Protection Toolkit progress, reports to Audit Committee **Level 3** ISO27001 – 3 yearly accreditation, external audit annually – ~~Apr 23~~ Feb 2024 MIAA audits of Data Security and Protection Toolkit - Substantial Assurance External Penetration Testing – July 2023 Regional Desktop Exercise –May 2023 Internal Desktop Cyber Exercise –May 2023 Trust Board Cyber Security Training – Jan 2024 Fixed term Cyber lead appointed and training in place MIAA Audit Reports on Cyber Security Controls	1. Third party assurances required regarding satellite sites 2. Ongoing work with NHS Digital to inform funding requirements 3. Local skillsets limited permanent resourcing (001)

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	On-going work with NHS Digital to inform funding requirements for Cyber Security post-Covid. Working on regional solution 2022/23 with Digital Lead, awaiting ICS input New Chief Digital Information Officer for ICS in post from October, planning Cyber Strategy is main focus. Update May 2023: Walton Centre Cyber position to be created for 2023/24 to avoid any delays. Training packages in place Update September 2023 - Fixed term Cyber Lead appointed	CFO	~~June 2022~~ August 2023	~~On hold~~ ~~In Progress~~ Closed
2	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid. Revisiting with ICS with new digital lead and Cyber skillsets. On hold while awaiting new Chief Digital Information Officer to join ICS. In post from October, planning Cyber Strategy is main focus. CIO Away day December to discuss steps. UPDATE: Awaiting update on Cheshire and Mersey Cyber funding 2023/24 UPDATE – Link into above item	CFO	~~August 2022~~ tbc	~~In progress~~ ~~On hold~~ ~~In Progress~~ Superseded
3	~~Expand Cyber service to underpin current processes with MIAA / C&M ICS~~ ~~Desk top exercise complete, penetration test booked for July complete~~ UPDATE: Desk top exercise completed May 2023, penetration test scheduled for July 2023 Update October 2023 - action plans now part of Annual cyber plan reported to Audit committee	CFO	August 2023	~~In Progress~~ Closed
4	Attainment of HIMMS level 6 through Digital Aspirant programme UPDATE ongoing although reliance on LUHFT Pharmacy CARL programme upgrade to complete closed loop may impact forecast completion date. ~~UPDATE May 2023 – Review of potential Liverpool place EPR May-July 23 which will impact timeframe for closed loop completion. Alternative solutions being investigated~~ Update March 2024– continued review of potential Liverpool place EPR which will impact timeframe for closed loop completion as WCFT utilises LUHFT Pharmacy and Blood Tracking.	Deputy CDIO	April 2024	On Hold
5	Transcription of operational risks from local IT risk register to Datix.	CDIO	March 2023	~~In progress~~ Complete
6	Creation of Monthly SIRO/Exec Lead for Digital Cyber Assurance Meeting, in line with Cyber Security Lead appointment Update March 2024- Cyber lead appointed and undergoing training in October. Meetings to commence in ~~Nov 23~~ March 2024	Deputy CDIO	~~November 2023~~ April 2024	New Action In Progress
7	Creation of GAP report and action plan against NHS Digital Maturity Assessment Update October 2023 - All items now included in JIRA to map out priorities with stakeholders NHSE playbook sessions completed October 2023 and data released. Organisational GAP meetings to be rescheduled for November 2023 onwards.	CDIO	~~August 2023~~ November 2023	~~New Action~~ ~~In Progress~~ Closed
8	Creation of Cyber Plan 2023/24 Update – Completed and 6 monthly review going to Audit Committee in October 2023	CDIO	July 2023	~~New Action~~ Closed
9	Creation of Action plan based on GCHQ Cyber Assurance Framework (CAF) Update – NHSE added Cyber assessment Framework items into DPST for 2024/25 so will be measured on this. Information Governance working with Technical team to go through changes and requirements . NHSE will use first response of toolkit 2024/25 to review organisation state of maturity.	CDIO	October 2023	~~New Action~~ Closed
10	Implementation of NHS Mail Multi Factor Authentication. This has already nationally shown a reduction of compromised accounts with the introduction of MFA.	Deputy CDIO	July 2024	New Action

Risk ID: 012	Date risk identified: April 2023	Date of last review:	December 2023
Risk Title: Digital If the Trust fails to deliver its digital commitments and its ambition to harness the full potential of digital technologies, increase its digital maturity and prioritise digital inclusion, it could lead to poor patient and staff experience, missed opportunities and reputational damage.		**Date of next review:**	April 2024
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Digital/ Cyber Security: To keep up with digital opportunities and threats
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks		
1041	If a solution is not sought to streamline the use of multiple digital systems (including paper), then there is a risk to quality of care and patient safety. This is as a result of the time it is taking away from patient care.	12
933	If there is no digital solution implemented for the reporting of microbiology results to the IPC Team then there is a risk of the team being unaware of infections. Delayed results in turn cause further risk to staff and patients with the potential increase of further transmission	12
1033	If the emergency referral system continues to be inadequate, this will lead to potential delays in patients receiving advice and treatment, resulting in a risk patient safety if it is a time sensitive referral.	12
Risk Appetite	**Moderate**	

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Investment does not result in anticipated benefits for patient care and safety - Reputational damage due to poor use of resources - Poor patient experience - Long term revenue commitments for new Systems - Sanctions from regulators	- Insufficient staff resource/sickness to deliver full performance - Financial funding constraints nationally

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Projects underway and supporting: i. Outpatient Transformation ~~ii. Theatres Transformation~~ iii. ITU System 2. Digital Strategy Board aligned to governance groups across the organisation 3. IT Technical Programme of work in place 4. Cyber Security Programme in place 5. SPMO Function underpinning the Digital Strategy 6. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 7. EPR rollout plan for paperlight continuing 8. HiMSS Level 5 achieved (working towards Level 6) 9. Digital Substrategy approved at Board April 2023 10. Representation on ICS Digital Programme Boards 11. Bi-Monthly report to Business Performance Committee 12. Monthly reporting to Executives 13. JIRA system bringing full overview to all projects 14. Board Development Day sessions, 15. NHS Digital Maturity annual review 16. Executive Director CDIO recruited in January 2024 17. IT Prioritisation Plan in place February 2024.	1. Difficulties in recruiting due to source skills shortage in area 2. Direction of C&M Health and Social Care Digital Strategy 3. Change in national priorities around Digital post-Covid response may not be aligned to Trust digital priorities 4. Lack of digital expertise on board 5. External funding ceased 2022/23 6. Measurable Impact of Digital Aspirant 7. GAP report against DMA scoring 8. Sustainable structure for Digital team reflecting a shift away from capital funded interim staff 9. System approach to developing IT systems such as a shared Electronic Patient Record.

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 Casenote scanning Project HITU project meetings Clinical Systems Safety/reference Groups – monthly Digital Programme Board – bi-monthly Information Governance & Security Forum – monthly ISMS Group Monthly ISMS Risk Group Monthly **Level 2** Strategic Project Management Officer oversight of transformation work Monthly update on digital transformation progress to BPC C&M Chief Information Officers Digital Collaboration Group National Chief Information Officer Weekly Meetings **Level 3** ~~Critical Applications Audit – Jan 2020~~ MIAA IT housekeeping Audit Healthcare Information and Management System Level 5 achieved ~~2021/22~~ NHS Digital Maturity Minimum level achieved NHS EPR maturity achieved	1. Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. 2. Digital Strategy Group and subgroups are not meeting consistently.

Information Security Management Systems Certification IS27001 accreditation full successful reaccreditation ~~April 23~~ Jan 2024 ~~Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19~~ Acceptance of approach and contribution to ICS by C&M Digit@LL ~~NHSE monitoring Digital Aspirant via CORA against LoA.~~ Data Security and Protection Toolkit annual audit and submission McKinsey digital maturity submission and peer review with NHS England Digital Maturity Assessment Review by Public Digital	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	New Digital Substrategy with MIAA / C&M ICS to be approved by Board. Initially paused while Trust Strategy approved and ICB digital strategy which both have now been published UPDATE further deferral to March Board	CPO	~~May 2021~~ ~~December 2021~~ ~~September 2022~~ ~~November 2022~~ March 2023	~~In progress~~ Complete
2	HIMMS level 6 UPDATE: Paused due to reliance on LUFHT Pharmacy upgrade and Blood Bank to complete closed loop. UPDATE: Awaiting first project group with LUHFT.	CDIO	~~October 2023~~ tbc	~~In progress~~ Paused
3	MIAA Technical Services Gap Audit (audit committee Aug 22) corrective actions. UPDATE May 2023: Update provided to MIAA with some actions closed or plans in place with agreed extended deadlines.	CDIO	~~October 2022~~ ~~February 2023~~ ~~March 2023~~ April 2024	In Progress
4	Transcription of risks from ISMS risk register to Datix inline with migration by NHSD from Sharepoint, which is being decommissioned April 2023	CDIO	~~Feb 2023~~ April 2023	Completed
5	Financial and non-financial benefits and impact of digital aspirant programme to be assessed at project end.	CPO	~~April 2023~~ April 2024	~~New Action~~ In progress
6	Digital Maturity Assessment (DMA) data to be released June 2023. GAP report completed and items included in JIRA to map out priorities with stakeholders. NHSE playbook sessions completed and data released. Organisational GAP meetings to be rescheduled for November 23 onwards. Update April 2024 – DMA v2 to be launched Feb 2024	CPO	Sept 2024	New Action
7	New digital team structure to be agreed and implemented. On hold pending recommendations in Digital Review and appointment of new Executive for Digital. Update April 2024, CDIO appointed and due to start by June 2024	CPO	~~September 2023~~ ~~March 2024~~ September 2024	~~New Action~~ On hold
8	External review of digital and business intelligence functions to take place following recommendations in Well Led Review.	CPO	August 2023	~~New Action~~ Complete

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Principal Risks and Risk Appetite 2024/25
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

✓ **Acceptable assurance**	☐ **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

- New principal risks for 2024/25 following consultation and development with Board Members and Board committees

Next Steps

- Each risk to be developed into full Board Assurance Framework (BAF) risks with the Executive Lead for the first report to Board (August 2024)

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	7 March 2024	K Dowson Corporate Secretary	All risks reviewed by Executives
Board of Directors Strategy Day	7 March 2024	K Dowson Corporate Secretary	2024/25 risks reviewed by Board and amendments suggested.
Quality Committee	21 March 2024	K Dowson Corporate Secretary	Risks reviews and no further changes made
Health Inequalities and Inclusion Committee	25 March 2024	K Dowson Corporate Secretary	
Business and Performance Committee	26 March 2024	K Dowson Corporate Secretary	
Research, Medical Education and Innovation Committee	2 April 2024	K Dowson Corporate Secretary	Outcome to be advised at the board meeting

Principal Risks and Risk Appetite 2024/25

Executive Summary

1. Thirteen principal risks are proposed by Executive Directors, in consultation with the Trust Board and its Committees. This is one more than in 2023-24 as it was considered that there was an additional risk to the achievement of the key elements/ ambitions of the Trust Strategy 2022-25. A number of risks have been carried forward, and others have been rewritten but the risk areas otherwise remain the same as the previous year.

Background

Principal Risks

2. In 2022 new principal risks were developed to tie in with the new Trust Strategy 2022-25 and these were further updated in April 2023. Progress against mitigations and actions to reduce these risks have been monitored by the Board Committees, Executive Leads and Board throughout 2023/24 through the Board Assurance Framework (BAF). This will be closed at the Board meeting on 4 April 2024.

3. On 7 March the Board met to review the new risks for 2024/25. These were then reviewed by each Board Committee at subsequent meetings and are now recommended for approval.

4. The risk descriptors which sets out the scoring approach and risk appetite definitions is attached as Appendix 1

Risk Appetite Statement

5. In 2022/23, the Board commissioned a review of the Trust's risk management processes and strategy to ensure it is aligned with the development of the new five-year Trust Strategy. This resulted in the Risk Management Strategy being replaced with a Risk Management Framework. This also included a review and subsequent implementation of new systems and processes to strengthen arrangements for the management of risk. Amendments to the risk flows and committee structure processes were presented and agreed by the executive team, including the scheduling and reporting of risks to various groups dependent on grading.

6. One of the five key objectives of the Risk Management Framework was the development of a risk appetite statement, to be approved by the Board and reviewed on an annual basis. This was agreed at the Board meeting on 6 April 2023.

7. The risk appetite statement outlines the Board's appetite for risk taking and aligns to the Trusts strategic ambitions. This clear understanding of the Board's appetite for risk taking is necessary to steer and influence the development of appropriate risk mitigation strategies and systems of control which will act as a point of reference for operational and strategic decision-making. Risk appetite is defined as 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives'.

2024/25 Review

8. The strategic risks for 2024/25 were reviewed by the Board at the recent Strategy Day on 7 March and comments and feedback received. The updated risks were then taken through the Board Committees for review before being recommended for approval here. A summary of the risks and the changes is attached as Appendix 2.

9. Changes were made to the following BAF risks
   - **001 Quality of Care** – No changes
   - **002 Collaborative pathways** – Minor change to risk descriptor to reflect that developing clinical pathways across the system and beyond is not always led by the Trust but the Trust needs to respond to proposals

     If the Trust does not succeed in responding to, developing and leading well led high quality standardised regional care pathways and networks with system partners that meet patient needs, then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable care which addresses health inequalities in its population.

   - **003 System Finance** – Update of risk to 2024-25 financial year and increase in scoring from 9 to 3 x 4 =12 (consequence moderate, likelihood increased from possible to likely)

   - **004 Operational Performance** – reference to improving productivity added

   - **005 Leadership Development** – minor amend to description

   - **006 Prevention and inequalities** – no change

   - **007 Capital Funding** – risk score increased from 9 to 3 x 4 =12 (consequence moderate, likelihood increased from possible to likely)

   - **008 Medical Education Strategy** – no change

   - **009 Research and Development** – risk descriptor rewritten as below to reflect the work completed to develop a business model, strategy and revised governance and management structures.

     ~~If the Trust does not develop a sustainable business model and strategy for research it will not attract the right staff or the research projects necessary for the Trust to become a world-class centre for Neurosciences and innovation.~~ If the Trust does not have the right environment to attract, generate and run sufficient research projects it will not attract the right staff or projects necessary for the Trust to become a world class centre for Neurosciences and innovation.

   - **010 Innovative Culture** – risk owner moved from Chief Executive to Chief People Officer and risk score reduced from 12 to 3 x 3 = 9 (moderate consequence x possible likelihood)

   - **011 Cyber Security** - risk descriptor rewritten as below to rephrase the focus to be on what the Trust can do to protect itself.

     ~~If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence.~~ If the Trust does not protect itself sufficiently against the threat of Cyber Security attacks, then a successful attack may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence.

   - **012 Digital** – risk descriptor rewritten to reflect the end of digital aspirant funding and the move towards developing shared systems with other local NHS providers.

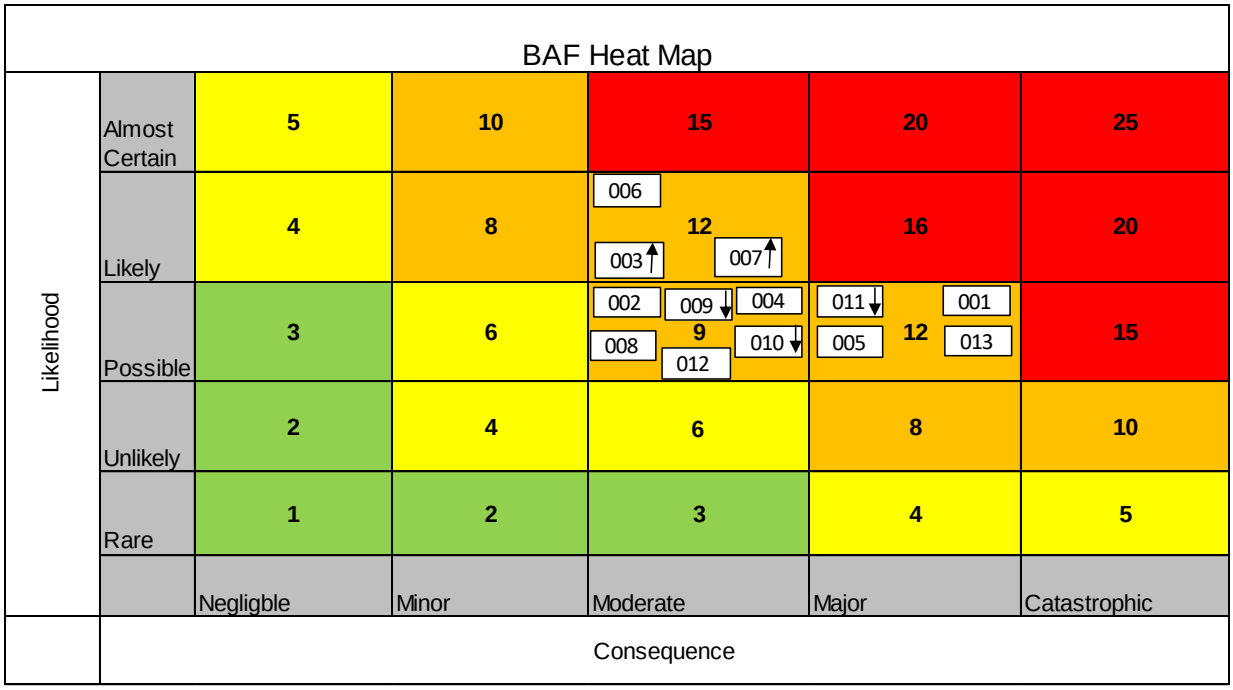
     If the Trust fails to deliver ~~its digital commitments and its~~ ambition to harness the full potential of digital technologies, increase its digital maturity, and prioritise digital inclusion and develop shared digital solutions with other local Trusts, it could lead to poor patient and staff experience, missed opportunities and reputational damage

10. Following discussions a new risk has been also been identified which would remain under the Chief Executive and Board:

    BAF 013 - If the Trust moves towards further shared functions and leadership across the Liverpool system then there is a risk that the clinical model could be fragmented which could impact the quality of care and patient experience and reduce the attractiveness of the Trust as a place to work, conduct research and innovate.
    Risk Owner: Chief Executive
    Assurance Committee: Board
    2023/24 Risk Score: 9 4 x 3 = 12 (Consequence Major x Likelihood Possible)
    Appetite: Open

11. The risk appetite statement has been reviewed and is attached as Appendix 3 for approval. There are no proposed changes to risk appetite for any of the strategic risks. The appetite for the new BAF013 risk has been proposed as Open.

12. The impact on the risk heat map is below.



Conclusion

13. The new principal risks were considered by the Executive Team, by the Board at a Board Development Day in March and by each Board Committee it was agreed that these are the risks that could prevent the delivery of the Trust Strategy.

Recommendation

To approve

Author: K Dowson
Date: 27 March 2023

Appendix 1 – Risk Descriptors
Appendix 2 - Summary of Proposed Principal Risks 2043/25
Appendix 3 – Risk Appetite Statement 2024/25

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

Proposed Principal Risks 2024/25

Links to Substrategies - People Quality Digital Finance and Commercial Development Estates, Facilities & Sustainability

Strategic Ambitions	Principal Risks		
Leadership: Clinically led leadership, with the right skills and values to deliver sustainable health services	**BAF 001** If the Trust does not deliver high quality care for all patients then this will lead to adverse clinical outcomes for patients and a deterioration of the patient, staff and family experience which may impact on the reputation of the Trust. **Risk Owner: Chief Nurse** **Assurance Committee: Quality** **2023/24 Risk Score: 12** **Appetite: Cautious**	**BAF 004** If the Trust does not deliver its agreed activity for the year and improve productivity ~~meet its weighted (based on 2019/20) levels of activity~~ then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust. **Risk Owner: Chief Operating Officer** **Assurance Committee: BPC** **2023/24 Risk Score: 9** **Appetite: Cautious**	**BAF 005** If the Trust does not provide the right culture, environment or opportunities for staff to develop, learn and progress the organisation will not have well led services or experienced staff. This will reduce the Trust's ability to operate in system working or provide ~~well led,~~ high quality services and this could lead to poor staff experience higher vacancy rates and the requirement for additional resource to recruit and train new staff. **Risk Owner: Chief People Officer** **Assurance Committee: BPC** **2023/24 Risk Score: 12** **Appetite: Open**
Collaboration: Working closely with partners and across internal teams to develop high quality standardised services	**BAF002** If the Trust does not succeed in responding to, developing and leading well led high quality standardised regional care pathways and networks with system partners that meet patient needs, then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable care which addresses health inequalities in its population. **Risk Owner: Medical Director** **Assurance Committee: Quality** **2023/24 Risk Score: 9** **Appetite: Open**	**BAF 003** If the Trust does not deliver its financial plan for 2024-25 the Trust's standing and influence in the system will be diminished and this may result in less resource and opportunities in the future for the Trust to grow and meet it strategic ambitions. **Risk Owner: Chief Finance Officer** **Assurance Committee: BPC** **2023/24 Risk Score: 9 3 x 4=12** **Appetite: Open**	**BAF 013** If the Trust moves towards further shared functions and leadership across the Liverpool system then there is a risk that the clinical model could be fragmented which could impact the quality of care and reduce the attractiveness of the Trust as a place to work, conduct research and innovate. **Risk Owner: Chief Executive** **Assurance Committee: Board** **2023/24 Risk Score: 9 4 x 3 =12** **Appetite: Open**
Social Responsibility: Supporting local communities and staff to prevent and support physical and mental health issues and be an Anchor Institution for Liverpool.	**BAF 006** If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population. **Risk Owner: Chief People Officer** **Assurance Committee: HIIC** **2023/24 Risk Score: 12** **Appetite: Open**	**BAF 007** If the Trust does not maximise its opportunities to acquire capital funding then it may not have enough resource to deliver its estates and wider strategies and provide a fit for purpose environment for staff and patients leading to poor staff morale, poor patient experience and the risk of increased backlog maintenance. **Risk Owner: Chief Finance Officer** **Assurance Committee: BPC** **2023/24 Risk Score: ~~9~~ 3 x 4 =12** **Appetite: Moderate**	**BAF 011** ~~If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence.~~ If the Trust does not protect itself sufficiently against the threat of Cyber Security attacks, then a successful attack may lead to service disruption, loss of data, sanctions, financial penalties and a loss of public confidence. **Risk Owner: Chief Finance Officer *(Chief Digital Information Officer from June 2024)*** **Assurance Committee: BPC** **2023/24 Risk Score: ~~15~~ 4 x3 = 12** **Appetite: Averse**
Education, training and learning: Expand the teaching offer to deliver at a national level for neurosciences education and training and improve the quality of care for patients with neurological symptoms.	**BAF008** If the Trust does not effectively manage the increase in demand regionally and nationally for its Medical Education offer, then the Trust will not meet its strategic ambition to offer a national medical education training programme in Neurosciences. **Risk Owner: Medical Director** **Assurance Committee: RIME** **2023/24 Risk Score: 9** **Appetite: Open**		
Research and Innovation: Deliver high-quality clinical research with partners and develop innovative solutions to improve patient outcomes and experience and shape organisational culture	**BAF 009** ~~If the Trust does not develop a sustainable business model and strategy for research it will not attract the right staff or the research projects necessary for the Trust to become a world class centre for Neurosciences and innovation.~~ If the Trust does not have the right environment to attract, generate and run sufficient research projects it will not attract the right staff or projects necessary for the Trust to become a world class centre for Neurosciences and innovation. **Risk Owner: Chief People Officer** **Assurance Committee: RIME** **2023/24 Risk Score: 12 3 x 3= 9** **Appetite: Open**	**BAF 010** If the Trust does not develop a culture where staff are able to innovate, develop solutions and put patient care first then it will not attract external funding and the right staff to support the ambitions of the Trust **Risk Owner: ~~Chief Executive~~ Chief People Officer** **Assurance Committee: RIME** **2023/24 Risk Score: ~~12~~ 3 x 3=9** **Appetite: Adventurous**	**BAF 012** If the Trust fails to deliver ~~its digital commitments and~~ its ambition to harness the full potential of digital technologies, increase its digital maturity, ~~and~~ prioritise digital inclusion and develop shared digital solutions with other local Trusts, it could lead to poor patient and staff experience, missed opportunities and reputational damage **Risk Owner: Chief People Officer *(Chief Digital Information Officer from June 2024)*** **Assurance Committee: BPC** **2023/24 Risk Score: 12** **Appetite: Moderate**

The Walton Centre NHS Foundation Trust

Risk Appetite Statement 2024/25

The Board recognises that the long-term sustainability of the Trust and improving patient care depends upon the achievement of its 2022-25 strategy, the delivery of its strategic ambitions and its relationships with its patients, staff, local communities and strategic partners. To be successful, the Trust must take risks, but in a managed way and to a level which is deemed acceptable.

This risk appetite statement describes the Trust's attitude to risk which will act as a point of reference for strategic and operational decision-making.

The Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, financial, etc.) is not tolerated and where every member of staff feels committed to identify and correct/escalate system weaknesses. The Trust wants staff to be empowered to take considered and thoughtful risk where the long-term benefits outweigh any short-term losses. Well managed risk-taking will ensure that the skills and knowledge are in place to support innovation, maximise opportunities to further improve services and work in collaboration with partners to improve services for patients.

The risk appetite set by the Board of Directors is necessarily more open than in previous years, this is partly due to the increasing maturity of the Board and the setting of an ambitious Trust Strategy (2022-25) which was approved by the Board in 2022.

The Board is committed to ensuring a robust infrastructure is in place to manage risks from operational level to board level, ensuring demonstrable improvements can be put in place. Risk Appetite is the amount of risk that the Board is willing to see or accept in the pursuit of its strategic ambitions. The Trust has an established matrix of risk appetite definitions

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.

The NHS is experiencing unprecedented challenges and the Trust needs to move towards greater collaboration particularly across the Integrated Care System (ICS) for Cheshire and Merseyside as well as meet the new priorities for the NHS in regard to improving population health outcomes, reducing health inequalities, improving productivity, effective use of resources and provision of the best healthcare. Society also continues to move at pace with changes to healthcare infrastructure needing to reflect societal and technological changes.

As a healthcare provider the most important priority of the Trust is to ensure safe, high quality and timely care for patients. The Trust will have a CAUTIOUS approach to the operational delivery of day to day care and will minimise risks that have the potential to cause harm to people, whether they be patients, staff, visitors or the public.

Global conflicts and technological developments have created heighted risks in regard to data security and data protection. The Trust will have an AVERSE appetite to cyber security which could lead to service disruption, financial penalties, loss of data and sanctions.

The digital agenda will continue to underpin clinical innovation and the delivery of services and is integral to all new developments; developments in this area can be resource intensive and the Trust must ensure that the impact on patients and staff is understood and that data protection is a priority; therefore the Trust will be MODERATE in this area.

It will also only take MODERATE risks in relation to its capital programme to ensure best use of resources and to provide modern estate that is fit for the future.

Supporting the Trust's staff and providing the right culture, environment and opportunities for staff to develop, learn and progress is essential. The Trust will have an OPEN appetite for risks in this area in order to retain and attract high quality staff and deliver the best care and experience for patients and families. It will take an innovative approach to medical education expanding its national offer in Neurosciences.

The Trust will have a more open attitude to risk in relation to working with partners in collaboration and will be more OPEN to taking risks for the Trust if there is a benefit of the wider healthcare system and for patients. This could include better service provision or financial support, as establishing new services and pathways may require a managed level of risk to achieve long-term benefits. This may mean making financial decisions that are the right ones for the system but which impact negatively on Trust finances.

The Walton Centre is an anchor institution, this means recognising the impact of a large organisation on its local community in terms of its economic and social value in providing work locally as well as engaging with its communities and influencing politically and socially. The Trust will be OPEN to exploring new opportunities to add social value and address health inequalities for its staff and local populations.

As a University Hospital the Trust needs to maximise its research capabilities and will be OPEN to developing new programmes that could improve patient care. Encouraging innovation amongst staff across research and all aspects of the Trust is key to the Trust's Strategy and therefore the Board is prepared to be ADVENTUROUS in how it creates the right culture for staff to innovate.

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

CHAIRS REPORT

Joint Site Sub-Committee meeting held on Thursday 8 February 2024 at 14:00, Boardroom, TWC

Introduction

The meeting of the LUHFT and TWC Joint Site Committee took place on Thursday 8th February 2024. The meeting involved representatives from Liverpool University Hospitals NHS Foundation Trust (LUHFT) and the Walton Centre NHS Foundation Trust (TWC).

A summary of the key agenda items and discussions is provided below.

Agenda Item	Key Discussions/ Decisions/ Actions
Minutes of Previous Meeting – 9th January 2024	The Committee **approved** the minutes from the Joint Site Committee (JSC) held on 9th January 2024.
Action Log	The Committee reviewed the rolling action tracker, from the previous meetings. The Committee **agreed** to close some actions following the update and others were **deferred** for completion at the next meeting.
Any Urgent Matters Arising	The Committee enquired about progress on the job harmonisation exercise across the region. Mike Eastwood, the Committee Vice Chair to take over as Chair of the Committee from April 2024 in line with the provisions of the Committee's Terms of Reference.
Joint Site Sub Committee Workplan Update • **Joint Partnership Group Exception Report**	**Revised Joint Site Sub Committee Workplan** The revised Joint Site Sub Committee workplan was yet to be developed due to workforce shortage but plans were underway for it to be presented at the next Committee meeting. **Joint Partnership Group Exception Report** Verbal updates were provided on the progress and priorities of the agreed deliverables across the three agreed areas. Good progress had been made on some of the target areas when compared against the key deliverables and key performance indicators. • Good progress had been made with regards the Thrombectomy service against rising demand. • Estates and Digital – Good progress made regarding the Health Procurement Liverpool scheme and a full business case would be presented to participating organisations for approval once it had been finalised. • Work was ongoing on the Head Injuries Data Pool and Spinal Pathway The Committee **noted** the Joint Site Sub Committee Workplan Update and the Joint Partnership Group Exception Report

Agenda Item	Key Discussions/ Decisions/ Actions
Liverpool Trusts Joint Committee Update	The Committee noted the update from the Liverpool Trusts Joint Committee (LTJC) meeting held on 21st December 2023.
Draft Agenda for the next meeting	The Committee **agreed** the following items will be included on the February agenda: • Joint Partnership Group Exception Reports • Revised Joint Site Sub-Committee Workplan • Liverpool Trusts Joint Committee Update • Joint Site Sub Committee Revised Terms of Reference
Next meeting date and venue: Thursday, 11 April 13.30 to 14:30 at the Boardroom, TWC.	

Recommendations for the Trust Board/Committee

The Board/Committee is asked to:

- note the contents of the report.

Board Committee Assurance Report

Report to	Board of Directors
Date	28 March 2024
Committee Name	Liverpool Trusts Joint Committee
Date of Committee Meeting	7 March 2024
Chair's Name & Title	David Flory, Chair Liverpool University Hospitals NHS Foundation Trust & Liverpool Women's NHS Foundation Trust

Matters for Escalation

There are no matters for escalation.

Key Discussions

Electronic Patient Record (EPR)

The Committee received an update on the latest position in relation to Liverpool University Hospitals NHS Foundation Trust's (LUHFT) Electronic Patient Record (EPR) Business Case. The Committee were asked to consider the opportunity to include other Liverpool Trusts in a market engagement and joint procurement, which would support the move to a more integrated digital architecture and more seamless data flows across Liverpool Place in the context of the Liverpool Clinical Services Review.

The benefits of the convergence to a monolithic EPR and platform architecture were discussed, with Committee members noting the importance of creating a cohesive approach to improving patient experience and outcomes and tackling health inequalities.

It was agreed that Liverpool Women's Hospital NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Liverpool Heart & Chest Hospital NHS Foundation Trust and The Walton Centre NHS Foundation Trust would be involved in the wider procurement exercise with LUHFT. Support for the Trusts involved would be provided by the Cheshire & Merseyside Integrated Care Board (ICB) to make the proposal at a national level and seek an extended timeline and additional funding to deliver a strategic solution for Liverpool. This included a collective undertaking for the ICB to work with Trust Chief Information Officers to develop an application and infrastructure strategy for Liverpool PLACE.

Sub-Committee and Partnership Updates

The Committee noted the following Sub-Committee and Partnership Updates:

- The Walton Centre/LUHFT
- Liverpool Heart & Chest/LUHFT
- Clatterbridge Cancer Centre/LUHFT
- Liverpool Women's Hospital
- Health Sub-Committee of ICB
- Liverpool Women's Health & Alder Hey Partnership Board
- Mersey Care NHS Foundation Trust Update

Decisions Made

No decisions were made at the meeting.

Recommendation

The Board of Directors is asked to note the Liverpool Trusts Joint Committee Assurance Report pertaining to the meeting of 7 March 2024.

Report to Trust Board
4 April 2024

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Rebecca Sillitoe, Senior Information Analyst
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- See summary for performance overview

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

- Ongoing

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

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

001 Quality Patient Care	004 Operational Performance	003 System Finance

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Integrated Performance Report

Executive Summary

This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's.

Conclusion

Performance is summarised per metric and appropriate conclusions drawn within the body of the report.

Recommendation

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

Author: Rebecca Sillitoe – Senior Information Analyst
Date: 25/03/2024

The Walton Centre NHS
NHS Foundation Trust

Board Report
April 2024

Data to end February 2024 unless indicated

Explanation of SPC Charts and Assurance Icons

The Walton Centre NHS Foundation Trust

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

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

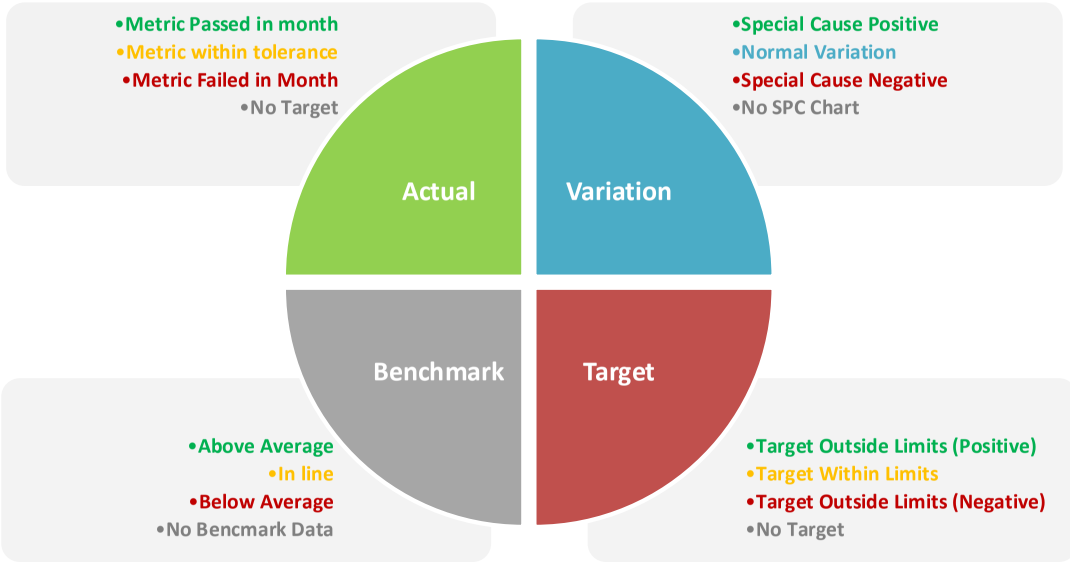
All SPC charts will follow the below key unless indicated

Actual UCL Average LCL National Average Target

= Part of Single Oversight Framework = Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

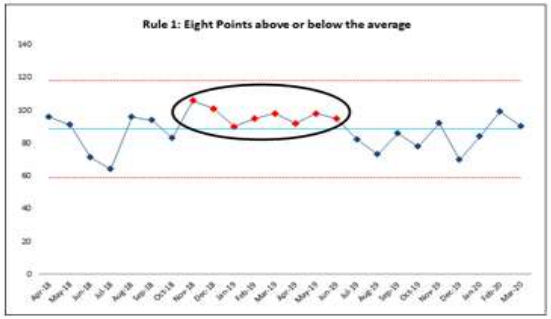
All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.

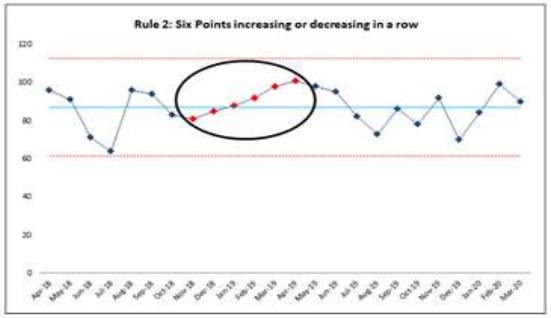


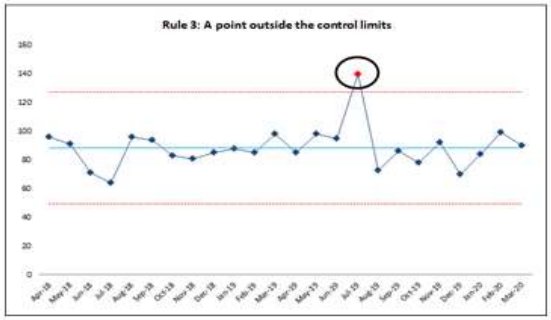
Statistical Process Control Chart Rules

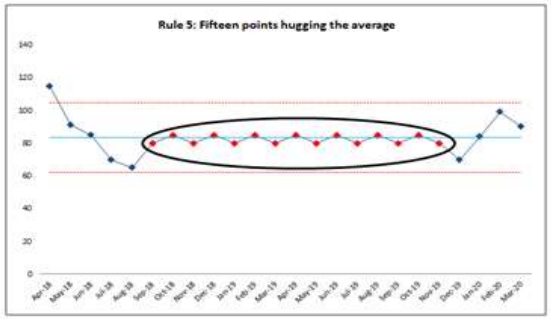
The Walton Centre NHS Foundation Trust

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









Operations & Performance Indicators

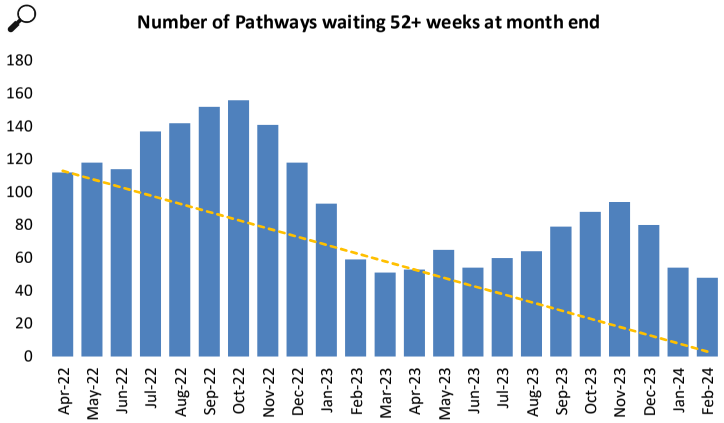
Referral to Treatment

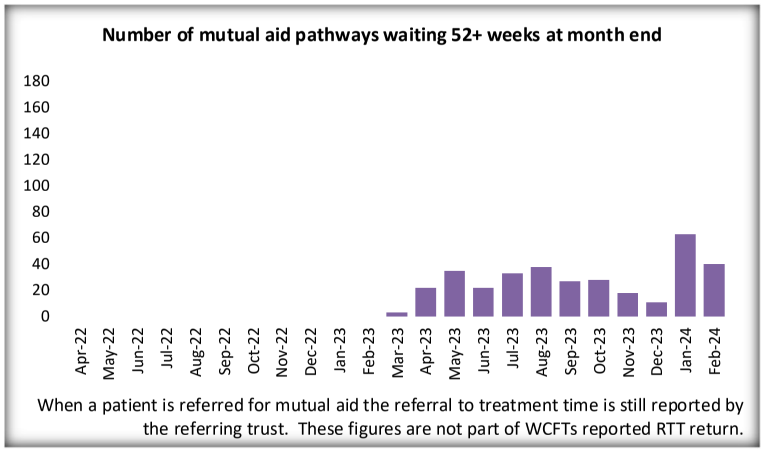
The Walton Centre NHS Foundation Trust

The number of patients waiting more than 52 weeks for treatment decreased in January and February and now stands at 40. The trajectory to reach zero patients waiting longer than 65 weeks has been extended to March 2024 and as at the end of February 2024 there were only one Walton Centre patient waiting longer than 65 weeks.

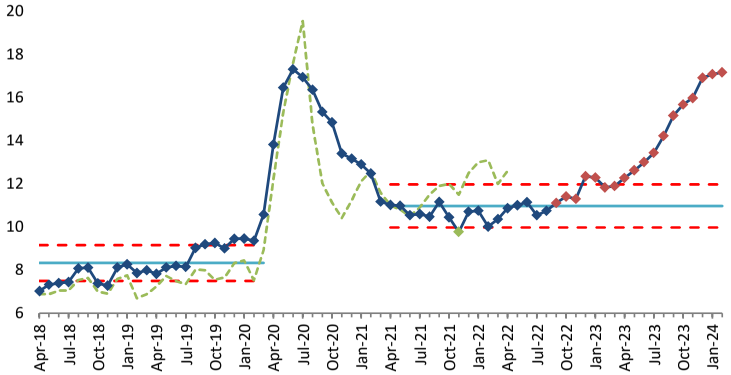
As at end of February there were 40 patients referred under mutual aid arrangements with other trusts who had been waiting more than a year for treatment.

Waiting times in England and Wales continue to deteriorate, with Welsh Performance now the worst it has been since April 2018. English average wait has increased again in February and is approaching the highest its ever been.





When a patient is referred for mutual aid the referral to treatment time is still reported by the referring trust. These figures are not part of WCFTs reported RTT return.

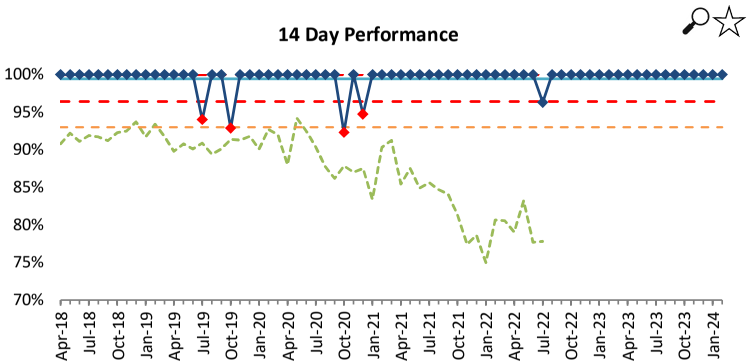


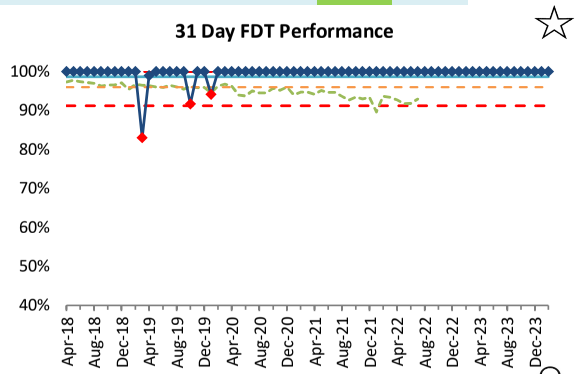
Cancer Standards

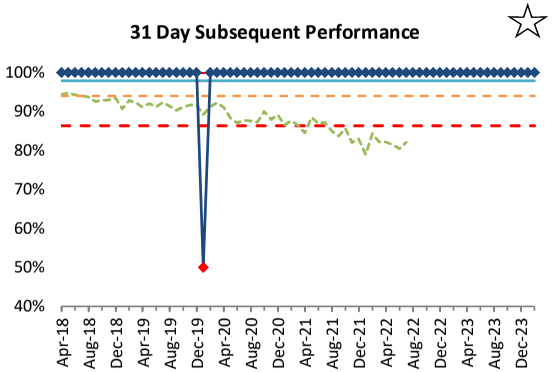
The Walton Centre NHS Foundation Trust

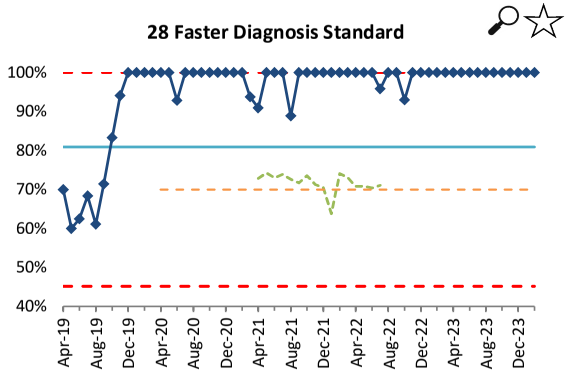
Access Standards	Target	Actual
Cancer TWW	93%	100%
Cancer 31 Day FDT	96%	100%
Cancer 31 Day Sub	94%	100%
Cancer 62 Day Standard	85%	NA
28 Day Faster Diagnosis Standard	70%	100%

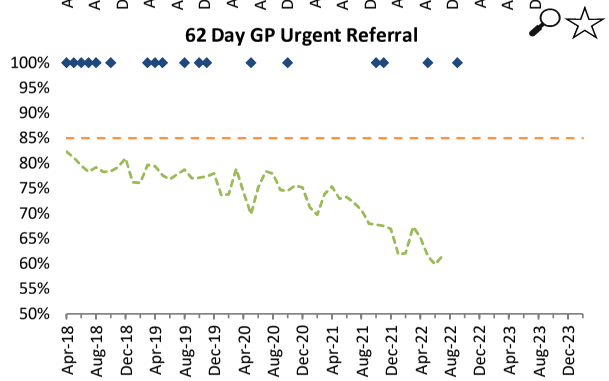
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, this is in line with NHSE requirements.

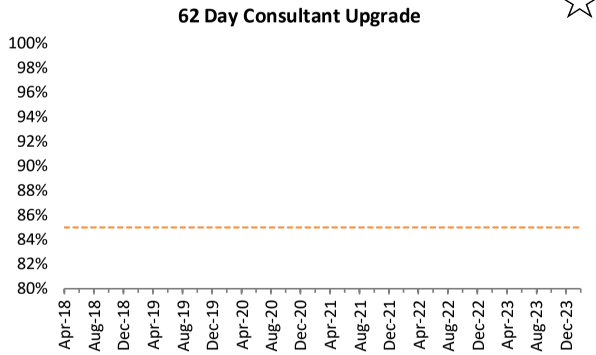












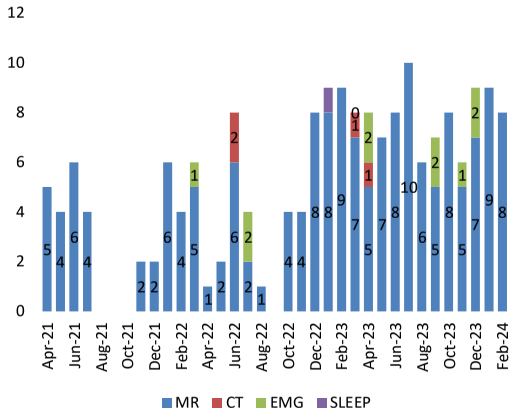
Diagnostics

The Walton Centre NHS Foundation Trust

Access Standards	Target	Actual
Diagnostic 6 Week Performance	1%	0.49%

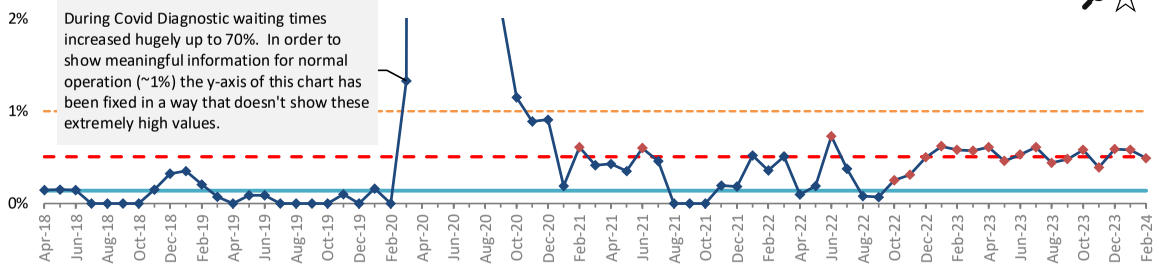
Achievement against the diagnostic six week standard has been met in month. There were eight breaches of the standard in month, all of which relate to MRI. Since Business Performance Committee papers were published the single EMG breach has been removed from the DM01 return because it was an administrative error and should not have been included originally. Diagnostic performance remains in special cause variation above the mean as it has been for the past seventeen months.

Diagnostic Breaches by Type

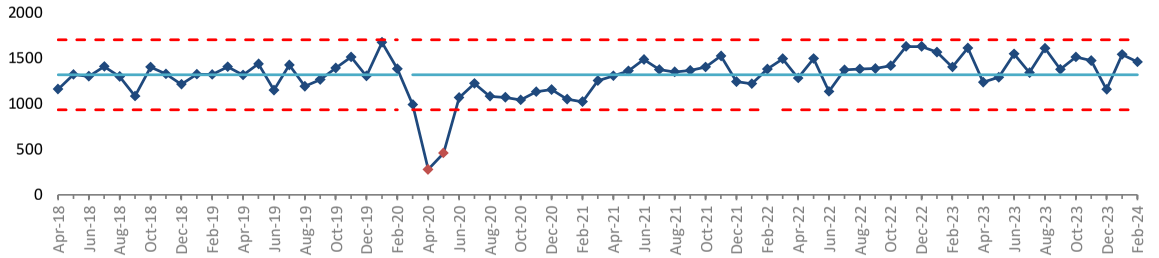


6 Week Diagnostic Performance

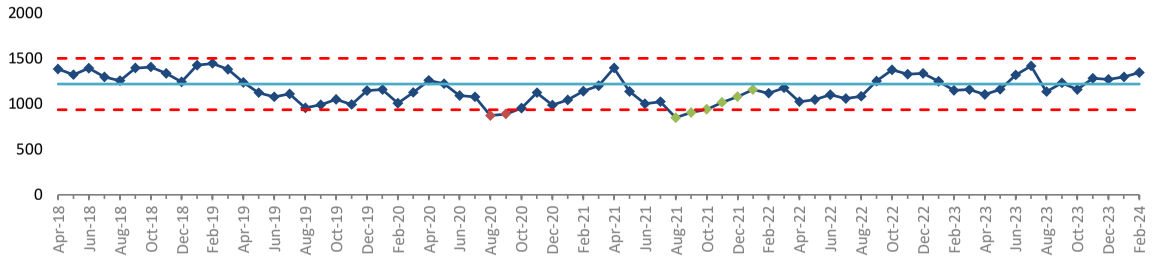
During Covid Diagnostic waiting times increased hugely up to 70%. In order to show meaningful information for normal operation (~1%) the y-axis of this chart has been fixed in a way that doesn't show these extremely high values.



Total Diagnostic Activity in Month*



Total Diagnostic Waits at Month End



Theatres

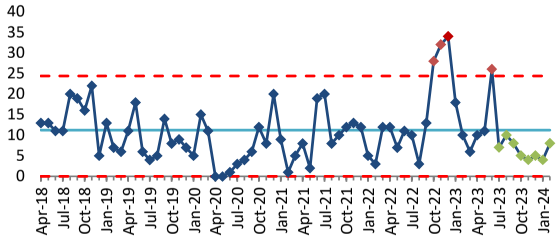
The Walton Centre NHS Foundation Trust

	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	8	
% Cancelled operations non clinical on day	0.80%	0.64%	
28 Day Breaches in month	0	1	

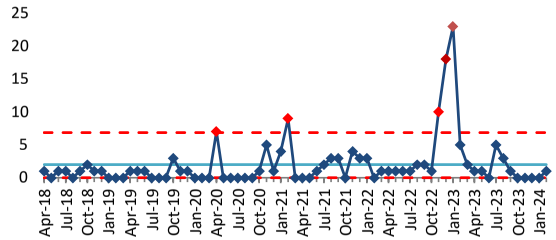
The Trust continues to work with Productive Partners as part of the theatre utilisation transformation work to ensure theatre capacity is utilised appropriately. In total eleven available sessions were unused in February, of which eight were due to theatre staff shortages and three to patient unavailability. Theatre closures due to refurbishment work have been excluded from the utilisation measure, so utilisation remains the percentage of sessions which could have been used that actually were.

There were eight non-clinical cancellations in February and one breach of the 28 day reschedule target. Three cancellations were due to emergencies/trauma, two cancellations in month were the result of list overrun, two the result of staff unavailability and one attributed to lack of available ITU/HDU beds.

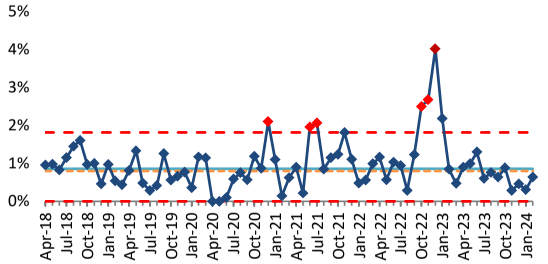
Number of Cancelled operations non clinical (on day)



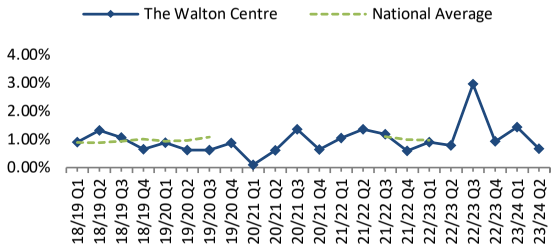
Number of cancelled operations not re-admitted within 28 days



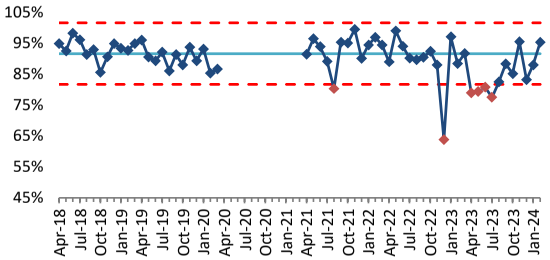
% of Cancelled operations non clinical (on day)



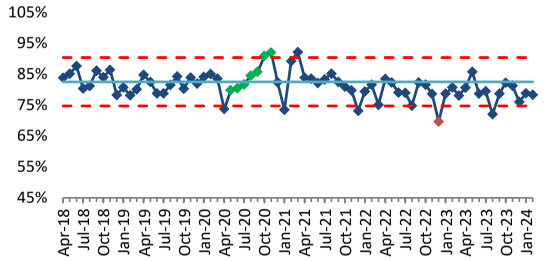
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



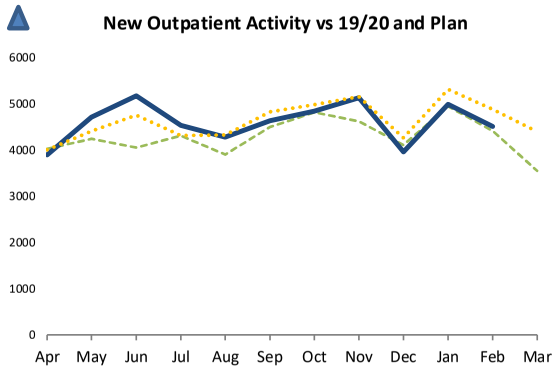
Elective Activity vs Plan

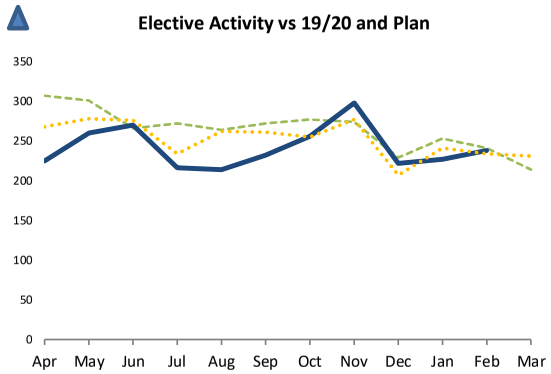
The Walton Centre NHS
NHS Foundation Trust

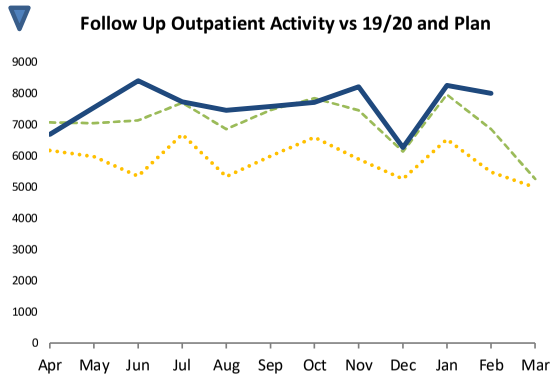
This page monitors the elective performance against plan for this year. The plan for follow up activity requires a reduction in activity rather than an increase as in the case of other metrics. The direction of good performance is indicated by the blue arrow in the top left of each chart.

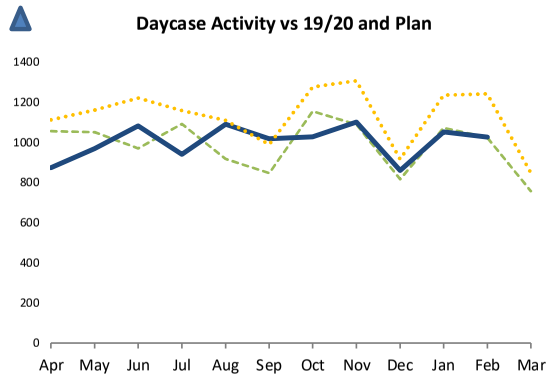
Both inpatient and new outpatient activity are lower than plan for the year to date. Follow ups are higher than plan but the target for these is to decrease.

	Actual YTD 2023/24	Plan YTD 2023/24	Percentage of Plan YTD
Daycase	11,043	12,731	86.7%
Elective	2,658	2,793	95.2%
Elective & Daycase Total	**13,701**	**15,524**	**88.3%**
Non-Elective	1,776	1,815	97.9%
New Outpatient	50,671	51,257	98.9%
Follow Up Outpatient	83,852	65,241	128.5%









Legend for all charts on page

19/20 Act 23/24 Act 23/24 Plan

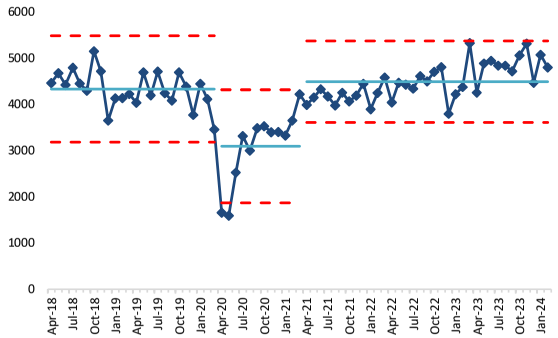
Activity

The Walton Centre NHS Foundation Trust

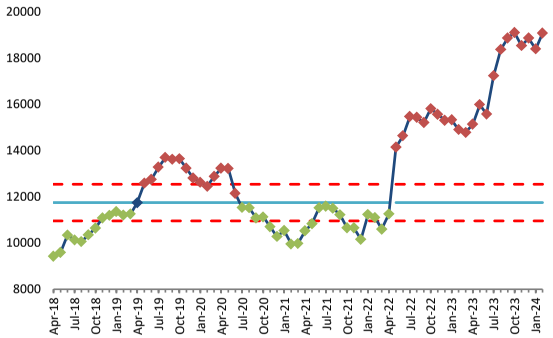
The number of new referrals has been above the mean in ten of the last twelve months (April 2023 was below the mean and December 2023 was almost equal to the mean value). A strict interpretation of special cause variation rules wouldn't count this as a continuous run above the mean but it is still worth noting. New Outpatient Waiting List remains very high compared to the control range and has increased again in February. Inpatient waiting list initially increased above the control limit in January 24 and continues to rise and remain above the upper control limit in February.

The Follow up outpatient waiting remains stable overall this month but the number of patients whose follow up appointment is overdue has increased slightly in the last month.

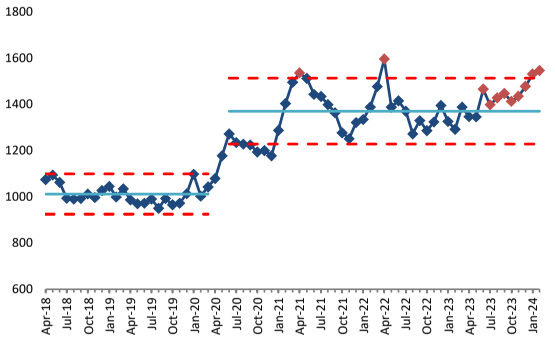
Total New Referrals Received



Trust New Outpatient Waiting List

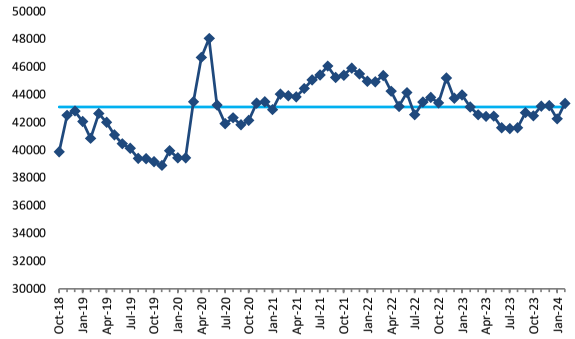


Inpatient Waiting List

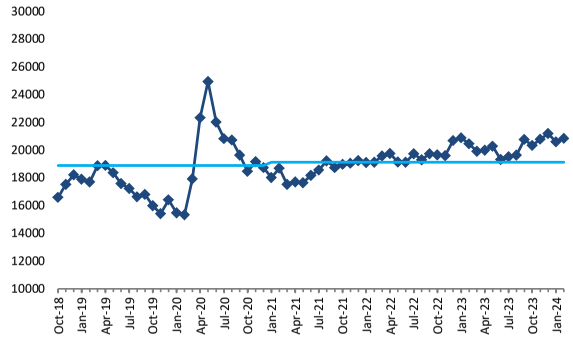


*Spinal transfer patients added to OPWL

Follow Up Outpatient Waiting List



Follow Up Outpatient Waiting List (Overdue)



Flow

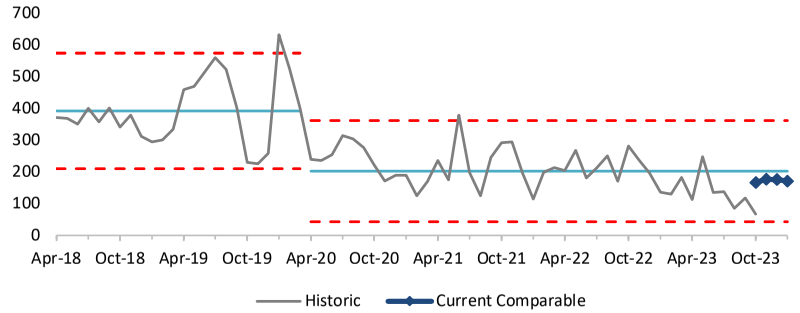
The Walton Centre NHS Foundation Trust

Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	5.15%	
Total Delayed Discharge Days	-	175	
% Discharges by 5pm	-	55.00%	
% 14 Day Stranded Patients	-	33.72%	

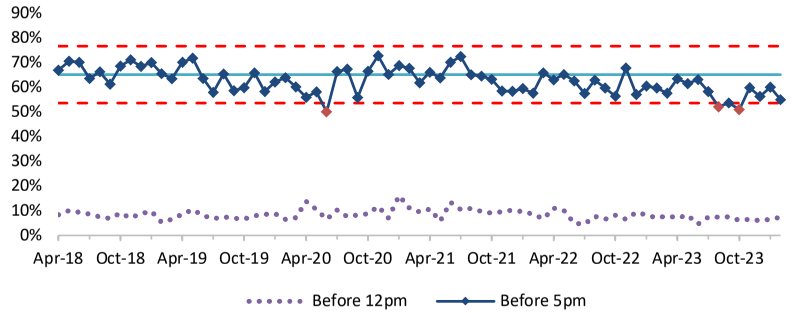
Information around delayed discharges is now being recorded electronically from October 2023. This improved reporting has increased the total number of delayed days considerably, for the purpose of comparison with history only External delays where the target destination is not Rehab or Repatriation to another Trust have been included here. This is in line with what has previously been reported.

The new reporting tool enables us to more accurately assess the impact of internal delays and repatriations to other Trusts on delays so it is proposed to report these separately in place of the percentage of bed days occupied by stranded patients.

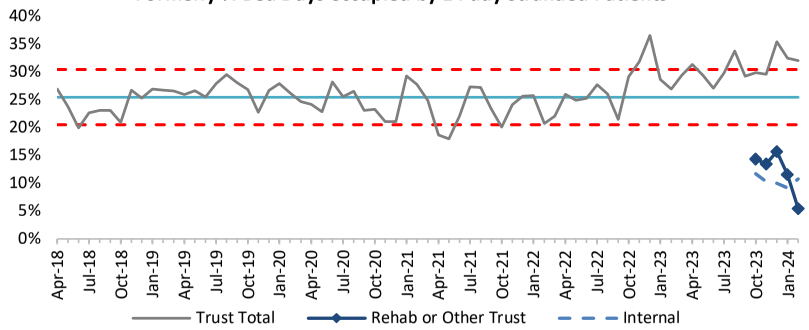
Delayed transfer of care days



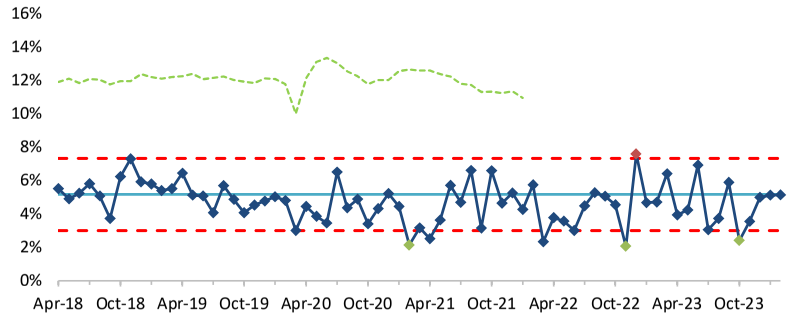
% Discharges to usual residence before 5pm



Formerly % Bed Days occupied by 14 day Stranded Patients



% 28 day emergency readmissions (local)



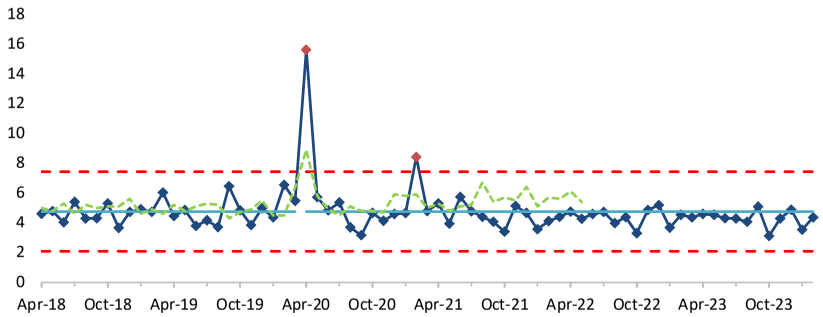
Flow (Leading Indicators)

The Walton Centre NHS Foundation Trust

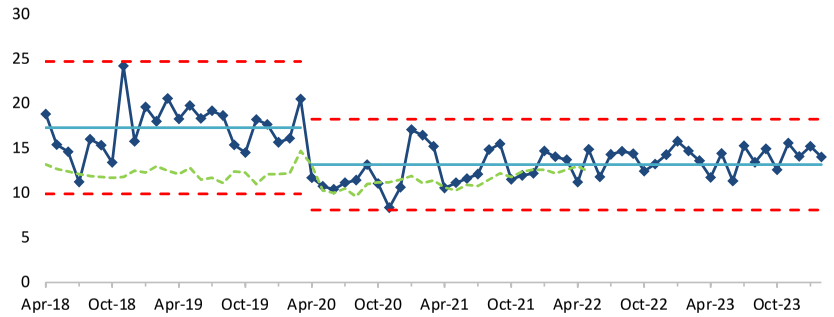
Effective - Flow	Target	Actual	Assurance
Elective LOS	-	**4.35**	
Non Elective LOS	-	**14.02**	
Day of Surgery Admission %	-	**75.00%**	
Day case Rate	-	**81.25%**	

All metrics are currently within normal variation.

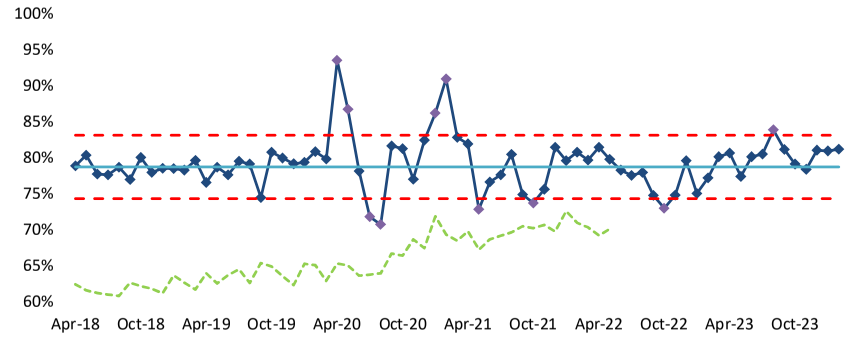
Elective Length of Stay (Days)



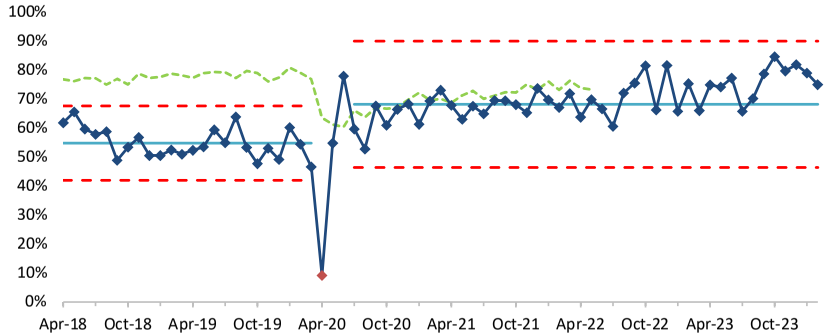
Non Elective Length of Stay (Days)



% of Elective Admissions as Day cases



Day of Surgery Admission %



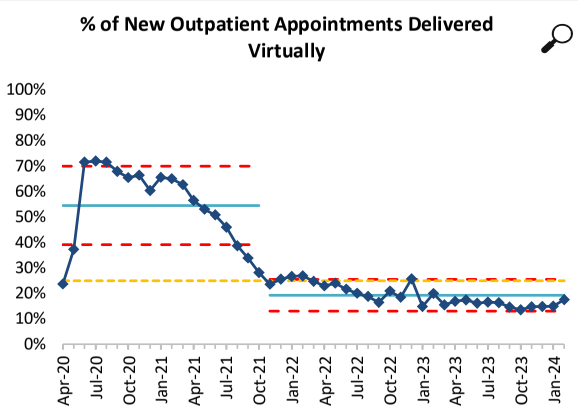
Outpatient Transformation

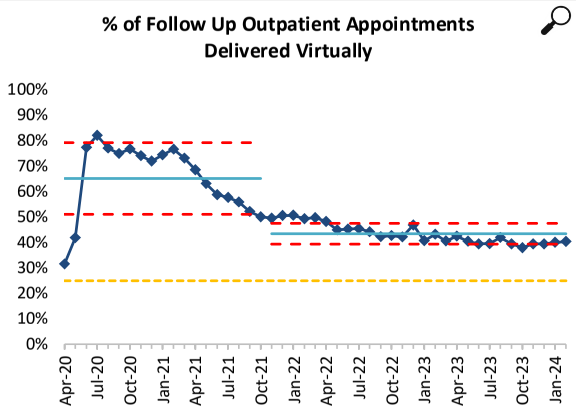
The Walton Centre NHS Foundation Trust

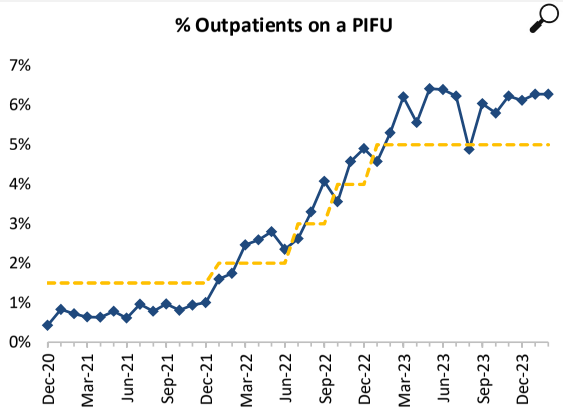
Virtual Appointments: The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. Although new appointments have dipped below this threshold the Trust as a whole remains above the target. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

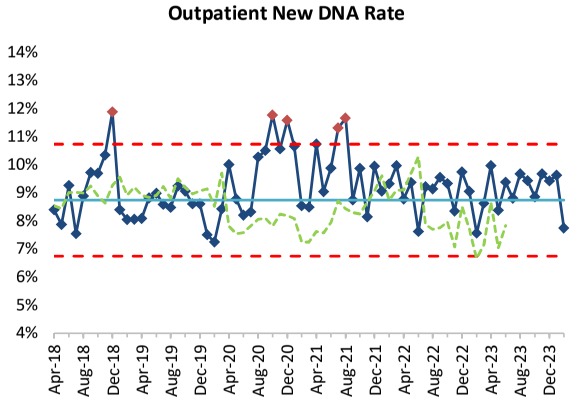
DNA Rate: The New DNA remains within normal variation, as it has been for the last two years and the Follow Up DNA rate remains in negative special cause variation but both rates have decreased significantly in February. Although a text reminder service is in trial this doesn't account for the drop in DNA rates seen this month. Improving DNA rates remains a focus of work in outpatient transformation.

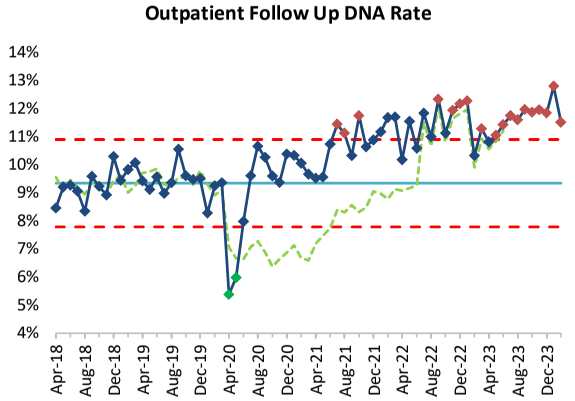
Patient Initiated Follow Up (PIFU): Since March 2023 there has been an expectation what 5% of all outpatient appointments would have a PIFU outcome. The Trust has been able to maintain performance above this target with reasonable consistency since Febraury of 2023. The percentage of outpatient appointments with PIFU outcome in February was 6.28%.

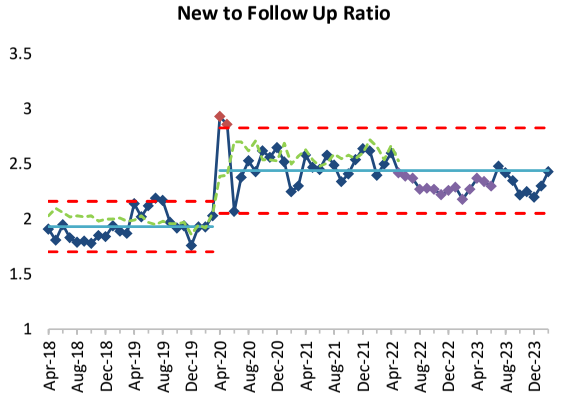












Workforce KPIs

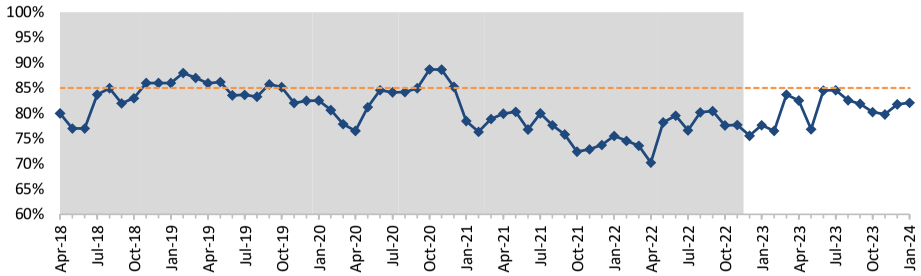
The Walton Centre NHS Foundation Trust

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	81.65%	
Mandatory Training Compliance	85%	88.55%	

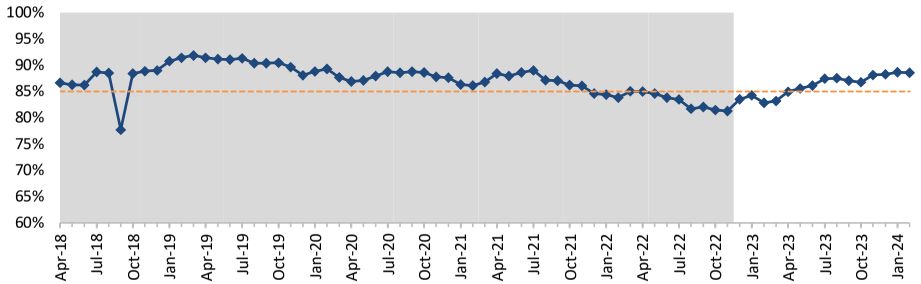
Appraisal compliance has stabilised in the last two months but remains slightly below target. Mandatory training compliance levelled off after increasing for the last eleven months and remains above target.
The grey shading represents data inclusive of junior doctors and the white background represents months with junior doctors removed.

Open Disciplinaries	Open Grievances
5	6

Appraisal Compliance (Rolling 12 months)



Mandatory Training Compliance (Rolling 12 months)



Doctors in Training Core Skills Training Framework

Feb-24

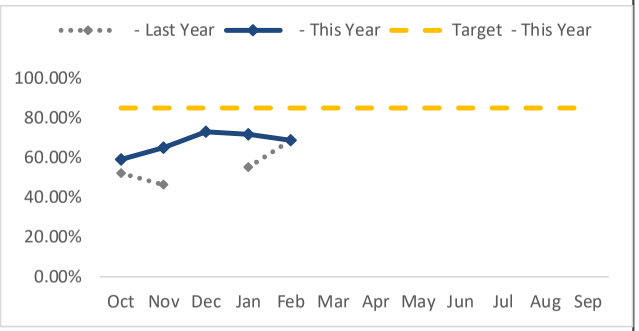
68.80%

Variance -2.96%

Target 85.00%

Compliance has declined in each of the two previous months and in February there has been no improvement over February last year.

Rank (of 31) 27



Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	5.71%	
Trust Turnover	-	15.79%	
Nursing Turnover	-	12.41%	
Other Staff Turnover	-	17.16%	

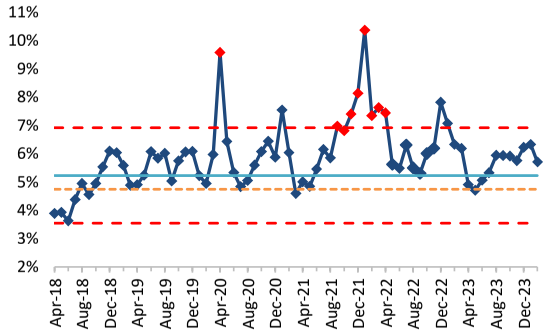
Sickness/Absence

Sickness absence is high in February but within the control and is lower than January.

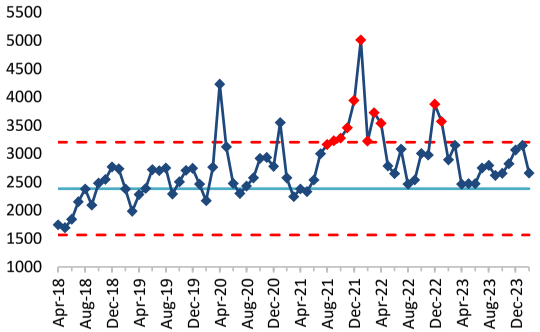
Turnover

Turnover for the Trust has remained at a significant level, largely driven by Corporate Services and Non Nursing Staff within Divisions. Nursing turnover is below normal variation and the Trust is fully established in this area.
Other staff turnover has increased steadily and reflects the pressures within the wider labour market. This is exacerbated by other NHS providers not adhering to principles of agenda for change.

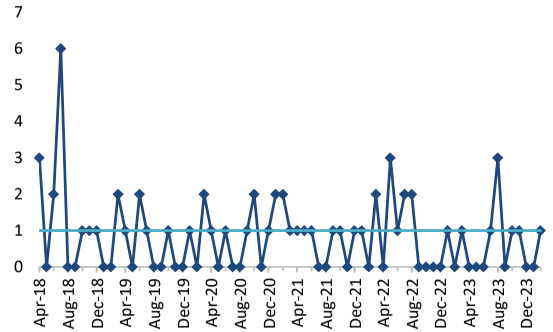
Sickness/Absence (Monthly)



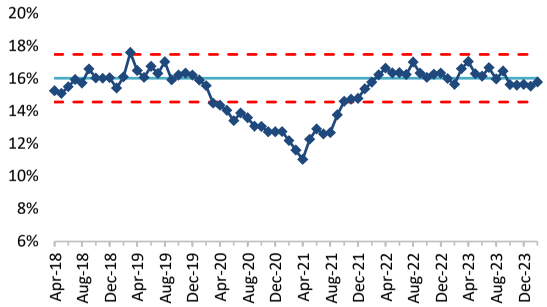
Lost Days due to Sickness/Absence (Monthly)



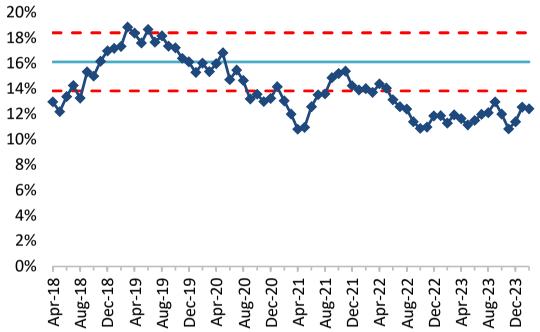
Medical Leavers



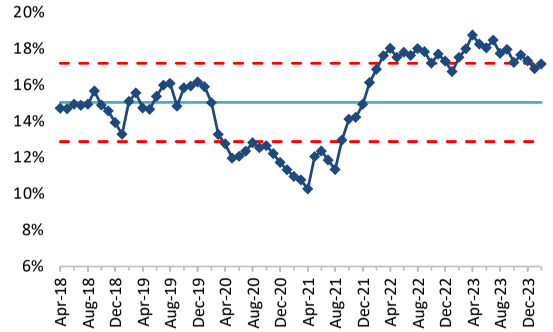
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



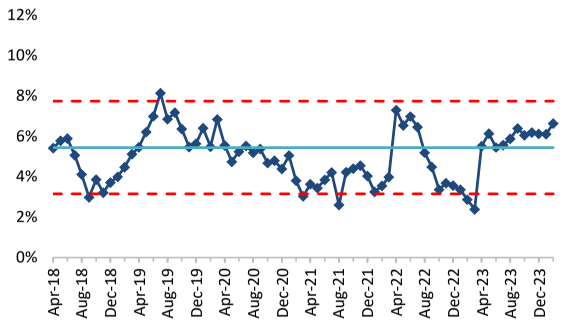
Other Staff Turnover (Rolling 12 months)



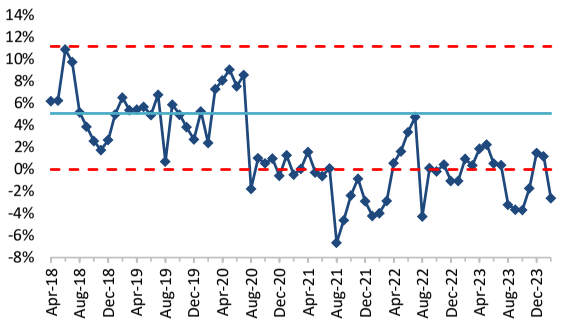
Workforce KPIs

The Walton Centre NHS
NHS Foundation Trust

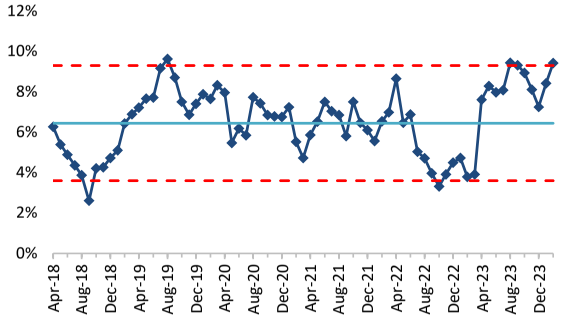
Overall Vacancy Level %



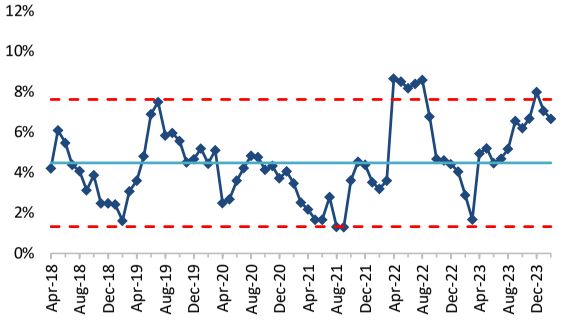
Medical Vacancy Level %



Nursing Vacancy Level %



Other Staff Vacancy Level %

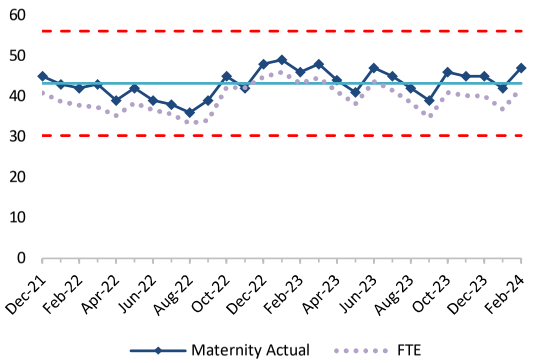


Vacancy Rates

The overall vacancy rate has remained within the control limits overall and for most groups. Medical vacancy rates have dropped below the lower control limit in February. Other staff vacancy levels decreased back within the control limits in January and have dropped again in February. Nursing vacancy rates are just above the upper control limit in February.

Vacancy rates include posts that have been recruited to but the post holder has not commenced employment yet.

Trust Level Maternity Data



Current month maternity figures

Directorate	Headcount	FTE
Corporate Services Directorate	5	4.37
Neurology & Long Term Care	19	17.11
Surgery & Critical Care	23	20.52
Grand Total	**47**	**42**

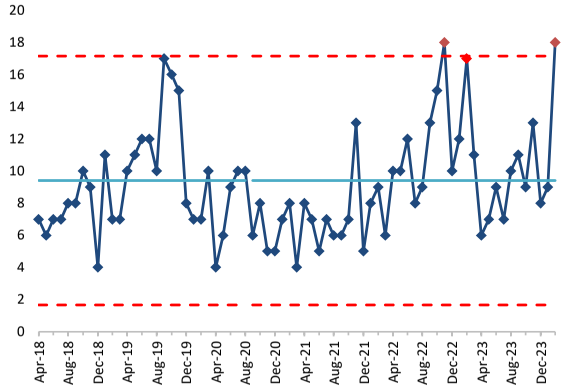
Quality Indicators

Complaints

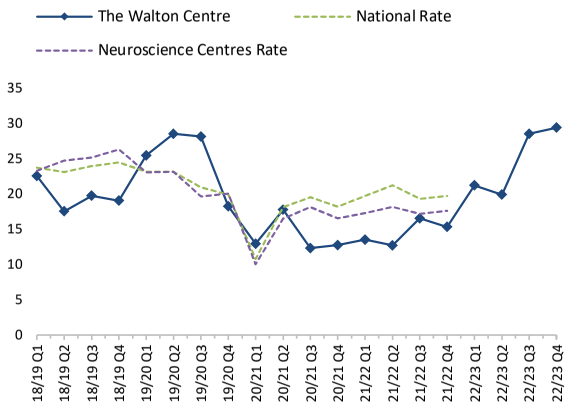
The Walton Centre NHS Foundation Trust

The Trust received eighteen new complaints in month which is above the control limit. Seven of these were in Neurosurgery, ten in Neurology and one has been jointly attributed.

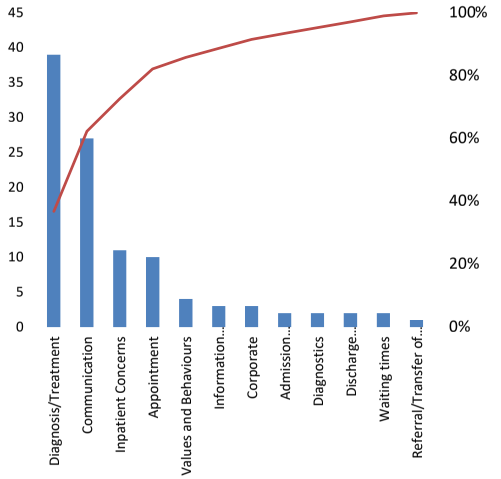
Total New Complaints Received in month



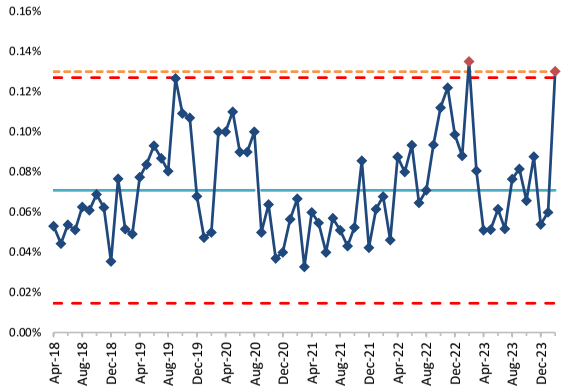
Quarterly Complaints per 1000 WTE



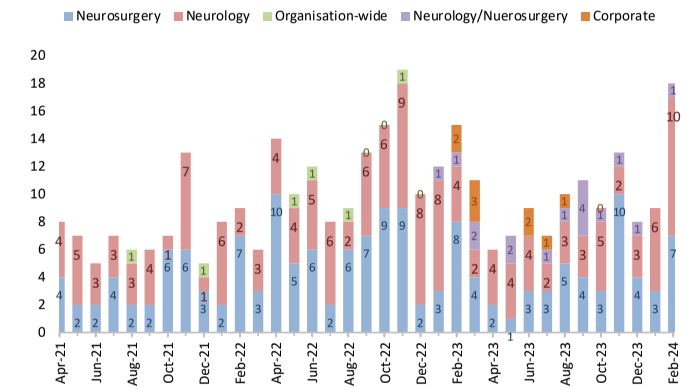
Complaints by Subject Financial Year to Date



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	38	18	17
20/21	44	24	5
21/22	38	22	10
22/23	64	36	36
23/24*	47	10	17

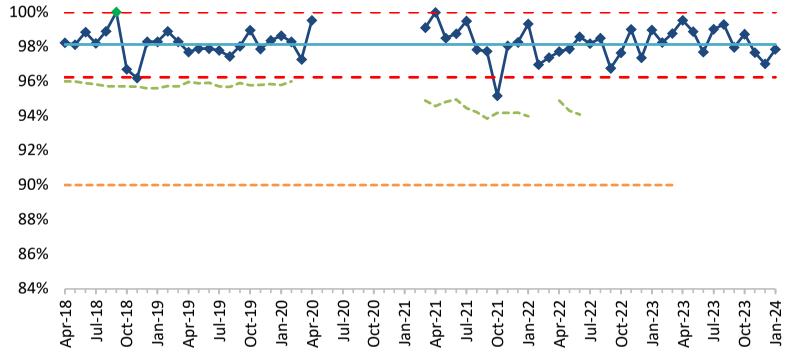
*from January 2023 there is now the option to attribute complaints to both divisions where this is necessary.

Family and Friends Test

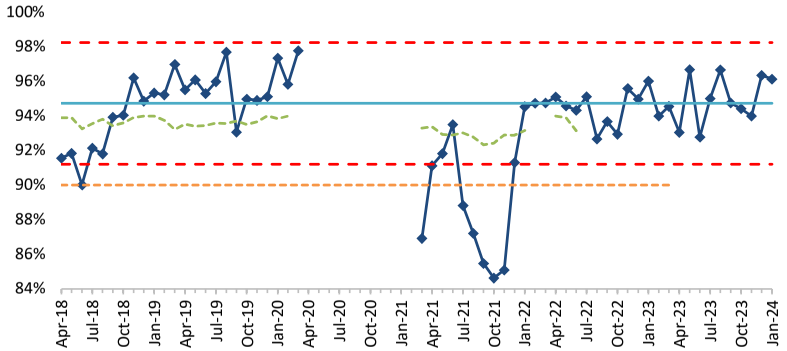
The Walton Centre NHS
NHS Foundation Trust

The response rate for February FFT is unfeasibly low and is being investigated. The charts below end in January 2024. A business case has been approved for an electronic FFT system and work is ongoing to establish a 'go-live' date.

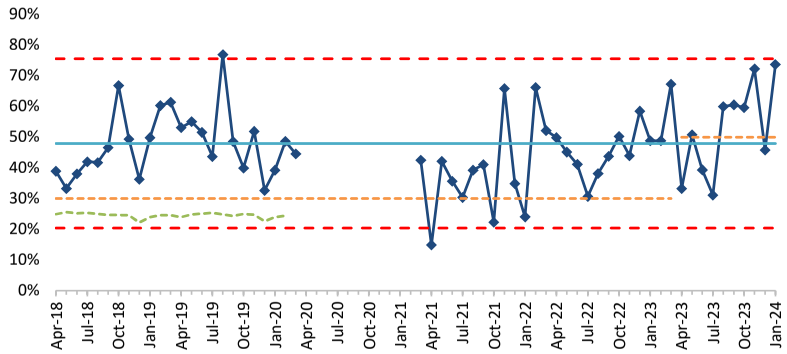
Inpatient FFT % Likely to Recommend



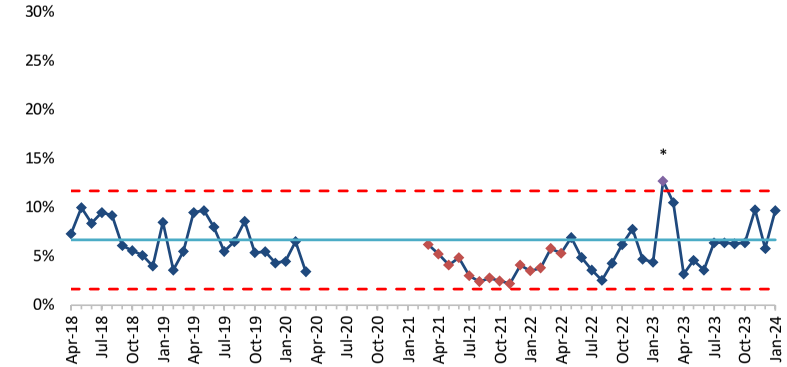
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate

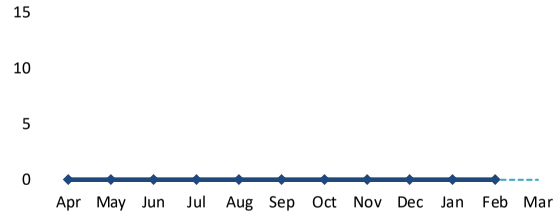


*This increase may be slightly inflated by a data collection issue leading to some January responses being recorded in February

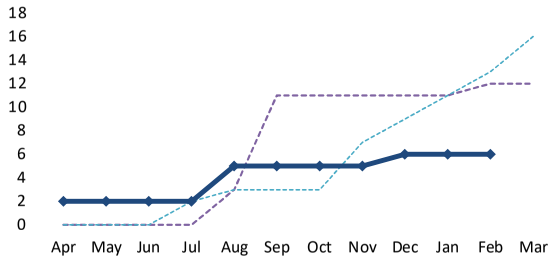
Infection Control

The Walton Centre NHS Foundation Trust

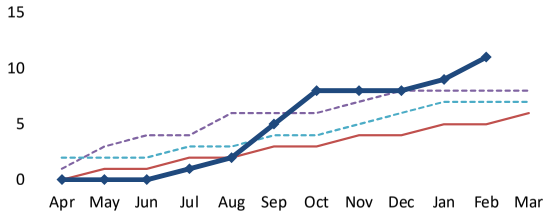
MRSA Bacteraemia



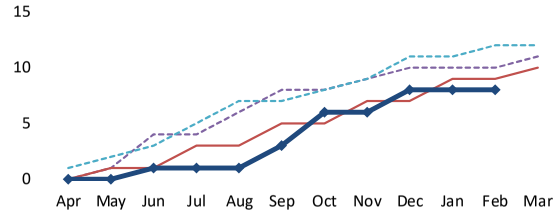
CPE



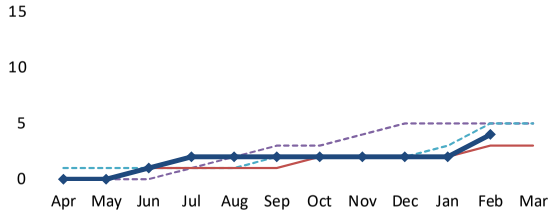
Clostridium difficile



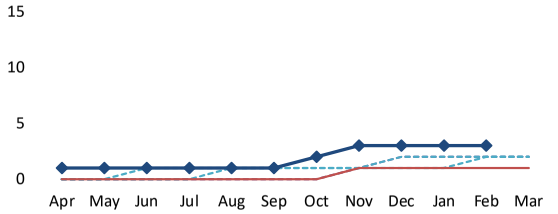
E.Coli



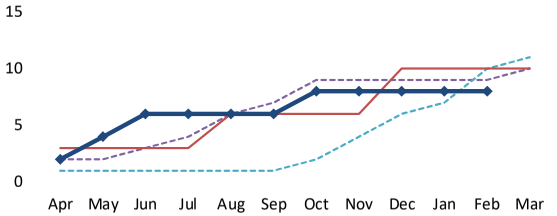
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2023/24

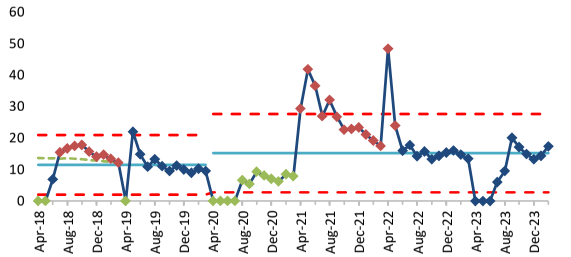
	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		3		2	1			**6**
Caton		1	1	1			1	**4**
Chavasse			1		1	1	3	**6**
CRU		1		1	2			**4**
Dott		1	2					**3**
Horsley			5	4		1	4	**14**
Lipton			2			1		**3**
Sherrington								**0**
Total	**0**	**6**	**11**	**8**	**4**	**3**	**8**	**40**

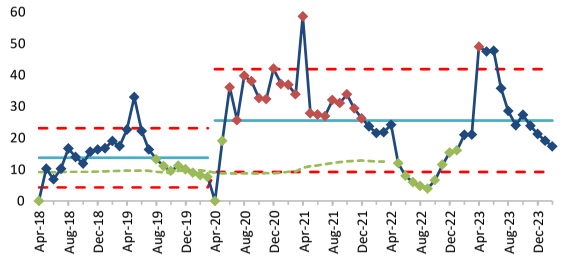
In Month Breakdown by Ward

Two CDT infections in month, one on each of Lipton and Horsley.
Two Klebsiella infections, one each on Chavasse and CRU.

Infection Control

The Walton Centre NHS Foundation Trust

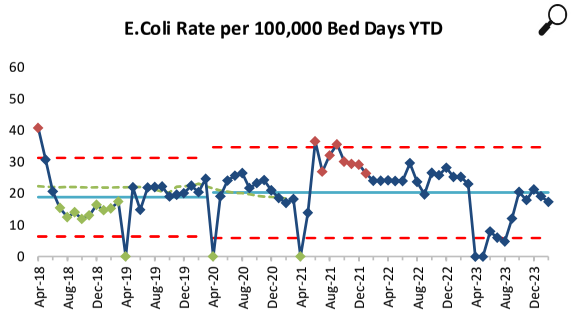


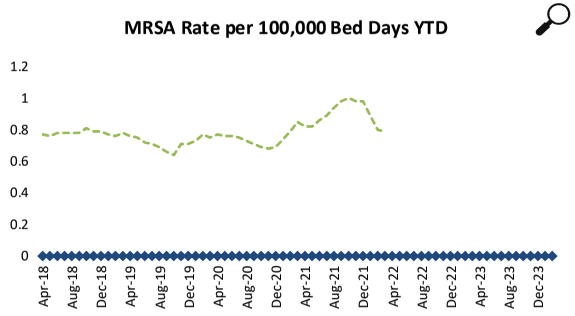


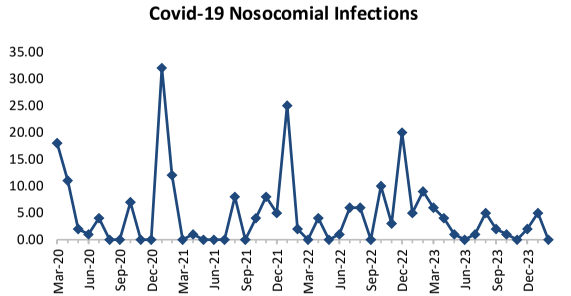
All infection rates are within normal variation this month.

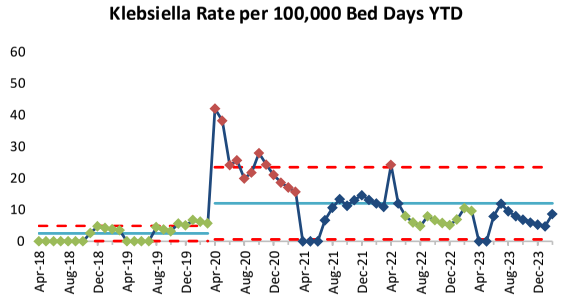
2023/24 to date

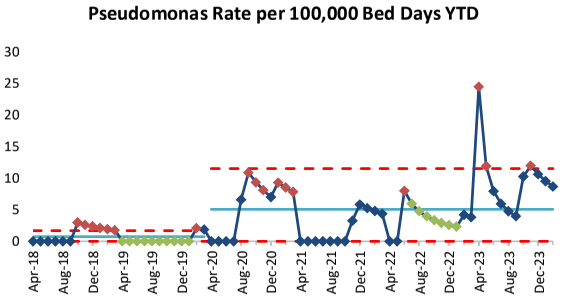
Infection	Number	Rate
C. Diff	11	17.35
MSSA	8	17.35
E. Coli	8	17.35
MRSA	0	0.00
Klebsiella Bacteraemia	4	8.67
Pseudomonas Bacteraemia	3	8.67
Covid -19	0	(in month)











Harm Free Care

The Walton Centre NHS Foundation Trust

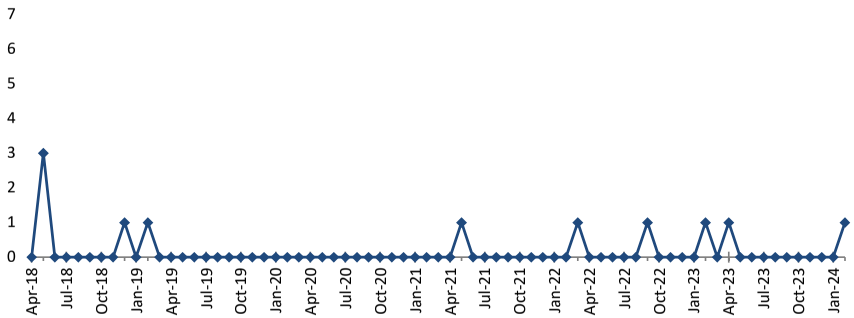
Falls: There was one fall in February which resulted in moderate harm, this has been reported as a patient safety incident.

CAUTI: There were two CAUTI incidents in February which is a return to control after a spike in January.

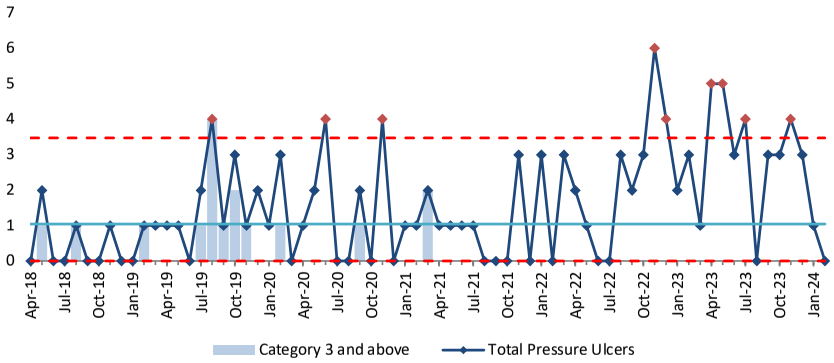
Pressure Ulcers: No pressure ulcers occured in February.

VTE: There were no VTE incident in month.

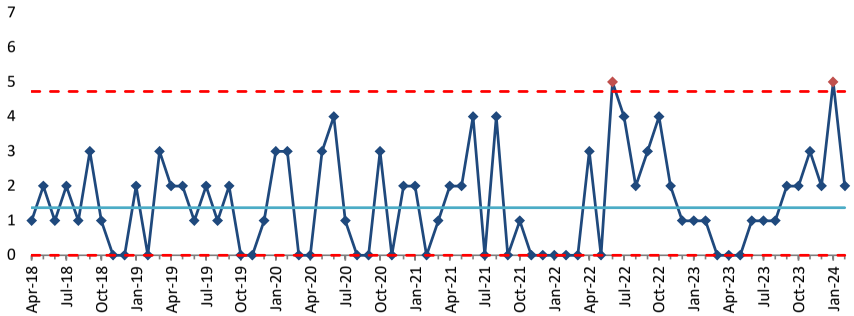
Total Moderate or Above Harm Inpatient Falls



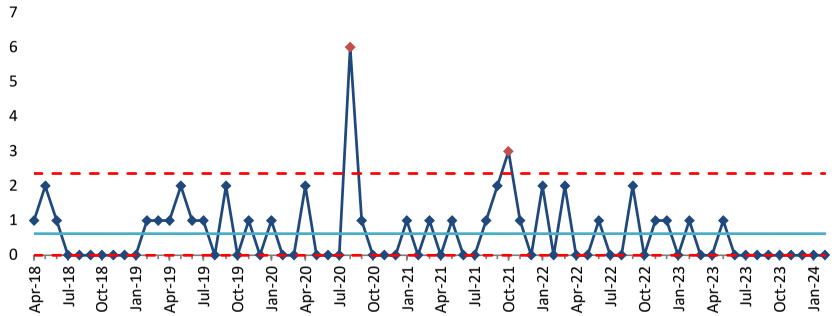
Total Hospital Acquired Pressure Ulcers



CAUTI Incidences



VTE Incidences

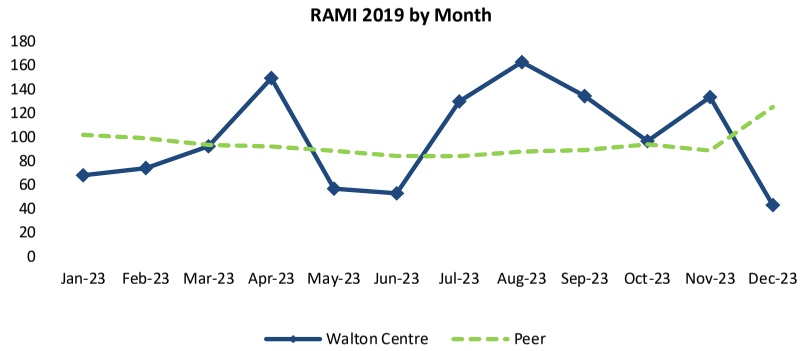


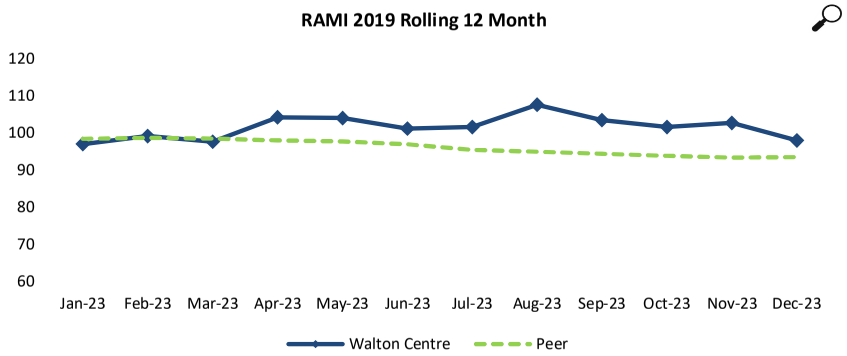
Mortality

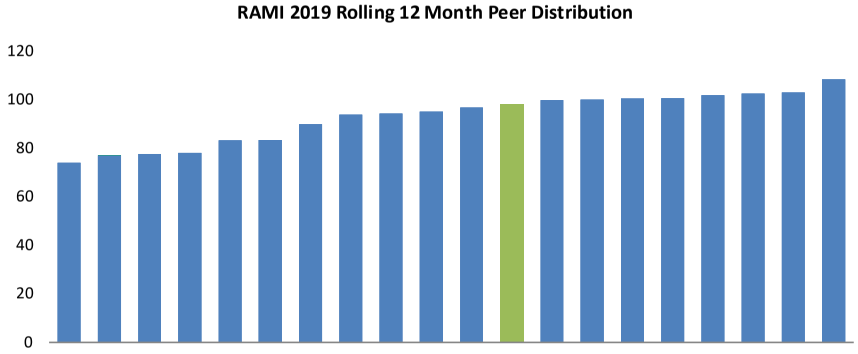
As at December 2023 the rolling 12 month RAMI19 figure is 98.05. During the period there were a total of 103 observed deaths against 105 expected deaths. When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 93.32.

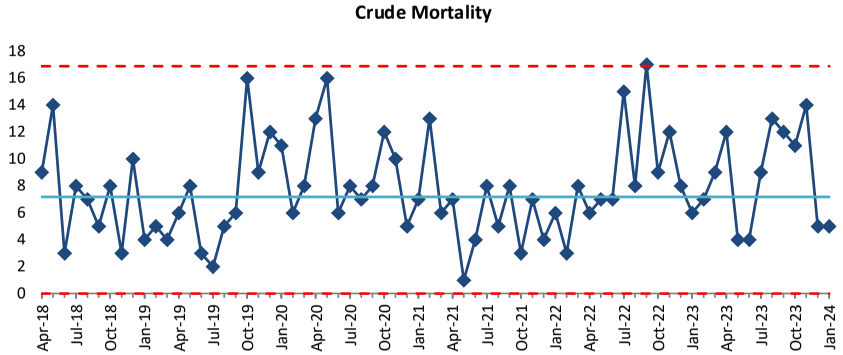
RAMI19 excludes deaths following a positive covid-19 result of which there have been zero since March.

Mortality rate and crude mortality remain within normal variation.



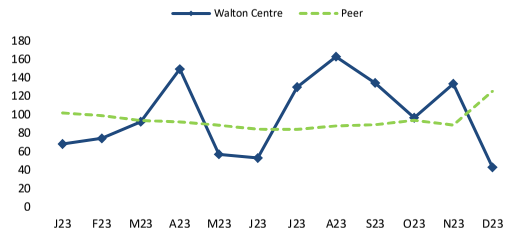


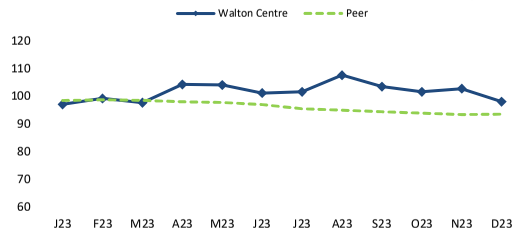


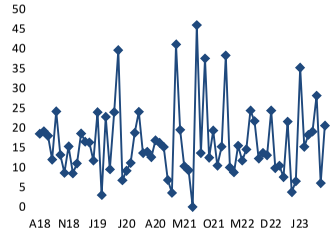


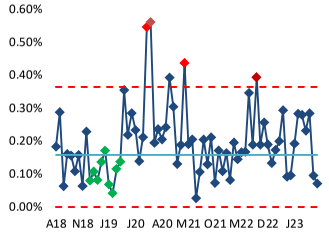
Mortality

The Walton Centre NHS Foundation Trust



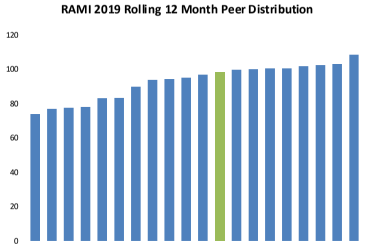


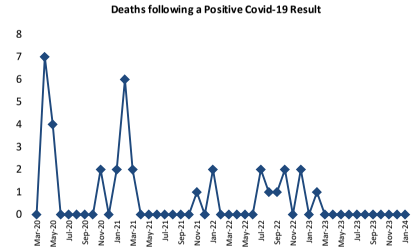




RAMI 2019 for all condition groups January 2023 to December 2023

CCS Group (Top 5)	Observed	Expected	Risk	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2019	**103**	**105**	**98.05**	**83.19**	**93.53**	**100.57**
109 - Acute cerebrovascular disease	39	48.00	81.90	85.98	92.68	102.79
233 - Intracranial injury	29	24.50	118.56	89.87	109.24	127.40
ereditary and degenerative nervous system conditions	4	4.20	96.05	50.30	82.38	110.75
237 - Complication of device; implant or graft	4	0.76	529.20	75.86	105.29	117.21
95 - Other nervous system disorders	3	1.91	157.20	95.10	120.67	154.97

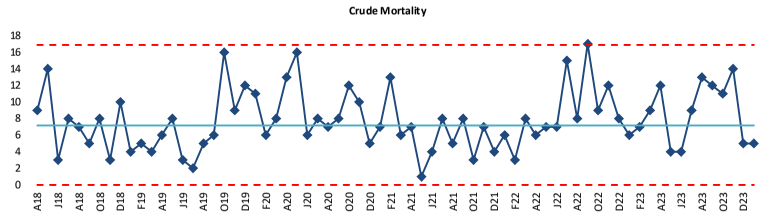


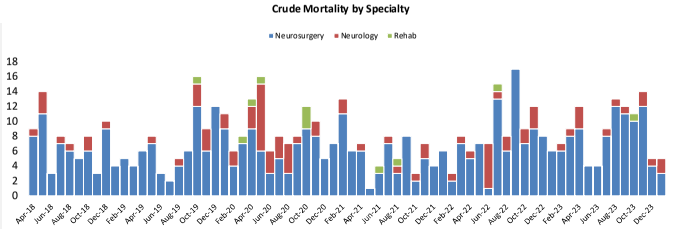


RAMI 2019 for HSMR condition groups January 2023 to December 2023

CCS Group	Observed	Expected	Risk	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2019	**77**	**83**	**93.32**	**81.16**	**90.28**	**98.55**
109 - Acute cerebrovascular disease	39	48.00	81.90	85.98	92.68	102.79
233 - Intracranial injury	29	24.50	118.56	89.87	109.24	127.40
237 - Complication of device; implant or graft	4	0.76	529.20	75.86	105.29	117.21
42 - Secondary malignancies	2	3.90	50.66	64.85	85.24	111.93
231 - Other fractures	2	1.25	160.53	88.14	112.37	144.07

*Conditions in the above tables are primary diagnosis so may not represent cause of death.





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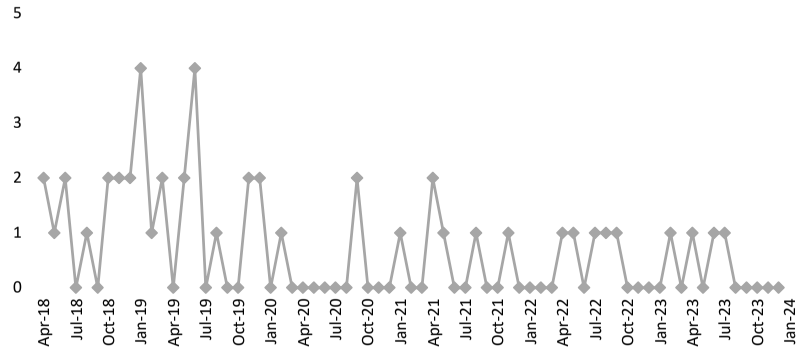
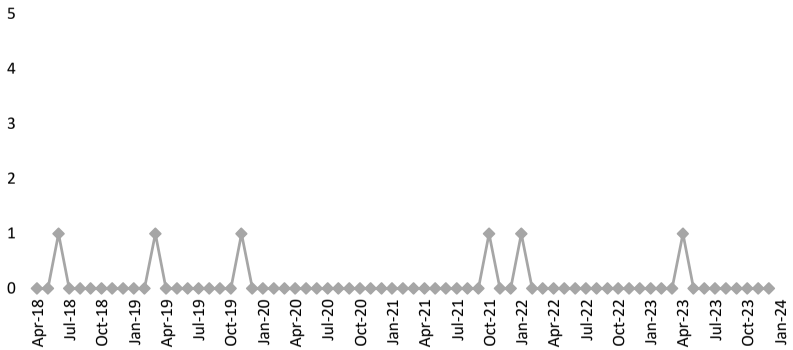
Governance

Total Confirmed SIs Reported



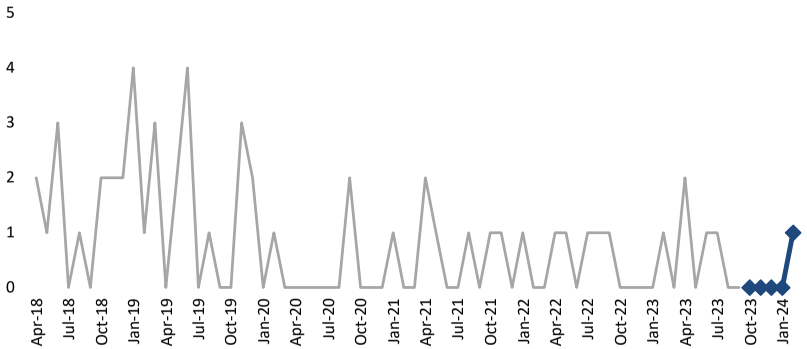
Total Confirmed Never Events Reported



From October 2023 reporting of SI and Never Events have been combined under a single metric National PSIIs (Patient Safety Incident investigations) in line with national standards.

The chart below shows the combined history of Serious Incidents and Never Events (in grey) to provide context for this new metric. The PSIIs will be reported in blue on the same chart from October 2023 data.

Patient Safety Incident Investigations



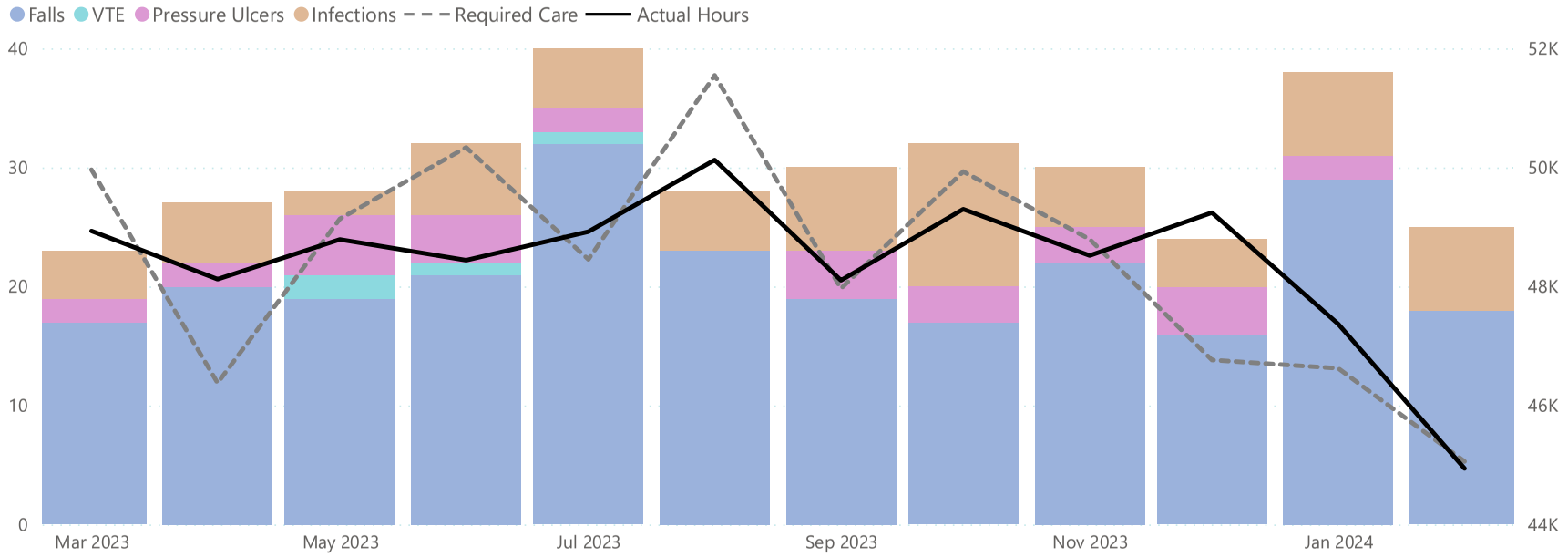
Required and Actual Care Hours Compared to Avoidable Harms by Ward.

The Walton Centre NHS Foundation Trust

The table below shows the individual instances of harms in month compared to the levels of staffing and leave.
All staffing metrics are measured in total hours and each incident or infection results in a single count in the appropriate column.

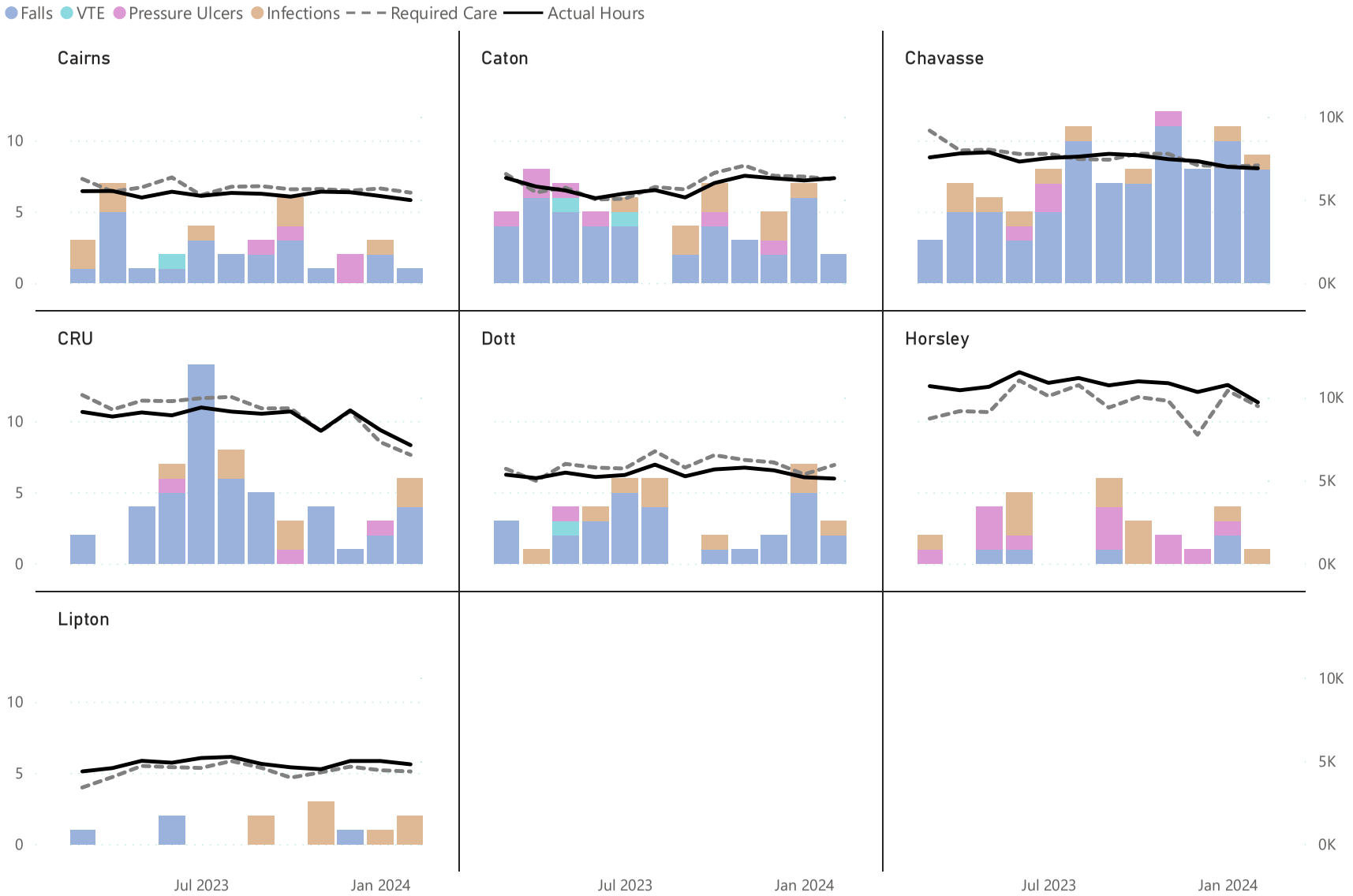
Ward	Planned	Required	Actual	Bank	Additional	Study	Sickness	Parental	Annual	Flags	Infections	VTE	Falls	PU
Cairns	4,785	5,435	4,984	1,642	55	1,535	3,803	5,470	5,682				1	
Caton	6,120	6,223	6,305	1,950	92	1,612	7,662	1,163	7,929	1			2	
Chavasse	6,360	7,069	6,898	1,851	114	1,403	3,669	1,598	7,144		1		8	
CRU	7,770	6,541	7,125	761		1,625	4,275	2,745	9,642		2		4	
Dott	4,350	5,935	5,116	1,939	168	1,033	3,295	1,134	5,780		1		2	
Horsley	14,348	9,475	9,702	2,240		1,977	12,901	6,927	20,235		1			
Lipton	4,350	4,381	4,810	1,293	125	905	4,027	7	4,880		2			
Total	**48,083**	**45,058**	**44,940**	**11,675**	**554**	**10,091**	**39,633**	**19,044**	**61,291**	**1**	**7**		**17**	

The chart below shows that we saw high harms in October and December 2022 which are months where the overall level of actual staffing is noticeably below the required level. However in July 2023 we also saw high harms in spite of well matched staffing levels. The next page will show that this is driven mostly by falls on CRU which did have less than required staffing in July.



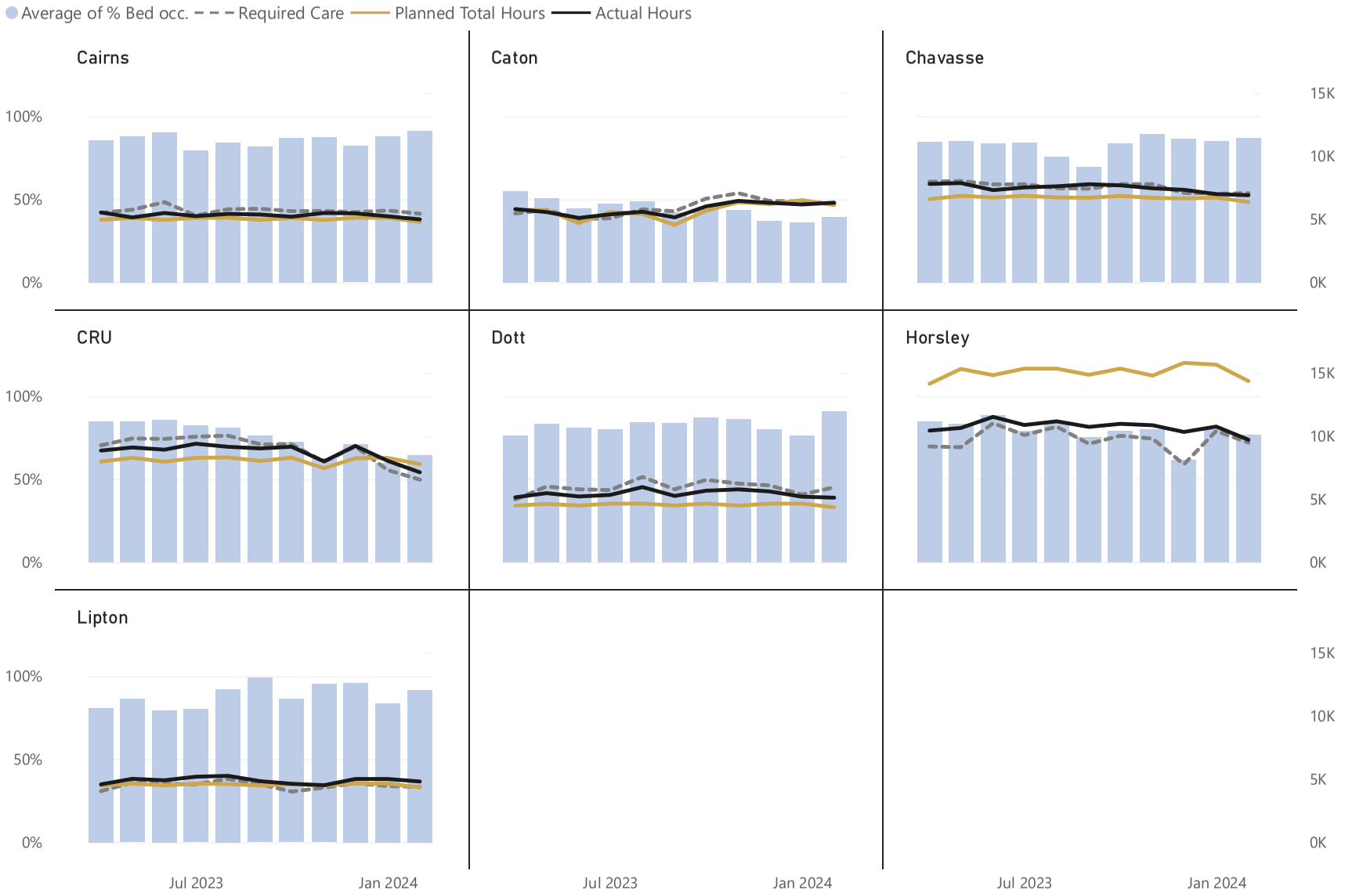
Required and Actual Care Hours Compared to Avoidable Harms by Ward.

The Walton Centre NHS Foundation Trust



Required and Actual Care Hours Compared to Occupancy and Establishment

The Walton Centre NHS Foundation Trust



WELL LED

Finance

Key Performance Indicators	December	January	February
% variance from plan - Year to date	70.0%	67.4%	74.0%
% variance from plan - Forecast	68.3%	68.3%	78.9%
% variance from efficiency plan - Year to date	0.0%	0.0%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	42.7%	53.5%	19.2%
Capital % variance from plan - Forecast	13.3%	5.9%	5.7%
Capital Service Cover *	3.9	4.1	4.3
Liquidity **	52.2	54.3	54.1
Cash days operating expenditure ***	100.0	102.0	104.0
BPPC - Number	89.7%	89.7%	90.0%
BPPC - Value	91.9%	92.1%	92.4%

* Capital service cover - the level of income available to fund the Trust's capital commitments

** Liquidity - the level of cash available to fund the Trust's activities

*** Number of days cash available to cover operating expenditure

Please see glossary at end of the finance IPR for an explanation of key performance indicators.

Trust I&E	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	14,026	14,949	923	154,279	165,185	10,906	168,305	179,989	11,684
Other operating income	645	657	12	7,096	8,267	1,171	7,745	9,155	1,410
Donated Income/Grants	0	0	0	0	0	0	0	100	100
Total Operating Income	**14,671**	**15,606**	**935**	**161,375**	**173,452**	**12,077**	**176,050**	**189,244**	**13,194**
Employee expenses	(7,486)	(7,448)	38	(82,297)	(86,044)	(3,747)	(89,787)	(93,791)	(4,004)
Operating expenses excluding employee expenses	(6,896)	(7,525)	(629)	(74,883)	(80,991)	(6,108)	(81,779)	(88,348)	(6,569)
Total Operating Expenditure	**(14,382)**	**(14,973)**	**(591)**	**(157,180)**	**(167,035)**	**(9,855)**	**(171,566)**	**(182,139)**	**(10,573)**
EBIT	**289**	**633**	**344**	**4,195**	**6,417**	**2,222**	**4,484**	**7,105**	**2,621**
Finance income	140	218	78	1,540	2,198	658	1,680	2,398	718
Finance expense	(48)	(39)	9	(528)	(485)	43	(578)	(529)	49
PDC dividends payable/refundable	(147)	(156)	(9)	(1,617)	(1,719)	(102)	(1,764)	(1,875)	(111)
Other gains/(losses) including disposal of assets	0	4	4	0	0	0	0	0	0
Financial performance surplus/(deficit)	**234**	**660**	**426**	**3,590**	**6,411**	**2,821**	**3,822**	**7,099**	**3,277**
I&E impact capital donations and profit on asset disposals	21	22	1	235	244	9	257	197	(60)
Adjusted financial performance surplus/(deficit)	**255**	**682**	**427**	**3,825**	**6,655**	**2,830**	**4,079**	**7,296**	**3,217**

The plan for 2023/24 was initially a £4,079k surplus position (submitted to the Cheshire and Merseyside Integrated Care System and NHS England in May as part of the 2023/24 planning process).

The current plan includes:

- 'Block' elective recovery fund (ERF) income and costs for the delivery of activity to deliver the national trajectory targets.
- 'Block' system funding for Top-up, and growth.
- Aligned incentive payment contracts (API) for both specialised and non-specialised activity in which all elective activity (outpatient first, procedures, day-case and inpatient elective activity) is paid on a cost per case basis.
- Recurrent efficiency requirement of 5.0% of operating expenses (excluding high-cost drugs and devices).

Month 11 – in month the Trust posted a £682k surplus position against a plan of £255k, £427k above plan.

Year to date-the Trust has reported a £6,655k surplus position against a planned position of £3,825k, £2,830k ahead of plan.

Income – Year to date overperformance of £12,077k, due to:

- Increased NHSE funding relating to overperformance on elective activity compared to target threshold;
- Increased NHS funding relating to the 2023/24 Agenda for Change and Medics pay award;
- Increased NHS funding for High-cost Drugs and Devices (offset in expenditure);
- Increased funding in relation to industrial action;
- Income received for training from NHS England; and
- Salary recharge income to external bodies.

Expenditure (inc. Financing Costs) – Year to date over-spend of £9,247k due to:

- Increased pay costs for year-to-date impact of Agenda for Change & Medic pay awards which the Trust was informed not to include in the plan; and
- Increased spend on High-Cost Drugs (Homecare Drugs & Prescribing Drugs) and Devices.

The Trust forecast for the year has increased to a £7,296k surplus against a plan of £4,079k, £3,217k above target. This is above the Trusts re-forecast position of £2,787k post M7 agreed at Trust Board and submitted to C&M ICB and NHS England following the lowering of national trajectory targets for elective performance to help fund pressures due to the impact of industrial action April to December. Further funding has now been made available to cover industrial action in December and January which has improved the Trusts overall forecast position.

STATEMENT OF FINANCIAL POSITION - 2023/24	Plan Feb 24	Actual Feb 24	Variance
	£'000	£'000	£'000
Intangible Assets	766	682	(84)
Tangible Assets	100,771	99,760	(1,011)
Leased Assets - Right of use assets	705	627	(78)
Receivables	324	324	0
TOTAL NON CURRENT ASSETS	**102,566**	**101,393**	**(1,173)**
Inventories	1,042	1,460	418
Receivables	7,401	8,817	1,416
Cash at bank and in hand	52,335	51,279	(1,056)
TOTAL CURRENT ASSETS	**60,778**	**61,556**	**778**
Payables	(35,748)	(32,594)	3,154
Borrowings	(1,783)	(1,708)	75
Provisions	(80)	(80)	0
TOTAL CURRENT LIABILITIES	**(37,611)**	**(34,382)**	**3,229**
TOTAL ASSETS LESS CURRENT LIABILITIES	**125,733**	**128,567**	**2,834**
Borrowings	(19,890)	(19,916)	(26)
Provisions	(499)	(484)	15
TOTAL ASSETS EMPLOYED	**105,344**	**108,167**	**2,823**
Public Dividend Capital	38,028	38,028	0
Revaluation Reserve	14,412	14,412	0
Income and Expenditure Reserve	52,904	55,727	2,823
TOTAL TAXPAYERS EQUITY AND RESERVES	**105,344**	**108,167**	**2,823**

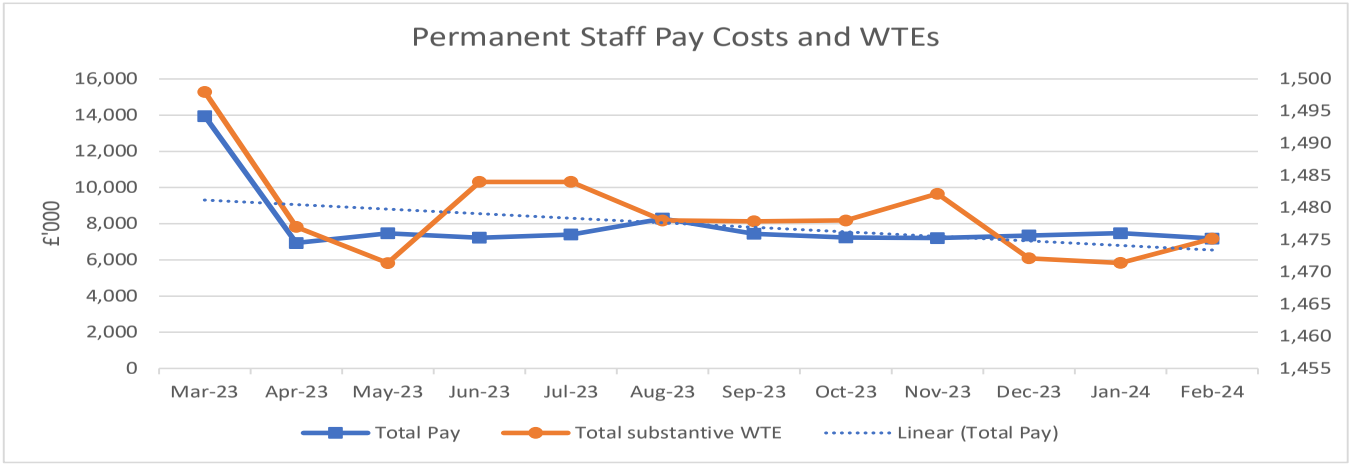
Leased assets are now split in line with acccounting requirements under IFRS 16.

STATEMENT OF CASH FLOW - 2023/24	Plan Feb-24	Plan Feb-24	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**4,195**	**6,420**	**2,225**
Non-cash income and expense:	7,191	7,666	475
Working Capital	(23)	(6,361)	(6,338)
Net cash generated from/(used in) operations	**11,363**	**7,725**	**(3,638)**
Cash flows from investing activities	(3,633)	(1,116)	2,517
Cash flows from financing activities	(3,114)	(3,049)	65
Increase/(decrease) in cash and cash equivalents	**4,616**	**3,560**	**(1,056)**
OPENING CASH	**47,719**	**47,719**	**0**
CLOSING CASH	**52,335**	**51,279**	**(1,056)**

At the end of February - £51,279k cash balance compared to £52,335k plan, an adverse variance of £1,056k:

- Operating Surplus £2,225k
- Depreciation £476k
- Movement in inventories: (£418k)
- Movement in payables/receivables: (£5,920k)
- Interest receivable: £658k
- Capital programme: £1,859k
- Other £64k
- **Total** **(£1,056k)**

This is driven by the payment of the 2022/23 non-consolidated pay award.



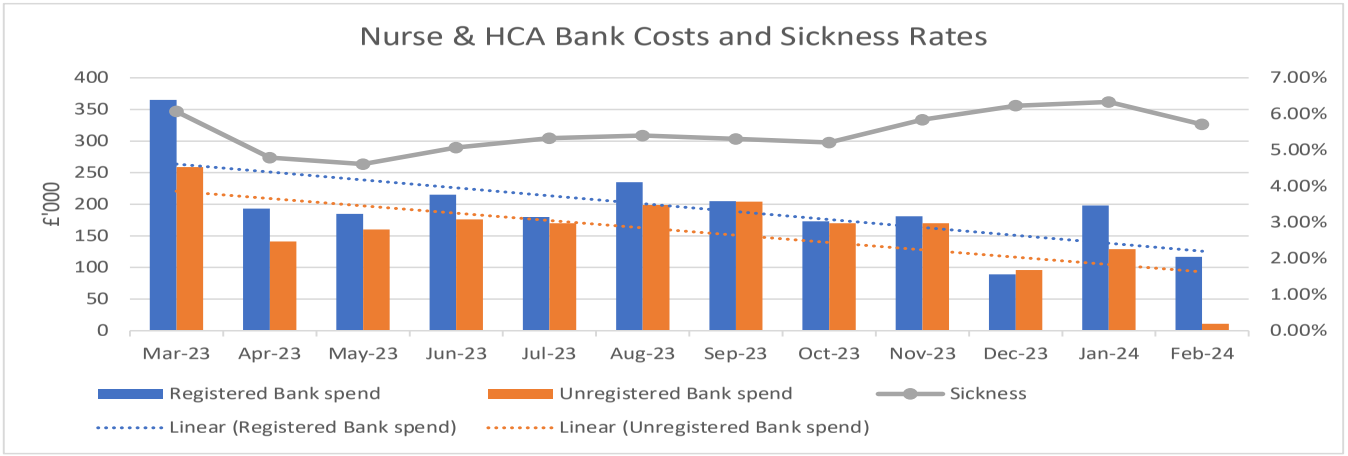
March 2023 increase is due to additional pay award and pension contribution, both offset in income.

Pay costs:

- Dec: £7,349k
- Jan: £7,477k
- Mar: £7,176k

WTE:

- Dec: 1,472 WTE
- Jan: 1,471 WTE
- Feb: 1,475 WTE



This is a key area of focus for NHSE/I.

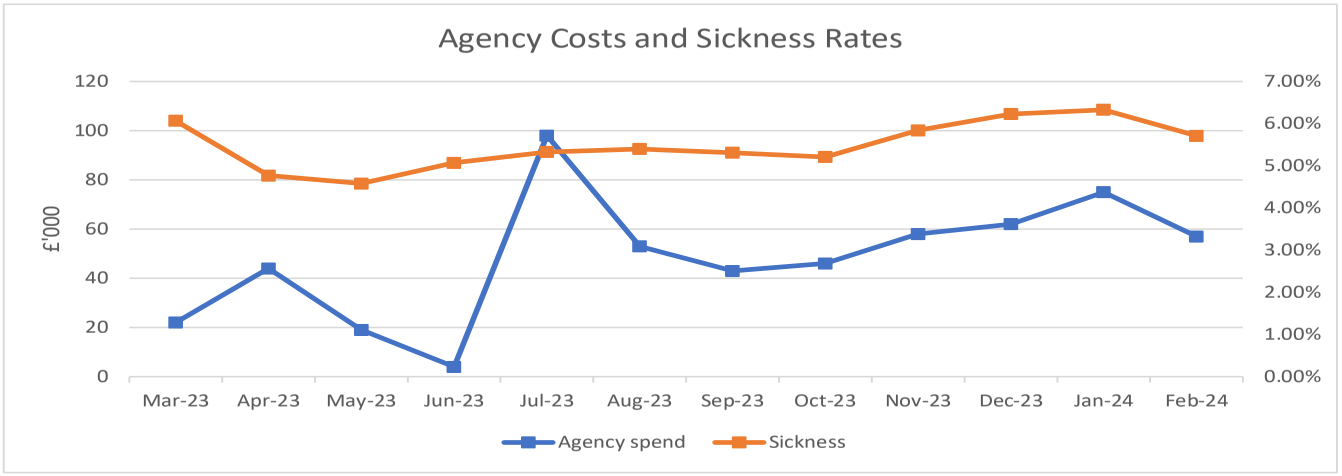
Increase in March 2023 is due to pay award for bank staff. Increase in RN costs in August 2023 due to bed days in ITU, and increased HCA costs due to bed days and acuity across the wards. Reduced cost in December 2023 due to reversal of estimate for 23/24 pay award now in the financial position.

Total Bank costs:

- Dec: £269k
- Jan: £386k
- Feb: £217k

Sickness rate:

- Dec: 6.23%
- Jan: 6.33%
- Feb: 5.71%



This is a key area of focus for NHSE/I.

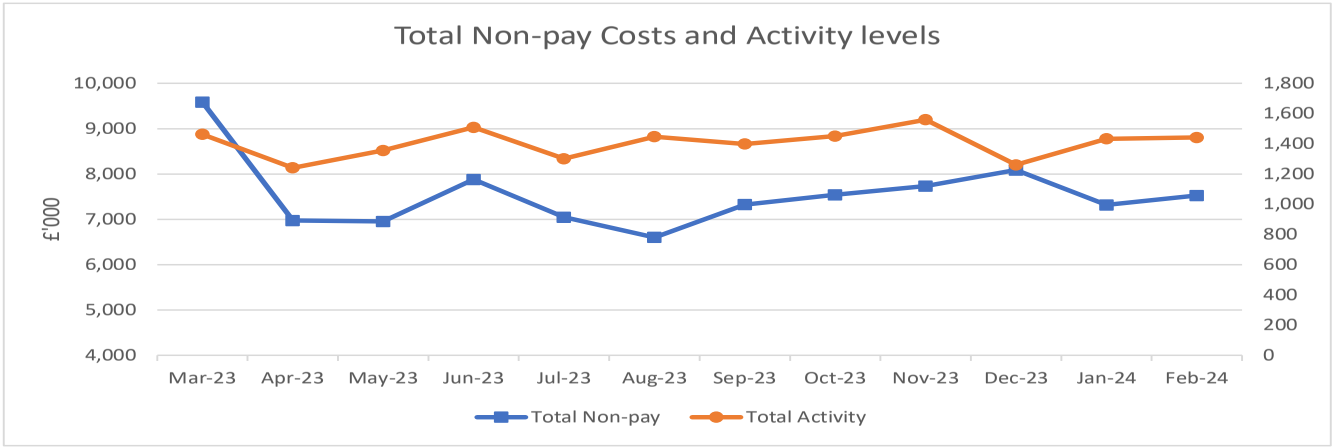
Increase in agency in July 2023 is due to recoding of IT agency staff previously allocated to specific capital projects.

Agency costs:

- Dec: £62k
- Jan: £75k
- Feb: £57k

Sickness rate:

- Dec: 6.23%
- Jan: 6.33%
- Feb: 5.71%



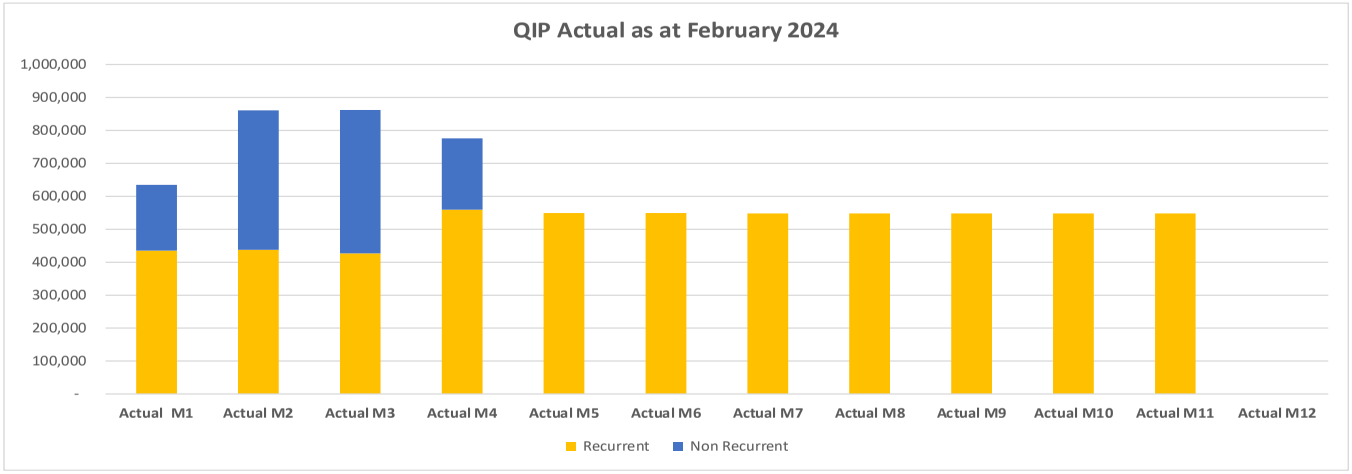
Increased costs in March 2023 are caused by increased consumable spend at the financial year end and works carried out by Estates.

Non-pay costs:

- Dec: £8,087k
- Jan: £7,319k
- Feb: £7,525k

Inpatient activity:

- Dec: 1,261 spells
- Jan: 1,437 spells
- Feb: 1,442 spells



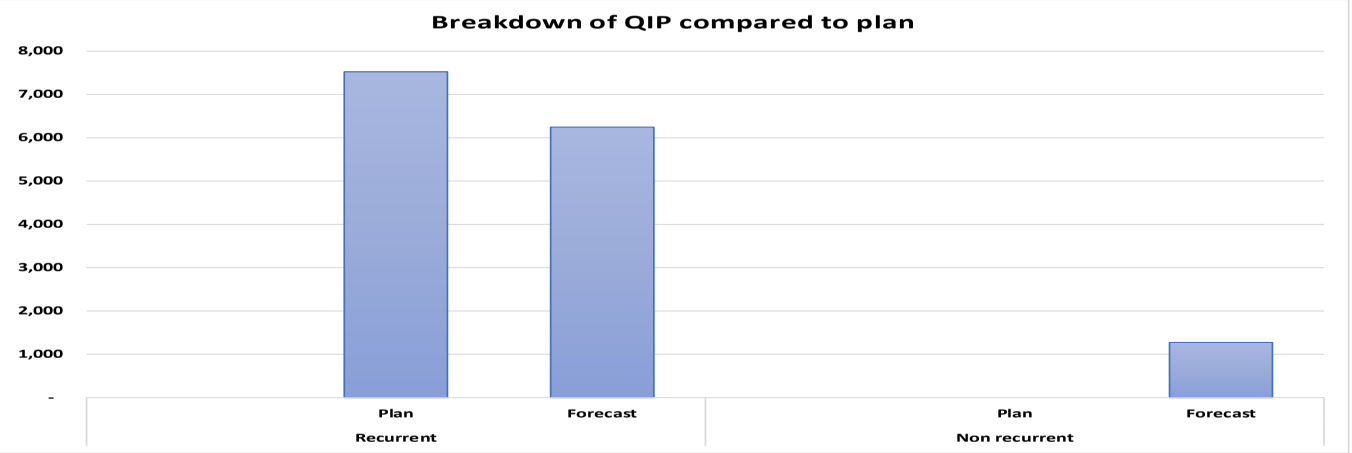
The Trust has a QIP target of £7,520k for the 2023/24 financial year. At M11 the QIP target YTD was achieved via £5,698k recurrent and £1,274k non recurrent savings.

Recurrent CIP:

- Dec: £548k
- Jan: £548k
- Feb: £548k

Non-recurrent CIP:

- Dec: £0k
- Jan: £0k
- Feb: £0k



The ICS has requested that all QIP be achieved recurrently this financial year with a Trust plan of £7,520k.

Year to date 83% of the target was achieved recurrently, with 17% achieved non recurrently.

As service transformation projects take place it is hoped that further recurrent savings will be identified.

QIP plans are currently being put in place for 2024/25 financial year as part of the 2024/25 business planning process.

PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
NHS England	9,927	9,509	(418)	109,200	116,992	7,792	119,128	127,482	8,354
Clinical Commissioning Groups	2,099	2,614	515	23,092	24,198	1,106	25,191	26,398	1,207
Wales	1,748	2,443	695	19,225	20,680	1,455	20,972	22,560	1,588
Isle of Man	177	226	49	1,952	1,910	(42)	2,130	1,942	(188)
Other Patient Related Income	75	157	82	810	1,405	595	884	1,607	723
Total Patient Related Income	**14,026**	**14,949**	**923**	**154,279**	**165,185**	**10,906**	**168,305**	**179,989**	**11,684**

To note that patient related income includes ERF income.

NON-PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Non-patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
Research & Development Income	92	71	(21)	1,008	1,157	149	1,098	1,262	164
Education And Training	273	402	129	3,004	3,468	464	3,277	3,923	646
Employee Benefits Income	190	211	21	2,062	2,690	628	2,249	2,935	686
Other Non-patient Related Income	90	(27)	(117)	1,022	952	(70)	1,121	1,135	14
Total Patient Related Income	**645**	**657**	**12**	**7,096**	**8,267**	**1,171**	**7,745**	**9,255**	**1,510**

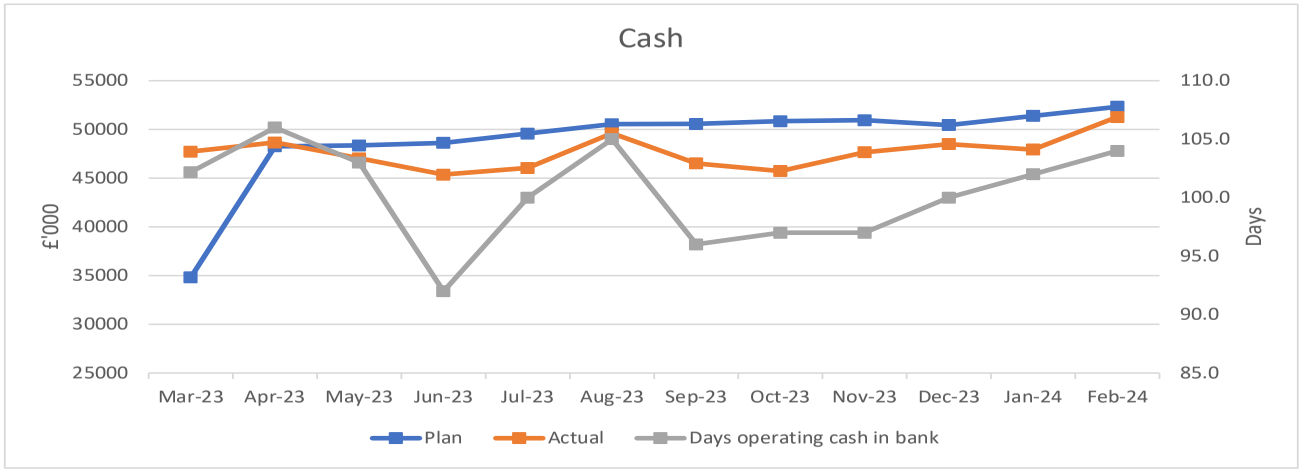
ERF

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Elective Recovery Funding	402	(702)	(1,104)	4,419	5,949	1,530	4,821	6,429	1,608

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	75	45	30	815	378	437	890	172	718
Estates-Ponta systems	0	0	0	450	396	54	450	396	54
Estates-Theatres air handling units	0	819	(819)	2,010	953	1,057	2,010	1,599	411
Estates-General	0	0	0	0	18	(18)	0	88	(88)
IM&T	19	0	19	201	0	201	220	0	220
Neurology-Ultramax Flouro machine	0	435	(435)	0	435	(435)	1,050	670	380
Neurology-Other clinical equipment	0	7	(7)	0	7	(7)	0	229	(229)
Neurophysiology	0	(26)	26	0	338	(338)	0	462	(462)
Neurosurgery-Other clinical equipment	19	36	(17)	206	450	(244)	225	1,229	(1,004)
TOTAL (excl. external funding)	**113**	**1,316**	**(1,203)**	**3,682**	**2,975**	**707**	**4,845**	**4,845**	**0**
Right of Use Assets - IFRS16	0	0	0	0	0	0	1,400	1,028	372
MR Offices and Canulation Area	0	0	0	0	0	0	13	13	0
Donated Assets	0	0	0	0	0	0	69	69	0
PACS (PDC)	0	0	0	0	0	0	31	31	0
Diagnostics Digital Capability (PDC)	0	0	0	0	0	0	185	185	0
TOTAL (incl. external funding)	**0**	**0**	**0**	**0**	**0**	**0**	**1,698**	**1,326**	**372**
TOTAL	**113**	**1,316**	**(1,203)**	**3,682**	**2,975**	**707**	**6,543**	**6,171**	**372**

- Capital expenditure in month of £1,316k, against a plan of £113k, a variance of £1,203k above plan.
- YTD capital is underspent by £707k.
- Current year spend on divisional schemes includes:
  - Ponta Systems ITU
  - Heating & Pipework
  - Air Handling Units
  - Radiology Flouroscopy suite:
  - Neurophysiology Equipment
  - Neurosurgery Equipment – Theatre Microscope.
- Full year plan is set at £4,845k (excluding the impact of IFRS 16 for leased assets, Donated assets and grant funded assets).
- VAT recovery on the Heating & Pipework has been confirmed with the forecast benefit to be transacted in March.
- Forecast £372k under-performance IFRS 16 leased assets.



The cash plan was updated this year to reflect the higher cash balances held by the Trust in 2022/23 hence the increase in the planned amount in April 2023.

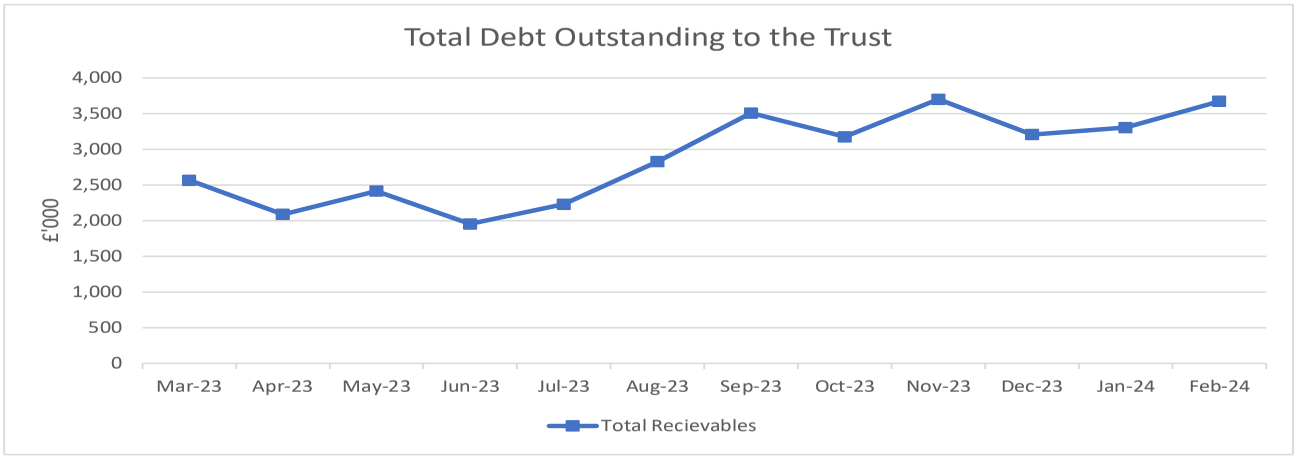
Performance against plan is driven by the payment of 2022/23 pay award.

Cash:

- Dec: £48,501k
- Jan: £47,943k
- Feb: £51,279k

Operating expenditure days cover:

- Dec: 100 days
- Jan: 102 days
- Feb: 104 days

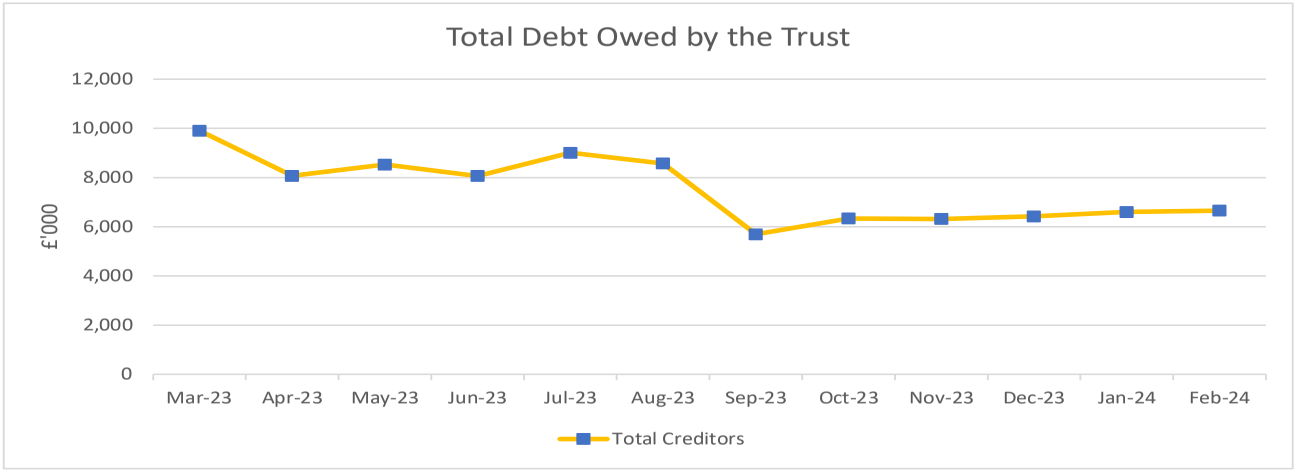


November 2023 due to an increased level of R&D invoices raised in month (0-30 days) and an adjustment invoice raised to Isle of Man, of which the Isle of Man has since been paid.

February 2024 due to a high level of NHS invoices raised and R&D Non-NHS invoices.

Debt outstanding to Trust:

- Dec: £3,208k
- Jan: £3,305k
- Feb: £3,673k

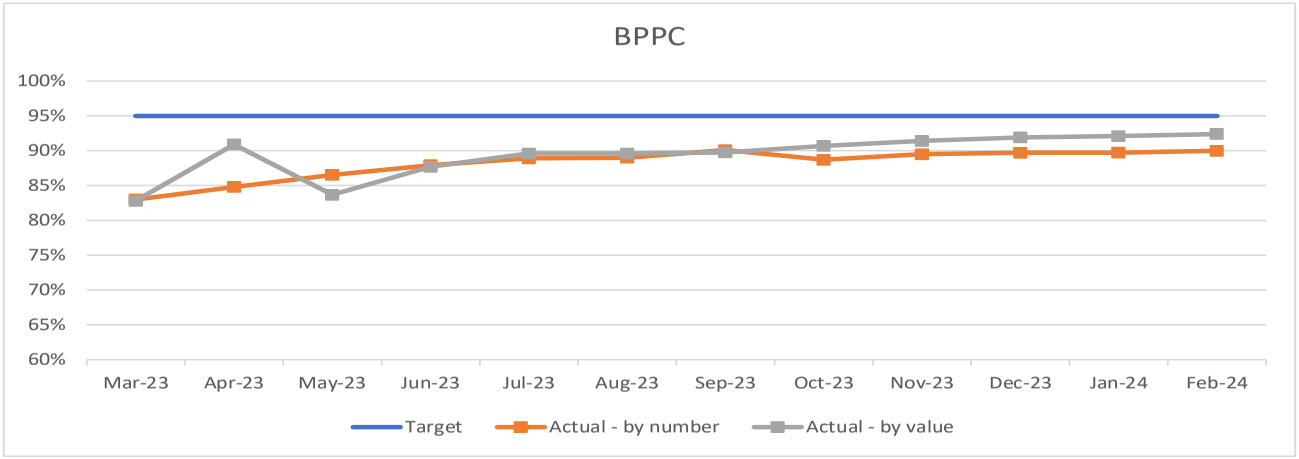


Debt owed by the Trust:

March 2023 due to both capital and estates works invoices received in month not due for Payment until April. NHS Supply Chain in month is also higher than previous periods with payment due in April.

Decrease in Sep 2023 due to payment of historic debt to Liverpool University Hospitals.

- Dec: £6,422k
- Jan: £6,602k
- Feb: £6,658k



This is a key area of focus for NHSE/I.

- The Trust BPPC percentage (by number of invoices paid) at the end of February is 90.0%. This has increased from 89.7% at the end of January.
- The Trust BPPC percentage (by value of invoices paid) at the end of January is 92.4%. This has increased from 92.1% at the end of January.
- The Trust continues to follow the action plan to improve BPPC performance. This involves collaborative working across the finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner prior to breaching the 30-day limit.
- BPPC is also being closely monitored by Audit Committee.

THE WALTON CENTRE NHS FOUNDATION TRUST
EXPENDITURE - NEUROLOGY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(523)	(439)	84	(5,721)	(4,947)	774	(6,244)	(5,386)	858
Allied health professionals	(544)	(510)	34	(5,981)	(5,751)	230	(6,521)	(6,261)	260
Other scientific, therapeutic and technical staff	(111)	(78)	33	(1,232)	(881)	351	(1,343)	(959)	384
Health care scientists	(77)	(73)	4	(782)	(753)	29	(859)	(826)	33
Support to nursing staff	(326)	(297)	29	(3,585)	(3,155)	430	(3,910)	(3,452)	458
Support to allied health professionals	(83)	(83)	0	(906)	(947)	(41)	(988)	(1,030)	(42)
Support to other clinical staff	(1)	(1)	0	(8)	(8)	0	(9)	(8)	1
Medical - Consultants	(874)	(856)	18	(9,745)	(9,379)	366	(10,615)	(10,234)	381
Medical - Junior	(282)	(335)	(53)	(3,035)	(3,153)	(118)	(3,304)	(3,488)	(184)
NHS infrastructure support	(239)	(221)	18	(2,606)	(2,373)	233	(2,845)	(2,594)	251
Bank/Agency	(39)	(140)	(101)	(519)	(1,877)	(1,358)	(519)	(2,016)	(1,497)
Total Pay Expenditure	**(3,099)**	**(3,033)**	**66**	**(34,120)**	**(33,224)**	**896**	**(37,157)**	**(36,254)**	**903**
Supplies and services – clinical (excluding drugs costs)	(715)	(735)	(20)	(7,885)	(9,355)	(1,470)	(8,600)	(10,206)	(1,606)
Supplies and services - general	(17)	(23)	(6)	(191)	(270)	(79)	(209)	(295)	(86)
Drugs costs	(2,004)	(2,443)	(439)	(22,041)	(26,075)	(4,034)	(24,044)	(28,446)	(4,402)
Establishment	(3)	(8)	(5)	(31)	(98)	(67)	(33)	(107)	(74)
Premises - other	(100)	(102)	(2)	(1,102)	(1,277)	(175)	(1,202)	(1,394)	(192)
Transport	(5)	(4)	1	(60)	(77)	(17)	(65)	(84)	(19)
Education and training - non-staff	(3)	(2)	1	(28)	(26)	2	(30)	(29)	1
Lease expenditure	(6)	(6)	0	(66)	(67)	(1)	(72)	(73)	(1)
Other	(8)	(9)	(1)	(90)	(66)	24	(98)	(72)	26
Total Non-pay Expenditure	**(2,861)**	**(3,332)**	**(471)**	**(31,494)**	**(37,311)**	**(5,817)**	**(34,353)**	**(40,706)**	**(6,353)**
Total Divisional Operating Expenditure	**(5,960)**	**(6,365)**	**(405)**	**(65,614)**	**(70,535)**	**(4,921)**	**(71,510)**	**(76,960)**	**(5,450)**

THE WALTON CENTRE NHS FOUNDATION TRUST
EXPENDITURE - NEUROSURGERY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,354)	(1,187)	167	(14,876)	(13,016)	1,860	(16,220)	(14,203)	2,017
Allied health professionals	(198)	(206)	(8)	(2,163)	(2,247)	(84)	(2,358)	(2,453)	(95)
Other scientific, therapeutic and technical staff	(54)	(59)	(5)	(598)	(592)	6	(653)	(651)	2
Health care scientists	(82)	(81)	1	(899)	(884)	15	(981)	(965)	16
Support to nursing staff	(298)	(262)	36	(3,278)	(2,865)	413	(3,575)	(3,126)	449
Support to allied health professionals	(13)	(16)	(3)	(144)	(166)	(22)	(157)	(182)	(25)
Support to other clinical staff	(2)	(2)	0	(20)	(18)	2	(22)	(20)	2
Medical - Consultants	(854)	(870)	(16)	(9,155)	(9,256)	(101)	(9,965)	(10,127)	(162)
Medical - Junior	(409)	(463)	(54)	(4,498)	(4,605)	(107)	(4,904)	(5,068)	(164)
NHS infrastructure support	(245)	(259)	(14)	(2,707)	(2,544)	163	(2,953)	(2,803)	150
Bank/Agency	(36)	(306)	(270)	(326)	(2,535)	(2,209)	(326)	(2,840)	(2,514)
Total Pay Expenditure	**(3,545)**	**(3,711)**	**(166)**	**(38,664)**	**(38,728)**	**(64)**	**(42,114)**	**(42,438)**	**(324)**
Supplies and services – clinical (excluding drugs costs)	(1,293)	(1,693)	(400)	(14,218)	(15,272)	(1,054)	(15,511)	(16,661)	(1,150)
Supplies and services - general	(23)	(32)	(9)	(257)	(343)	(86)	(281)	(374)	(93)
Drugs costs	(85)	(38)	47	(939)	(1,036)	(97)	(1,024)	(1,130)	(106)
Establishment	(11)	(12)	(1)	(116)	(128)	(12)	(126)	(140)	(14)
Premises - other	(45)	(94)	(49)	(493)	(726)	(233)	(538)	(792)	(254)
Transport	(6)	(5)	1	(63)	(88)	(25)	(69)	(96)	(27)
Education and training - non-staff	(3)	(1)	2	(38)	(42)	(4)	(42)	(45)	(3)
Lease expenditure	(10)	(10)	0	(109)	(102)	7	(119)	(111)	8
Other	(21)	(34)	(13)	(213)	(317)	(104)	(233)	(346)	(113)
Total Non-pay Expenditure	**(1,497)**	**(1,919)**	**(422)**	**(16,446)**	**(18,054)**	**(1,608)**	**(17,943)**	**(19,695)**	**(1,752)**
Total Divisional Operating Expenditure	**(5,042)**	**(5,630)**	**(588)**	**(55,110)**	**(56,782)**	**(1,672)**	**(60,057)**	**(62,133)**	**(2,076)**

THE WALTON CENTRE NHS FOUNDATION TRUST
EXPENDITURE - CORPORATE

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(119)	(79)	40	(1,307)	(992)	315	(1,426)	(1,071)	355
Support to nursing staff	(1)	0	1	(10)	0	10	(11)	0	11
Medical - Consultants	(6)	(26)	(20)	(61)	(88)	(27)	(67)	(114)	(47)
NHS infrastructure support	(997)	(907)	90	(10,955)	(10,052)	903	(11,952)	(10,959)	993
Apprenticeship Levy	(27)	(28)	(1)	(294)	(326)	(32)	(321)	(354)	(33)
Bank/Agency	0	(35)	(35)	0	(512)	(512)	0	(548)	(548)
Total Pay Expenditure	**(1,150)**	**(1,075)**	**75**	**(12,627)**	**(11,970)**	**657**	**(13,777)**	**(13,046)**	**731**
Non-executive directors	(11)	(19)	(8)	(125)	(126)	(1)	(136)	(137)	(1)
Supplies and services – clinical (excluding drugs costs)	(18)	(11)	7	(194)	(185)	9	(212)	(201)	11
Supplies and services - general	(293)	(317)	(24)	(3,220)	(3,453)	(233)	(3,512)	(3,767)	(255)
Consultancy	(2)	4	6	(26)	(147)	(121)	(28)	(160)	(132)
Establishment	(82)	(38)	44	(906)	(1,273)	(367)	(988)	(1,389)	(401)
Premises - business rates payable to local authorities	(69)	(128)	(59)	(756)	(756)	0	(824)	(824)	0
Premises - other	(428)	(83)	345	(4,712)	(4,304)	408	(5,140)	(4,695)	445
Transport	(9)	(25)	(16)	(97)	(350)	(253)	(105)	(382)	(277)
Audit fees and other auditor remuneration	(9)	(1)	8	(94)	(104)	(10)	(103)	(113)	(10)
Clinical negligence	(528)	(529)	(1)	(5,809)	(5,811)	(2)	(6,337)	(6,340)	(3)
Education and training - non-staff	(11)	(35)	(24)	(117)	(250)	(133)	(128)	(273)	(145)
Lease expenditure	0	0	0	0	(4)	(4)	0	(4)	(4)
Other	(129)	(395)	(266)	(1,420)	(1,856)	(436)	(1,550)	(2,024)	(474)
Total Non-pay Expenditure	**(1,589)**	**(1,577)**	**12**	**(17,476)**	**(18,619)**	**(1,143)**	**(19,063)**	**(20,309)**	**(1,246)**
Total Divisional Operating Expenditure	**(2,739)**	**(2,652)**	**87**	**(30,103)**	**(30,589)**	**(486)**	**(32,840)**	**(33,355)**	**(515)**

KPI Glossary	Green	Amber	Red
% variance from plan - Year to date	value > 0%	0% > value > -5%	value < -5%
% variance from plan - Forecast	value > 0%	0% > value > -5%	value < -5%
% variance from efficiency plan - Year to date	value > 0%	0% > value > -5%	value < -5%
% variance from efficiency plan - Forecast	value > 0%	0% > value > -5%	value < -5%
Capital % variance from plan - Year to date	value = 0%	0% > value > +/-5%	value > +/-5%
Capital % variance from plan - Forecast	value = 0%	0% > value > +/-5%	value > +/-5%
Capital Service Cover	value > 2.5	2.5 > value > 1.25	value < 1.25
Liquidity	value > 0	0 > value > -14	value < -14
Cash days operating expenditure	value > 60 days	30 days < value < 60 days	value < 30 days
BPPC - Number	value > 95%	95% > value > 90%	value < 90%
BPPC - Value	value > 95%	95% > value > 90%	value < 90%

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 06/04/24		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 26/03/24		**Membership Numbers: 5 (Quorate)**
1	**Agenda**	The Committee considered an agenda which included the following: • Investors in People Assessment Outcomes Report • Trust Annual Staff Survey Report • Succession Planning Update Report • People Substrategy Update • Finance and Commercial Development Substrategy Update • Capital Programme 2023/24 Update • Board Assurance Framework Closure Report 2023/24 • Digital Transformation Monthly Update • Digital Review Update • Integrated Performance Report • Theatre Refurbishment Project Update • Finance, Performance and Environment Group Terms of Reference • Information Governance and Safety Forum Terms of Reference • Annual Committee Effectiveness and Terms of Reference Review • Renewal on Internal Audit Contract Recommendation Report • Artificial Intelligence Stroke Decision Software Recommendation Report
2	**Alert**	• Referral To Treatment average waits continue to deteriorate; the Trust has raised concerns to the Integrated Care Board, seeking mutual aid, but no material support has been offered.
3	**Assurance**	*Integrated Performance Report* ***Operations and Performance*** • All cancer wait/treatment and diagnostic standards continue to be achieved. • The number of long waiters (52+ weeks) is much improved and remains a key focus. There are no 78+week waits and the Trust is on track for no 65 week waits by the end of March 24. • Elective activity was underperforming due to the impact from industrial action and sickness. Focus remains on the high level of Did Not Attends (DNA) and revalidation of neurology follow-up waiting lists within the outpatient transformation programme. ***Workforce*** • Sickness at 5.71% remains within normal variation. • Mandatory training remains above target at 88.55% and Appraisal compliance stood at 81.65%.

		• Vacancies of corporate and other non-clinical staff have remained largely static and nursing turnover remains steady with a small decrease recorded in month. ***Finance*** • The Income & Expenditure surplus was ahead of plan (£6.6m YTD) in line with the revised target. The YTD Quality Improvement Programme (QIP) target was delivered, of which 82% is recurrent. • Better Payment Practice Code stands at 90.0% of invoices paid and 92.4% of value against target of 95%. *Other matters* • The outcome of the 3-yearly reassessment for the Investors in People 'We Invest in People' and 'We Invest in Wellbeing' standards was received. Gold Awards were retained in both; in the former case, contingent on an improvement plan leading to further assessment in late 2024. • The results of the annual national Staff Survey were reviewed; a number of year-on-year improvements were noted together with proposals for improvement actions which will be further explored in forthcoming staff engagement sessions. Some themes mirrored findings from the Investors in People report. • A robust process for succession planning, including identification of business-critical roles, was noted. • Measures now put in place to mitigate the loss of theatre capacity during refurbishment mean that only minor impact is foreseen. • Good progress was demonstrated progressing the short-term actions from the 2023 Public Digital review of digital maturity. • Updates of implementation of the People and Finance & Commercial Development sub-strategies demonstrate good progress. • The Board Assurance Framework principal risks were updated for board endorsement. • A committee effectiveness review indicated largely positive performance in discharging its duty and further continual improvement of effectiveness, addressing points highlighted in the prior year's review.		
4.	**Advise**	• Recommendation reports for renewal of internal audit contract, artificial intelligence stroke decision software and provision of power drills in theatres were approved. • Key Issues reports from 10 sub-groups were received and reviewed. The current set of 13 sub-groups will be replaced by 3 new exec-led strategic sub-groups shortly. • Terms of reference for the new Finance, Performance and Environment Group and updated terms of reference for the Information Governance and Security Forum were approved. • Updated terms of Reference for BPC were endorsed for Board approval.		
5.	**Risks Identified**	• No new risks.		
6.	**Report Compiled**	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Board of Directors
4 April 2024

Report Title	Business Performance Committee Terms of Reference
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of the Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23.

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

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**
BPC	26 March 2024	Katharine Dowson, Corporate Secretary	Effectiveness review discussed and ToR reviewed. Updates made to subgroups and substrategies/plans list.

Business Performance Committee (BPC) Terms of Reference

Executive Summary

1. The purpose of this report is to present the BPC Terms of Reference (ToR) for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - Embedding of the amended Committee membership and structure providing a much improved Committee.
   - Improvements in the quality and consistency of papers presented.
   - Improved and more focused challenge and debate from the membership.

Changes to ToR

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These have been reviewed and the proposal is to leave these largely unchanged apart from the following:
   - Paragraph 23 has been amended to reflect the changes in the groups reporting into the committee
   - The frequency of meetings has been amended to reflect the changes to the meeting schedule for all board committee meetings. (Paragraph 24).

Conclusion

4. The Board is asked to approve the revised Terms of Reference.

Recommendation

To approve

Author: Katharine Dowson
Date: 26 March 2024

Appendix 1 – BPC Draft Terms of Reference March 2024

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 Digital 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 areas, strategies, substrategies and associated strategic implementation plans and action plans:
    - Cost/Quality Improvement Plan
    - Data Security & Protection Toolkit
    - Digital Substrategy
    - Estates, Facilities and Sustainability Substrategy
    - Financial and Commercial Development Substrategy
    - Health Procurement Liverpool Strategy
    - Financial Plan
    - Long Term Financial Plan
    - People Substrategy
    - Staff Survey Action Plan

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 Responses (including Pulse Survey)
- 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 Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

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:
    - Digital Strategy Group
    - Finance, Performance and Environment Group
    - People Group

Administration of Meetings

24. Meetings shall be held bi-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 six 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: 4 April 2024
Review Date: March 2024

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date 22/03/24		**Report of: Quality Committee**
Date of last meeting: 21/03//2024		**Membership Numbers: 5 (Quorate)**
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report and Joint Divisional Report • Board Assurance Framework Closure Report 2023/24 • Quality Substrategy Progress Update • Patient Safety Incident Response Framework (PSIRF) Update • NICE Guidance Exceptions Report • Infection Prevention and Control Report • Patient Experience Update Report • Quality Committee Annual Effectiveness Review and Terms of Reference • Patient Experience Group Terms of Reference • Non-Executive Director Walkabout Review
2.	**Alert**	No specific alerts were recorded for escalation.
3.	**Assurance**	**Board Assurance Framework** The Committee endorsed the closure report of the 2023-24 Board Assurance Framework for Board approval. Changes made to each risk were reviewed and an update on the principal risks and risk appetite for 2024-25 provided. **Quality Substrategy Progress Update** Assurance was provided on progress against Quality Substrategy objectives for 2023-24. A session was planned in diaries to identify focussed objectives for 2024-25. **Patient Safety Incident Response Framework (PSIRF) Update** It was recognised that Trust progress against the PSIRF was progressing well however there was still more work to be undertaken. Options for protected time for the Patient Safety Specialist Role were being explored. A number of workstreams were being implemented however these would need time to be fully embedded. Options for delivery of Level 3 to Level 5 PSIRF training on a regional level were being explored. **NICE Guidance Exceptions Report** The Committee recognised that a lot of good work had been completed to address previous issues and this work was now fully embedded into normal working practice.

		NICE Guidance was closely monitored at Clinical Effectiveness and Services Group and consideration would be given to the level of Committee oversight required moving forwards as previous issues and concerns were no longer applicable. **Infection Prevention and Control (IPC) Report** A number of improvements have been made in the last year however it was recognised that there was still more work to be done. An overarching Trust wide action plan had been developed combining all individual IPC action plans. A proactive education framework programme has been developed along with a programme for IPC Champions. A change in culture to recognise that IPC is everybody's responsibility was in the process of being embedded across the Trust. **Quality Committee Annual Effectiveness Review and Terms of Reference** The terms of reference were endorsed for Board approval. Feedback from the effectiveness review had been positive and the Committee noted the potential challenges that changes in the reporting governance structure may bring in ensuring line of sight.		
4.	**Advise**	**Integrated Performance Report (IPR)** It was agreed that there would be an increased focus on the overall approach to assurance with each Executive reviewing the content of the IPR before publication and ensuring the narrative accompanying the data focuses on assurance. Three Quality Improvement priorities had been identified and these would be discussed and monitored at the Patient Safety Incident Review Group. The Executives agreed to explore how the quality committee would be sighted on this data. **Patient Experience Update Report** The patient experience update report would be submitted to Quality and Patient Safety Group moving forwards with exceptions highlighted to Committee via the key issues report. Concerns around some elements of patient experience remained and an improvement plan would be developed and presented to the July Committee meeting where an agreement would be made on a reporting schedule of updates to this plan. **Non-Executive Director Walkabout Review** The current process for visibility walkabouts for Non-Executive Directors and Governors was reviewed and an amended process was agreed. The amended process would finalised and trialled on ITU prior to roll out across each area. **Key Issues Reports** Key Issues reports from 6 sub-groups were received and reviewed.		
5.	Risks Identified	There were no new risks identified.		
6.	Report Compiled by	Ray Walker – Non-Executive Director	Minutes available from:	Katharine Dowson – Corporate Secretary

The Walton Centre
NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Quality Committee Review of Terms of Reference
Executive Lead	Nicola Martin, 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** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed to reflect changes to frequency of all board committees

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

- Overarching review of all Board Committee's effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2023/24.

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

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**
Quality Committee	19 March 2024	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Quality Committee Terms of Reference

Executive Summary

1. The purpose of this report is to present the Quality Committee terms of reference for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - Embedding of the amended Committee membership and structure providing a much improved Committee.
   - Improvements in the quality and consistency of papers presented.
   - Improved and more focused challenge and debate from the membership
   - Review and agreed change to the reporting structure reporting into Quality Committee.

Proposed Changes

4. The Quality Committee ToR can be found at Appendix 1. Proposed changes are marked in red text and reflect the changes agreed to the reporting structure beneath Quality Committee with a number of groups no longer reporting in directly to the committee (Appendix 1, Paragraph 20). The frequency of meetings has been updated to every two months (Appendix 1, Paragraph 21).

Conclusion

5. The Board is asked to approve the revised Terms of Reference.

Recommendation

To approve

Author: Katharine Dowson
Date: 22 March 2024

Appendix 1 – Quality Committee Draft Terms of Reference April 2023

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 subgroups, 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, integrated and effective 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
    - Chief Operating Officer

8. The Corporate Secretary shall also attend as a non-voting member of the Committee.

9. The Quality Committee will be deemed quorate when three voting members are present, including at least one Executive and at least 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'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 should attend at least 75% of all meetings each financial year and 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 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 Substrategy
    - Quality Account

- Ensure that governance and assurance systems operate effectively and underpin programme delivery to include:
    - Clinical Audit
    - Clinical Care
    - Complaints, Compliments and Concerns
    - 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 Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

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 subgroups:

- ~~Clinical Effectiveness Group~~
- Corporate Risk and Governance Group
- ~~Health, Safety & Security Group~~
- ~~Human Tissue Act Group~~
- Infection Prevention and Control Group
- Neurosurgery Divisional Risk and Governance Group
- Neurology Divisional Risk and Governance Group
- ~~Organ Donation Committee~~
- Patient Experience Group
- Quality & Patient Safety Group
- ~~Safeguarding Group~~
- ~~Serious Incident Review Group~~
- ~~Sharing and Learning Forum~~

Administration of Meetings

21. Meetings shall be held bi-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 six 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: March 2025) 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.

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	National Staff Survey 2023
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Jane Mullin, Deputy Chief People Officer
Action Required	To note

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

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

Key Messages

- All Trusts are required to participate in the national staff survey on an annual basis.
- The report presents results in the form of seven people promises and two themes.

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

- Divisions to agree and submit divisional action plans.
- TEA events to be held in July 2024.

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

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

004 Leadership Development	001 Quality Patient Care	006 Prevention & Inequalities

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Annual Staff Survey 2023

Executive Summary

1. The 2023 National NHS Staff Survey was conducted in The Walton Centre NHS Foundation Trust by Quality Health, the survey was distributed between September and December 2023. The full survey findings are attached in **Appendix 1** and the breakdown report by division and staff group **at Appendix 2**

2. 581 staff took part in the survey compared to 614 in 2022. This was a response rate of 38.3% a decrease of 3% from last year.

3. The median response rate for Acute Specialist Trusts in the 2023 survey was 54% an increase of 2% from 2022.

4. Successes to celebrate include the score for recommending the organisation if a friend or relative needed care, the organisation taking positive action on health and well-being and the score or staff reporting any violence that occurs at work.

5. Areas for focus for 2024 include continuing to support staff who experience violence from patients, providing feedback to staff on the actions taken as a result of these incidents and ensuring pathways to jobs with greater responsibility are clear to all staff.

Background and Analysis

6. The staff survey questions are aligned with the NHS People Promise, covering seven key elements: we are compassionate and inclusive; we are recognised and rewarded; we each have a voice that counts; we are safe and healthy; we are always learning; we work flexibly; and we are a team. Within these seven overall elements are sub-scores for the questions relating to each key element. The survey also looks at two additional themes: ‘staff engagement’ and ‘morale’.

7. Within the Acute Specialist Trusts whose survey is administered by IQVIA the Trust scored significantly better in 17% of questions, significantly worse in 4% and there was no significance in 79%.

Key highlights

- The Trust scores higher/same as the average in all elements of the NHS People Promise bar one (‘we are always learning’ - this was scored average but is an improvement on last year’s score and had improved consistently since 2021).
- Compared to our 2022 results, the Trust has improved scores for 3 elements of the People Promise, we are recognised and rewarded, we are safe and healthy, and we are always learning).
- The Trust scored average or higher than average for 10 of the 15 areas that make up the sub-scores of the People Promise (the 5 areas that are lower are not significantly lower.)
- The Trust scored 85.61% for the question: ‘Care of patients/service users is my organisation’s top priority’, this is higher than last year’s score of 83.83% and higher than the 2021 score of 84.45%, the 2023 score is the same as the national average which has also increased from 84.48% in 2022 to 85.61% in 2023.
- The Trust scored 89.89% for the question: ‘If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation’, this is higher than last

year's score of 86.50%, higher than 2021 score of 88.78% and higher than the national average score of 87.82%

- 71.51% staff reported that they feel safe to speak up about concerns, which is higher than last year's score of 68.28% and confidence around concerns being addressed also increased.
- For the two additional themes, 'staff engagement' and 'morale', our overall score for morale is an improvement on last year's score, whilst our overall score for staff engagement is slightly lower than last year. We also score above average in all areas covered under these two themes,

Areas for improvement

- The Trust scores 'average' for the People Promise: 'we are always learning'. This is split into two strands: development and appraisals, whilst our appraisal score has increased from 2022 it is slightly below the national average and our development **score has decreased from 2022 and now sits at the national average**. There has been a decline in staff feeling there are opportunities for career progression and staff feeling supported to develop their potential.
- **Violence at work** continues to be an issue, with the Trust scoring the worst result of 15.64% for the question " In the last 12 months how many times have you personally experienced physical violence at work from…patients, relatives or other members of the public" this was an improved score from 17.08% in 2022.
- **51.32%** of staff feel they can eat nutritious and affordable food whist at work compared to an average of 55.16%
- **Flexible Working** whilst staff still report they achieve a good home/work life balance and can approach their manager to talk about flexible working the score around commitment of the organisation to help this balance has decreased from 56.70% to 51.64% and satisfaction for flexible working opportunities has decreased from 62.84% to 59.39%.
- There is a general theme emerging around line manager support and respect for colleagues.

Workforce Race Equality Scheme (WRES)

8. Four key questions make up the WRES section of the staff survey as follows:
    - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months- this score has decreased from 26.40% to 21.91% for white staff and has decreased from 25.93% to 22.95% for all other ethnic groups.
    - Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months- this score has decreased from 26.40% to 21.91% for white staff and 25.93% to 22.95% for all other ethnic groups.
    - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion- this score has decreased by over 8% for white staff and increased by 11% for all other ethnic groups.
    - Percentage of staff experiencing discrimination at work from manger/team leader or other colleagues in the last 12 months- this score has decreased by 0.48% for white staff and has decreased by 2.42% for all other ethnic groups.

9. 554 white staff responded to the survey and 37 staff from other ethnic groups.

Workforce Disability Equality Scheme (WDES)

10. Seven key questions make up the WRES section of the staff survey as follows**:**
    - Percentage of staff experiencing harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months- this score has decreased for staff with or without a long-term condition (LTC)
    - Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months- this score has decreased from 15.22% to 8.03% for staff with a LTC and has increased from 6.58% to 9.72% staff without a LTC
    - Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months- this score has decreased by 4% for staff with a LTC and has increased slightly for staff without a LTC
    - Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it- this score has decreased for both groups of staff.
    - Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion- this score has decreased for both groups of staff
    - Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties- this score has decreased by 7.6% for staff with a LTC and 3.21% without a LTC
    - Percentage of staff satisfied with the extent to which their organisation values their work- this score has decreased for both groups of staff.

11. The number of staff saying reasonable adjustments have been made to support them in the workplace increased from 70.59% to 72.94%

12. 479 staff without a LTC responded to the survey and 120 staff responded with a LTC

Conclusion

13. As in previous years, work will be undertaken to understand the results through the scores and the qualitative feedback to put together an action plan of improvements, paying close attention to the areas where scores are lower than 2022 and below average.

14. In response to last year's survey results, several TEA (talking, engagement, action) rounds / staff feedback sessions were held, there will be further TEA staff events on 23rd and 30th July 2024.

15. The Divisions will be asked to submit a divisional action plan based on their results, this will be monitored through the People Group.

Recommendation

- To note the 2023 national staff survey results and next steps.

Author: Jane Mullin
Date: 28 February 2024

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

NHS Staff Survey 2023

Jane Mullin
Deputy Chief People Officer

Criteria

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

- Seven people promise elements
- Two themes
  - Staff engagement
  - Morale

Top level results

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Above national average in all People Promise elements and the two additional themes, apart from “ we are always learning”
- Above average in all elements and the two themes across the north west
- Improved scores from 2022 across several questions
- Second in the north-west for ‘recommend as a place to work’
- Issues remain around violence against staff, though improved score from 2022
- Improved scores around priority of patients and raising concerns
- New issues highlighted include flexible working and working with team/colleagues

North west comparison – place to work

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Trust	2022	2023
Liverpool Heart and Chest	78%	83%
The Walton Centre	70%	72%
Alder Hey	67%	71%
The Christie	71%	71%
Clatterbridge	64%	71%
Mid-Cheshire	64%	68%
Mersey and West Lancs		67%
Wrightington, Wigan and Leigh	61%	63%
Warrington and Halton	56%	63%
Liverpool Women's	61%	62%
East Lancashire	64%	62%
East Cheshire	60%	62%
Blackpool	60%	62%
Stockport	53%	61%
Lancashire	57%	59%
Bolton	60%	56%
Northern Care Alliance	56%	58%
Manchester University	50%	57%
Morecambe Bay	54%	57%
Tameside and Glossop	56%	57%
Wirral	55%	56%
LUFT	46%	54%
Countess of Chester	43%	45%

Key themes

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Successes to celebrate
  - The score for staff recommending the organisation if a friend or relative needed care has improved and is significantly better than the sector
  - Staff feel that the organisation takes positive action on health and well-being
  - The score for staff reporting any violence that occurs at work is particularly high compared to the sector
- Areas of focus for 2024
  - Identify and address the staff groups experiencing violence, harassment or bullying from patients/service users and members of the public by drilling into your data
  - Provide feedback to all staff on the actions taken as a result of incidents reported, celebrating those who raised the issue and provided solutions
  - Ensure that the pathways to jobs with greater responsibility are clear to all staff and that the training and support mechanisms for personal development are clearly signposted to all staff

People promise scores

The Walton Centre NHS Foundation Trust

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	WC 2022	WC 2023	Average	Best
 We are compassionate and inclusive	7.7	7.6	7.5	8.0
 We are recognised and rewarded	6.2	6.2	6.1	6.6
 We each have a voice that counts	7.2	7	7	7.5

People promise scores

The Walton Centre NHS Foundation Trust

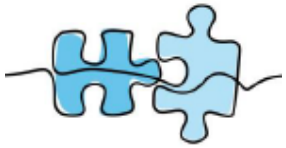
Excellence in Neuroscience

	WC 2022	WC 2023	Average	Best
 We are safe and healthy	6.4	6.5	6.4	6.8
 We are always learning	5.7	5.7	5.7	6.3
 We work flexibly	6.6	6.4	6.4	6.9

People promise scores

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

	WC 2022	WC 2023	Average	Best
 We are a team	7.1	7	7	7.4
 Staff engagement	7.4	7.3	7.3	7.7
 Morale	6.2	6.3	6.2	6.6

Promise element 1: We are compassionate and inclusive

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Above average or average in:
  - Compassionate culture
  - Compassionate leadership
  - Diversity and equality
  - Inclusion

  - *Acting fairly with regards to promotion (15) below average and decrease from 2022*
  - *Working with team and colleagues (7i, 8b, 8c)* – seen some decreases versus 2022
  - *Care of patients / service users is my organisation's top priority (25a)* – average and improved from 2022
  - *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (25d)* - higher than average and improved from 2022

Promise element 3: We each have a voice that counts

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Above average in all:
  - Autonomy and control
  - Raising concerns

- Raising concerns/addressing concerns (25) improved versus 2022
- *Trusted to do job/opportunities to show initiative/involved in deciding on changes (3b,c, e)* - declined versus 2022

Promise element 4: We are safe and healthy

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Above average or average in :
  - Health and safety climate
  - Burnout
  - Negative experiences
  - Improved scores across the board

  - *Adequate staff and equipment (3h, i)* –improved versus 2022
  - *Feeling burnt out (12b)* – improved versus 2022
  - *Organisation takes positive health and wellbeing action (11a)* - increase versus 2022
  - Unrealistic time pressures (5a) declined versus 2022

Promise element 5: We are always learning

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

- Below average in:
- Appraisals -.15
- Development -.1

- Opportunities to develop/ challenging work (24a,24b) declined versus 2022
- *Appraisals (23 a)* – improved versus 2022
- Agreeing clear objectives (23 c) improved versus 2022

Promise element 6: We work flexibly

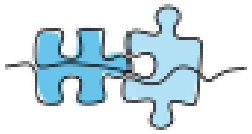
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- average in:
  - Support for work-life balance

  - Below average in:
  - Flexible working - .2

  - *Work-life balance (6b)* – decreased from 2022
  - *Flexible working opportunities (4d)* - decreased versus 2022



Promise element 7: We are a team

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- average in all sub-scores:
  - Team working -.4
  - Line management +.4

- *Effectiveness and respect within teams (7b, c)* – no change versus 2022
- *Working with other teams (8a)* – significant decrease versus 2022
- *Immediate manager respect and support (9a – d)* - 2 increased, 2 decreased versus 2022

Staff engagement

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Above average in all sub-scores:
  - Motivation
  - Involvement
  - Advocacy

- Increased in five scores and decreased in four versus 2022

- *Care of patients (25,a)* –increased versus 2022
- Place to work (25 c) – increased versus 2022

Morale

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NHS Foundation Trust
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- Above average in two sub-scores:
  - Thinking about leaving (a higher score is more positive)
  - Stressors (a higher score is more positive)
- Same in one sub-score:
  - Work pressure

- Increased in two, decreased in one versus 2021

  - *Respect from colleagues (7c)* – increase versus 2021 and above national
  - *Encouragement from manager (9a)* – increase versus 2021 and above national
  - *Thoughts about leaving (24a – c)* – all decreased versus 2021

What people said

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Over 50 pieces of qualitative feedback were received
- Good mix of positive, constructive and negative
- Key negative themes included:
  - Lack of career progression
  - Staffing levels
  - Workload
  - Flexible working

What people said

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

"The reason I am looking at other Trusts is because of lack of career progression - I do love working in and am passionate about my Trust."

"I feel proud to work at The Walton Centre and love my job. "

"I do believe that in some department new staff are not supported or given enough time to learn a new role. Certain managers do not allow flexible working. Some staff have far to heavy a workload which is impossible to keep on top off."

"All areas of the NHS are short staffed and that puts pressure on everyone else. The increase in part time working puts additional pressure on team members and the establishments in some areas need to be reviewed."

"My organisation claims to have a strong commitment to health and wellbeing but is entirely inflexible in supporting staff to attend medical appointments that would help them remain well and prevent sickness"

WRES

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Four key questions make up the WRES section of the staff survey as follows:
  - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months- this score has decreased from 26.40% to 21.91% for white staff and has decreased from 25.93% to 22.95% for all other ethnic groups
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WDES

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

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  - Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months- this score has decreased from 15.22% to 8.03% for staff with a LTC and has increased from 6.58% to 9.72% staff without a LTC
  - Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months- this score has decreased by 4% for staff with a LTC and has increased slightly for staff without a LTC
  - Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it- this score has decreased for both groups of staff.

WDES continued

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion- this score has decreased for both groups of staff
- Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties-this score has decreased by 7.6% for staff with a LTC and 3.21% without a LTC
- Percentage of staff satisfied with the extent to which their organisation values their work- this score has decreased for both groups of staff
- The number of staff saying reasonable adjustments have been made to support them in the workplace increased from 70.59% to 72.94%
- 479 staff without a LTC responded to the survey and 120 staff responded with a LTC

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26th March 2024		**Report of: Health Inequalities and Inclusion Committee**
Date of last meeting: 25th March 2024		**Membership Numbers: 11 (Quorate)**
1.	**Agenda**	The Committee considered an agenda which included the following: • Equality, Diversity and Inclusion (ED&I) Action Plan • Public Sector Equality Duty and EDS Report • Gender Pay Gap Report • Board Assurance Framework • Information on Health Inequalities for Annual Report • Code of Governance – Band 8a+ BAME Action Plan • People Substrategy Annual Review • Liverpool Citizens Listening Campaign Update • North West SBAC Key Issues Report • ED&I Steering Group Key Issues Report • Staff Network updates: @RACE, Disability, LGBTQIA+, Veteran's and Women's • Anchor Institute Group Key Issues Report • Annual Committee Effectiveness and Terms of Reference Review • Process for Contacting Patients of No Fixed Abode
2.	**Alert**	There were no specific alerts to be escalated to Board.
	Assurance	**Public Sector Equality Duty and Equality Delivery Scheme (EDS) Report** An update on all sectors of the Trusts public sector equality duty was provided. It had been previously agreed that the Trust would complete the EDS2 standard reporting for 2023/24 and move to reporting against the EDS2022 standard in 2024/25 with a working group to be formed to identify how best to progress against this standard. The Committee approved the publication of the Trusts equality data subject to completion of a proof-reading process. **Gender Pay Gap** The Trust is required to publish gender pay gap data on an annual basis and it was reported that the Trust had reduced the gender pay gap by 7.33% since it was first published in 2018 however the gender pay gap currently stood at 25.9%. This was due to the high percentage of male Consultants in the field on Neurosurgery and Neurology which was reflected on a national basis. Clinical Excellence Awards were divided across all Consultants during Covid however this had now reverted to a formal process and the Trust had provided support to female clinicians as part of the

		application process. The Committee approved the publication of gender pay gap data subject to agreement of updated actions for 2024 to be circulated after the meeting. **Information on Health Inequalities for Annual Report** New requirements for reporting health inequalities in the Annual Report have been published by NHS England. Data reviewed by Committee with 3 main areas highlighted; Did Not Attends (DNA) are linked to both deprivation indices and ethnicity and the Trust receives lower levels of referrals from those from a BAME background than local population levels. Work is underway in the Trust to address this and these actions are linked to the Board Assurance Framework risk. **Code of Governance – Band 8a+ BAME Action Plan** Action plan to be published by 31 March as per the requirements of the Code of Governance. The Trust is part of a regional accreditation pilot led by the NW BAME Network to publish action plans to support BAME members of staff, with all regional Trusts committing to achieve bronze status before working towards silver status. An action plan to support staff into managerial positions of band 8a and above is part of silver accreditation and would be developed in readiness for the Trust achieving bronze accreditation. **People Substrategy Annual Review** An overview of key achievements against the People substrategy in 2023/24 was provided along with plans to progress further in 2024/25. **Board Assurance Framework (BAF) Closure Report 2023/24** The Committee endorsed the closure report of the BAF for 2023/24 and it was noted that the strategic risk that the Committee is responsible for would remain on the BAF for 2024/25.		
	Advise	**Liverpool Citizens** A target date for founding status of Liverpool Citizens has been set for November 2024. **Process for Contacting Patients of No Fixed Abode** Following a recent incident where issues were identified following a GP referral of a patient with no fixed abode it was highlighted that there is a nationally recognised process in place for referrals and for patient correspondence to be sent to the GP practice. Contact would be made with Liverpool Healthwatch to confirm the process. **Staff Networks** Staff networks continue to grow with the launch of the Women's Network which generated more than 50 members of staff signing up for the network. It has been evidenced that staff are feeling more confident in approaching network Leads to highlight issues identified in the workplace.		
2.	Risks Identified	There were no risks identified for escalation to Board.		
3.	Report Compiled by	John Baxter – Executive Office Team Leader	Minutes available from:	John Baxter – Executive Office Team Leader

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Public Sector Equality Duty & Equality Delivery System Report
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Emma Sutton, Equality and Diversity Manager
Action Required	To note

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

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

Key Messages

- The Trust is required to publish equality data on an annual basis and demonstrate it's compliance with the Public Sector Equality Duty
- This report has been approved by Equality, Diversity and Inclusion Steering Group and Health Inequalities and Inclusion Committee

Next Steps

- Progress with current projects and actions

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

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**
Equality Diversity and Inclusion Steering Group	6/3/24	Emma Sutton, Equality and Diversity Manager	None
Health Inequalities and Inclusion Committee	25/3/24	Emma Sutton, Equality and Diversity Manager	Small changes to introduction

Public Sector Equality Duty & Equality Delivery System Report

Executive Summary

1. The Trust is required to publish equality data on an annual basis as well as demonstrate it's compliance with the Public Sector Equality Duty in terms of both he general and specific duties.

2. This report must be published on the Trust website by 31st March 2024.

3. The report provides an overview of the Equality Diversity and Inclusion (EDI) related work undertaken by the Trust in the past 12 months. Over the past year, the Trust have taken positive action to eliminate discrimination, advance equality of opportunity and foster relationships in a number of ways

4. An update in relation to NHS England's high impact actions is included within the report.

5. Links to other published reports (Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES)) are included in the report including the Gender Pay Gap report, also for approval at this meeting.

6. Equality profiling for staff, new starters, applicants and patients is included within the report.

7. Equality Delivery System (EDS) report is included within the report to provide evidence of how the Trust meets it's specific duties under the Equality Act 2010.

Recommendation

To approve for publication

Author: Emma Sutton
Date: 18th March 2024

Appendix 1: Public Sector Equality Duty & Equality Delivery System Report

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Public Sector Equality Duty

Equality, Diversity and Inclusion Annual Report 2023/24

Contents

1 Introduction

The Walton Centre NHS Foundation Trust Annual Equality Diversity and Inclusion (EDI) Report 2023/24 sets out the Trust's approach to EDI and how the Trust meets the Public Sector Equality Duty (PSED).

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

1.1 Our Vision

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

1.2 Our Purpose

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

1.3 Our Ambitions

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

- **Education, training and learning** - Leading the way in neurosciences education and training
- **Research and Innovation** - Delivering high-quality clinical neuroscience research, in collaboration with universities and commercial partners
- **Leadership** - Developing the right people with the right skills and values to enable sustainable delivery of health services
- **Collaboration** - Clinical and non-clinical collaborations across and beyond the ICS, building on existing relationships and services
- **Social Responsibility** - Supporting our local communities and providing services for patients within and beyond Cheshire and Merseyside

1.4 Our Values

Walton Way:

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

The Walton Centre is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place in 2023/24 and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity. We will continue to monitor our equality diversity and inclusion progress against our action plans and report annually and openly.

2 Equality Act 2010

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

The Act protects people from discrimination based on 'protected characteristics'.

The nine protected characteristics are:

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

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

2.1 The General Duty

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

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

2.2 The Specific Duty

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

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

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

Demonstrating the Trusts continued commitment to EDI and the General Equality Duty, our Chief Executive commissioned two reviews of services via external Equality, Diversity and Inclusion consultancy firms at the end of 2022 to review our practises and make any recommendations for improvements.

Recognising the expanding remit of interlinking work, relating to EDI, health inequalities and social value, a committee restructure was undertaken earlier this year. Our previous Strategic Black, Asian and Ethnic Minority (BAME) Advisory Committee (SBAC) has since been replaced with our Health Inequalities and Inclusion Committee (HIIC), a Board level committee in June 2023. HIIC receives input from numerous work streams including our EDI Steering Group and Staff Network Groups directly.

In line with changes to our committee structure and following the publication of NHS England's EDI Improvement Plan in June 2023, a master action plan has been developed to amalgamate actions from a number of reports/work streams including NHS EDI Improvement plan 2023, Workforce Race and Disability Equality Standard reports, Gender Pay Gap report and others to provide assurance and ensure all actions are monitored and progressed appropriately. This is monitored by our EDI Steering Group with overall responsibility at HIIC.

Following external reviews and committee changes, two EDI projects were commissioned and launched in October 2023, in collaboration with South, Central and West Commissioning Unit (SCW - one of the providers who undertook an initial review of services in 2022). One project was to develop training for Building a Culture of Conscious Inclusion and recruit in-house trainers to deliver this to staff across the organisation. The other was an EDI Solutions Package to review policies and processes within a staff members journey, including recruitment, induction, career progression, appraisals and training to identify any gaps and make recommendations for improvements. A further project in collaboration with SCW was launched in January 2024 to co-deliver a Gender Dynamics Seminar to staff.

The train the trainer sessions were undertaken at the end of November 2023 with training cohorts released to staff from January – March 2024. Initial uptake and feedback has been positive; the training will be reviewed in April 2024 with a plan to launch further dates for staff. It is expected that the Solutions Package and Gender Dynamics Seminar projects will be completed by the end of the financial year and that this will have a significant positive impact for new and existing staff. Actions will be tracked via the EDI Master Action Plan and regular updates will be provided to the Health Inequalities and Inclusion Committee as this work progresses.

Over the past year, the Trust have taken positive action to eliminate discrimination, advance equality of opportunity and foster relationships in a number of ways as listed below.

- Our incident management system has been updated to ensure all protected characteristics are collected for both patients and staff to allow any themes and trends to be highlighted and escalated appropriately.

- 25 Freedom to Speak Up Champions have been recruited across the Trust (including both clinical and non-clinical), empowering staff to raise issues.

- Staff have been given the opportunity to attend training sessions in relation to Neurodivergence and Transgender Awareness to increase staff knowledge and reduce instances of discrimination.

- A new Reasonable Adjustments policy for staff has been introduced to ensure staff with disabilities are fully supported at work, including the introduction of disability leave for those who may require additional time off work to attend appointments.

- We were accredited as Veteran Aware and received a Silver Award as part of the Defence Employer Recognition Scheme, formally recognising our commitment to the Armed Forces community.

- The Trust achieved it's Navajo Merseyside & Cheshire LGBTQIA+ Charter Mark reaccreditation for a further two years. The mark reflects our commitment to equality, diversity and inclusion for our patients and staff.

- Building a Culture of Conscious Inclusion Training was launched in January 2023, delivered to staff across the Trust by in-house trainers.

- Our Staff Network Groups have grown to include Anti-racism, LGBTQ+, Disability and Veterans. Plans are in place to introduce a Women's Group in 2024.

- The Trust continues to recognise awareness days and celebrations and share staff stories. A quarterly EDI newsletter has been introduced to ensure all EDI information and events can be easily accessed by all.

3.1 Published Reports

The Trust demonstrates its continuing commitment to race equality via its compliance with the NHS, Workforce Race Equality Standards (WRES). These standards provide a number of indicators and corresponding action to drive improvements. The WRES findings for 2023 can be viewed using the following link:
https://www.thewaltoncentre.nhs.uk/Downloads/Reports-and-Publications/Equality-Diversity-and-Inclusion/WRES%2022%2023%20Final.pdf

The Trust demonstrates its continuing commitment to disability equality via its compliance with the NHS, Workforce Disability Equality Standards (WDES). These standards provide a number of Metrics and corresponding action to drive improvements. The WDES findings for 2023 can be viewed using the following link:
https://www.thewaltoncentre.nhs.uk/Downloads/Reports-and-Publications/Equality-Diversity-and-Inclusion/2022%2023%20WDES%20Report%20Final.pdf

In addition to the WDES, the Trust also takes action to ensure that we are giving full and fair consideration to applications for employment made by disabled persons, having regard

to their particular aptitudes and abilities. The Trust operates guaranteed interviews for all Disabled job applicants who meet the specified criteria for the job and the Trust also provides Reasonable Adjustments for Disabled applicants at interview. For staff who notify the Trust of their disability during their employment at the Trust, we provide Reasonable Adjustments if required to continue their employment and the Trust make available appropriate training, technology and adjusted work arrangements for those employees where appropriate. Information on reasonable adjustments is made available to all employees via the staff intranet pages.

The Trust demonstrates its continuing commitment to gender equality via its compliance with the Government Gender Pay Gap reporting requirements. The Trust reports and publishes its gender pay gap on an annual basis. This reporting allows the Trust to understand the average difference in pay between male and female staff. It also allows the Trust to take actions to close the gender pay gap. The Trust's Gender Pay Gap report 2023 can be viewed using the following link:

Insert link once published

The Trust demonstrates its continuing commitment to equality for LGBT+ patients and staff by its participation in the Navajo Charter Mark Scheme. In 2023 the Trust successfully completed reaccreditation and gained the privilege of holding the Navajo Charter Mark for a further two years, which is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA+ people in Merseyside.

The Trust's EDI performance if facilitated by a number of policies and guidance documents which include the following:

- Equality Diversity & Human Rights Policy
- Transgender Policy
- Tailored Reasonable Adjustment Template
- Equality Impact Assessment (EIA) Form

3.2 NHS England EDI Improvement Plan High Impact Actions and Progress

High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. • Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024). • Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). • NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	• All Non-executive Directors and Chair have EDI objectives included in their appraisal. Plans are in place for all Exec Board members to have these established in line with their usual appraisal cycle. • Staff and patient data is regularly reviewed by the Board and Health Inequalities and Inclusion Committee to highlight key priorities and implement actions which and reviewed and monitored appropriately via the Board Assurance Framework and EDI Action Plan. • Organisational data and lived experience is shared throughout the Trust via Trust communications, EDI Newsletter, intranet and website and quantitative and qualitative data has informed EDI projects and training programmes (BCCI, Solutions Support, Gender Dynamics).
High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. • Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025) • Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024). Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint. Read case studies from a range of organisations that share good practice around embedding inclusive recruitment.	• A talent management plan is being developed regionally and work is ongoing in relation to this. • The Trust are working closely with and exploring opportunities to widen recruitment opportunities within local communities via our partnerships with Liverpool Citizens and Liverpool City Region.
High impact action 3: develop and implement an improvement plan to eliminate pay gaps. • Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce (by March 2024). • Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. This article gives more information around pay gap reporting, useful resources and some tips. • Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (March 2024)	• The Trust have reviewed our Flexible Working policy and were reported as top in the country in the 2022/23 NHS Staff Survey. • Recommendations from the Mend the Gap review have been included in our EDI Action Plan to progress and monitor. • Plans are in place to analyse data to understand pay gaps by protected characteristic and put in place improvements. The Trust publish our Gender Pay Gap data annually and reporting mechanisms for Ethnicity Pay Gap data have been built in to the National ESR system for 2024/2025. The Trust will continue to expand our reporting in relation to pay gap data in coming years.
High impact action 4: develop and implement an improvement plan to address health inequalities within the workforce. • Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework. (by October 2023). • Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health	• Regular wellbeing conversations are encouraged and supported by being incorporated into our annual appraisal process and by our health and wellbeing support for staff. • The Trust are working closely with and exploring partnership opportunities with community organisations via Liverpool Citizens and Everton in the Community and will continue to expand our community partnerships in the coming years.

Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare (by April 2025). This NHS Confederation page has guidance and tools for tackling health inequalities.	
High impact action 5: implement a comprehensive induction, onboarding and development programme for internationally-recruited staff. • Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options (by March 2024). • Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback (by March 2024). • Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety (by March 2024). • Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression (by March 2024).	• Building rapport training in place and mandatory for all line managers. • Building a Culture of Conscious Inclusion in-house trainers in place with courses made available to all staff from January 2024. this training will continue to be reviewed and new cohorts launched and delivered over the coming years. Initial uptake has been good and feedback positive with a number of line managers/ senior managers having attended the training. • Current EDI Solutions project is being undertaken in collaboration with South, Central and West Commissioning Unit to which include the review of our recruitment, onboarding and induction policies and procedures. • Pre-interview support offered to internationally recruited staff and direct encouragement from Senior Nursing Team and Professional Nurse Advocates (PNA) in place to support staff in their career progression.
High impact action 6: create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur. • Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year. • Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this (by March 2024). • Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it (by June 2024) • Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff (by March 2024). • Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence (by March 2024).	• Data collected for all protected characteristics in our Datix incident management system to allow the Trust to capture this data and be aware of any themes/trends. Informal and formal debrief process in place following any incidents of violence and aggression. Task and finish group to be set up to review data and agree next steps. • NOSS counselling service in place for staff. • Mental Health First Aiders in place across the Trust. • Freedom to Speak Up Guardian and champions in place. • Policies in place including dignity at work policy, management of violent and aggressive individuals. • Staff Networks in place (LGBTQIA+, Veterans, Anti-racism, Disability and Women's) to provide a safe space for staff. • Trust signed Sexual Safety Charter and plans in place to progress this work and improve how we support staff affected by domestic abuse and sexual violence (DASV).

4 The Specific Equality Duty and the Walton Centre

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

Providers within the NHS are now moving to a new EDS reporting system; EDS2022. For this financial year, however, it was acknowledged by the Board that, as a result of vacancies in key roles, the Trust were not in a position to effectively undertake a review as outlined by new EDS2022 guidance. As a result, and following seeking advice from NHS England, it was agreed that the Trust would complete a review using previous EDS2 methodology in order to meet our Public Sector Duty requirements and outline our current position prior to adopting the new EDS2022 approach in 2024/25.

4.1 EDS

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

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

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

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

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

4.2 The current equality objectives are:

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

These objectives are currently under review as part of our ongoing EDI Solutions Package project and, once work is completed, new objectives will be set in 2024.

4.3 Current 2023/24 The Walton Centre EDS2: The Goals and Outcomes			Grade Status
Goal	**Sub**	**Description of outcome**	
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing
	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
	2.3	People report positive experiences of the NHS	Achieving
	2.4	People's complaints about services are handled respectfully and efficiently	Achieving
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

5 Next steps

The Trust will continue to deliver BCCI training to staff to encourage a culture of equality and belonging. Following completion of our EDI Solutions project, action will be taken as required to improve our processes and practices to enhance staff experience and ensure equality of opportunity. In line with NHS England's EDI Improvement Plan, the Trust will continue to progress actions and broaden the recording and reporting of data from an EDI perspective, allowing us to acknowledge and recognise where positive action is required and improve our services for all.

To ensure we continue to build a culture of inclusion and raise the profile of EDI work, the Trust will continue to engage with staff through our staff networks and ensure EDI awareness days and events are recognised and celebrated, sharing staff stories to bring these to life. Communication with all staff is key to ensuring such matters remain high on our agenda and continued communication via our quarterly EDI newsletter, utilisation of Trust bulletins and celebrating of key events via multiple platforms including our communication screens in key areas and on social media will help to increase visibility.

The Trust will move from EDS2 to the new EDS2022 evaluation and reporting system in 2024/25 to further scrutinise our service delivery to patients from an EDI perspective to ensure access and quality of care is consistent and positive steps are taken were appropriate to ensure equality and inclusion at all levels.

During the 2024/25 financial year, the Trust will be developing a strategy to confirm our vision and objectives in relation to a number of health inequality and inclusion areas which will encompass EDI, health inequalities and social value. Work undertaken during 2023/24 to review our practises, raise awareness and have a robust structure of staff network leads and BCCI trainers across the Trust will inform the strategy and help to ensure this is robust and fully embedded.

6 Workforce EDI Profile

Workforce EDI Profile 1st January 2023-31st December 2023.

6.1 Workforce by Age

Age Range	No. of Staff
<=20 Years	14
21-25	69
26-30	181
31-35	241
36-40	225
41-45	171
46-50	186
51-55	180
56-60	150
61-65	115
66-70	23
>=71 Years	5
Grand Total	**1560**

Staff Group by Age

Age Range	Add Prof Scientific and Technic	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
<=20 Years	0	4	10	0	0	0	0	0	14
21-25	1	15	20	8	0	1	0	24	69
26-30	0	23	49	22	1	6	5	75	181
31-35	9	31	55	36	2	5	23	80	241
36-40	7	28	48	35	1	8	34	64	225
41-45	9	23	45	30	1	5	18	40	171
46-50	4	40	54	16	1	3	24	44	186
51-55	2	28	52	21	3	3	32	39	180
56-60	1	33	51	10	3	0	17	35	150
61-65	0	38	41	4	4	1	6	21	115
66-70	0	4	8	1	3	0	0	7	23
>=71 Years	0	0	2	0	1	0	2	0	5
Grand Total	**33**	**267**	**435**	**183**	**20**	**32**	**161**	**429**	**1560**

6.2 Workforce by Gender

Gender	No. of Staff
Female	1188
Male	372
Grand Total	**1560**

The National ESR system for the NHS only allows gender data to be collected as either female/male.

Staff Group by Gender

Staff Group	Female	Male	Grand Total
Add Prof Scientific and Technic	26	7	33
Additional Clinical Services	227	40	267
Administrative and Clerical	305	130	435
Allied Health Professionals	147	36	183
Estates and Ancillary	12	8	20
Healthcare Scientists	20	12	32
Medical and Dental	50	111	161
Nursing and Midwifery Registered	401	28	429
Grand Total	**1188**	**372**	**1560**

6.3 Workforce by Ethnic Origin

Ethnic Origin	No. of Staff
A White - British	1231
B White - Irish	32
C White - Any other White background	41
CH White Turkish	1
CP White Polish	2
D Mixed - White & Black Caribbean	1
E Mixed - White & Black African	3
F Mixed - White & Asian	3
G Mixed - Any other mixed background	5
H Asian or Asian British - Indian	128
J Asian or Asian British - Pakistani	8
K Asian or Asian British - Bangladeshi	5
L Asian or Asian British - Any other Asian background	17
LH Asian British	1
LK Asian Unspecified	1
M Black or Black British - Caribbean	2
N Black or Black British - African	26
PC Black Nigerian	1
PD Black British	1
R Chinese	5
S Any Other Ethnic Group	26
SC Filipino	1
SE Other Specified	1
Z Not Stated	18
Grand Total	**1560**

Staff Group by Ethnic Origin

Ethnic Origin	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
A White - British	29	235	408	163	19	29	48	300	1231
B White - Irish	2	1	4	9	0	0	1	15	32
C White - Any other White background	1	6	3	2	0	1	21	7	41
CH White Turkish	0	1	0	0	0	0	0	0	1
CP White Polish	0	1	0	0	0	0	0	1	2
D Mixed - White & Black Caribbean	0	0	1	0	0	0	0	0	1
E Mixed - White & Black African	0	0	0	0	0	0	2	1	3
F Mixed - White & Asian	0	1	1	0	0	0	0	1	3
G Mixed - Any other mixed background	0	2	0	0	1	0	1	1	5
H Asian or Asian British - Indian	0	5	3	1	0	2	46	71	128
J Asian or Asian British - Pakistani	0	0	1	0	0	0	6	1	8
K Asian or Asian British - Bangladeshi	0	0	1	0	0	0	4	0	5
L Asian or Asian British - Any other Asian background	0	2	1	0	0	0	4	10	17
LH Asian British	0	0	0	0	0	0	1	0	1
LK Asian Unspecified	0	0	0	0	0	0	0	1	1
M Black or Black British - Caribbean	0	0	0	0	0	0	1	1	2
N Black or Black British - African	0	5	2	3	0	0	8	8	26
PC Black Nigerian	0	0	1	0	0	0	0	0	1
PD Black British	0	0	0	0	0	0	0	1	1
R Chinese	0	0	3	0	0	0	1	1	5
S Any Other Ethnic Group	1	4	3	2	0	0	8	8	26
SC Filipino	0	0	0	1	0	0	0	0	1
SE Other Specified	0	1	0	0	0	0	0	0	1
Z Not Stated	0	3	3	2	0	0	9	1	18
Grand Total	**33**	**267**	**435**	**183**	**20**	**32**	**161**	**429**	**1560**

6.4 Workforce by Disability

Disability	No. of Staff
No	1316
Not Declared	37
Prefer Not To Answer	3
Unspecified	140
Yes	64
Grand Total	**1560**

Staff Group by Disability

Staff Group	No	Not Declared	Prefer Not To Answer	Unspecified	Yes	Grand Total
Add Prof Scientific and Technic	31	0	0	2	0	33
Additional Clinical Services	228	9	0	22	8	267
Administrative and Clerical	375	6	1	30	23	435
Allied Health Professionals	148	4	1	13	17	183
Estates and Ancillary	18	1	0	0	1	20
Healthcare Scientists	25	0	0	7	0	32
Medical and Dental	137	11	0	11	2	161
Nursing and Midwifery Registered	354	6	1	55	13	429
Grand Total	**1316**	**37**	**3**	**140**	**64**	**1560**

6.5 Workforce by Religion or Belief

Religion/Belief	No. of Staff
Atheism	207
Buddhism	9
Christianity	968
Hinduism	48
I do not wish to disclose my religion/belief	128
Islam	40
Judaism	3
Other	104
Unspecified	53
Grand Total	**1560**

Staff Group by Religion or Belief

Staff Group	Atheism	Buddhism	Christianity	Hinduism	Not Disclosed	Islam	Judaism	Other	Unspecified	Grand Total
Add Prof Scientific and Technic	8	0	15	0	3	1	0	5	1	33
Additional Clinical Services	20	2	174	1	24	4	0	29	13	267
Administrative and Clerical	67	0	288	0	29	3	1	37	10	435
Allied Health Professionals	33	1	125	0	12	1	1	3	7	183
Estates and Ancillary	4	0	13	0	1	0	0	2	0	20
Healthcare Scientists	8	0	16	0	3	1	0	3	1	32
Medical and Dental	25	1	38	32	25	24	1	6	9	161
Nursing and Midwifery Registered	42	5	299	15	31	6	0	19	12	429
Grand Total	**207**	**9**	**968**	**48**	**128**	**40**	**3**	**104**	**53**	**1560**

6.6 Workforce by Sexual Orientation

Religion/Belief	No. of Staff
Bisexual	12
Gay or Lesbian	29
Heterosexual or Straight	1375
Not stated (person asked but declined to provide a response)	77
Other sexual orientation not listed	2
Undecided	2
Unspecified	63
Grand Total	**1560**

Staff Group by Sexual Orientation

Staff Group	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated	Other	Undecided	Unspecified	Grand Total
Add Prof Scientific and Technic	0	0	31	0	0	1	1	33
Additional Clinical Services	1	8	225	19	0	0	14	267
Administrative and Clerical	3	8	396	17	1	0	10	435
Allied Health Professionals	2	5	162	5	0	0	9	183
Estates and Ancillary	0	1	18	1	0	0	0	20
Healthcare Scientists	0	0	29	1	0	0	2	32
Medical and Dental	0	2	129	20	0	1	9	161
Nursing and Midwifery Registered	6	5	385	14	1	0	18	429
Grand Total	**12**	**29**	**1375**	**77**	**2**	**2**	**63**	**1560**

6.7 Workforce by Marital Status

Marital Status	No. of Staff
Civil Partnership	28
Divorced	74
Legally Separated	7
Married	742
Single	661
Unknown	41
Widowed	7
Grand Total	**1560**

Staff Group by Marital Status

Staff Group	Civil Partnership	Divorced	Legally Separated	Married	Single	Unknown	Widowed	Grand Total
Add Prof Scientific and Technic	3	1	0	19	10	0	0	33
Additional Clinical Services	8	20	2	103	122	11	1	267
Administrative and Clerical	7	27	3	178	208	9	3	435
Allied Health Professionals	3	2	0	100	76	1	1	183
Estates and Ancillary	1	1	0	10	5	3	0	20
Healthcare Scientists	0	1	0	16	15	0	0	32
Medical and Dental	3	6	2	115	28	7	0	161
Nursing and Midwifery Registered	3	16	0	201	197	10	2	429
Grand Total	**28**	**74**	**7**	**742**	**661**	**41**	**7**	**1560**

7 New Starters

New starters EDI Profile 1st January 2023-31st December 2023.

Age Range	No. of Staff
<=20 Years	13
21-25	40
26-30	41
31-35	48
36-40	33
41-45	24
46-50	17
51-55	14
56-60	19
61-65	15
66-70	1
Grand Total	**265**

Gender	No. of Staff
Female	186
Male	79
Grand Total	**265**

Disability	No. of Staff
No	245
Not Declared	1
Unspecified	4
Yes	15
Grand Total	**265**

Marital Status	No. of Staff
Civil Partnership	7
Divorced	12
Legally Separated	2
Married	102
Single	137
Unknown	5
Grand Total	**265**

Ethnic Origin	No. of Staff
A White - British	185
B White - Irish	3
C White - Any other White background	7
CH White Turkish	1
CP White Polish	1
F Mixed - White & Asian	2
G Mixed - Any other mixed background	1
H Asian or Asian British - Indian	19
J Asian or Asian British - Pakistani	4
K Asian or Asian British - Bangladeshi	1
L Asian or Asian British - Any other Asian background	7
N Black or Black British - African	8
PC Black Nigerian	1
R Chinese	3
S Any Other Ethnic Group	9
SC Filipino	1
SE Other Specified	1
Unspecified	3
Z Not Stated	8
Grand Total	**265**

Religion	No. of Staff
Atheism	52
Buddhism	3
Christianity	151
Hinduism	10
I do not wish to disclose my religion/belief	16
Islam	18
Judaism	1
Other	12
Unspecified	2
Grand Total	**265**

Sexual Orientation	No. of Staff
Bisexual	4
Gay or Lesbian	3
Heterosexual or Straight	249
Not stated (person asked but declined to provide a response)	7
Unspecified	2
Grand Total	**265**

Nationality	No. of Staff
Australian	2
Bangladeshi	1
Brazilian	1
British	206
Bulgarian	1
Central African	2
Egyptian	2
Filipino	3
Hong Kong (British/Chinese)	1
Indian	16
Irish	3
Italian	1
Kenyan	1
Maltese	2
Myanmar	1
Namibian	1
Nepalese	2
Nigerian	5
Northern Irish	3
Pakistani	3
Polish	2
Portuguese	1
Romanian	1
Sri Lankan	1
Swedish	1
Turkish	1
(blank)	1
Grand Total	**265**

8 Recruitment Data

Recruitment EDI Profile 1st January 2023-31st December 2023.

Category	Description	Applications	% of total applications	Shortlisted	% shortlisted in this group	% of those who applied that were shortlisted
Gender	Male	1534	40.52%	420	34.60%	27.38%
	Female	2198	58.06%	789	64.99%	35.90%
	Prefer not to say	16	0.42%	5	0.41%	31.25%
Is your gender the same as that assigned at birth?	Yes	3707	97.91%	1202	99.01%	32.43%
	No	19	0.50%	3	0.25%	15.79%
	Prefer not to say	22	0.58%	9	0.74%	40.91%
Disability	Yes	192	5.12%	86	7.08%	44.79%
	No	3486	93.03%	1096	90.28%	31.44%
	Prefer not to say	69	1.84%	32	2.64%	46.38%
Criminal Conviction	Yes	28	0.74%	7	0.58%	25.00%
	No	3704	97.83%	1207	99.42%	32.59%
Ethnicity	White: English, Scottish, Welsh, Northern Irish, British	1363	36.00%	755	62.19%	55.39%
	White: Irish	20	0.53%	15	1.24%	75.00%
	Any other white background	153	4.04%	43	3.54%	28.10%
	Asian/Asian British: Bangladeshi	41	1.08%	6	0.49%	14.63%
	Asian/Asian British: Chinese	45	1.19%	10	0.82%	22.22%
	Asian/Asian British: Indian	587	15.50%	116	9.56%	19.76%

	Asian/Asian British: Pakistani	223	5.89%	27	2.22%	12.11%
	Asian/Asian British: Other	83	2.19%	15	1.24%	18.07%
	Black/Black British: African	892	23.56%	155	12.77%	17.38%
	Black/Black British: Caribbean	13	0.34%	3	0.25%	23.08%
	Black/Black British: Other	6	0.16%	1	0.08%	16.67%
	Mixed: White and Asian	24	0.63%	6	0.49%	25.00%
	Mixed: White and Black African	61	1.61%	6	0.49%	9.84%
	Mixed: White and Black Caribbean	4	0.11%	1	0.08%	25.00%
	Mixed: Other	33	0.87%	6	0.49%	18.18%
	Any other ethnic group	135	3.57%	27	2.22%	20.00%
	Prefer not to say	65	1.72%	22	1.81%	33.85%
Age Range	Under 24 years	474	12.52%	182	14.99%	38.40%
	24-44 years	2762	72.95%	773	63.67%	27.99%
	45-59 years	450	11.89%	223	18.37%	49.56%
	60-74 years	33	0.87%	22	1.81%	66.67%
	75+ years	0	0.00%	0	0.00%	0.00%
	Prefer not to say	29	0.77%	14	1.15%	48.28%
Religion	Atheism/no religion	548	14.47%	280	23.06%	51.09%
	Buddhism	45	1.19%	11	0.91%	24.44%

	Christianity (including Church of England, Catholic, Protestant and all other Christian denominations)	2079	54.91%	710	58.48%	34.15%
	Hinduism	296	7.82%	52	4.28%	17.57%
	Judaism	5	0.13%	2	0.16%	40.00%
	Islam	541	14.29%	81	6.67%	14.97%
	Sikhism	8	0.21%	1	0.08%	12.50%
	Jainism	2	0.05%	0	0.00%	0.00%
	Any other religion	46	1.22%	10	0.82%	21.74%
	Prefer not to say	178	4.70%	67	5.52%	37.64%
Sexual Orientation	Heterosexual/straight	3449	91.10%	1127	92.83%	32.68%
	Bisexual	100	2.64%	22	1.81%	22.00%
	Gay/lesbian	65	1.72%	28	2.31%	43.08%
	Other sexual orientation not listed	9	0.24%	3	0.25%	33.33%
	Undecided	6	0.16%	1	0.08%	16.67%
	Prefer not to say	119	3.14%	33	2.72%	27.73%
Marital Status	Married	1590	42.00%	453	37.31%	28.49%
	Single	1889	49.89%	645	53.13%	34.15%
	Civil Partnership	84	2.22%	32	2.64%	38.10%
	Legally separated	10	0.26%	5	0.41%	50.00%
	Divorced	65	1.72%	32	2.64%	49.23%
	Widowed	17	0.45%	8	0.66%	47.06%
	Prefer not to say	93	2.46%	39	3.21%	41.94%
Are you currently pregnant, or on maternity/paternity leave, or have you given birth in the last 26 weeks?	Yes	56	1.48%	17	1.40%	30.36%
	No	3664	96.78%	1187	97.78%	32.40%
	Prefer not to say	28	0.74%	10	0.82%	35.71%

Impairment	Physical impairment	13	6.84%	8	9.30%	61.54%
	Sensory impairment	7	3.68%	5	5.81%	71.43%
	Mental health condition	24	12.63%	11	12.79%	45.83%
	Learning disability/difficulty	47	24.74%	20	23.26%	42.55%
	Long-standing illness	59	31.05%	30	34.88%	50.85%
	Other	40	21.05%	12	13.95%	30.00%
Total	Total	3786	100.00%	1214	100.00%	32.07%

9 Patients

Patients' EDI Profile 1st January 2023-31st December 2023.

9.1 Gender

Sex	Description	Inpatient	Outpatient	Grand Total	% of Total
F	Female	10,265	81,618	91,883	58.25%
I	Indeterminate/Other	1	12	13	0.008%
M	Male	6,554	59,251	65,805	41.72%
U	Unknown/Not Stated	5	32	37	0.023%
Grand Total		16,825	140,913	157,738	100.00%

9.2 Age Band

Age Band	Inpatient	Outpatient	Grand Total	% of Total
Under 18	64	1,082	1,146	0.73%
18-24	715	7,514	8,229	5.22%
25-34	1,832	15,848	17,680	11.21%
35-44	2,532	20,157	22,689	14.38%
45-54	3,483	24,282	27,765	17.60%
55-64	3,909	30,043	33,952	21.52%
65-74	2,630	24,620	27,250	17.28%
75+	1,660	17,367	19,027	12.06%
Grand Total	16,825	140,913	157,738	100.00%

9.3 Religion

Religion	Religion Description	Inpatient	Outpatient	Grand Total	% of Total
UNK	UNKNOWN	1,101	6,369	7,470	4.74%
AGN	AGNOSTIC	18	106	124	0.08%
ANG	ANGLICAN	19	74	93	0.06%
ATH	ATHEIST	109	581	690	0.44%
BAP	BAPTIST	7	187	194	0.12%
BUD	BUDDHIST	29	138	167	0.11%
CHR	CHRISTIAN	719	4,128	4,847	3.07%
COE	CHURCH OF ENGLAND	3,267	25,498	28,765	18.24%
CON	CONGREGATIONAL	0	8	8	0.01%
COS	CHURCH OF SCOTLAND	19	69	88	0.06%
COW	CHURCH OF WALES	53	327	380	0.24%
GO	GREEK ORTHODOX	6	43	49	0.03%
HIN	HINDU	20	183	203	0.13%
JEW	JEWISH	31	155	186	0.12%
JW	JEHOVAH'S WITNESS	19	241	260	0.16%
MET	METHODIST	115	941	1,056	0.67%
MOR	MORMON	1	30	31	0.02%
MUS	MUSLIM	73	688	761	0.48%
NRP	NO RELIGIOUS PREFERENCE	4,907	26,291	31,198	19.78%

NULL	NULL	3,469	55,909	59,378	37.64%
OC	OTHER CHRISTIAN	132	988	1,120	0.71%
ONC	OTHER NON CHRISTIAN	4	92	96	0.06%
PRE	PRESBYTERIAN	27	48	75	0.05%
QUA	QUAKER	6	11	17	0.01%
RC	ROMAN CATHOLIC	2,648	17,652	20,300	12.87%
REF	PATIENT REFUSED TO GIVE INFO	2	15	17	0.01%
RO	RUSSIAN ORTHODOX	9	1	10	0.01%
SAL	SALVATION ARMY	3	22	25	0.02%
SEI	SEIKH	8	49	57	0.04%
SPR	SPIRITUALIST	2	68	70	0.04%
WW	WHITE WITCHCRAFT	2	1	3	0.00%
Grand Total		16,825	140,913	157,738	100.00%

9.4 Ethnicity

Ethnic Group	Ethnic Group Description	Inpatient	Outpatient	Grand Total	% of Total
UNK	Unknown	1,629	27,507	29,136	18.47%
A	WHITE - BRITISH	13,498	95,891	109,389	69.35%
B	WHITE - IRISH	67	326	393	0.25%
C	WHITE - ANY OTHER BACKGROUND	207	1,314	1,521	0.96%
D	MIXED - WHITE/BLACK CARIBBEAN	25	103	128	0.08%
E	MIXED - WHITE/BLACK AFRICAN	4	103	107	0.07%
F	MIXED - WHITE AND ASIAN	34	145	179	0.11%
G	MIXED - ANY OTHER	38	222	260	0.16%
H	ASIAN - INDIAN	29	291	320	0.20%
J	ASIAN - PAKISTANI	18	138	156	0.10%
K	ASIAN - BANGLADESHI	8	71	79	0.05%
L	ASIAN - ANY OTHER BACKGROUND	27	267	294	0.19%
M	BLACK - CARIBBEAN	3	101	104	0.07%
N	BLACK - AFRICAN	19	226	245	0.16%
P	BLACK - ANY OTHER BACKGROUND	18	237	255	0.16%
R	OTHER - CHINESE	20	211	231	0.15%
S	OTHER - ANY OTHER	73	694	767	0.49%
Z	NOT STATED	1,108	13,066	14,174	8.99%
Grand Total		16,825	140,913	157,738	100.00%

9.5 Disability

Disability Risk Flag Y/N	Inpatient	Outpatient	Grand Total	% of Total
N	16,100	135,881	151,981	96.35%
Y	725	5,032	5,757	3.65%
Grand Total	16,825	140,913	157,738	100.00%

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

10 The use of interpretations services

Interpreter Services use 1st January 2023-31st December 2023.

9.1

Number of interpreter appointments conducted per language spoken 1st January 2023 to 31st December 2023					
ALBANIAN	AMHARIC	ARABIC	BANGALI & SYLHETI	BULGARIAN	CANTONESE
6	1	212	16	21	85
CREOLE	CZECH	FARSI (PERSIAN)	FRENCH	GREEK	GUJARATI
6	21	123	9	3	2
HINDI	HUNGARIAN	ITALIAN	KURDISH	LATVIAN	LITHUANIAN
2	26	16	79	7	24
MACEDONIAN	MALAYALAM	MANDARIN	OROMO	OTHER	PAKISTANI
2	4	21	4	32	1
PASHTO (PASHTOO)	POLISH	PORTUGUESE	PUNJABI	ROMANIAN	RUSSIAN
13	235	44	12	77	31
SERBIAN/ CROATIAN	SLOVAKIAN	SOMALI	SPANISH	TAMIL	THAI
4	23	9	37	26	4
TIGRINYA	TURKISH	UKRAINIAN	URDU	VIETNAMESE	WELSH
13	57	1	27	18	2
Total appointments made:		1356			

9.2

Number of sign language appointments conducted per language spoken 1st January 2023 to 31st December 2023			
Total number of appointments	37	Number of cancellations by the provider	0

11 Conclusion

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

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End of Report

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Equality Delivery System – *EDS2* Summary Report 2023

The Equality Delivery System – EDS2 was made mandatory in the NHS standard contract from April 2015. NHS organisations are strongly encouraged to follow the implementation of EDS2 in accordance with the
'9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at:
http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. Once completed, this Summary Report should be published on the organisation's website.

NHS organisation name:

The Walton Centre NHS Foundation Trust

Organisation's Board lead for EDS2	Organisation's EDS2 lead
Mike Gibney (Chief People Officer)	Jane Mullin (Deputy Chief people Officer)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

- EDI Steering Group
- Patient Experience Group
- Health Inequalities and Inclusion Committee
- Staff Partnership Committee

Organisation's Equality Objectives (including duration period):

2017-2022 – currently undergoing review

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

EDS2 Grades

Goal	Outcome	Grade and reasons for rating
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust are committed to providing the highest quality services to all patients which meet the health needs of the local communities, which is reflected in the Trust's corporate objectives and mission statement. The Trust works in partnership with commissioners to shape their contract thus ensuring that services are commissioned to meet the needs of the local population and to reduce health inequalities. Equality performance is routinely monitored in the quality contract with the Trust's commissioners.** **In order to ensure we are taking action and having a positive impact on our local communities, the Trust are involved in Liverpool Citizens, an alliance of active citizens and leaders from local institutions who are dedicated to working together for the common good. In addition to this, the Trust are working with Liverpool City Region and other providers across the city to actively consider the way in which policies and strategic decisions can increase or decrease inequalities through the 'socio-economic duty' as set out in Section 1 of the Equality Act 2010.** **In June 2023, the Trust introduced a Board level Health Inequalities and Inclusion Committee (HIIC), replacing the previous Strategic BAME Advisory Committee, recognising the expanding remit required of the committee and to oversee work in relation health inequalities, social value and EDI.** **A specific health inequalities dashboard has been created to track and analyse data for both patients and staff by indices of multiple deprivation (IMD) and ethnicity. Patient data includes referral rates, missed appointments (DNAs) and inpatient, new and follow up waiting lists. This data is regularly presented and discussed at HIIC with further work being undertaken by Operational Leads to understand the data further in relation to themes identified (e.g. higher DNA rates in areas of highest deprivation) to ensure action is being taken where possible to support patients.** **In order to respond to patients' need for local services, to reduce a patient's visits to hospital and aligned with Getting It Right First Time (GIRFT) recommendations, the Trust offer local satellite services across over 15 acute hospitals, providing both outpatient services and support to inpatients. Alongside this, the Trust have a number of treatment pathways in place to ensure patients receive the highest quality care at point of access including the below:** • **Rapid Access Neurology Assessment (RANA) service - provides rapid and direct access for patients with acute neurological issues to specialist neurology service in consultant led clinics and reduce unnecessary hospitalisations and facilitate speedy diagnosis and management plans.** • **Brain Tumour Optimisation Pathway – working with other providers across Cheshire and Mersey, a new pathway has been introduced in 2023 to ensure optimal and immediate diagnosis of a brain tumour.** • **Headache Pathway – with advice for both District General Hospital (DGHs) and General Practitioners (GPs) in managing primary headache disorders and recognising red flags and take appropriate and timely action.** • **Suspected Papilledema/Increase Intracranial Hypertension (IIH) Pathway – ensuring appropriate investigation and treatment is undertaken in a timely manner within local hospitals with advice provided as necessary from our on call teams.** • **Parkinson's Disease (PD) Management Pathway – advice to Acute hospital Trusts in appropriately assessing and managing patients with PD in a local setting** • **Seizure/Epilepsy Pathway – to support front-line clinicians to recognise and manage seizures and facilitate rapid referral of seizure patients to an outpatient appointment at The Walton Centre.** • **24/7 Thrombectomy service – ensuring rapid transfer, treatment and repatriation of appropriate acute stroke patients.** • **Enhanced Triaging Process – providing full and appropriate advice and management plans in response to referrals from primary care, reducing the need for appointments in specialist clinics and the likelihood of a rereferral in future.** **Following a joint tender process with local Trusts and Clinical Commissioners Groups, a new provider for interpretation and translation services have been implemented since September 2023 to ensure information provided to our patients is accessible and of the highest quality.** **Any new services or existing services undergoing change are assessed for possible equality impact on patients, visitors and staff. In addition, services are designed to be compliant with the Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) standards and guidelines and are fully accredited by awarding bodies. The Trust is planning to undertake a review of our Equality Impact Assessment/Equality Analysis procedures in 2024/25 in order to strengthen and streamline the process.** **The Trust believes that the services offered by the Trust are available to all irrespective of their protected characteristics, and data from the patient data report, complaints and concerns monitoring, patient surveys and engagement supports this belief. Patients, carers, Foundation Trust members and other stakeholders and local organisations and community groups are consulted with and involved in the design and delivery of services, thus ensuring that the health needs of the local communities are considered. All tenders assess equality and diversity, with responses considered as part of the tender process. All contracts include equality clauses.**

		For this outcome, the Trust has good evidence and data to demonstrate that services are equality impact assessed. The Trust can also demonstrate that the health and well-being of its staff and patients is taken seriously through strategic planning processes and policy making.
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** • **Grade: Developing** • **Evidence drawn upon for rating:** **Patient & Family Centred Care (PFCC) is a top priority at The Walton Centre to ensure patients' individual needs are met and to enhance their experience whilst receiving care from/at the Trust. This includes a number of initiatives which are implemented and monitored by our PFCC Steermg Group which was relaunched with a new work plan in December 2023 this is made up of members from many staff croups across the Trust including; , Senior Nursing Team, Quality Improvement Sustainability Team, Estates/Facilities, a clinical representative and Patient Experience Team. Initiatives this year have included our Noise at Night Campaign, review of our environment via PLACE assessments resulting in updated signage, equipment and furnishings for all ward areas.** **Our Enhanced Triaging Process ensures patient referrals are appropriately assessed and individual advice and care plans are provided.** **Risk assessments are undertaken on all patients in relation to falls, pressure ulcers, venous thromboembolism (VTE) and nutrition, in line with Commissioning and quality targets. The assessment includes review of patient's religious and cultural requirements, communication and care requirements, family support and carer needs. Individual care plans are developed for each patient and reviewed throughout their period of care. These plans are contributed to by all members of the Trust multidisciplinary team as and referrals made to subsequent services such as smoking cessation, dieticians, support groups or district nursing and rehabilitation services as appropriate.** **Following an individual health needs assessment, either in an outpatient, inpatient or community setting, all patients are provided access to the services they require in an appropriate and effective manner. The Trust ensures effective assessments are undertaken and case note and nursing quality audits support this process.** **The Trust ensures that reasonable adjustments are made where appropriate for patients and that supporting documents (e.g. carers passports and Learning Disability passports) are completed and/or utilised appropriately to ensure continuity of care and appropriate involvement of necessary parties. In addition, the Trust has access to 24-hour interpretation services (including BSL) for face-to-face/virtual appointments and support inpatient care. Any other reasonable adjustments are required, for example patients are supported to make a complaint, should they require additional support due to their conditions.** **Patient & family stories are shared at the Patient Experience Group and Trust Board, these are examples of how patients/families have accessed and received care. For example, to the sister of a patient with learning disabilities shared her story on how she had been invited to meet with staff prior to her sisters' admission to plan and put all measure in place to support the patient and family.** **Details are provided in our Patient & Visitor Information Guide and in posters across clinical areas about how to provide feedback regarding services including details for our Patient Experience Team, QR codes for our Friends and Family Test and a dedicated Listening Line which is manned 24 hours a day by a member of the senior nursing team for any inpatient concerns or advice. Themes and trends are monitored and reported to our Divisional Governance meetings and Quality Committee in order for actions and learning to be agreed, implemented and monitored.**
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust has numerous examples to demonstrate effective and appropriate transitions from services to support individual needs. This happens during transfer of patients into the Trust from the Trauma Network, from District General Hospitals, from other specialist Trust, for example Alder Hey, and GP referrals. We also transfer patients onto various points of care, including services within the Rehab Network, repatriating hospitals and social care or specialist services. This includes patients from Warrington, Cheshire, Merseyside, Wales and the Isle of Man. For outpatient services, a number of joint clinics are also held to assist in the transition of patients from one service to another, whether that be across providers or from one service to another within the Trust.** **Individual care plans are developed for each patient and reviewed throughout their period of care. The patient's assessment includes a review of their religious and cultural requirements, communication and care requirements, family support and carer needs. These plans are contributed to by all members of the Trust's multidisciplinary teams with input from the patient and carers, alongside health and social care professionals. Any change in services provided is planned and communicated with all concerned and any referrals are made to subsequent services with full handover of information.** **The Trust has good links with local communities and social services across its footprint. Holding multi-disciplinary meetings with internal and external stakeholders, as well as family members, to ensure arrangements are agreed and planned in the best interests of individual patients.** **The Trust actively signposts carers to appropriate support, includes them as partners in care and has implemented the 'Carers Passport' along with 11 other trust across Merseyside and Cheshire to highlight and acknowledge the importance of involving families as partners in care. The Trust is currently allocating space for a carers resource where it will provide information and a quiet space for carers to access. This resource will be**

		supported by the Brain Charity in partnership with the Trust.
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse • Grade: Developing • Evidence drawn upon for rating: The Trust believes that patient safety and quality must be at the heart of everything it does. The Quality Accounts Annual Report provides the backdrop to demonstrate the organisations commitment to improving the quality of services and safety of care. The Trust must ensure that it listens to and acts on feedback received. From 1st September 2023, The Walton Centre began to respond to patient safety incidents in line with Patient Safety Incident Response Framework (PSIRF) which supports the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than apportioning blame, allowing for more effective learning, and ultimately safer care for patients. In addition to this, the Trust have appointed 3 Patient Safety Partners (roles held by members of the public, patients or carers) to involve patients in patient safety. Our Patient Safety Partners have been invited and attended Trust Board, Patient Safety Training, to be a member of the Patient Information Panel and Patient Experience Group. One will also sit on the Quality & Patient Safety Group to help improve patient safety across the Trust. The Head of Patient Experience & Governance Lead meet monthly with the group to gain feedback on their evolving roles and provide 1:1 support. The organisation has a system in place whereby incidents of abuse must be reported by staff whether the abuse is directed at staff by patients, patient to patient or staff to patient. All incidents are reported via Datix, our incident reporting system to the Safeguarding Team. Abuse includes behaviours such as violence, verbal abuse, gestures, sexual or racial abuse. Reporting is web based, and all incidents are investigated thoroughly, and actions undertaken to address the behaviours. All incidents are reported through the appropriate governance committee structures. Some incidents, such as neglect, abuse of vulnerable adults or children, are reported directly to the Strategic Executive Information System (STEIS) as per NHS standard procedures for external reporting. Any concerns raised via the Patient Experience team will be escalated to the SG team. Patient Led Assessment of Cleanliness and Environment (PLACE) inspections are carried out annually. Teams are made up of patient representatives and members of staff, volunteers and patients with long term conditions and disabilities. The visits are planned but unannounced and intended to review the hospital for standards in cleanliness, hand hygiene, quality of accommodation and food and food service. The Trust also has an appointed Freedom to Speak Up Guardian to ensure that staff are encouraged and supported to report any mistakes, mistreatment and abuse. This year 25 Freedom to Speak Up Champions have been recruited across the Trust including both clinical and non-clinical staff from all levels of the organisation. Champions empower staff to raise issues and listen to concerns about patient care or staff safety. Any incidents reported collect all protected characteristics for both patients and staff and any themes and trends are highlighted and escalated appropriately. The Trust seeks causes through incident reporting and whistle-blowing systems and Freedom To Speak Up Guardians, which informs actions to be undertaken. Policies are in place to protect people making complaints and follow strict guidelines. Staff and patients are able to make complaints without fear of victimisation. Along with the safeguarding annual report, the Trust has a Safeguarding Adults and Children team to ensure the Trust operates within national statutory and non-statutory guidance for on safeguarding vulnerable people. Policies have been introduced to provide guidance to staff on the management of allegations of abuse and deprivation of liberty safeguards. In addition, staffs have access to taught sessions and e-learning training packages on safeguarding issues. For this outcome, the Trust firmly believes that all people from all protected characteristics are given the same protection in accordance with its mission statement to provide the very best care for each patient on every occasion, which is at the core of everything it does. However, grading has been identified as developing. This is due to the good data and evidence to demonstrate patient safety across the protected characteristics available in comparison to the less adequate data available for incident reporting of bullying or harassing behaviours. Patients from all protected characteristics are engaged with in the above processes.
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities • Grade: Developing • Evidence drawn upon for rating: The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance. The Trust has an extensive range of health programmes and initiatives in place to support staff and patients alike in accessing public health, vaccination and screening programmes. The Trust is able to provide evidence to demonstrate that people are accessing services; Previously, due to the data collection system we were only able to collect information on 4 of the protected characteristics but this has now risen to 8. Work is underway to enhance the current data collection systems to cover all protected characteristics. Throughout the hospital's wards, outpatients and public areas there is an extensive range of public health information for staff and patients to access, examples being for infection control and smoking cessation. Audits are undertaken to ensure sufficient coverage and appropriate placement of information is provided. All patient information is available on request in alternative formats. Interpreters are utilised to ensure communication is most effective.

		The Trust carried out an extensive COVID-19 vaccination programme on 2020 and took particular steps to ensure a high vaccination rate amongst Black, Asian and minority ethnic staff in response to national reports of their being a disproportionate impact of COVID-19 on these groups. This vaccination programme continues alongside our flu campaign which runs each year. **Health, vaccination and screening programmes include: pre-natal advice for epilepsy patients, flu vaccination programmes and smoking and alcohol intake screenings. After a positive trial for epilepsy patients a number of Nurse advice lines have also been rolled out to enable patients to get disease specific advice and support between appointments.** **The Trust believes that a healthy workforce leads to safer and better patient care and is committed to improving the health and wellbeing of all staff. The Trust has also been re-accredited with the Workplace Wellbeing charter and continues to run regular schemes and initiatives including health checks, fitness classes, various mental well-being initiatives, and discounted weight loss programmes.** **For this outcome, the Trust is again able to present data for 4 of the protected characteristics for patients, and all but 1 protected characteristic for staff (although not all staff services are monitored for equality purposes).**
Improved patient access and experience	**2.1**	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** • **Grade: Developing** • **Evidence drawn upon for rating:** **Our Patient Administration System (PAS) collects protected characteristics in terms of age, ethnicity, gender, gender at birth, religion, sexual orientation and disability. We are therefore able to monitor patient groups who are accessing our services and analyse the data as to where access does not meet our expectations in relation to our local population. As noted earlier, a dedicated health inequalities dashboard is regularly presented to our Board level Health Inequalities and Inclusion Committee with work undertaken by our Operational Leads to understand the data further in relation to themes identified (e.g. higher DNA rates in areas of highest deprivation) to ensure action is being taken where possible to support patients.** **All referrals made to the service are triaged by a clinical member of staff and dealt with appropriately. Any referrals which are rejected are provided with clear and appropriate reasons for this and will offer advice and guidance to the referrer either in relation to a more appropriate onward referral or treatment options.** **The Trust recognises that accessing services can be more difficult for some people. Our Health Inequalities data confirms that patients are more likely not to attend a follow up appointment (DNA) if they are from an area of higher deprivation. Work is ongoing with our Operational Leads to understand this further and implement any reasonable actions the Trust can take to help patients attend their appointments as needed. We also recognise that patients who have learning difficulties or require an interpreter (people whose first language is not English and/or those who are Deaf) often find it more difficult to access our services. The Trust is committed to ensuring that reasonable adjustments are made where required, including the use of interpreting services, adjustments to appointment times and changes to environment. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities.** **When patients telephone to make appointments, the access, booking and choice receptionists ask patients whether they have caring responsibilities or any disability in order to ensure that the best appointment possible is provided to suit their needs. Patients are also able to make appointments via email if preferred. Text messages are also sent to patients to remind them of their appointment, and the Trust has a self-check in kiosk, which has been reviewed regarding its accessibility (assisted check-in at the desk also remains available if required). Any enquiries or concerns from patients with regards to accessibility, for example, if a patient is unable to use the telephone due to a hearing impairment and they inform the Patient Experience Team, they will liaise with the appropriate team to ensure reasonable adjustments are put in place, for example, to communicate via email with the patient.** **The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings.** **The Trust provides access to the following services and facilities on request:** • **Face to face interpreters for non-English speakers** • **Telephone interpreters for non-English speakers** • **British Sign Language (BSL) interpreters for Deaf people** • **Translated written information upon request for patients who do not read English** • **Translated information into audio format for those who cannot read or blind or are visually impaired** • **Large print for those with vision impairment** • **Braille for those who are blind or visually impaired** • **Easy read version on request** • **Information on coloured paper for those who are visually impaired or who have dyslexia** • **Provide information and explanations in a clear and comprehensive way**

		'Meet and Greet' volunteers are in place to support patients to navigate around the hospital and the Trust is working with local communities and charities to ensure training is appropriate regarding peoples cultural and disability requirements, i.e. patients with vision impairment being guided appropriately. The Trust has recently provided Visually Impaired or Blind/Deaf training for staff and continues to provide Visually Impaired Training for all staff and volunteers. **For this outcome, the Trust is able to demonstrate that patients, carers and communities from 4 of the protected characteristics readily access services and there are no obvious concerns as demonstrated in the patient data report.**
	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** • **Grade: Achieving** • **Evidence drawn upon for rating:** **The Trust is committed to ensure that all patients, irrespective of protected characteristics, are informed, supported and involved in their diagnosis and decisions about their care where appropriate.** **Patient Initiated Follow Up (PIFU) is in place to allow patients/carers more autonomy in relation to follow up appointments. Suitable patients remain on the PIFU to make decisions about when they feel they require a further appointment and this is managed and validated by our Consultants to ensure appropriateness.** **Quality Boards are in place across the Trust to allow patients and visitors the opportunity to suggest improvements in individual areas and be involved in improving patients' experience.** **An open clinic is held by senior nursing staff in on Complex Rehab Unit (CRU) for patients and families to discuss care and provide feedback with business cards provided with appropriate contact information. Patient within our CRU are often an inpatient for an extended period of time and involving patients and their families directly in decision about their care is vital.** **The CQC National Inpatient Survey is the main source of reporting the perceptions of patients across the NHS and is used in comparative performance tables and quality indicators. In 2023, The Walton Centre were ranked 8th out of 133 providers for overall positive patient experience. The results in relation to being actively involved in decisions about care and treatment were positive with the Trust performing 'better than expected' on questions such as 'how much information about your condition or treatment was given to you?', 'when nurses spoke about your care in front of you, were you included in the conversation?' and 'when you asked doctors questions, did you get answers you could understand?' The Trust also scored 'much better than expected' on questions such as 'to what extent did staff looking after you involve you in decision about your care and treatment?', 'to what extent did staff involve you in decisions about you leaving hospital?' and 'to what extent did hospital staff involve your family and carers into account when planning for you to leave hospital?'** **The Trust has an active Patient Experience Group which meet quarterly, and the membership includes Healthwatch representatives and governor, the group receives a report bi-annually on the progress of patient information developed across the Trust. Standard, easy read and talking leaflets are being developed continually. A Patient Safety Partner has been recruited as part of the membership in 2024.** **Staff are able to access the interpreting services to ensure that patients whose first language is not English, or those patients who use British Sign Language, are fully able to understand their diagnoses and treatment and this should always be used during the consent process. Indeed, where patients are to be given 'bad news' interpreting provision takes place face to face and not by telephone.**
	2.3	**People report positive experiences of the NHS** • **Grade: Achieving** • **Evidence drawn upon for rating:** **The Trust has been assessed as Outstanding by the CQC. As part of this assessment NHS England reviewed and assessed the delivery of care to patients and their experiences when accessing services. They also undertook a review of equality and diversity provision and compliance within the Trust and found the outcome to be good.** **In 2023, The Walton Centre were ranked 8th out of 133 providers for overall positive patient experience. For overall experience, the Trust scored 8.9/10 which was 'much better than expected' when compared with other Trusts.** **Feedback through surveys and social media indicate a very good patient experience of services at the Walton Centre. Scheduled quarterly reports on all patient experience and dignity and respect activities are presented to the Trust Board and to the specialist CCG commissioners. The patient experience team meet with divisions on a weekly basis to discuss experiences of patients and discuss any open concerns or complaints. This is then reported via a report monthly to Divisional Governance meeting and the bi-monthly Executive meeting and the Quarterly Quality Committee of the Board. This information also goes to Patient Experience Group which has representatives from Healthwatch, Trust Governors and local charitable organisations.** **All patients are asked to complete a Friends and Family Test during their admission and upon discharge. The results of these surveys are reported though the Integrated Performance Report and the quarterly Patient Experience Group. All wards receive feedback on a monthly basis to share the positive comments and put actions in place for any negative comments or themes.**

		The Trust has Dignity Champions across the organisation with each ward having at least one Dignity Champion. The Champions act as role models, identifying breaches of dignity in care, addressing and challenging issues as they arise and promoting dignity in care for every patient. **For this outcome, the Trust is firmly committed to listening to the views of patients, carers and other local interest groups and communities and ensuring positive patient experience. Evidence from all of the above leads us to suggest that we are Achieving with regards to this sub-goal.**
	2.4	**People's complaints about services are handled respectfully and efficiently** • **Grade: Achieving** • **Evidence drawn upon for rating:** **Complaints about care and our services are taken very seriously and all concerns and complaints are managed by Patient Experience Team and investigated by the appropriate division to provide a response. Statistical information and lessons learnt are reported to the Patient Experience Group and the Quality Committee and Trust Board on a quarterly basis. This report also highlights actions taken as a result of complaints, together with any trends and themes. Responses are provided in line with the complainant's preference, for example written responses from the Chief Executive are provided for formal complaints but some patients/family members prefer a verbal explanation following raising a concerns.** **Local resolution meetings following complaints are also advocated especially following a death or sensitive complaint to provide complainants with the opportunity to discuss their concerns face to face with senior staff/clinicians. All patients/families are supported by the Patient Experience Team both prior to and during the meeting. All meetings are followed by a written response.** **Providing Patient & Family Centred Care is a high priority, and the key stages of the patient & family journey is outlined as 6 steps. This strategy was recently re-designed and relaunched in February 2023. A workplan and working groups underpins the progress and on-going work.** **The Trust Board receive a monthly Patient & Family Story at the beginning of each board meeting. This can be in person or via MS teams where both positive and negative experiences are shared from all service lines and following any new innovations.** **The Patient Experience Team capture all concerns/enquiries and complaints in line with the 9 protected characteristics. The details of which along with any action or learning is included within the quarterly reports, reported to Quality Committee. Any themes or trends would be highlighted to the relevant divisional management team in real time.** **In line with Trust Policy, complaints are responded to within a specific timeframe which is negotiated with the complainant. All complaints are responded to within either Level 1 (25 working days), Level 2 (45 working days) and Level 3 (60 working days). These KPIs are closely monitored and reported bi-monthly to the Exec Team, Quarterly to Quality Committee.**
A representative and supported workforce	**3.1**	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** • **Grade: Achieving** • **Evidence drawn upon for rating:** **The Trust uses NHS Jobs which collects data on 7 of the 9 protected characteristics (gender reassignment and pregnancy/maternity are currently not recorded). Recruiting managers are unable to see any of the monitoring information at any point and are also unable to see the applicants name or right to work status until after the shortlisting process has been completed either. All figures and demographics can be found in the E&D Workforce Annual Report.** **An EDI Solutions Project is currently underway in collaboration with an external provider to review our policies and procedures including those in relation to recruitment, onboarding and induction. This project has been ongoing since October 2023 and is expected to conclude prior to the end of March 2024.**
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and actions highlighted have been included in our EDI Action Plan.** **In our latest reporting, a 7.33% decrease in average gender pay gap figures could be seen when compared to 2017/18 figures when reporting began.** **In line with NHS England's EDI Improvement Plan, the Trust plans to introduce monitoring of other protected characteristics to pay gap reporting, beginning with ethnicity and disability with a view to bringing further characteristics online in future.**
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust provides mandatory equality, diversity & human rights training on a 3 yearly basis, as opposed to a one off session. Furthermore, the Trust's e-Learning allows employees to complete parts of their mandatory training at a time and place convenient to them. Adjustments have been accounted for to support individuals as needed including 1:1 support sessions.**

		All training opportunities are well publicised, through weekly communications and the monthly team brief. Data is collected on 7 of the protected characteristics (gender reassignment and pregnancy/maternity are not captured, although questions are asked around pregnancy where appropriate to ensure training can be adjusted where necessary). There is still an under-representation of BME staff, compared to the overall workforce demographics accessing training. The percentages of applications by age group, sexual orientation and religion or belief are all comparable with the workforce demographics with the percentage by disability also being broadly in line. **The ongoing EDI Solutions Project will review training opportunities and processes to ensure these are distributed fairly and that all staff have equal access to opportunities. The Trust have also undertaken a recent project to train inhouse trainers to deliver Building a Culture of Conscious Inclusion Training, this training is available to all Trust staff and has been communicated via a number of different channels. Five cohorts have taken place between January and March 2024 with good uptake and positive feedback. Training will be reviewed based on any constructive feedback and new dates will be launched later in the year.**
	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** • **Grade: Developing** • **Evidence drawn upon for rating:** **Data in respect of all employee relation cases (grievances, disciplinaries, and dignity at work) is monitored against the 7 protected characteristics currently recorded in ESR. The E&D Annual Report includes analysis of this.** **In relation to race, monitoring is also conducted via the Workforce Race Equality Standard (WRES).** **In relation to Disability, monitoring is also conducted via the Workforce Disability Equality Standard (WDES).** **The Trust has robust policies in place for the management of violence and aggressive behaviours (as well as guidelines for supporting staff following traumatic stressful incidents) and HR policies in relation to dignity at work, Equality, Diversity and Human Rights and disciplinary and grievance policies.** **Due to the nature of the patients treated by the Walton Centre aggression is quite common and is often a symptom of their illness/lack of capacity. Whilst any patient behaving inappropriately will be spoken to it is often the case that they are either unable to help their actions or they forget the warning given, this makes it very difficult to eradicate this behaviour completely, however, the Trust does offer staff additional support in these cases.** **A dedicated Patient Safety Lead is in place to respond to incidents, support staff and provide debriefing sessions to those involved. Preventative actions are taken where possible to minimise the likelihood of escalating behaviours and all patient facing staff undertake personal safety training on an annual basis. Any themes and trends are reported to the Health & Safety Group for monitoring and escalation as appropriate.** **Staff listening weeks and Freedom to Speak Up services also promote an open culture to ensure staff feel they have appropriate channels to raise any concerns.**
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust's Flexible Working Policy enables all employees from the point at which they join the Trust to request a flexible working arrangement. In addition to part-time working, flexible working options also include compressed or adjusted hours, job-sharing, flexi-time, term-time working, home working (where possible) and career breaks. The Trust has an Agile Working policy in place in relation to home based/hybrid working.** **The Trust also offers flexible retirement options, as detailed in the Trust's Flexible Retirement policy. This aims to support older employees in their retirement plans and therefore demonstrates our commitment, and appreciation of, a diverse workforce.**
	3.6	**Staff report positive experiences of their membership of the workforce** • **Grade: Developing** • **Evidence drawn upon for rating:** **Evidence can be taken from the National Staff Survey; for 2022 the Trust scored higher than average in relation to all People promise Elements and Themes.** **The Trust also monitors staff experience via Workplace Race Equality Standards (WRES) reporting and Workplace Disability Equality Standards (WDES) reporting and has corresponding actions to improve staff experience. The Trust also has an extensive suite of wellbeing activities that are promoted to staff.** **This year saw the opening of our Wellbeing Hub in April 2023 – Hub provides staff with a safe space to collect their thoughts and find out what health and wellbeing activities we have coming up at the Trust. We will also be using the space to hold events and drop-in sessions that we run as part of our Walton wellbeing programme.**

		The Trust have been awarded Investors in People Gold award for both 'we invest in people' and 'we invest in wellbeing' standards.
Inclusive leadership	**4.1**	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** • **Grade: Developing** • **Evidence drawn upon for rating:** **The Trust board review and approve the Equality and Diversity Annual Report, which covers all the protected characteristics. All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed.** **In June 2023, the Trust introduced a Board level Health Inequalities and Inclusion Committee (HIIC), replacing the previous Strategic BAME Advisory Committee, recognising the expanding remit required of the committee and to oversee work in relation health inequalities, social value and EDI. The Trust also commissioned two external reviews of EDI within he Trust at the end of 2022 and, as a result, have continued to work with an external provider on three separate EDI focused projects to review policies and procedures, implement Building a Culture of Conscious Inclusion training at the Trust and deliver a seminar on Gender Dynamics in the workplace.** **Examples of when Board members and senior leaders have demonstrated their commitment to equality include the commissioning of 2 external reviews of EDI across the Trust as well as two projects in collaboration with an external provider to review policies and procedures and train inhouse trainers to deliver Building a Culture of Conscious Inclusion training. Members of the Board are also involved in EDI events such as attending Liverpool PRIDE and sharing staff stories in their communications to staff. The Board also attend EDI focused workshops to further their awareness and attended such in relation to transgender awareness and sexual misconduct and work in 2023.** **The Trust are members of Liverpool Citizens, working with other organisations and groups across the city to positively impact the lives of local residents and have involved patients/volunteers in some of their working groups. As well as working with Liverpool City Region in relation to Socio-economic Duty.**
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** • **Grade: Developing** • **Evidence drawn upon for rating:** **All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed. To support this, the EIA screening tool has been added to the policy template. As part of the Trusts ongoing EDI Action Plan, our EIA process is due to be reviewed in the next financial year to ensure this is robust.** **Risk in relation to health inequalities and prevention is monitored via the Board Assurance Framework.**
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** • **Grade: Developing** • **Evidence drawn upon for rating:** **Our Building Rapport training programme for managers, includes an equality section aimed at Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.** **Building a Culture of Conscious Inclusion training is now available for all staff across the Trust to book with inhouse trainers available.** **Staff Network groups (LGBTQIA+, Disability, Anti-racism and Veterans) are available to all staff and line managers are advised to allow staff protected time to attend where possible.** **Staff stories are shared across the Trust and EDI events marked in internal communications including weekly Trust newsletter, Team Brief, information screens in staff areas, intranet, closed staff facebook group and a quarterly EDI newsletter.**

Report to Trust Board
4 April 2024

Report Title	Gender Pay Gap Report 2022/23
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Emma Sutton, Equality and Diversity Manager
Action Required	To note

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

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

Key Messages

- The Trust is required to publish Gender Pay Gap data annually by 30 March
- The pay gap has reduced by 7.33% since it was first reported in 2018

Next Steps

- Progress with current actions

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

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**
Equality Diversity and Inclusion Steering Group	18/1/24	Emma Sutton, Equality and Diversity Manager	Report agreed
Health Inequalities and Inclusion Committee	25/3/24	Emma Sutton, Equality and Diversity Manager	Report agreed

Gender Pay Gap Report 2022/23

Executive Summary

1. The Trust is required to publish gender pay gap data annually. The pay gap has reduced by 7.33% since it was first reported in 2018 and currently stands at 25.9%. An action plan is in place to continue to close the gap.

2. This report must be submitted to the government website and published on the Trust website by 30th March 2024.

Background and Analysis

3. Pay Gap indicators including the mean, median of basic and bonus pay is included within the report and demonstrates a 25.9% average pay gap and 17.25% bonus average in favour of male staff.

4. The report also indicates the gender ratio of male to females across four quartiles of pay.

5. Actions are set out within the report to reduce the gender pay gap and promote gender equality.

Recommendation

To approve for publication

Author: Emma Sutton, Equality and Diversity Manager
Date: 18th March 2024

Appendix 1: Gender Pay Gap Annual Report

GENDER PAY GAP REPORT 2022-2023
For publication in 2024

1. Background

In 2017 it became mandatory for all public sector organisations with more than 250 staff to report Gender Pay Gap information on an annual basis. These results must be uploaded via a portal to be displayed on the government website and be available on the Trust's own website where it should remain for 3 years.

Gender Pay reporting looks at the difference between male and female pay within an organisation. Nationally, records show that there is a disparity between gender pay with females generally paid less than males and this is thought to be because more men than women occupy higher paid jobs. The NHS is 75% female (NHS Property Service) and if higher paid jobs are predominantly occupied by males, this could well create comparatively lower pay for the female workforce. The purpose of Gender Pay reporting to help address this imbalance. The Gender Pay Gap shows the differences in the average pay between men and women rather than unequal pay.

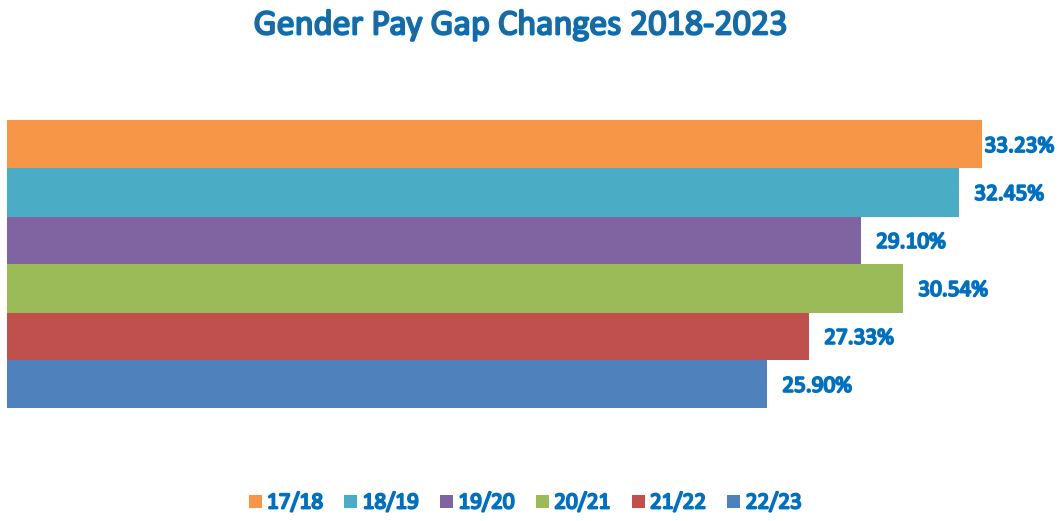
This report shows the Walton Centre NHS Foundation Trust's Gender Pay Gap figures from the snapshot date of 31 March 2023. The findings reflect pay by gender for the previous financial year to that date. This report covers all staff including those under Agenda for Change terms and conditions, medical staff and very senior managers.

2 Organisational Context

The Walton Centre is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce. This report details the Trust's 6th set of findings following the introduction of Gender Pay Gap reporting and also details how the organisation plans to respond to the data analysis.

It is important to note that although our Gender Pay Gap reflects a senior manager/consultant gender ratio that cannot be resolved in a short period of time, the Trust has been working on a number of initiatives that help to create the best culture in which all staff can prosper. The Walton Centre NHS Foundation Trust acknowledges that society exhibits widespread disparities in the pay that women receive in comparison with men and that public sector organisation such as the Walton Centre both reflect these disparities and have a part to play in eliminating them. The Walton Centre is happy to publish this Gender Pay Gap report as an expression of our Walton Way value of Openness: being open and honest in all we do. The Trust is proud that Gender Pay Gap has continued to drop since it was first recorded in 2018 with an overall reduction of 7.33%.

Graph 1 – demonstrates the changes in gender pay gap over the period since reporting began



2. The Six Gender Pay Gap Indicators

2.1 Organisations must show the following calculations when reporting:

a. Average gender pay gap as a mean average
b. Average gender pay gap as a median average
c. Average bonus gender pay gap as a mean average
d. Average bonus gender pay gap as a median average
e. Proportion of males and females receiving a bonus payment
f. Proportion of males and females in each of the four quartile pay bands

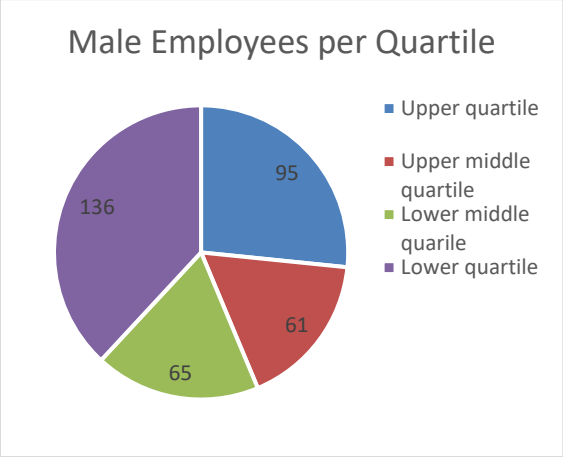
Main highlights

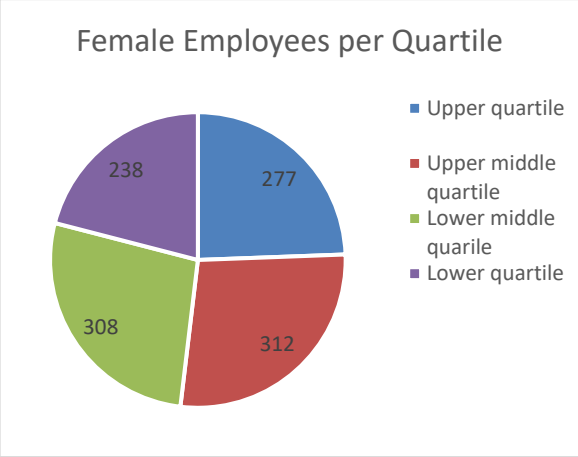
a	b	c	d	e	f
7.33% decrease in average gender pay gap figures since 2017	1.92% decrease in median gender pay gap figures since 2017	17.25% Bonus average in favour of males – last year this was in favour of females	0% Difference between median bonus	18.77% of males received a bonus compared with 2.77% of females	More even spread in quartiles - Males in top quartile dropped from 41% (last year) of total males to 27% with females at 24.5%

The gender pay gap looks at hourly rate percentage difference paid to males and females in the workforce. The Walton Centre has a largely female workforce with

76.1% of employees recorded as female. This is comparable with the NHS as a whole at 76.7% recorded in 2021 (NHS England) According the Office for National Statistics (2022), The national average pay gap is recorded as 8.3% in full-time employees and the NHS as a whole at 9.5% (Gov.uk). This is lower than the 25.9% at the Walton Centre, but the gap is slowly closing and has reduced by over 7 percent since 2017. This gap is thought to be caused by the fact that majority of female employees working at the Walton Centre are healthcare workers and fall into the middle and lower quartiles. Comparatively, a high percentage (68.4%) of the medical staff are male and this means they fall into the upper quartile. Overall however, the trust does have more females than males in the top quartile (222 females compared to 141 male). The figures for each of the quartiles is fairly consistent from the previous year.

When comparing percentage of the total male employees and the same for the female employees, the numbers are generally more evenly distributed throughout the four quartiles. A percentage of the female staff cohort can be seen compared to the male cohort below and demonstrates that whilst the female cohort are very evenly distributed, the male figures show a higher percentage in both the highest and the lowest quartiles. This is thought be due to a higher number of males in medic positions and a large number of males staff doing lower skilled jobs





Bonuses given to staff at the Trust are target driven clinic excellence schemes which are given to senior medical staff. This means that 18.37% of males received a bonus compared to 2.77% of females but this is mainly due to the fact that there are more male medics than female ones as mentioned previously.

Data on the Gender Pay Gap 2022/2023 based on data relating to 31st March 2023

Total Number of relevant staff:	1492	Female 1135	Male: 357

1. The mean (average) gender pay gap using hourly pay and the median gender pay gap using hourly pay as at 31st March 2023.

Table 1

Gender	Average Hourly Rate	Median Hourly Rate
Female	£18.99	£16.84
Male	£25.63	£20.43
Difference	£6.64	£3.58
Pay Gap %	**25.90%**	**17.54%**

2. Percentage of men and women receiving bonus pay 31st March 2023.

Table 2

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	*34*	*1229*	*2.77%*
Male	*72*	*392*	*18.37%*

3. The mean (average) gender pay gap using bonus pay and the median gender pay gap using bonus pay as at 31st March 2023.

Table 3

Gender	Average Bonus Pay	Median Bonus Pay
Female	£6,608.50	£4,743.36
Male	£7,986.25	£4,743.36
Difference	£1,377.74	0.0
Pay Gap %	**17.25%**	**0.0**

4. Percentage of men and women in each hourly pay quarter as at 31st March 2023.

Table 4

Quartile	Female Headcount	Male Headcount	Female %	Male %
Upper quartile = £63,634	277	95	74.46%	25.54%
Upper middle quartile = £33,314	312	61	83.65%	16.35%
Lower middle quartile = £23,733	308	65	82.57%	17.43%
Lower quartile = £17,254	238	136	63.64%	36.36%

4. Actions to Reduce the Gender Pay Gap

The Trust will undertake a self-assessment checklist that highlights key considerations that may affect the Gender Pay Gap. Completing the checklist will enable the Trust to assess our progress against different areas and understand those which require focus and should be addressed with further actions. The self-assessment checklist will ensure the following:

Branding/communication/transparency

- We are transparent about our promotion, pay and reward processes.
- We consider the language, images and branding that we use to promote and advertise roles and careers within our organisation.
- We encourage salary negotiation by showing salary ranges when advertising vacancies.

Recruitment and promotion processes

- We provide good-quality guidance to our line managers.
- We support progression for part-time and flexible workers.
- We give recruiters structured interview templates, so they give every candidate an equal chance.

Maternity and paternity and parental leave policies

- We actively support women on maternity leave and encourage line managers to ensure staff use ‘keeping in touch days’ as a steppingstone to creating a positive return to work experience.
- We encourage staff who have not returned to the organisation after maternity leave to consider how we could support them in doing so.
- We actively promote the existence of a shared parental leave policy and encourage new parents to take advantage of the scheme.

Wellbeing and retention

- We offer and actively promote a range of opportunities for flexible working to all staff, to suit their parental and caring responsibilities and commitments outside of work.
- We actively analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals.

Supporting female staff

- We identify and support aspiring women leaders within our organisation by providing them with opportunities for development and career progression.
- We offer women networking opportunities promote access to mentoring and coaching from colleagues and peers.
- We actively support our female staff in considering and applying for clinical excellence awards (if appropriate) and other opportunities to seek recognition for their work.

5 Action Plan

The EDI steering Group will be responsible for developing and implementing the Trust's future Gender Pay Gap actions.

Area and objective	Action	Lead	Timescales	Resources	Outcome and impact
Action planning and review.	Complete the checklist and identify and carry out further actions based on any gaps found.	The EDI Steering Group.	March 2024	Data and information. Internal communications.	The Trust will gain a more detailed analysis and action plans in relation to closing the Gender Pay Gap.
Supporting female staff to take up more opportunities for career advancement.	Offer and promote networking opportunities to female staff.	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	October 2023	Data and information. Internal communications.	Female staff will be supported to know about and take advantage of the opportunities for career advancement that are available.
Recruitment processes	Recruitment policy and guidance to be reviewed	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	March 2024	Data and information. Internal communications.	All recruiting managers are aware of good practice.
Communication Improving staff understanding of and support for closing the Gender Pay Gap.	A member of the Trust Board will write a piece for Walton Weekly.	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	April 2024	Data and information. Internal communications.	All staff will be informed about the Trusts commitment to reduce our gender pay gap.

Further sources of advice and actions to close the Gander Pay Gap:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

https://www.nhsemployers.org/sites/default/files/2021-06/Addressing-your-gender-pay-gap-guide.pdf

The Walton Centre NHS Foundation Trust

Report to Board of Directors
4 April 2024

Report Title	Accountability and Performance Framework 2024-2026
Executive Lead	Lindsey Vlasman, Chief Operating Officer Mike Burns, Chief Finance Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages

- New document which outlines how the Trust holds itself to account and how it measures performance
- This was noted as a gap in the Well Led Review in 2023

Next Steps

- Front cover to be updated by Comms and links to new intranet site to be created once launched
- Upload to CQC portal
- Disseminate to staff

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

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

004 Operational Performance	001 Quality Patient Care	004 Leadership Development

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	28 February 2024	K Dowson Corporate Secretary	Additional section on hosted networks to be included and feedback from Divisional Directors incorporated.

Accountability and Performance Framework

Background

1. The purpose of an accountability framework is to define where accountability for the achievement of the Trust's strategy, vision and ambitions lies. The document should enable all staff to understand what they are accountable for personally and as part of a team and how this links through the Trust and how governance systems support this.

2. The Well Led review highlighted that the Trust did not have a document in place that described this and also that there was no performance framework in place or clear description of how quality and safety is managed in the Trust.

3. As part of a scan of existing documents and best practice it became clear that there was no defined approach and very little consistency across Trusts about the best approach for an accountability framework. Some Trusts had more of a corporate governance manual which included templates and details of how meetings should be managed. The Trust now has this as a standalone document through the recently published Meetings Guidance Guide. An outline proposal for what should be included was agreed by Executives in September 2023.

Well Led Review

4. The Well Led review in March 2023 highlighted that the Trust could strengthen its accountability framework and consider ways in which to create more formal divisional autonomy arrangements and generate effective accountability. It was recommended that the Trust should "consider reviewing its accountability and performance management arrangements to better formalise and improve accountability to support delivery of required targets via suitably devolved arrangements."

5. It was therefore agreed in the Well Led action plan that an accountability framework should be created to formalise existing arrangements. This was in addition to setting up the weekly finance, operations and performance meeting.

6. This framework has now been drafted and is attached at Appendix 1.

New Code of Governance

7. The new Code of Governance which came into effect on 1 April 2024 also requires a description of the responsibilities for the Chair, Chief Executive, Senior Independent Director, Board and Committees to be published that has been agreed by the Board of Directors. This is included in the new Framework and will therefore also be available on the internet as well as the staff intranet.

Conclusion

8. This document has been reviewed by Executive Directors and Divisional Directors and is considered to be a thorough and comprehensive description of the Trust's accountability and performance framework that should be made available for all staff to understand their role in achieving the Trust's objectives.

Recommendation

To approve

Author: Katharine Dowson
Date: 18 March 2024

Appendix 1 – Performance and Accountability Framework

NHS
The Walton Centre
NHS Foundation Trust

Accountability and Performance Framework 2024-2026

Table of Contents

Section A - Overview

Introduction and Purpose

Good governance – the way we run ourselves - is essential to the provision of safe, sustainable and high-quality care for patients. Corporate Governance is the system and processes by which we as an organisation are directed and make decisions. Effective corporate governance, along with clinical governance, is essential for a NHS provider trust to achieve its clinical, quality and financial objectives.

This Accountability and Performance Framework sets out how and where decisions are made and for which we can be held accountable, at different levels, as individuals, teams and as groups. This includes the key enabling structures and processes to support the delivery and achievement of our vision, strategy and strategic objectives as well as monitoring performance and outcomes.

> **"We define accountability as the requirement for organisations to report and explain their performance"** Kings Fund, 2011.

All of us involved in the leadership, management and delivery of The Walton Centre's service have a role in being accountable for performance management and outcomes.

Fundamental to effective corporate governance is having the means to verify the effectiveness of this management and decision-making which is achieved through independent review and assurance.

Trust Strategy, Ambitions, Vision and Values

Trust Strategy and Ambitions

The Strategy covers the three years from 2022 to 2025 and sets out what we want to achieve and how we want to grow through our five strategic ambitions in order to carry on delivering world-class care for patients. More detail about the Strategy can be found on our website Our Strategy (www.thewaltoncentre.nhs.uk). The Board of Directors is responsible for the setting of our Strategy and holds our Executive Directors to account for the delivery of it and the seven underlying substrategies. All staff are asked to link their personal objectives with the Trust's strategic ambitions as part of their annual Personal Development Review (PDR).

Vision, Mission and Values

The vision of The Walton Centre is *Excellence in Neuroscience.*

Our mission is *Specialist staff working collaboratively to reduce health inequalities and achieve excellent clinical outcomes and patient experience*

Our vision at The Walton Centre is underpinned by a shared set of values. These values should be at the centre of we do. These are collectively known as The Walton Way and include a learning culture that empowers staff to make and lead change, be curious and seek continuous improvement.

Section B- Corporate Governance

Statutory and regulatory framework

The **NHS Constitution**[1] established the principles and values of the NHS in England. It sets out the rights and pledges we are all entitled to and how we will achieve delivery of them. As a NHS provider of services and care we must hold a **Provider Licence**[2]**.** Failure to comply with the license provisions can result in enforcement action from NHS England.

NHS foundation trusts (FT) are legal entities in the form of public benefit corporations by the National **Health Service (NHS) Act 2006**[3] . NHS FT boards of directors have the autonomy to make financial and strategic decisions. They also have a framework of local accountability to the public and its members through a Council of Governors. FTs are free to decide locally how to meet their obligations. They have specified powers to enter into contracts in their own name and to act as Corporate Trustees for charitable funds, in which role they are accountable to the Charity Commission.

The **Health and Care Act 2022**[4] further added the responsibility to all Trusts to collaborate across the NHS and local government; we have a shared duty to pursue the 'triple aim' of the NHS Long Term Plan – better health and wellbeing, better quality health care and ensuring the financial sustainability of the NHS. This means working collaboratively with other provider trusts within the local Integrated Care System (ICS) for Cheshire and Merseyside.

Corporate Governance Documents

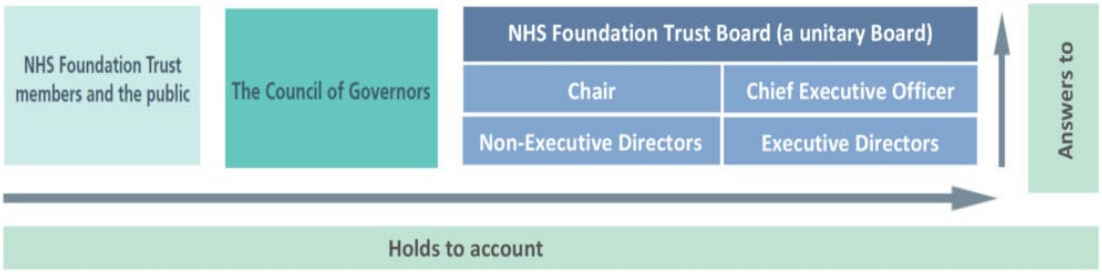
There are a number of key documents that govern the way our Trust is run and how staff and leaders are held to account. Our governance structure is largely dictated by national guidance which must be followed such as the **Code of Governance for NHS Trusts**.[5] The Board is ultimately accountable for all areas, but number of core documents set out who can make decisions, including levels of financial authority, in order to delegate areas of responsibility to individuals, committees and groups.

Trust Constitution

The Constitution[6] sets out the rules that guides how our Trust works. This includes the **standing orders** which are the rules by which our Board of Directors and Council of Governors operate. It also includes details of how Governors are elected and the role of the Members. This document is published on the website; any changes must be approved by the Board of Directors and Council of Governors and ratified at the Annual Members Meeting.

[1] NHS Constitution for England - GOV.UK (www.gov.uk)
[2] NHS England » The NHS provider licence
[3] National Health Service Act 2006 (legislation.gov.uk)
[4] https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[5] NHS England » Code of governance for NHS provider trusts
[6] Trust Constitution (updated 2023)

The chain of accountability as shown in the diagram below is fundamental to our governance structures and roles.



Terms of Reference

Every constituted Committee and Group on the Corporate Governance Group Structure (Appendix 1) has a Terms of Reference which sets out its duties, powers, authority and membership. This creates a clear line of delegated responsibility through the structure which ties back to the Board of Directors. For the Board of Directors and Council of Governors this is found within the standing orders of the Trust Constitution. Templates for Terms of Reference can be found on the Corporate Governance intranet page. There are three different versions, one for Board Committees, one for decision-making groups and one for engagement and consultation groups

Scheme of Reservation and Delegation (SoRD)

The SoRD sets out how the Board has delegated its decision making powers, this includes detail of the individual, committee or group delegated to. 'Matters Reserved to the Board' cannot be delegated to any groups that are not wholly made up of Board Members this includes setting of the Trust Strategy, approval of business cases or contracts over £1m and approval of the financial plan and budget. Link to finance page of the intranet.

The Scheme of Delegation shows only the "top level" of delegation within our structure. The Scheme is used in conjunction with the system of budgetary control and other established procedures.

Standing Financial Instructions (SFIs)

The SFIs set out the financial responsibilities and levels of financial authority for all our staff. This document is available on the finance page of the intranet.

Expenditure Controls

As there is a system responsibility for reaching a financial balance across Cheshire and Merseyside all Trusts have been asked to implement a national set of expenditure controls. The controls focus heavily on governance arrangements and processes across recruitment and are applicable to any additional commitment of expenditure over £10k.

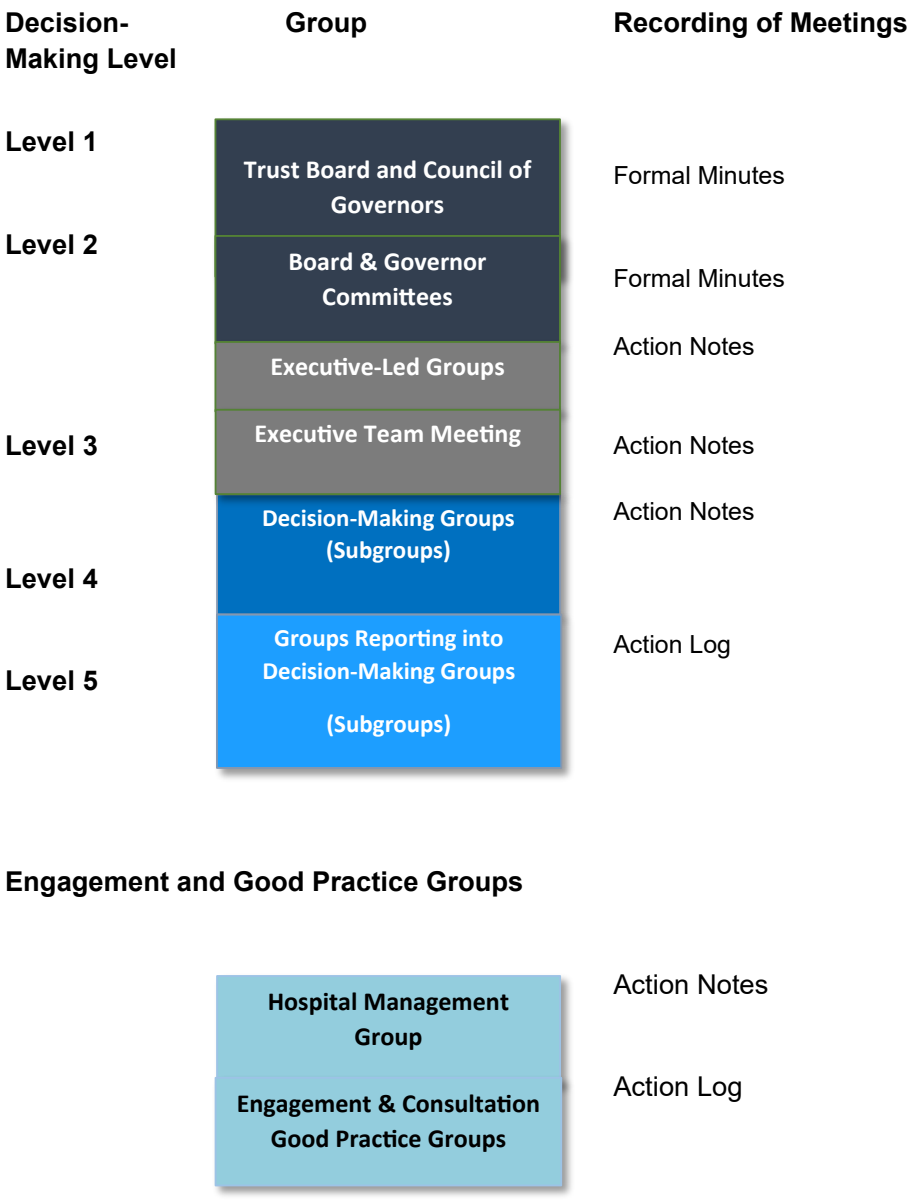
Annual Report and Accounts

Every year we must publish an annual report and set of accounts for the previous year which is laid before Parliament. The annual report provides information, which is consistent across all NHS providers, about how we have managed our resources efficiently and effectively. The report is audited by the external auditors and presented to the Council of Governors each year at the Annual Members Meeting. Once laid before Parliament the Annual Report and Accounts is published on the Trust website.

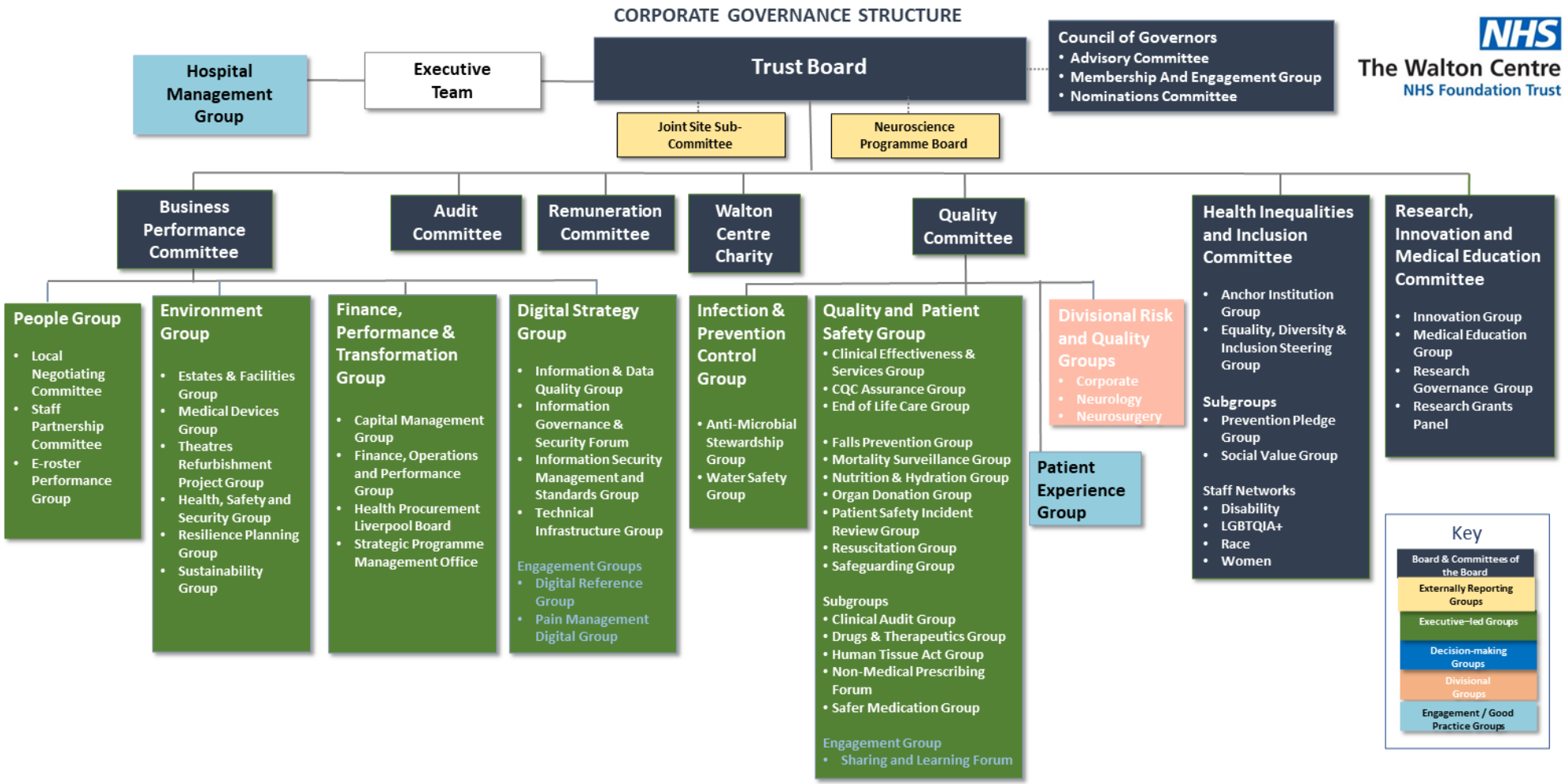
Corporate Governance Structures

The corporate governance structure which sets out the decision-making groups and committees is attached at Appendix 1 and is also available on the corporate governance page on the intranet. A simplified version is on the following page. The following groups in Figure 1 have specific roles in the structure and there are several defined 'types' of meetings. In addition to these there will be task and finish groups set up for a specific project, team meetings and locally defined meetings that are not on this structure as they are not part of the formal decision-making process.

Figure 1



There is a good meeting guidance document on the Corporate Governance Intranet page which includes detail about how to run an effective meeting.



February 2024

Hosted Networks

In addition to our own structure we also host three networks on behalf of wider partners. These are below with links to further information on our website where available:

- Cheshire and Merseyside Rehabilitation Network (CMRN)
- Operational Delivery Network for Major Trauma and Critical Care
- Cheshire and Merseyside Neurosciences Programme Board

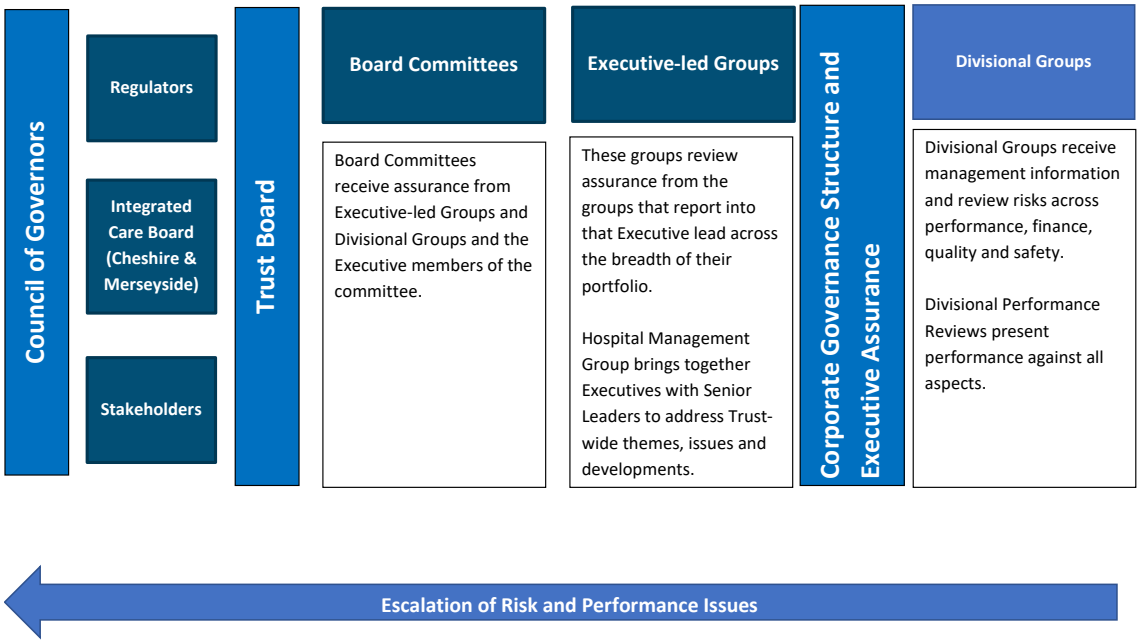
Escalation, Assurance & Triangulation

The purpose of escalation is to effectively share information. It ensures that the necessary help and support is provided to resolve issues. It is also important for senior staff and the Board to be appropriately briefed on what is happening in our front-line services.

Frameworks and structures exist to support us all. They are there to help us make the right decisions, whilst sharing information appropriately across the Trust. The Trust's meeting structure has been set-up to support the flow of information with routes and methods of escalation being embedded within the structure.

Flow of Information Overview

Figure 2



Looking at the key structures within this document will allow you to visualise how information is shared and managed throughout our Trust. It will enable you to see how it applies within your own area. The Board has a crucial role in ensuring the Trust provides safe, effective care and fulfils its statutory and regulatory obligations. To do so it needs to have in place effective internal and external sources of assurance which includes anything that negatively impacts on quality of care and identification of early warning triggers in relation to workforce, finance, and clinical services.

The value of assurance, based on robust evidence, can be further enhanced through 'triangulation'. This involves collecting and evaluating evidence relating to a similar subject or activity from several different sources, ideally more than two and considering them together rather than separately. Triangulation enhances our ability to confirm the accuracy and completeness of what is being presented. The better the quality of information provided, whether through walkabouts or through papers, the easier the process of triangulation is for leaders.

The examples below demonstrate how triangulation can be used and illustrate its value:

Use

- visiting front line staff to determine whether data in performance reports is reflective of the current situation
- considering findings from internal and external reviews and visits alongside papers presented at the meetings to corroborate findings
- reviewing qualitative information such as comments from service user and carer feedback and staff surveys alongside data in performance reports
- identifying potential risk areas through consideration of a range of different data simultaneously (e.g. workforce data on staff turnover, quality indicators, etc)
- identifying common themes

Value

- indicators or metrics of quality performance are valid and reliable
- concerns about findings can be escalated
- there are detailed, credible and evidence-based findings underpinning action plans which can be delivered
- there is confidence in how we work together, challenge evidence and action plans and resolve concerns
- the Board/committee/group avoids bias and undue influence
- 'peers' would be likely to reach a similar judgment based on the same information, in the same context

Section C- Accountable Roles

Your Role in Accountability

Being accountable not only means being responsible for something, but also ultimately being answerable for your actions. Individuals are held to account only after a task is done or not done, whereas individuals can be responsible before and / or after a task. Every member of staff is responsible for undertaking work that is in the best interest of our patients and their families, whilst contributing to the delivery of our Trust Strategy. All staff are also expected to abide by the Standards of Business and Personal Conduct Policy.

The **accountable person** is the individual who is ultimately answerable for the activity or decision. This includes 'yes' or 'no' authority and 'veto' power. Only one accountable person can be assigned to an action. Formally constituted groups can also be an '**accountable person'** for decisions made. The Board of Directors for example is collectively responsible for the decisions made in its name.

The **responsible person** is the individual/s who actually complete the task. The responsible person is responsible for action/ implementation and this responsibility can be shared. The degree of responsibility is determined by the individual with accountability.

All staff have a level of accountability for themselves and others regardless of any management responsibility and these are outlined in different staff policies. These are:

- **Health and Safety**: -all staff have a duty to act if they become aware of anything that could cause injury or harm to their colleagues, patients or visitors. *Health and Safety Policy*
- **Freedom to Speak Up (FTSU):** all staff should speak up if they are concerned about anything that gets in the way of patient care or affects their working life. There is a Freedom to Speak Up Guardian, a number of FTSU Champions and a Non-Executive Director Champion for FTSU. Staff can also speak to their line manager or the patient experience team. There is a page on the intranet, posters around the Trust and a FTSU policy which all provide further guidance.
- **Incident Reporting:** all staff should report any incidents, or near misses, irrespective of levels of injury or damage on the same day as the incident occurred, or as soon as it becomes apparent. We have a system for incident reporting called Datix which can be accessed on any Trust desktop or through the staff intranet with tools available to explain the process. The Clinical Governance team will review all incidents and investigate where required. See page 25 for more information about learning from incidents and complaints
- **Information Governance:** all staff must be responsible for the data and information that they have access to and ensure that it is protected and not divulged inappropriately. Any incidents can be reported via Datix and will be managed by the Information Governance (IG) Team. The Deputy Medical Director is the Caldicott Guardian and so has the named responsibility in the Trust for security of information. All staff must complete Data Security training every year.
- **Standards of Business and Personal Conduct Policy:** This policy applies to all staff and sets out the expectations for how all employees, Governors and Non-Executive Directors are expected to behave, this policy is linked to the managing Conflicts of Interest Policy and Anti-Fraud Bribery and Corruption Policy which also apply to all staff.
- **Equality, Diversity and Inclusion (ED&I):** Creating and maintaining an inclusive environment is the responsibility of all staff and the ED&I Policy applies to all patients, services users, carers and visitors to us. Board members have specific objectives set each year to promote ED&I and reduce

inequalities. We report our performance on ED&I through three national documents which are published annually on its website.

- Gender Pay Gap Report
- Workforce Disability Equality Standard (WDES)
- Workforce Race Equality Standard (WRES)

Named Accountable Roles

Council of Governors

The Council of Governors has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts so as not to breach the conditions of the provider licence. They also have a range of specific duties including the appointment and removal of the Chair, Non-Executive Directors and the Chief Executive. Governors must act in the best interests of the NHS Foundation Trust and should adhere to its values and their code of conduct.

The Governors are responsible for representing the interests of Foundation Trust members and the public. Governors should regularly feedback information about the Trust, its vision and its performance to members, the public and the stakeholder organisations that either elected or appointed them. We must ensure governors have appropriate support to help them discharge this duty.

The **Trust Constitution** defines the composition of the Council of Governors and the process for the election, appointment and if necessary termination of Governor appointments. Governors are either elected by the public (representing geographical areas), staff groups or by key stakeholder organisations such as local authority, third sector organisations and local higher education providers.

The Council of Governors meet in public a minimum of four times a year and meet with Members once per year to receive the **Annual Report and Accounts**. The Council also has a number of Subgroups set up which have no powers in their own rights but can review and make recommendations to the full Council. These are the Advisory Group, Membership and Engagement Group and Nominations and Remuneration Committee which reviews the remuneration and appointment of all the Non-Executive Directors including the Chair.

Board of Directors and Board Committees

The Board of Directors is a unitary Board consisting of a Chair, Non-Executive Directors, Chief Executive and Executive Directors. A unitary board is one where the Non-Executive and Executive Directors make decisions as a collective and share the responsibility and liability. There are always more Non-Executive Directors than Executive Directors. All members of the Board have equal responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. Board members sign up to a Code of Conduct which sets out expected behaviours for individuals. All Board members must also adhere to annual checks under the Fit and Proper Persons Regulations.[7]

[7] NHS England » NHS England fit and proper person test framework for board members

The role of the Board is to:

- set the overall strategic direction of the Trust
- regularly monitor performance against agreed goals
- provide effective financial stewardship through value for money, financial control and planning
- ensure that the Trust provides high quality, effective services
- promote good communications with the people we serve.

The Board of Directors meet in public a minimum of six times each year. Every meeting in public starts with a story from a patient or staff member. Matters deemed to be confidential or prejudicial to public interest will be heard in a part two meeting which excludes any press or members of the public.

Board Committees

The Board also has a number of Board Committees which take a closer interest in particular areas such as quality or performance. Only Board Members can be voting members. Two of these committees are mandated by national guidance: the Audit Committee which focuses on systems of internal control such as financial management and risk management and the Remuneration and Nominations Committee. This is made up entirely of Non-Executive Directors who review the remuneration and performance of the Executive Directors. All new Executive Director appointments must be approved by this Committee.

At The Walton Centre the Board of Directors has also approved the setup of the following Board Committees:

- Business Performance (focusing on finance, performance and workforce)
- Health Inequalities and Inclusion (focusing on health inequalities and equality, diversity and inclusion)
- Quality (focus on quality, patient safety and experience including divisional accountability)
- Research, Innovation and Medical Education (RIME)
- Walton Centre Charity Committee (to support the Board to discharge its responsibility as the Corporate Trustee for the Charity).

Executive Directors

This weekly meeting oversees the operational running of the Trust, reviewing and monitoring progress against plans. They also approve business cases for development within the delegated authority for Executive Directors.

Hospital Management Group

Hospital Management Group consists of our Executive Directors or Deputies, together with the divisional management and heads of service. This group reviews all business cases and issues and themes that are Trust-wide

Chair

The Chair is appointed by our Governors in an open recruitment process. The Chair can serve for up to two three-year terms and acts as the Chair for both the Board of Directors and the Council of Governors. The Chair's role is non-executive and therefore not involved in the day to day running of our Trust.

The Chair is responsible for:

- the leadership of our Board
- creating the conditions necessary for good governance and overall Board effectiveness
- ensuring that there is sufficient information available to enable appropriate decisions to be made
- ensuring that all Board Members and Governors have the skills and knowledge required to do their role and that there is a programme of development in place.

A Deputy Chair is appointed by the Chair to deputise as required and stand in for the Chair should they be absent.

Non-Executive Directors

Non-Executive Directors bring in external skills and knowledge, often from other sectors, to advise and shape our strategic ambitions. Their key role is to hold the Executive Directors to account for our performance through assurance papers and reports presented to Board. They triangulate this evidence with reports from other sources including those provided by third parties such as the Internal Auditors and from what they see and hear from staff and patients in and around our Trust. Further details about our Non-Executive Directors including the Chair are available on the website.

Senior Independent Director

One of the Non-Executive Directors will be appointed as the Senior Independent Director (SID) by the Chair in consultation with the Council of Governors. The SID will continue to act as a Non-Executive Director but in addition has a key role in acting as a sounding board and source of advice for the Chair and is also an alternative contact point for Governors or Members if there are concerns that the normal communication channels of Chair, CEO, Corporate Secretary or Chief Finance Officer have failed to address an issue, or where it would be inappropriate to use these channels.

The SID carries out the annual performance appraisal for the Chair and ensures that a suitable process has been completed and approved by Governors and submitted to NHS England by the deadline. The SID also ensures that an orderly succession process is in place for the Chair.

Lead Governor

NHS England request that all Foundation Trusts appoint a Lead Governor as an alternative point of contact to the Governors should normal communication channels through the Chair or Corporate Secretary fail. The Lead Governor does not lead the Council of Governors or have any greater power or responsibility than other Governors. They do collate responses and views of the Council to input into appraisal, discussion and consultation processes and chair any informal meetings of the Governors.

Corporate Secretary

The role of Trust Secretary is a mandated role under the Code of Governance for NHS Trusts. Their role is to act as Company Secretary and provide advice on corporate governance issues to the Board, Chair and CEO and monitor compliance with Standing Orders, legislation and related guidance.

Internal Auditors

The internal auditors are an outsourced company that conduct reviews into particular processes and controls to check that they work as they should. This enables us to manage risk or gaps in processes. Each year the Audit Committee agree an internal audit plan that includes those areas that have to be reviewed on a cyclical basis, such as financial controls, and those that the Board think need attention and are linked to risks identified on the Board Assurance Framework or incidents. The internal auditors test the systems and processes and provide us with an assurance rating between ‘None’ to ‘High’. The

management lead then has a limited period of time to adopt the recommendations to improve systems and processes.

External Auditors

The external auditors are appointed by the Council of Governors at least every ten years. Their role is to check that the statements made in the Annual Report and Accounts match what they have found in their checks of our systems. They provide a report which must accompany the Annual Report and Accounts when they are laid before Parliament and which they present to the Governors and Members at the Annual Members Meeting each year.

Chief Executive

The CEO may make decisions in all matters affecting the Trust's operations, performance and strategy with the exception of those matters reserved for the Board or Council of Governors, or specifically delegated by the Board to its Committees. The CEO prepares the Scheme of Delegation (described on page 5) for approval by the Board identifying which functions the CEO will undertake personally and which have been delegated to other directors and officers. All powers delegated can be reassumed by the CEO should the need arise. The Chief Executive (CEO) is responsible for:

- Overall delivery of expected quality care, activity, financial targets and workforce
- implementation of the strategy and objectives approved by the Board and overall performance and conduct of the Trust as the Accountable Officer.
- management and leadership of all the Executive Directors
- responsibility for the corporate governance systems compliance with all statutory requirements
- lead for collaboration and system working
- responsible for implementing the desired progressive culture that is values-driven and inclusive
- development and implementation of strategic communications and engagement with all stakeholders

A Deputy CEO is appointed by the CEO to deputise as required and stand in for them. This is currently the Medical Director.

Executive Directors

The following table outlines the key responsibilities and accountabilities of each of the Executive Directors managed by the CEO

Role	Key Responsibilities and Accountabilities
Chief Finance Officer	• Financial strategy and ensuring effective financial management and control • Providing financial leadership by setting, evaluating and developing organisation-wide service and financial frameworks within which operational services can be delivered and ensuring that these link to the requirements of the Integrated Care System • Effective operation of financial performance, management and accountability framework including Standing Financial Instructions and Scheme of Reservation and Delegation • Senior Information Responsible Officer (SIRO) for the provision and security of information held • Executive Lead for Health Procurement Liverpool
Chief Nurse	• The systems, processes and behaviours by which quality is governed and measures and objectives to seek continuous improvement to the level of care provided • Responsible for systems and processes of infection prevention and control – Director of Infection Prevention and Control • Driving professional accountability of nurses / midwives and allied health professionals and engendering effective clinical leadership • Lead for patient experience and family centred care • Compliance with Care Quality Commission standards

Chief Operating Officer and Director of Strategy	• Delivery of services that provide optimum patient care and effective use of resources • Providing operational leadership through setting, evaluating and developing effective systems and processes which ensure the efficiency of the organisation and the achievement of targets • Accountability for the management and performance of clinical divisions • Leading the development and delivery of the organisation wide strategy and substrategies and a coherent annual planning and business development strategy • Co-ordination, production and oversight of business cases and annual activity plans • Executive Lead for transformation through the Strategic Project Management Officer (SPMO) and driver of Quality Improvement Projects (QIPs) • Responsible for estates and facilities, health and safety and sustainability.
Chief People Officer	• Leading the development and delivery of strategies relating to all aspects of employment, workforce, health and wellbeing, equality, diversity and inclusion and organisational development practices, ensuring that these link into other strategies and are aimed at enhancing quality care • Provision of workforce advice and compliance with legal and social obligations for staff • Development and delivery of a strategy to increase charitable income, aligned to the Trust Strategy, ensuring optimum benefit to patients and staff • Support and lead the innovation and research functions of the Trust to maintain the Trust's reputation and position as a specialist, research-led Trust
Medical Director & Deputy CEO	• Quality of care, including the systems, processes and behaviours by which quality is governed and improved such as Clinical Audit • Ensuring professional accountability and effective clinical leadership of the medical workforce • Responsible for ensuring that the Trust's educational offering to medical students is effective and that there are high standards of education and development for in-training doctors and the wider medical workforce line with the Trust's reputation as a centre of excellence for neurosciences • Providing medical leadership across the Integrated Care System (ICS) while promoting collaboration to provide the best outcomes for all.
Chief Digital Information Officer	• Leading the development of the Digital Substrategy and service, providing innovative solutions to improving the efficiency and effectiveness of the Trust's operation • Developing the infrastructure to support the delivery of ICT systems across the Trust • Influencing and supporting the delivery of ICT systems across the Cheshire and Merseyside ICS • Leading the business intelligence team, to support clinical teams by providing accurate and information efficiently based on high quality data

Deputy Directors

Each Executive Director has a named deputy who will deputise for them in their absence, they have no voting powers at Board unless formally agreed as 'Acting' during a prolonged absence. There is no Deputy Chief Operating Officer but there are three senior operational directors who are the two Directors of Operations for Neurology Division and Neurosurgery Division respectively and the Associate Director of Operations who leads on transformation, estates and facilities and sustainability.

Heads of Departments

Within the corporate division there are some areas with a specialist head of Departments who report into an Executive Director. Examples of this include the Communications and Marketing Manager, Chief Procurement Officer, Head of Business Intelligence, Corporate Secretary, Head of Estates and Facilities and Head of Risk and Clinical Governance. The full top tier management structure is at Appendix 2.

Divisional Governance (Triumvirate)

Each clinical division (Neurology and Neurosurgery) has its own clear structure in place. The clinical divisions are led by a Director of Operations (with Deputy), a Clinical (medical) Director and a Nurse Director, this group is known as the **Triumvirate** and is responsible for the day to day running of clinical and support services within each division.

Section D- Performance Management

Performance management exists to ensure that the Trust successfully delivers national standards for performance and contractual targets as agreed with commissioners. The Trust utilises information management to drive better performance and ensure a rigorous, supportive and consistent approach to performance management is achieved at all levels of the organisation.

Performance management is a process of setting goals, monitoring progress towards delivery and ensuring those goals are consistently met in an efficient and effective manner. The aim of performance management is to ensure that all parts of the organisation are optimally working together and taking action in response to actual performance to improve the outcomes for our patients and users. Performance management requires both good management systems and processes, and an organisational culture that supports and integrates them into the daily work of frontline staff and managers to promote the continuous improvement of services.

Ownership of performance should sit at every level of the organisation, not just the top. If everyone performs to the best of their ability at all times then the organisation will see the benefit. Performance management should be at the heart of what we do to enable continuous improvement in delivering quality, efficient and patient-focused services through a cycle of Plan-Do-Review.

Divisional Governance Accountability

The Clinical Divisions (Neurology and Neurosurgery) are held to account as described in Figure 3 below. This includes regular **Divisional Performance Management Reviews** with Executive Directors. These are an opportunity for the triumvirate to meet with the executive directors to discuss in detail operational performance, targets and the risks to achieving these. Areas of investment or development can be highlighted through these sessions.

Divisional Risk and Governance Groups

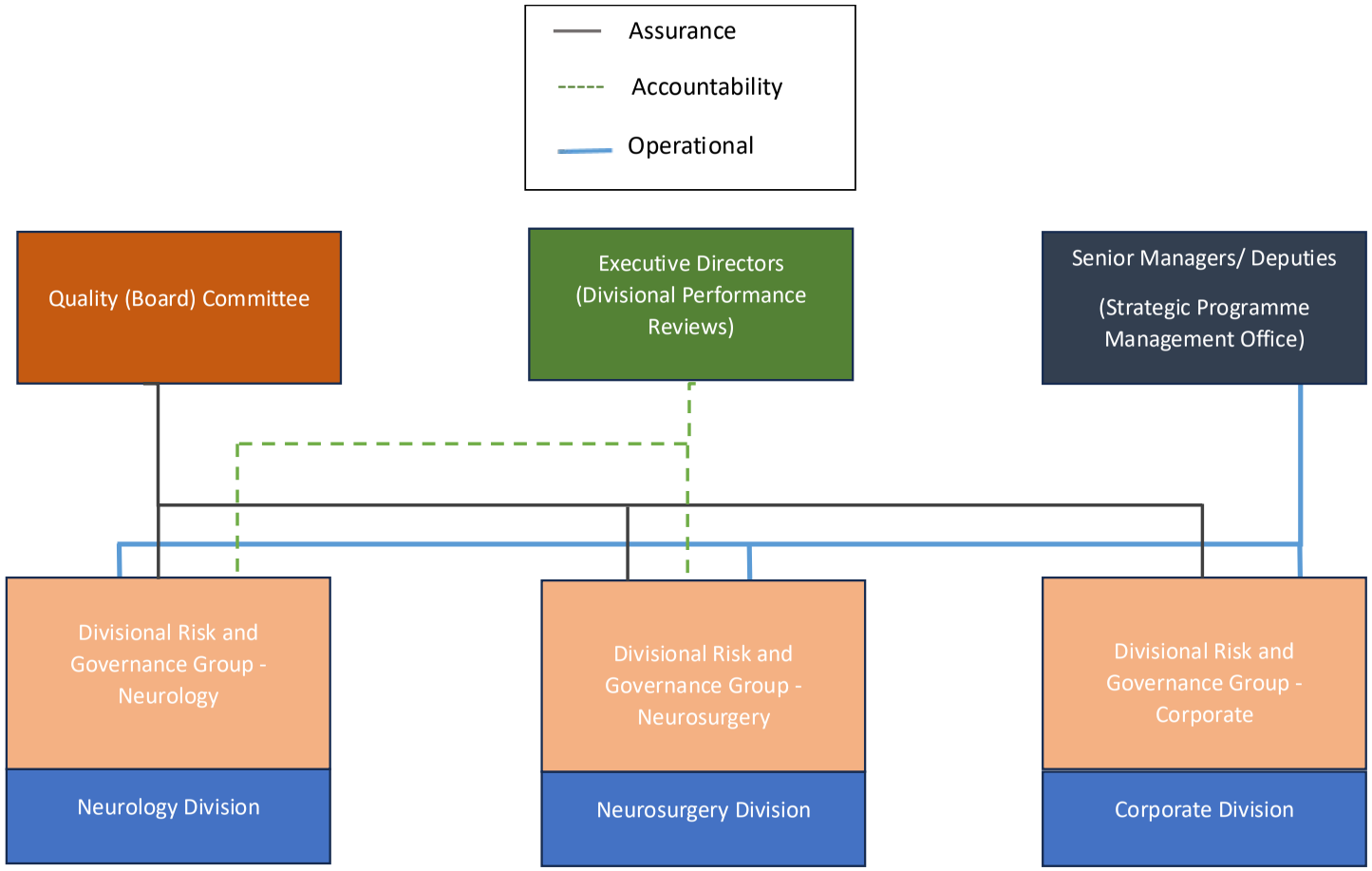
All Divisions provide assurance about the quality of care, performance and risk management through the Key Issues reports to the Quality Committee from the **Divisional Risk and Governance Groups**. These groups meet monthly in order to review clinical governance and risk management through the division. Their duties are:

- To have divisional oversight, ensuring that all elements of governance, risk and patient experience are adhered to
- Ensure clinical, operational and delivery leads are adequately supported in their work and held to account for the delivery of their areas of responsibility
- To escalate to Quality Committee any areas of concern relating to quality of care
- To review any incidents raised, outstanding recommendations, lessons learnt including learning from deaths and to receive the patient safety newsletter
- To review and monitor progress against all divisional risks
- To review any complaints, concerns, compliments and claims received and ensure that any themes are reviewed and lessons learnt
- To receive monthly reports on clinical Audit, NICE Guidelines, mandatory training for staff, NSPA alerts, external visits and recommendations.

Figure 3 on the next page illustrates how the divisions are held to account as part of performance management.

We have two clinical divisions and one corporate division.

Figure 3


Assurance
Accountability
Operational
Quality (Board) Committee
Executive Directors (Divisional Performance Reviews)
Senior Managers/ Deputies
(Strategic Programme Management Office)
Divisional Risk and Governance Group - Neurology
Divisional Risk and Governance Group - Neurosurgery
Divisional Risk and Governance Group - Corporate
Neurology Division
Neurosurgery Division
Corporate Division

Key Performance Indicators

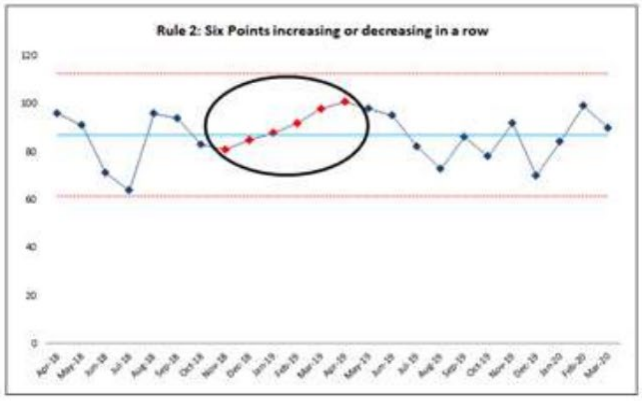
We have agreed a broad range of Key Performance Indicators (KPIs) which form the basis of our performance management framework. These KPIs are aligned to our Strategic Priorities and take into account all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching 2025 Vision, enabling strategies and to address key areas of risk.

Integrated Performance Report (IPR)

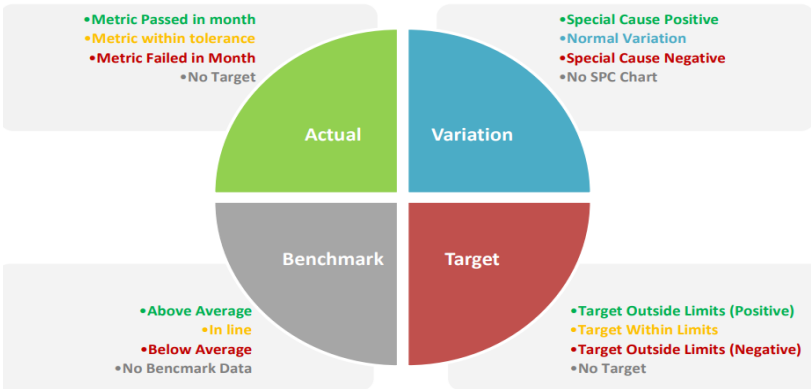
The IPR is a consolidated report across performance, quality, financial and workforce KPIs that we have to report nationally. This is presented to the Board each month by the Board Committee Chair (Non-Executive Director) and the Executive Lead for the relevant area, this follows detailed discussion and review at the relevant Board Committee where a more granular detail is provided.

Examples of metrics reported are diagnostic waits, cancellation of operations, activity levels, length of stay, mandatory training compliance, sickness absence, staff turnover, complaint numbers, patient experience feedback, hospital acquired infections, incidents whether leading to harm or not, mortality, safe staffing, income and expenditure, capital spend, agency costs and efficiency savings.

SPC charts are widely used in the IPRs report in order to provide increased assurance, insight and an indication of future performance. When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).



All 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.



CQUINs (Commissioning for Quality and innovation)

Every year we are asked to deliver against targets by commissioners. Delivery of these targets is linked to funding. These are designed to drive improvement and quality in services. Examples of CQUINs in the past have been the number of frontline staff getting the flu vaccination and assessment and documentation of pressure ulcer risk.

Quality Priorities

We are also required by NHS England to agree quality priority areas for a focus for each year. These are developed in consultation with staff, Quality Committee, Quality and Patient Safety Group and external agencies such as Healthwatch as well as the Integrated Care Board (ICB) for Cheshire and Merseyside. The final priorities are agreed by the Council of Governors. Quarterly meetings are then held with the ICB to monitor achievement of the agreed targets.

Assurance Reports

Alongside the presentation of the IPR by the Board Committees a selection of additional assurance reports are presented in line with their business cycle. These reports will have been scrutinised in the first instance through decision-making groups, according to their Terms of Reference. A smaller number of reports are presented directly to Board by the Executive Lead as they are matters that must be approved by the Board or are matters reserved for the Board as described in the Scheme of Reservation and Delegation (page 6). There is a prescribed template for reports that are going to any decision-making group in order that information is reported consistently and clearly to members of those groups. The template for this is available on the Corporate Governance intranet page link here.

Reports which go directly to Board are:

- Annual Medical and Nursing Revalidation
- Safe Staffing
- Freedom to Speak Up Guardian
- Guardian of Safe Working Hours
- Modern Slavery Act Statement
- Use of the Trust Seal
- Constitution and Standing Orders
- Reports from Joint Committees with other bodies

Well Led Framework

The Board of Directors is responsible for all aspects of the leadership of The Walton Centre. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that the Trust is providing high quality, sustainable care. In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries and in the NHS the Well Led Framework[8] is used.

Rather than assessing current performance, these reviews identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance. The external input helps safeguard against optimism bias and group think to which even the best organisations may be susceptible. Externally facilitated, developmental reviews of leadership and governance using the well-led framework are completed every three to

[8] https://www.england.nhs.uk/well-led-framework/

five years. The last review took place in March 2023 and the subsequent action plan is still being delivered.

Board Effectiveness

In addition to the Well Led Framework, the Board is assessed annually on its effectiveness with feedback sought from the Board members, Governors and staff. All Committees and decision making groups also undertake an annual review of effectiveness which evaluates the impact of the group, its work during the year, its engagement and how it is meeting its terms of reference. Improvement plans are put in place if required. The Council of Governors also completes a similar exercise annually.

Personal Development Reviews

Individual performance is reviewed annually by line managers for every member of staff. Training is available for manager and those being appraised and there is a template for the review on the intranet (HR forms page). This conversation should cover performance, achievement of objectives, setting of new objectives linked to the Trust's strategic objectives, consideration of development and training needs and a discussion regarding health and wellbeing.

Section E – Operational Governance

Risk Management

The goal of risk management is to identify potential problems before they occur, evaluating the potential consequences and impact and implementing the most effective way of controlling them. Risk management looks at both internal and external risks that could negatively impact our Trust.

The Risk Statement from the **Risk Management Framework** is below (available in the policies section of the staff intranet)

> "Effective risk management in healthcare is essential to the delivery of high quality and safe provision of its services. The Trust intends to demonstrate an on-going commitment to improving risk management throughout the organisation through risk management processes and systems, embedding a culture that underpins and supports the delivery of the Trust's strategies and achievement of its strategic ambitions. The Trust aims to ensure that risk management forms an integral part of the organisations business planning and not viewed or practised as a separate process."

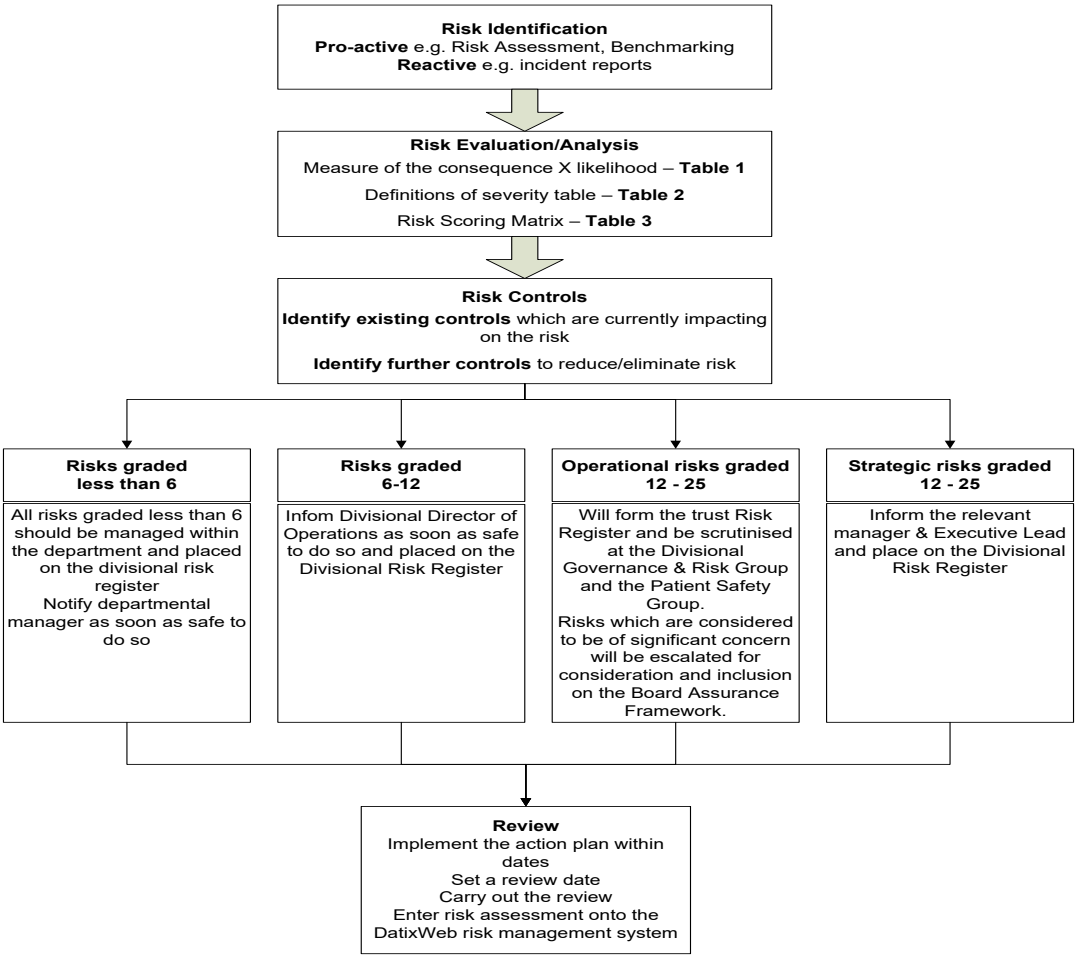
The Risk Management Policy (available on the staff intranet) explains how to manage risk at the Trust.

Risk Registers

Any member of staff can identify a risk, this must be something that has not yet occurred (otherwise it is an issue). Any urgent risks should be escalated verbally to an appropriate manager or your line manager. New risks are logged on the Datix system using the Risk Register link, no log on to the system is required. New risks are entered onto the risk register, along with a risk score and an action plan to mitigate the likelihood or impact of the risk if it occurred. The department manager is responsible for monitoring the associated actions. Support is available from the Risk Manager regarding how to write a risk and score it; the full process is described in the Risk Management Policy which is available on the staff intranet.

The Divisional Risk and Governance Groups will monitor all divisional risks to ensure that they are being managed appropriately. All risks scoring over 12 will be reviewed three times per year by Executive Directors and by a Board Committee and may be linked to the strategic risks on the Board Assurance Framework.

Figure 4 – Risk Management Process



Board Assurance Framework

Risk Management is embedded through the organisation and oversight of risk is integral to the work of our Board of Directors. Every year the Board set the **strategic risks** for The Walton Centre, these are the risks that could prevent the delivery of our Strategy and its five strategic ambitions. These risks are monitored through the Board Assurance Framework which is reviewed by the Board and its Committees three times per year. Every year our internal auditors also review the Assurance Framework on our behalf to provide a third-party view that risks are being managed identified and appropriately and to also learn from other trusts do. The Audit Committee is responsible for ensuring that we have a robust risk management framework in place.

Quality Performance

Patient Safety Incident Response Framework (PSIRF)[9]

In 2023 a new national approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety was launched. This replaced the Serious Incident Framework (SIF) on how to identify, report and investigate any incident resulting in severe harm or death.

The new PSIRF is designed to be focused on learning from patient safety incidents, with the emphasis placed on the system and culture that supports continuous improvement. As part of the implementation there has been a refocus towards a rigorous identification of interconnected causal factors and system issues.

There is a PSIRF Plan and Policy on the staff intranet which includes flowcharts of the investigation process and there is mandatory staff training dependent on your level of patient contact and seniority.

All patient safety incidents are reviewed at the Patient Safety Incident Review Group (PSIRG) and learning is shared with the Weekly Safely Group, through patient safety newsletters and alerts. PSIRG reports to the Quality and Patient Safety Group to provide assurance about how incidents are being investigated, escalated as required and if lessons are being disseminated to all relevant staff. Any significant alerts, risks or issues will be shared with Quality Committee through the key issues report and on to Board.

Ward Accreditation Programme (Walton CARES)

The Walton CARES uses an electronic solution (Tendable) which is a tool that allows the monitoring of trends and themes across the organisation and highlights new concerns that are recurrent issues. This data is combined with other sourced of data such as friends and family feedback, patient surveys, walkabouts and performance against the quality KPIs and priorities. Reviews are held in each ward and a rating of Bronze, Silver or Gold awarded.

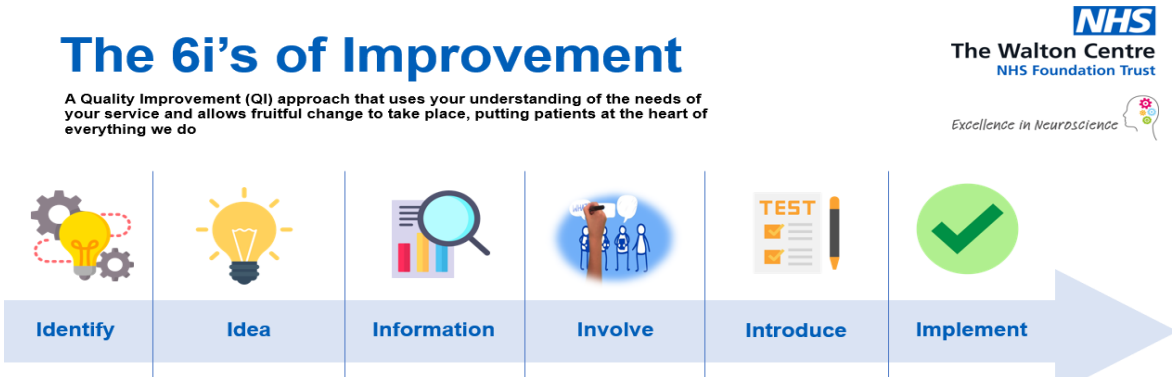
Strategic Programme Management Office

The **Strategic Programme Management Office (SPMO)** brings together the Divisional Directors of Operations, Transformation Team, Communications and Deputy Directors to monitor progress on the delivery of Quality Improvement Projects and the Trust's Substrategies. More information on this can be found on the Quality Improvement intranet page.

Quality Improvement

Quality Improvement aims to find areas and processes that can be made more efficient while improving patient experience. A good example of this is the bed repurposing project in Lipton Ward in 2023 which created a better patient and staff environment but also meant that beds could be used more effectively and therefore savings were made. Each year the Integrated Care Board for Cheshire and Merseyside ask all providers to make savings of core costs which should drive the transformation and improvement of services. The Quality Improvement programme is overseen by the SPMO and monitored in the weekly Finance, Operations and Finance Group and reported through Finance, Performance and Environment Group to Business Performance Committee and on to Board.

[9] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

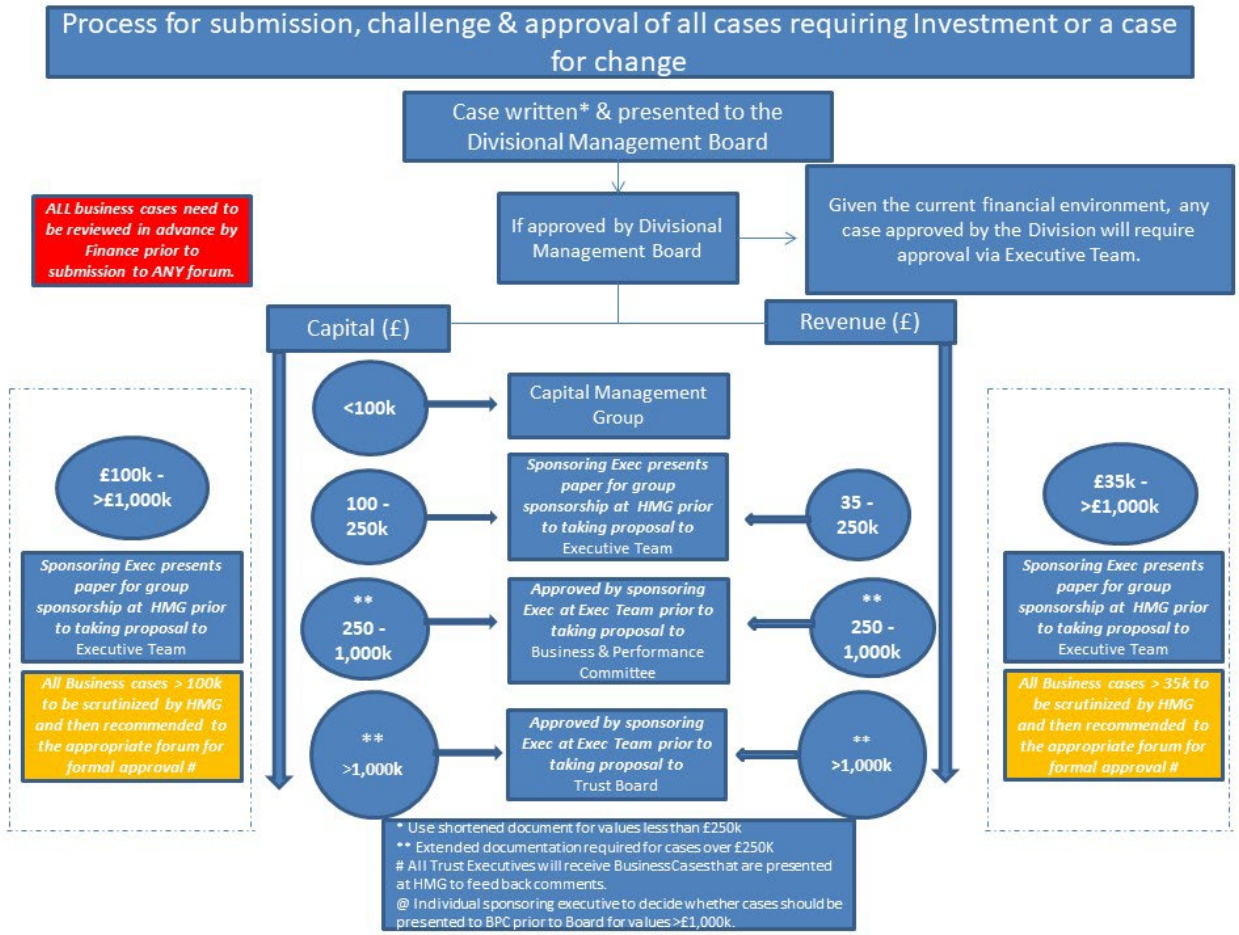


Business Case Approval Process

There is a defined route for the approval of all new investment dependent on the value of the investment required and a flow chart in Figure 5 below. There is also a template which is available on the Finance team page of the intranet.

Where there is no available budget or financial plan to support the business case a decision will be made on whether the case is added to the pressures and developments list for the following year. This is a Trust-wide list that will be agreed as part of the annual financial planning cycle.

Figure 5



Workforce and Succession Planning

Periodically each team is asked to complete a workforce planning tool to consider developments and issues that may emerge over the coming years. This includes review of the teams establishment and any anticipated increase or decrease in work. Heads of Team will be invited to complete a workforce planning intelligence template. This allows the Trust to identify any areas of risk and plan accordingly. This also prompts the team leader to consider any business critical roles where there is one person in post with sole responsibility and knowledge of a particular area and to develop, with HR support, a succession plan for any key roles.

Vacancy Control Panel

In order to comply with the system expenditure control requirements and HR processes an Executive Director-led panel meets weekly to agree any proposed recruitment or changes to contracts in order to ensure that all staff are being treated fairly and in line with trust policy.

Health Procurement Liverpool (HPL)

HPL has been in place since May 2021 and is a shared Procurement service across Alder Hey Children's Hospital , Clatterbridge Cancer Centre and Liverpool Heart & Chest Hospital NHS Foundation Trusts hosted by The Walton Centre. An expansion is being proposed to include Liverpool Women's and Liverpool University Hospitals.

The objectives of this project are to:

- reduce duplication and deliver strategic focus and enhance realisation of benefits through the establishment of robust clinical engagement
- increase purchasing power and economies of scale
- strategic supplier management of the top spending suppliers
- enhanced performance management of contracts against KPIs and realisation of benefits
- develop, retain and attract high calibre procurement staff by providing opportunities for career progression and training that a larger organisation brings
- structure for strategic delivery by taking advantage of resource efficiencies to develop enhanced services that add value
- provide resilience and flexibility in the structure and deployment of resources to respond to complex and changing patterns of healthcare provision

Section F - National and Regional Oversight, Regulators and Collaboration

Regulators and Oversight

Proportionate, risk-based regulation plays an important role in building public confidence in the NHS. Two main regulators hold NHS Foundation Trusts to account for the quality of care they deliver and how they are run.

- The **Care Quality Commission** is the independent regulator of health and social care services, they register, inspect and monitor providers of health services including NHS Foundation Trusts, and enforce action where necessary https://www.cqc.org.uk/
- **NHS England** is responsible for overseeing providers of NHS funded care acting as both an economic regulator and supporting providers to meet standards set by the CQC https://www.england.nhs.uk/

NHS Oversight Framework [10]

The NHS oversight framework outlines NHS England's approach to performance management and sanctions and is aligned with the ambitions set out in the NHS Long Term Plan and the NHS operational planning and contracting guidance. The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate.

A set of oversight metrics has been published to support implementation of the framework. These are used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources and leadership and capability.

System Governance and Collaboration

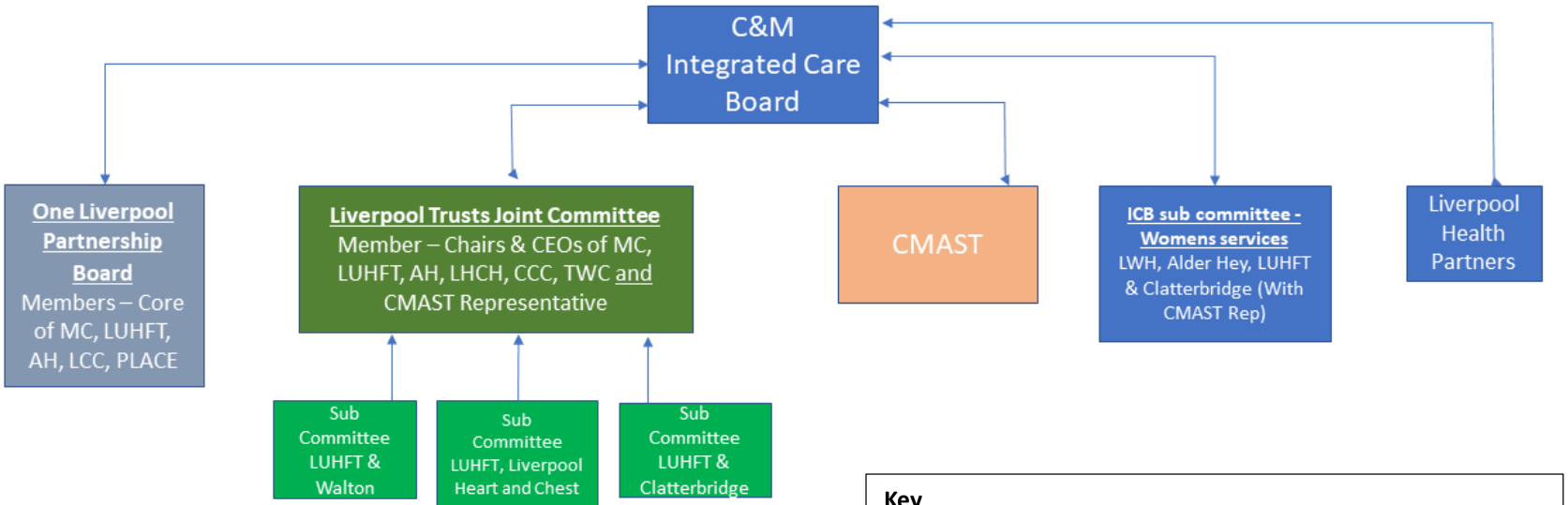
Since the establishment of the ICS a system governance structure has been set up across the Liverpool and wider Cheshire and Merseyside area with the structure shown in Figure 6.

We are now involved with regional groups across Liverpool Place and the wider Cheshire & Merseyside system. This includes a new Site Joint Sub-Committee which focuses on areas for collaboration and improvement of patient experience for those services which are based on the Aintree site.

Collaboration is one of the five strategic objectives of the Trust (see page 4). As a small specialist Trust we have always worked closely with health and other partners to deliver high quality care to our patients. We already share a pharmacy service with Aintree Hospital as well as shared estates and parking resource. As described on page 5 since the introduction of the Health and Care Act 2022 we have a duty to have regard for the wider effect of decisions outside the Trust through the 'Triple Aim' and consider how further collaboration would have a positive impact on our patients and community.

[10] https://www.england.nhs.uk/nhs-oversight-framework/

Figure 6 Liverpool Governance Structure

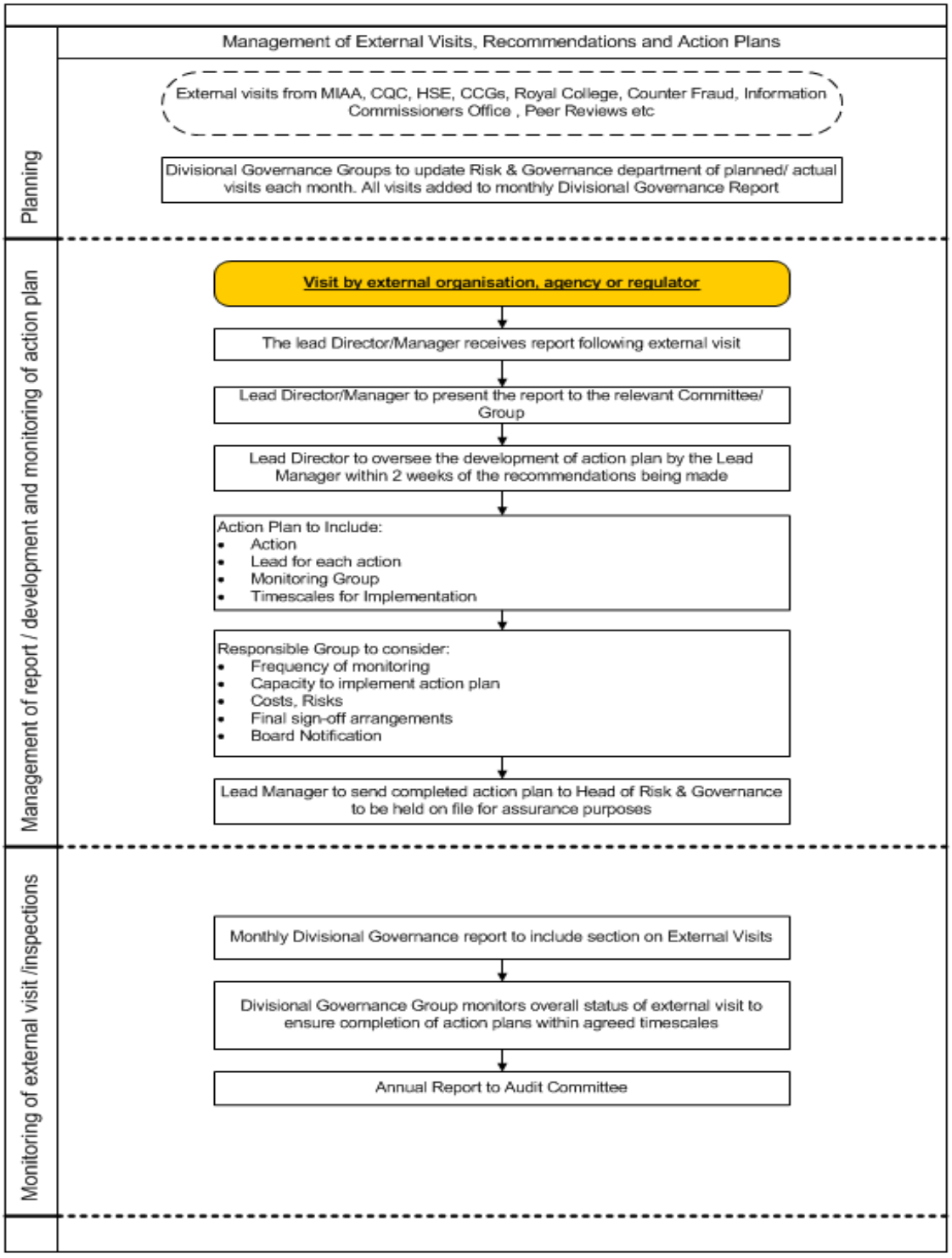


Key

AH - Alder Hey Children's NHS Foundation Trust
CCC - Clatterbridge Cancer Centre NHS Foundation Trust
CMAST - Cheshire & Merseyside Acute and Specialist Providers
LCC – Liverpool City Council
LHCH - Liverpool Heart and Chest Hopsital NHS Foundation Trust
LWH - Liverpool Women's Hospital NHS Foundation Trust
LUHFT - Liverpool University Hospitals NHS Foundation Trust
MC - Merseycare NHS Foundation Trust

External Visits

In addition to CQC we host a number of visits from external regulators through the year. These include the ACSA the Anaesthesia Clinical Services Accreditation and the Human Tissue Authority which checks our compliance with Human Tissue Act standards in the research labs and for organ donation. In order to ensure all recommendations made are completed there is an agreed process which is overseen by the Audit Committee. This is shown below at Figure 7.



Review of this Framework

This framework will be reviewed every two years by the Corporate Secretary and will be submitted to the Board for approval and implementation.

Next review date is April 2026.

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Annual Board Effectiveness Evaluation 2023/24
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary Jennifer Ezeogu, Deputy Corporate Secretary
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Self-assessment annual review completed with feedback received from Board Members, Governors and staff
- Generally positive responses from the Board, with a collective recognition of areas for improvement and the actions being taken to address these
- More mixed responses received from Governors and staff

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

- Results to be shared with staff and the Council of Governors through internal communications

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Leadership	Choose an item.	Choose an item.	Choose an item.

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Annual Board Effectiveness Evaluation 2023/24

Executive Summary

1. The responses to the survey were overall positive about the effectiveness of the Board from Board Members. There were some areas of disagreement with the statements, but the comments acknowledged that these were areas where work had been carried out, but further work was required.

2. For the second year Governors and staff were also asked to respond to a series of statements about the Board and its effectiveness. The Governor responses were balanced and comments were provided where disagreement was raised. There were 30 responses from staff members which were more mixed, but some helpful high-level themes have emerged.

3. A summary of the results has been provided in the appendices with a selection of some of the comments received.

Background

4. A formal self-evaluation of performance of the Board is recognised good practice and there is an explicit requirement for this in the NHS Foundation Trust Code of Governance. This links closely to the duty of directors to promote the success of the Trust to maximise the benefits for the members as a whole and for the public, as laid out in the NHS Act 2006. Self-evaluation is also a core principle of the NHS England Well Led Framework by which Board's should evaluate their overall performance and leadership.

5. An annual evaluation allows the Board to benchmark itself, assess its performance, set action plans and identify development gaps. The effectiveness review should be considered alongside individual appraisals of the performance of directors (as Board Members) and the performance of the Board's Committees to develop an overall view of the Board's performance. It is also an opportunity for the Board to reflect on its recent achievements and the work of the past year.

6. The Board were asked to assess and rate their agreement or disagreement with 19 statements across five themes: Support, Structure, Leadership, Effectiveness and Engagement. Respondents had the option to state that they were unable to answer, for example if they were new in post and had not yet been able to sufficiently assess a particular aspect of the Board and also the opportunity to provide comments on each question.

7. For a second year, the Governors and wider staff body were also asked for their views. This provides evidence of how the Board is effectively linking and communicating with the Council of Governors and staff and how the Board is perceived by its key internal stakeholders. The staff responses also provide an insight into the culture of the Trust and together with staff surveys and engagement provide a picture of the satisfaction of the staff workforce and areas where focus by the Board would have the most impact.

Analysis – Board Self-Evaluation

8. There were 12 responses out of 14. The responses to the self-evaluation (Appendix 1) were positive on the whole. While improvement was noted there remains room for improvement in

board papers and the information received by the Board in order to make decisions. Executive summaries and excessive levels of detail (particularly in appendices) were areas that were particularly noted as needing improvement.

9. The most positive responses were in regard to the visibility of Board members, monitoring progress on the Trust strategy, identification of strategic risks, the Board Assurance Framework, sufficient challenge on issues on the agenda and that the decision and policies adopted by the Board reflected the views of the Board members.

10. The majority of Board Members felt that the Board had a good focus on organisational culture, but there were two disagrees although no associated further comments were provided. The comments made on this statement reflected positive responses.

11. Succession planning still remains an area of concern as half of the respondents either disagreed or were unable to answer that there was a succession plan in place for all Board roles. This is a standing item on the cycle of business for Remuneration Committee with a report due in June 2024 but only the Non-Executive Directors sit on this Committee with the outcome reported to Board through a Chair's assurance report.

12. Stakeholder strategy has been an area that has been addressed this year with a session held with the Board at a strategy day in November and ongoing work taking place with the Chair and Chief Executive. This further work will be shared with the Board.

Analysis – Council of Governors Feedback

13. There were seven responses to the Governor survey from 25 Governors in comparison to twelve responses received for 2022/23 which is disappointing. The Governor statements were different to those for Board Members and staff members.

14. The responses were generally positive, with the majority of Governors responding positively to the statements. Comments were generally provided for statements were the respondents disagreed with a statement. All respondents felt that the Governors were treated with respect by the Board and were listened to. All respondents felt that Board members were capable and worked well together.

15. All Governors felt that quality of care drives the agenda of the Board and that there was no history of 'nasty surprises', with one comment stating "it seems as if reporting is accurate and questions are answered honestly"

16. Most respondents agreed that that they had been able to shape the future direction of the organisation and this reflects the work currently been carried out and feedback from various Governor events. given by Governors as part of the Well Led review. This is a significant improvement from the previous year where a large number of respondents responded negatively to this statement. Trust would continue to explore opportunities to engage with Governors regarding shaping the future plans and strategy of the organisation.

17. Mixed responses were received from Governors that what they were told by Directors matches what they are told by staff and patients. Two Governors disagreed with one strongly disagreeing. One comment highlighted that staff on a walkround were concerned about the pressure from low staffing levels and patient safety risks. Engaging with members including staff and patients is a key part of the Governor role and these responses suggest that staff

morale is low in some areas due to the pressures in the health system. Therefore, further work needs to be done to ensure that staff are encouraged to speak up, utilise the various Trust reporting channels and promote attendance at the various speak up events to bring these issues to the attention of the Board. Sharing safe staffing figures with the Council of Governors at their next meeting may bring some assurance that levels of staffing are monitored and meet plans and that there are low levels of vacancies in nursing generally.

Analysis – Staff Feedback

Wordle of Staff Comments

18. A series of statements was sent out to all staff via Walton Weekly to obtain feedback on the Trust and the staff perception of the effectiveness of the Board. There were 30 responses received which showed a decline in response from 92 received in the previous year despite promotion through Walton Weekly and the Walton staff facebook page. Many of the respondents disagreed with almost all of the statements and unfortunately not many additional comments were provided where staff disagreed. The results are attached at Appendix 3.

19. The responses provide some insight into the culture and views of the Trust's workforce and the Board's role in leadership of this but it is a very small group and is likely to include those with more strongly held positive or negative views as with all surveys of this kind. Areas which received the strongest responses were about the visibility of Board members, staff engagement with the Trust Strategy, key risks facing the organisation, the culture of the organisation, tolerance of bad behaviours from staff and some who are disengaged in their role. There were a number of comments which have been shared in full with the Board but the focus here is on the trends that emerge from this survey. Key themes identified were:

    - Board visibility is as expected and there is still room for improvement, Executive Director recognition was about two-thirds. Understandably, given their time commitment in the Trust, Non-Executive Directors were less recognisable, with the majority stating that they were not aware of whom the Non-Executive Directors (NEDs) were despite the walkabouts and visits carried out by the NEDs and the new display boards recently installed recently to help staff be more familiar with the NEDs. Work will continue to improve awareness and visibility of the Board members in 2024/25.

      "I can see them in the promotional boards along ground floor"

    - About half of respondents felt that the Trust had not actively engaged staff in the development of the Trust Strategy this is understandable as this work was carried out in

2021/22 but a number of staff still felt that they were unable to understand their role in helping to deliver the Trust Strategy. This was also an area of concern from staff last year. It appears that more work still needs to be done to 'socialise' the strategy and substrategies with staff which would help staff understand their role in delivering the strategic ambitions and understand the key risks to the organisation

"The Strategy was released and I think it's existence was well communicated, but I still don't know what I should do differently in my role day to day in order to bring the Trust closer to achieving its objectives."

- There was a more positive response to line managers with two-thirds of respondents stating that their line manager got the best out of them

- There was a mixed response about innovation and support available to find and adopt new ways of working although just over half agreed with the statement

"*I think the Trust is understandably risk averse but also quite siloed which makes making changes involving multiple departments difficult"*

"Yes but it often feels there are barriers put in place to prevent innovative practises by the trust board.

"Encouraged but not supported with time or staff"

"Sometimes feels like 'lip service'"

- Half of the respondents agreed that the Trust did not tolerate bad behaviours by patients and visitors and three respondents were unable to answer.

- There was a much more negative response to the statement that the Trust does not tolerate bad behaviour by staff with more staff disagreeing than agreeing to this statement and similar to those that felt there was a safe and supportive work environment in place which reflects the value and behaviours reflected in the Walton Way. Unfortunately, comments were not provided for these statements.

- Mixed responses were received regarding if the Trust routinely sought the views of staff and communicated what actions had been taken as a result of the feedback.

"Seeks the views of staff but the communication of actions is meaningless. If the change implemented has made a difference those staff whom it affects will notice and it's not relevant to staff whose areas it doesn't impact. The "You Said We Did" communication is a little patronising."

Conclusion

20. The responses from the three groups create a broad picture of the effectiveness of the Board and reflect the areas for improvement and focus for the Board to consider although it is a small sample of staff. Due to the low response rate, it is not practicable to produce a like for like comparison for the key areas of concerns. The low response rate reflects a trend across all similar surveys at the Trust and more widely across the NHS.

Recommendation

To note

Author: Jennifer Ezeogu
Date: March 2024

Appendix 1 – Board of Directors Self-Assessment Results
Appendix 2 – Council of Governors Survey Results
Appendix 3 – Staff Survey Results

Appendix 1

Board Effectiveness Review March 2024

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Actions
Theme 1 Support and Infrastructure						
The Board receives timely information.	3	10				This has become slightly more difficult given the move to bi-monthly meetings.
The papers received are of an appropriate quality.	2	8	3			-Some are better than others. There are standards but they are inconsistently applied, Exec summaries are particularly poor, and in some instances little thought seems to be given to the audience and how they will receive the paper. -Continue to improve. Still more work needed on executive summaries which are variable and sometimes no more than an introduction. -The quality of papers is improving and becoming more focussed on evidence, assurance and identifying gaps to enable appropriate discussion and solutions to mitigate gaps. -This has been a key area of improvement.
The papers received are concise and focused.		9	5			-Some are better than others but generally they are too long, too much detail especially in appendices, difficult sometimes to see the relationship between narrative and charts, etc. -Not always. Some reports are still overly long. -Better executive summaries would enable this. shorter papers -They are becoming more so in a concerted effort by report writers. -This has been an area of improvement

The information received is in an appropriate form to enable the Board to make sound decisions.		11	2			-It often requires clarifying questions, and significant discussion to tease out the appropriate decision and its rationale. -The majority of papers are sound and in an appropriate form. Others are certainly on the road to improvement. -The front sheets have really helped with this.
Theme 2 –Structure						
The Committee has the right balance of experience, knowledge and skills to deal with current and anticipated challenges.	3	10				-One identified area of skills gap was identified (digital) and a process has been completed to recruit a Board member to fill this gap. -Some good, experienced executives and NEDs with a range of skills.
There is a succession plan in place for all Board roles.	2	5	3		3	-In the sense of short-term continuity planning, not necessarily successors in waiting. -I am not aware of a formal succession plan however I would expect that board roles would be advertised externally given the skills / experience needed and to benchmark against any internal candidates.
Theme 3 - Leadership						
The Board periodically review organisational culture and plans to maintain a positive culture.	4	7	2			-Indirectly via people surveys, IiP, feedback on walkabouts, evidence of values being lived out, etc. -Through staff survey and plans around key areas of these outcomes.
The Board collectively and individually models behaviours consistent with organisational values and culture.	3	10				-There could be more robust (but still constructive) challenge in meetings. -In the main this is true, though there are occasions when this is not the case individually.
Members of the Board are visible in the organisation.	4	9				-Efforts have been made in a number of areas, walkabouts, back to floor sessions and ad hoc visits. -To varying extent dependent on role.

						-I think they are in this organisation in comparison to some others.
Theme 4 – Effectiveness						
The Board has set a strategy for the Trust and regularly monitors progress against this at Board meetings.	8	5				This is on the cycle of business.
The Board has identified the strategic risks facing the organisation and that it has the controls to manage them.	5	8				Through the BAF that is on the cycle of business.
The Board Assurance Framework is effective.	4	9				It is more fluid in terms of updates which I think makes it more effective.
The agenda is sufficient to allow the Board to carry out its functions	3	10				Agendas cover all requirements of board business.
The agenda prioritises the right issues.	2	11				As above, some items are mandatory and any key areas are prioritised under board development sessions.
Sufficient time is spent on each agenda item.	3	10				-Sometimes I think we could reduce the time spent on some items. -Changes to the agenda mean there is now more time to focus on the right issues and more balance towards strategy. -Boards usually run to time on agenda items though the patient story can sometimes over run and push time on other board items.
The time spent on strategy results in defined proposals to be incorporated into the forward plan of the Trust.	2	9	1			There are several enabling strategies below the main strategy that tend to drive the forward plan although this needs to be flexible given the environment.
The chair ensures that there is sufficient challenge on each issue on the agenda.	5	8				Chair allows all to input as required.
Theme 5 – Engagement						

The decisions and policies adopted by the Board reflect the views of the Board members.	5	7				
The Board informs and involves key stakeholders in its work.	4	8	1			-Focus on stakeholder comms over the last year which is still evolving. Session held at Board Strategy Day. -This is probably an area that could be developed.

General Comments on Board Effectiveness

- The Board is effective but there are opportunities to take its effectiveness to an even higher level of performance, notably with regard to the consistent quality of the Board papers.
- Continual improvement is evident in board maturity and effectiveness, alongside some rotation of members. There is a willingness to adapt and try new things.
- There has been a big improvement in the quality of papers which are now more concise and relevant to Board discussions. There is still some room for improvement which has been identified and is being worked on.
- As noted, the board has a mix of some experienced executives and NEDs from a range of backgrounds which makes for some wide ranging input and debate.

Appendix 2 – Governors responses to the Board of Directors Effectiveness Survey

Statement No of responses received - **7**	**Strongly Agree**	**Agree**	**Slightly Agree**	**Slightly Disagree**	**Disagree**	**Strongly Disagree**	**Cannot Say**	**Comments/Actions**
The quality of patient care drives the work of the Board of Directors.	3	4						
The organisation's performance against key targets and key risks are reported to Governors on at least a quarterly basis.	2	4	1					
There is not a history of nasty surprises and only being told half the story by the Board of Directors – I am told the truth in a timely way.		3	1				1	- As a new member, it may be too early to say, but it seems as if reporting is accurate and questions are answered honestly. - I assume we are.
What I'm told by Directors matches what I'm told by staff and patients.		3	1		1	1		- I've not yet had a real chance to speak with staff/patients. - At a walk about patients were very happy but some of the staff were quite vocal about the pressure they were under due to low staffing levels and felt they were not being heard. They felt that patient safety was at risk with 7 adverse incidents that week. I fed back my comments in an email.
If performance slips, I understand the reasons why it has slipped and the key actions that are being undertaken to rectify the situation.		5	1				1	
The Board of Directors has a history of quickly getting performance back on track.		5					2	
The Board of Directors take the Council seriously and treat Governors with respect								

– Directors genuinely listen to what we have to say and deliver on their promises.	2	3	2					
When the Board of Directors does not agree with the view of the Council, the reasons are effectively explained and communicated on a timely basis.	1	1	1				3	Not found that to be an issue
Issues I have raised with the Board of Directors have been dealt with promptly and to my satisfaction.	1	4				1	1	There was no response to my email
Governors and the wider membership have been able to shape the future direction of the organisation.		1	5				1	
I am kept appropriately informed about progress towards delivering the organisational visions, Trust Strategy, and the strategic ambitions.		6	1					A strategy day was recently held for new Governors, to deliver on this which was very well received and hopefully will become a regular event.
The Board of Directors has an appraisal process in place for its members that is consistent with best practice, is undertaken on at least an annual basis and reported to Governors.	2	3					2	
From what I observe, Directors seem to work well together.	2	5						
Individual Executive and Non-Executive Directors on the Board of Directors appear to be highly capable.	1	6						
As Governors, we are regularly briefed on major service developments and issues impacting on the FT.	1	3	2				1	Issues are not always communicated to the governors. There appears to be a keenness to mainly present the positives, and gloss over the negatives. For example, the ongoing issues with a mixed paper and electronic patient record system with no one place having all the

								information and the review of vascular services.

General Comments on Board Effectiveness

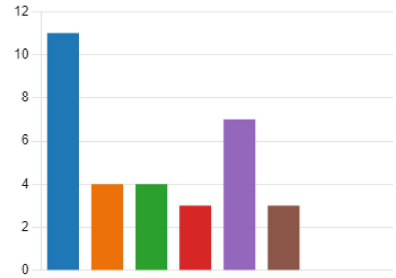
- I find the board and individual directors to be approachable and open.
- As a new Governor, I have been assured at what I have seen so far around how the board operates and reports. There are still some gaps in my knowledge, so I hope to improve these over the coming months.
- The effectiveness of the board should be measured against its results and performance. From my perspective the Board is well led, the CEO and Chair are particularly impressive.
- The Board work well together and have a good rapport.

Board Effectiveness Staff Survey 2023/24

30	04:05	Active
Responses	Average time to complete	Status

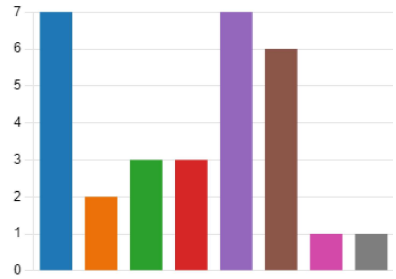
1. I would recognise a member of the Trust Executive if they visited my work environment.

Strongly Agree	11
Agree	4
Slightly Agree	4
Slightly Disagree	3
Disagree	7
Strongly Disagree	3
Cannot Say	0
Other	0



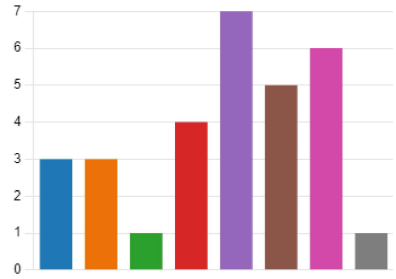
2. I am aware of who the Non-Executive Directors are.

Strongly Agree	7
Agree	2
Slightly Agree	3
Slightly Disagree	3
Disagree	7
Strongly Disagree	6
Cannot say	1
Other	1



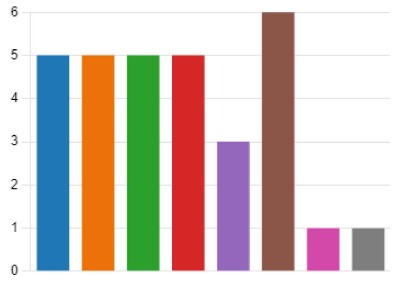
3. The Board of Directors has actively engaged staff in the development of the Trust Strategy and strategic ambitions.

Strongly Agree	3
Agree	3
Slightly Agree	1
Slightly Disagree	4
Disagree	7
Strongly Disagree	5
Cannot Say	6
Other	1



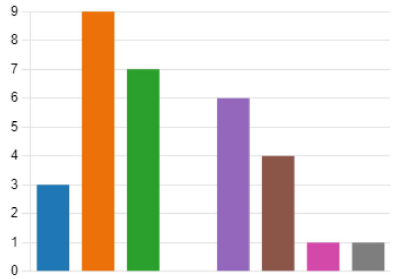
4. I understand the future direction of this organisation and my role in helping to deliver the Trust Strategy

Strongly Agree	5
Agree	5
Slightly Agree	5
Slightly Disagree	5
Diasgree	3
Strongly Disagree	6
Cannot Say	1
Other	1



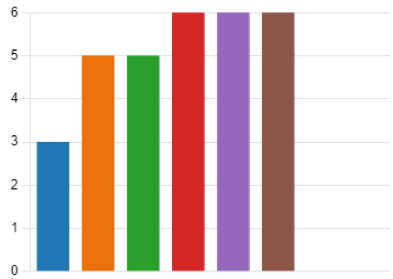
5. I am aware of the key risks faced by this organisation and my responsibilities in minimising these risks.

Strongly Agree	3
Agree	9
Slightly Agree	7
Slightly Disagree	0
Disagree	6
Strongly Disagree	4
Cannot Say	1
Other	1



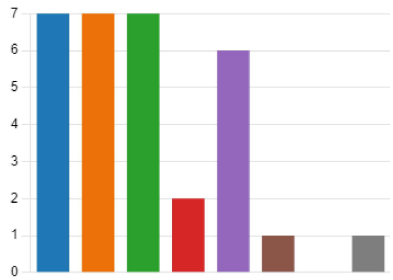
6. There is a safe and supportive work environment at work which reflects the values and behaviours described in the Walton Way.

Strongly Agree	3
Agree	5
Slightly Agree	5
Slightly Disagree	6
Disagree	6
Strongly Disagree	6
Cannot Say	0
Other	0



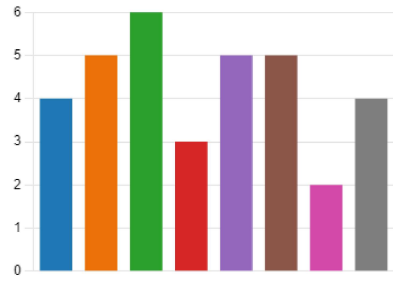
7. My line manager behaves in a way that gets the best out of me.

Strongly Agree	7
Agree	7
Slightly Agree	7
Slightly Disagree	2
Disagree	6
Strongly Disagree	1
Cannot Say	0
Other	1



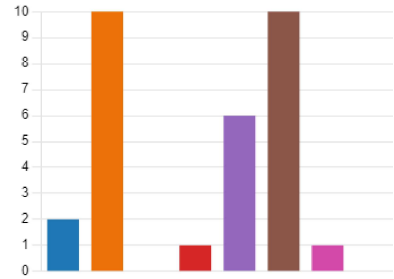
8. Staff are encouraged to find and adopt new ways of doing things.

Strongly Agree	4
Agree	5
Slightly Agree	6
Slightly Disagree	3
Disagree	5
Strongly Disagree	5
Cannot Say	2
Other	4



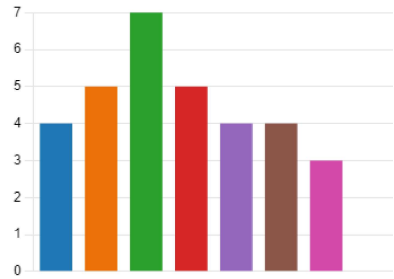
9. The Trust does not tolerate bad behaviour by staff.

Strongly Agree	2
Agree	10
Slightly Agree	0
Slightly Disagree	1
Disagree	6
Strongly Disagree	10
Cannot Say	1
Other	0



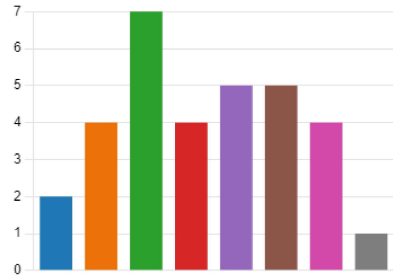
10. The Trust does not tolerate bad behaviour by patients and visitors.

Strongly Agree	4
Agree	5
Slightly Agree	7
Slightly Disagree	5
Disagree	4
Strongly Disagree	4
Cannot Say	3
Other	0

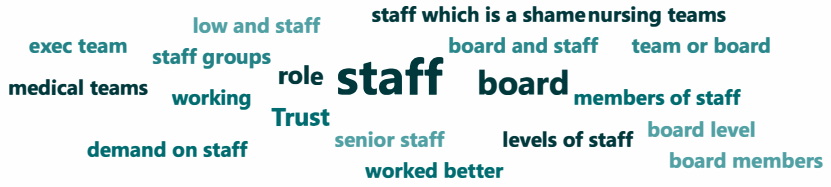


11. The Trust routinely seeks the views of staff and communicates what actions have been taken as a result of this feedback.

Strongly Agree	2
Agree	4
Slightly Agree	7
Slightly Disagree	4
Disagree	5
Strongly Disagree	5
Cannot Say	4
Other	1



6 respondents (**55%**) answered **staff** for this question.



The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	NHS England Leadership Competency Framework
Executive Lead	Jan Ross, Chief Executive
Author (s)	Jennifer Ezeogu, Deputy Corporate Secretary 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

- NHS England (NHSE) have published a Leadership Competency Framework (LCF) for all board members which forms part of the wider NHSE revised Fit and Proper Person Test Framework.
- The LCF establishes a more standardised approach to the annual appraisal for all board members and is to be incorporated into all job/role descriptions, recruitment and appraisal process.
- The LCF is based on 6 domains each with a range of competencies to support board members to perform at their best.
- A revised chair appraisal framework and multi-source assessment was also published by NHSE on 28 February 2024 and a Board Member Appraisal Framework for other board members will be published by autumn 2024.

Next Steps

- Fit and Proper Persons Policy to be reviewed and updated
- Job descriptions and job roles to be updated
- Incorporate the elements of Leadership Competency Framework and competency domain into Board members appraisal process over the next year, pending the publication of the Board Member Appraisal Framework
- To adopt the Chair Appraisal Framework with immediate effect.

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

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

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**
n/a			

NHS England Leadership Competency Framework

Executive Summary

1. The NHS England (NHSE) Leadership Competency Framework (LCF) provides a consistent competency and skills benchmark against which board members will individually self-assess as part of the annual appraisal process. This will be completed annually alongside the Fit and Proper Persons Framework (FPPF) checks as contained in the revised FPPT Framework published by NHSE in August 2023. This paper sets out the key messages and the implications for Board Members.

Background and Summary

2. NHS England (NHSE) published a Leadership and Competency Framework [1] on 28 February alongside guidance for the Chairs appraisal which take into account the NHS People Promise, the NHS Long Term Workforce Plan and Integrated Care Board (ICB) formation as well as the core NHS values, Peoples promise, Principles of Public Life, NHS Leadership Way and the Health and Care Act 2022.

3. The framework responds to the recommendations made by the Kark Review in 2019 to the Fit and Proper Persons Test which included a recommendation for 'the design of a set of specific core elements of competence, that all directors should be able to meet and against which they can be assessed.

4. The LCF is aimed at supporting the development of a diverse range of highly skilled professional and proficient leaders who are focused on delivering the best outcomes for patients, workforce, and the public and to help organisations develop and appraise all board members. It supports the assessment of board members in their role as part of a unitary board.

5. Board members are expected to self-assess against the six competency domains in preparation of their annual appraisal, review the self-assessment with their line managers and obtain feedback and identify and plan development activities as part of ongoing continuous professional development, taking into account any professional standards that are also applicable for their specific roles.

6. The six domains are:
   - Driving high quality and sustainable outcomes
   - Setting strategy and delivering long-term transformation
   - Promoting equality and inclusion, and reducing health and workforce inequalities
   - Providing robust governance and assurance
   - Creating a compassionate, just and positive culture
   - Building a trusted relationship with partners and communities

7. It has been stated that very few Board members would be able to fulfil all of the competencies at all times, particularly for first time directors who may need to develop proficiency.

8. There is a description of what good looks like for each of the domains formulated as 'I' statements 'to indicate personal actions and behaviours that board members ought to

[1] NHS England » NHS leadership competency framework for board members

demonstrate in undertaking their roles, as well as an optional scoring guide to help with the self-assessment and identify development areas. Elements of the framework and the six competency domains competency domains are expected be incorporated into Board member role descriptions, recruitment and appraisal process from 1 April 2024.

Chair's Appraisal Framework

9. A revised chair appraisal framework and multi-source assessment (to be completed by arrange of stakeholders) was also published by NHSE on 28 February 2024. Elements of the LCF and the six domain competencies have been integrated into the chairs annual appraisal process as chairs are to be assessed against the principles of the LCF through the multi-source assessment (external and internal stakeholders). This is a similar process to that previously used but the assessment against the 6 domains is more extensive. The Chair's appraisal process, which will start shortly and complete by 30 June, will adopt this new framework.

10. The annual appraisal for the chair will be conducted and signed off by the Senior Independent Director (SID) or the Deputy Chair based on the elements of the framework and other objectives who will ensure that findings are fed into the personal development plan of the Chair.

Board Member's Appraisal Framework

11. A new Board Member's Appraisal Framework will be published by autumn 2024. It will provide guidance on how to assess board members performance against the competency domains dependent on levels of experience. Each board member to self-access against the six competency domains in preparation for their annual appraisal process and this should be reviewed with their line manager and feedback obtained. This will be adopted once the revised framework is published so will not apply to non-executive director appraisals for 2023/24 which will take place during quarter 2 of 2024/25 but it is anticipated that the new framework will be in place ahead of the next executive director appraisals in early 2025.

12. The Framework applies to all board members including interim appointments and non-voting members i.e. Associate Non-Executive Directors (NEDs). Elements of the LCF and the competency domains should form a core part of board members appraisals and the ongoing development of board members individually and as a unitary board.

13. The LCF will be reviewed as part of the planned national review of the FPPF in 2025.

Oversight of the LCF

14. The Chair is accountable for ensuring that the individual appraisals for the Chief Executive (CE) and NEDs is based on the elements of the framework and other objectives and to ensure that findings are fed into the personal development plans of the NEDs and CE.

15. The Chief Executive is accountable for ensuring that the that the individual appraisals for the Executive Directors (EDs) is based on the elements of the framework and other objectives and ensure that findings are fed into the personal development plans of the Executive Directors.

16. There are no new responsibilities for the Council of Governors (CoG) in relation to the FPPF. However, it is recommended that the CoG receive a summary of the outcomes of the LCF based appraisal, for the Chair and NEDs as part of their involvement in Chair and NED appraisals.

17. Within the Trust, the Audit Committee will maintain oversight of the LCF process through the annual directors FPPF report. This will be reported back to the Board through the Audit Chair's key issues report.

18. The Chair will be supported in this annual process by the Corporate Secretary to ensure these are completed and submitted as required to NHS England (North West) in the case of the Chair and non-executive directors.

Conclusion and Recommendations

19. To ensure compliance with the new framework the following recommendations are made:
    - The Chair and board members appraisal process to be updated
    - Director, NED and Chair's role/ job descriptions to be updated to include the LCF
    - The FPPF policy is updated in line with the new FPPT Framework, to include the six competency domains from the Leadership Competency Framework
    - The new competency self-assessment form (Appendix 3) will be updated ready to be used for 2024/25 appraisal process

Recommendation

To approve the recommendations set out in the paper.

Author: Jennifer Ezeogu, Deputy Corporate Secretary
Date: 21 March 2024

Appendix 1 – New Leadership Competency Framework
Appendix 2 – Framework for Conducting Annual Appraisals for NHS Chairs
Appendix 3 – Responses to statements relating to the NHS Leadership Competency Framework

Classification: Official

NHS England

NHS Leadership Competency Framework for board members

Publication reference: B0496_i

Contents

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1 Introduction

1.1 Context

Leaders in the NHS help deliver better health and care for patients by setting the tone for their organisation, team culture and performance.

We have worked with a wide range of leaders from across the NHS to help describe what we do when we operate at our best. We have engaged with stakeholders including NHS Providers, NHS Employers and NHS Confederation, and built in best practice from other industries. We have used the feedback to design the 6 competency domains in the Leadership Competency Framework (the framework) to support board members to perform at their best.

The competency domains reflect the NHS values and the following diagram shows how they are aligned:

Working together for patients[1]	Compassion
Building a trusted relationship with partners and communities	Creating a compassionate, just and positive culture
Respect and dignity	**Improving lives**
Promoting equality and inclusion and reducing health and workforce inequalities	Setting strategy and delivering long term transformation Driving high quality sustainable outcomes
Commitment to quality of care	**Everyone counts**
Driving high quality and sustainable outcomes Setting strategy and delivering long term transformation	Promoting equality and inclusion and reducing health and workforce inequalities Creating a compassionate, just and positive culture
Providing robust governance and assurance	

[1] Wherever the word “patient” is used in this document, this refers to patients, service users and carers.

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The competency domains are aligned to Our NHS People Promise, Our Leadership Way and the Seven Principles of Public Life (Nolan Principles). A high-level summary of the values and concepts from these documents is in Appendix 1.

1.2 Background

In 2019, the Tom Kark KC review of the fit and proper person test was published. This included a recommendation for 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. This framework responds to that recommendation and forms part of the NHS England Fit and Proper Person Test Framework for board members (FPPT).

The framework takes account of other NHS England frameworks and strategies including:

- NHS England Operating Framework
- NHS National Patient Safety Strategy
- NHS Long Term Workforce Plan
- NHS Equality, Diversity and Inclusion Improvement Plan
- National Quality Board Shared Commitment to Quality
- NHS Well Led Framework
- The statutory framework of the Health and Care Act 2022

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1.3 Purpose

Being an NHS board member means holding an extremely demanding yet rewarding leadership responsibility. NHS board members have both an individual and collective role in shaping the vision, strategy and culture of a system or organisation, and supporting high-quality, personalised and equitable care for all now and into the future.

This framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs.

People taking on first-time director roles, in particular, are unlikely to be able to demonstrate all the competency examples. However, this framework should provide a guide by which, over time, directors can measure themselves and develop proficiency in all areas. Where development areas are identified, commitment to working on these will be important.

As non-executive directors have different roles and responsibilities to those of executive directors, and there are differences between executive director roles, the framework supports the assessment of board members in their role as part of a unitary board. All six competency domains should be considered for all board members, taking account of any specific role related responsibilities and nuances.

Achievement against the competency domains supports the Fit and Proper Person assessment for individual board members.

2 The six leadership competency domains

2.1 Driving high-quality and sustainable outcomes

The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

2.2 Setting strategy and delivering long-term transformation

The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development.

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2.3 Promoting equality and inclusion, and reducing health and workforce inequalities

The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.

2.4 Providing robust governance and assurance

The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.

2.5 Creating a compassionate, just and positive culture

The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.

2.6 Building a trusted relationship with partners and communities

The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

3 Using the framework

3.1 Recruitment

The competency domains should be incorporated into all NHS board member[2] job/role descriptions and recruitment processes. They can be used to help evaluate applications and design questions to explore skills and behaviours in interviews, presentations and other aspects of the recruitment and assessment process.

3.2 Appraisal

The competency domains in section 5 should form a core part of board member appraisals and the ongoing development of individuals and the board as a whole. The framework should be applied as follows – a new Board Member Appraisal Framework incorporating the competencies will be published to support this:

Chairs should:

- Carry out individual appraisals for the chief executive and non-executive directors, based on the framework and other objectives

[2] 'Board member' refers to all board members – executive and non-executive

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- Assure themselves that individual board members can demonstrate broad competence across all 6 domains and that they have the requisite skills, knowledge and behaviours to undertake their roles
- Assure themselves there is strong, in-depth evidence of achievement against the competency domains collectively across the board, and ensure that appropriate development takes place where this is not the case
- Ensure the findings feed into the personal development plans of non-executive directors
- As and when required, include relevant information in the Board Member Reference when a board member leaves

Chief executives should:

- Carry out individual appraisals for the executive directors based on the framework and other objectives
- Ensure the findings feed into the personal development plans of the executive directors

The senior independent director (or deputy chair) should:

- Carry out the appraisal for the chair based on the framework and other objectives
- Ensure the findings feed into the personal development plan of the chair

Board members should:

- Self-assess against the six competency domains as preparation for annual appraisal
- Identify and plan development activity as part of ongoing continuous professional development (CPD), taking into account any professional standards that are also applicable for specific board member roles
- Review the self-assessment with their line manager and obtain feedback

All board members will have more detailed individual, team and organisational objectives. The 6 domains identify competency areas and provide examples of leadership practice and behaviours which will support delivery against objectives.

3.3 Development

Even the most talented and experienced individuals are unlikely to be able to demonstrate how they meet all the competencies in this framework all of the time. However, it should provide a means by which, over time, individuals can measure themselves and develop proficiency in all areas.

The competency domains will be built into national leadership programmes and support offers for board directors and aspiring board directors. All board members should actively engage in ongoing development to enable continued and greater achievement across the competency domains over time, and should be supported to do so.

Board members should refer to the directory of board level learning and development opportunities for existing development offers.

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3.4 Scoring guide

Appendix 2 is an optional scoring guide for individual board members to use when self-assessing against the competency domains.

4 Next steps

The Board Member Appraisal Framework will be published by autumn 2024. It will reflect the competency domains in this framework, as well as other performance objectives. It will also provide guidance on how to assess performance against the 6 competency domains, including for experienced board members and those who have been in post less than 12 months.

The LCF will continue to be kept under review, and may be updated periodically to reflect changes in the NHS operating environment, as well as feedback received from users. Feedback can be sent to england.karkimplementationteam@nhs.net.

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5 Detailed leadership competency domains

The individual competencies are expressed as 'I' statements. This is to indicate personal actions and behaviours that board members will demonstrate in undertaking their roles. However, it is recognised that, including in the context of a unitary board, high performance and delivery against objectives is also achieved through effective team working and collaboration.

1. Driving high-quality and sustainable outcomes

What does good look like?

I am a member of a unitary board which is committed to ensuring excellence in the delivery (and / or the commissioning) of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation[3] demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement.

Competencies

1. **I contribute as a leader:**
    a. to ensure that my organisation delivers the best possible care for patients
    b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation

2. **I assess and understand**:
    a. the performance of my organisation and ensure that, where required, actions are taken to improve
    b. the importance of efficient use of limited resources and seek to maximise:
        i. productivity and value for money
        ii. delivery of high quality and safe services at population level
    c. the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements

3. **I recognise and champion the importance of:**
    a. attracting, developing and retaining an excellent and motivated workforce
    b. building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles
    c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate

4. **I personally:**
    a. seek out and act on performance feedback and review, and continually build my own skills and capability
    b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training

[3] All references to "organisation" also refer to systems for board members of integrated care boards

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2. Setting strategy and delivering long-term transformation

What does good look like?

I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.

Competencies

1. **I contribute as a leader to:**
    a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities
    b. ensure there is a long-term strategic focus while delivering short-term objectives
    c. ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates
    d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same

2. **I assess and understand:**
    a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments
    b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy
    c. clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans

3. **I recognise and champion the importance of long-term transformation that:**
    a. benefits the whole system
    b. promotes workforce reform
    c. incorporates the adoption of proven improvement and safety approaches
    d. takes data and digital innovation and other technology developments into account

4. **I personally:**
    a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same
    b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies

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3. Promoting equality and inclusion, and reducing health and workforce inequalities

What does good look like?

I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and communities, including our workforce, and continued improvements to health and workforce inequalities.

Competencies

1. **I contribute as a leader to:**
    a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care
    b. ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes
    c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups

2. **I assess and understand:**
    a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)

3. **I recognise and champion:**
    a. the need for the board to consider population health risks as well as organisational and system risks

4. **I personally:**
    a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds
    b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities.

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4. Providing robust governance and assurance

What does good look like?

I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.

Competencies

1. **I contribute as a leader by:**
    a. working collaboratively on the implementation of agreed strategies
    b. participating in robust and respectful debate and constructive challenge to other board members
    c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options
    d. contributing to effective governance and risk management arrangements
    e. contributing to evaluation and development of board effectiveness

2. **I understand board member responsibilities and my individual contribution in relation to**:
    a. financial performance
    b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities
    c. delivery of high quality and safe care
    d. continuous, measurable improvement

3. **I assess and understand:**
    a. the level and quality of assurance from the board's committees and other sources
    b. where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making
    c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements
    d. the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks[4]

[4] Including, for example, incident data; surveys; external reviews; regulatory intelligence; understanding variation and inequalities

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4. **I recognise and champion:**
    a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders
    b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement

5. **I personally:**
    a. understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same

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5. Creating a compassionate, just and positive culture

What does good look like?

As a board member I contribute to the development and ongoing maintenance of a compassionate and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.

Competencies

1. **I contribute as a leader:**
    a. to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues
    b. to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement
    c. to improve staff engagement, experience and wellbeing in line with our NHS People Promise[5]
    d. to ensure there is a safe culture of speaking up for our workforce

2. **I assess and understand:**
    a. my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture

3. **I recognise and champion:**
    a. being respectful and I promote diversity and inclusion in my work
    b. the ability to respond effectively in times of crisis or uncertainty

4. **I personally:**
    a. demonstrate visible, compassionate and inclusive leadership
    b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice
    c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly
    d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention

[5] For example, with reference to equality, diversity and inclusion; freedom to speak up; personal and professional development; holding difficult conversations respectfully and addressing conflict

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6. Building trusted relationships with partners and communities

What does good look like?

I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.

Competencies

1. **I contribute as a leader by:**
    a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners
    b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest

2. **I assess and understand:**
    a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems
    b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners

3. **I recognise and champion:**
    a. management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues
    b. open and constructive communication with all system partners to share a common purpose, vision and strategy

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Appendix 1: Values and concepts from key documents which form an anchor for this framework

Our People Promise

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

NHS Values

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Our Leadership Way

We are compassionate

- We are inclusive, promote equality and diversity, and challenge discrimination
- We are kind and treat people with compassion, courtesy and respect.

We are curious

- We aim for the highest standards and seek to continually improve, harnessing our ingenuity
- We can be trusted to do what we promise

We are collaborative

- We collaborate, forming effective partnerships to achieve our common goals
- We celebrate success and support our people to be the best they can be

Health and Care Act 2022

- Collaborate with partners to address our shared priorities and have the core aim and duty to improve the health and wellbeing of the people of England.
- Improve the quality, including safety, of services provided.
- Ensure the sustainable, efficient use of resources for the wider system and communities served.

Seven Principles of Public Life

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The competency domains reflect the NHS values, Our NHS People Promise, Our Leadership Way and the Seven Principles of Public Life (Nolan Principles).

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Appendix 2: Optional scoring guide for individual self-assessment against the competencies

Domain 1: Driving high quality, sustainable outcomes						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to ensure that my organisation delivers the best possible care for patients					
1b	to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
2	**I assess and understand:**					
2a	the performance of my organisation and ensure that, where required, actions are taken to improve					
2b	the importance of efficient use of limited resources and seek to maximise: i. productivity and value for money **ii.** delivery of high quality and safe services at population level					
2c	the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
3	**I recognise and champion the importance of:**					
3a	attracting, developing and retaining an excellent and motivated workforce					
3b	building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					
3c	retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
4	**I personally:**					
4a	seek out and act on performance feedback and review, and continually build my own skills and capability					
4b	model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					

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Domain 2: Setting strategy and delivering long term transformation

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b	ensure there is a long-term strategic focus while delivering short-term objectives					
1c	ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d	ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2	**I assess and understand:**					
2a	the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b	the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					
2c	clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans					
3	**I recognise and champion the importance of long-term transformation that:**					
3a	benefits the whole system					
3b	promotes workforce reform					
3c	incorporates the adoption of proven improvement and safety approaches					
3d	takes data and digital innovation and other technology developments into account					
4	**I personally:**					
4a	listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					
4b	seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

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Domain 3: Promoting equality and inclusion, and reducing health inequalities

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b	ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c	reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2	**I assess and understand:**					
2a	the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)					
3	**I recognise and champion:**					
3a	the need for the board to consider population health risks as well as organisational and system risks					
4	**I personally:**					
4a	demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b	encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

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Domain 4: Providing robust governance and assurance						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	working collaboratively on the implementation of agreed strategies					
1b	participating in robust and respectful debate and constructive challenge to other board members					
1c	being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
1d	contributing to effective governance and risk management arrangements					
1e	contributing to evaluation and development of board effectiveness					
2	**I understand board member responsibilities and my individual contribution in relation to:**					
2a	financial performance					
2b	establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
2c	delivery of high quality and safe care					
2d	continuous, measurable improvement					
3	**I assess and understand:**					
3a	the level and quality of assurance from the board's committees and other sources					
3b	where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making					
3c	how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
3d	the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					

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4	**I recognise and champion:**					
4a	the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
4b	working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
5	**I personally:**					
5a	understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same					

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Domain 5: Creating a compassionate, just and positive culture						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b	to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c	to improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d	to ensure there is a safe culture of speaking up for our workforce					
2	**I assess and understand:**					
2a	my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3	**I recognise and champion:**					
3a	being respectful and I promote diversity and inclusion in my work					
3b	the ability to respond effectively in times of crisis or uncertainty					
4	**I personally:**					
4a	demonstrate visible, compassionate and inclusive leadership					
4b	speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					
4c	challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe; or staff or people being excluded in any way or treated unfairly					
4d	promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

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Domain 6: Building trusted relationships with partners and communities						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
1b	identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
2	**I assess and understand:**					
2a	the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
2b	the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
3	**I recognise and champion:**					
3a	management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					
3b	open and constructive communication with all system partners to share a common purpose, vision and strategy					

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NHS England

Framework for conducting annual appraisals of NHS chairs

Publication reference: B0496_iii

Contents

1. Introduction

This framework establishes a more standardised approach to the annual appraisal of chairs, including ICB, NHS trust and foundation trust chairs. The appraisal should be a valuable and valued undertaking that provides an honest and objective assessment of a chair's impact and effectiveness, while enabling potential support and development needs to be recognised and fully considered. The framework is aligned with the NHS Leadership Competency Framework and informed by multi-source feedback.

We recognise that many organisations have developed and implemented local processes that are equally comprehensive, and which reflect specific contexts and good practice. Therefore, this framework is not intended to be prescriptive. Local variations should be consistent with the framework's broad principles and include mechanisms for adequate multi-source assessment against the components of the Leadership Competency Framework.

Context

The framework is informed by the provisions of NHS England's code of governance for provider trusts,[1] the seven principles of public life (Nolan Principles)[2] and the Financial Reporting Council's publications (UK corporate governance code[3] and guidance on board effectiveness[4]). These provisions emphasise the pivotal nature of the chair's role in creating the conditions for the board's effectiveness in maintaining a focus on strategy, performance, culture and values, stakeholders and accountability.

In 2019, the Tom Kark KC review of the fit and proper person test was published, and this included a recommendation for 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. The Leadership Competency Framework responds to this recommendation and forms part of the wider NHS England Fit and Proper Person Test Framework (FPPT) as the competency and skills benchmark against which board members will individually

[1] www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance

[2] www.gov.uk/government/publications/the-7-principles-of-public-life

[3] UK Corporate Governance Code 2024 (frc.org.uk)

[4] Guidance_on_Board_Effectiveness_MmfcOrz.pdf (frc.org.uk)

self-assess as part of the annual ‘fitness’ attestation. We recognise it is unlikely that board members will fulfil all competency areas all the time.

Integrating the Leadership Competency Framework within chair appraisals will enable holistic conversations about performance, values and behaviours and support the ongoing development of chairs and boards. The directory of board level learning and development opportunities supports ongoing development.

The Leadership Competency Framework takes account of NHS England frameworks and strategies and is anchored by core NHS documents[5].

In leading the board, the chair should set clear expectations about the style and tone of board discussions, ensuring it has effective decision-making processes and applies sufficient challenge in conducting its business. This requires an ability to foster relationships based on trust, mutual respect and open communication between non-executive directors and the executive team, and between the unitary board and its key partners (both internal and external).

[5] NHS England Operating Framework, NHS National Patient Safety Strategy, NHS Long Term Workforce Plan, NHS England Equality, Diversity and Inclusion Improvement Plan, National Quality Board Shared Commitment to Quality, NHS Well Led Framework, *(forthcoming)* Insightful Board, The statutory framework of the Health and Care Act 2022

As a minimum, chairs should participate in a face-to-face annual appraisal that is informed by self-evaluation and assessments of impact and personal effectiveness from a range of internal and external stakeholders.

The frame of reference for self-evaluation and stakeholder assessment is the 6 leadership competency domains of the Leadership Competency Framework (template provided in Appendix 2). The outcomes from the appraisal discussion will be recorded and shared with the senior appointments and assessment team (SAAT) at england.chairsappraisal@nhs.net to facilitate regional director review (template provided in Appendix 3).

The preparation for and conduct of the appraisal discussion should be facilitated by the senior independent director (SID) or deputy chair. Pending the SID's appointment in ICBs or trusts where this role does not currently exist, an experienced non-executive director should be nominated via the remuneration committee. The SID or nominated non-executive director (ie the 'appraisal facilitator') will be responsible for receiving the chair's self-evaluation and collating all assessment feedback from the participant stakeholders.

For annual appraisals to be meaningful and contribute beneficially to chairs' personal development, appraisal facilitators should place significant emphasis on developing a highly functional working relationship with their chairs, built on openness, honesty and trust. This will ensure the appraisal does not feel like an impersonal or isolated annual event but an important cornerstone of continuous and supportive dialogue and objective informal feedback, relating to personal impact and effectiveness. Above all, chairs should be genuinely willing to seek and act on constructive criticism about their impact and effectiveness.

2. Annual process

This framework establishes a standard process, consisting of four key stages, to be applied to the annual appraisal of chairs. The process is described below and presented as a summary flowchart in Appendix 1.

Stage 1: Appraisal preparation

At a pre-appraisal meeting, the chair and the appraisal facilitator should review the contents of the assessment template (see Appendix 2) and determine whether they will seek feedback for any additional areas: if so, the template will need to be adapted accordingly. Additional areas of focus are likely to be identified by, for example, considering the chair's previous appraisal outcomes, personal development plan and in-year objectives; key aspects of the board development plan; the Leadership Competency Framework; and the current overall performance of the respective system or organisation.

The chair and the appraisal facilitator should also determine which stakeholders they will invite to contribute to the appraisal through multisource assessment and agree the overall timetable for completing the required appraisal activity. The agreed timetable should ensure all associated stages of the process are completed by the end of quarter 1 in any given year.

Another important part of the preparation is for the appraisal facilitator to speak with their NHS England regional director to ascertain whether they consider that any areas of competency should receive particular focus.

Stage 2: Multisource assessment

Assessments of the chair's effectiveness should be sought from a range of key stakeholders who represent the organisation and external partner organisations. For foundation trusts, the lead governor (on the council of governors' behalf) should always be included. For all provider chairs the chair of the ICB should also be included. Other stakeholders might include non-executive directors, the chief executive, executive directors, commissioners and other system partners, patient and public representative leads and a peer(s) from another system or trust(s). Careful consideration should be given to ensure there is an appropriate number and span of representative participants.

Concurrently, the chair should be invited to conduct a self-assessment using the chosen criteria included in the multisource assessment template (see Appendix 2). This self-evaluation should include commentary on any identified personal development or support needs.

Stage 3: Evaluation

The appraisal facilitator will need to devote sufficient time to evaluating all the collated stakeholder assessments. As part of this, it may well be necessary to seek further information from one or more of the assessors, to gain greater insight and/or to clarify certain areas. The evaluation of stakeholders' views should then be considered alongside the chair's own self-assessment. Again, the chair may ask the appraisal facilitator for further information and/or comment.

Stage 4: Appraisal output

The collective evaluation of the multisource assessment should form the basis of, and subsequently guide, an appraisal discussion between the chair and the appraisal facilitator. During the discussion, equal consideration should be given to assessing in-year performance, how any previously identified development and support needs have been met, identifying any continuing or additional development or support required, and determining key objectives for the current year.

The key points arising from the appraisal discussion should be formally recorded by the appraisal facilitator and agreed by the chair. A template is provided in Appendix 3.

After completing all local activity, a copy of the appraisal reporting template should be sent to the senior appointments and assessment team (SAAT) at england.chairsappraisal@nhs.net to facilitate regional director review. Once approved by the regional director, SAAT will send it to NHS England's Chief Operating Officer for review (and for ICBs and NHS trusts, endorsement). NHS England's Chief Operating Officer will exercise discretion in seeking further information and/or moderating the appraisal outcomes, if such action is deemed necessary.

Appendix 1: Process for annual appraisal of NHS chairs – summary flowchart

Stage 1: Appraisal preparation

Chair; appraisal facilitator

Review of assessment template and determination of additional areas of focus; consideration of multi-source assessment contributors; agree timetable for multi-rater assessment and feedback.

Sources of reference:

chair's previous appraisal outcomes, personal development plan and in-year objectives; key aspects of the trust's board development plan; the Leadership Competency Framework domains; current overall trust performance.

↓

Stage 2: Multi-source assessment

Identified stakeholders; chair

Assessments of chair's effectiveness sought from a range of stakeholders identified at Stage 1; completion of self-assessment by chair.

Source of reference:

chair multi-source assessment template (**Appendix 2**)

↓

Stage 3: Evaluation

Appraisal facilitator

Evaluation, by appraisal facilitator, of all collated stakeholder assessments; if necessary, further information sought from assessors; evaluation of stakeholders' views considered alongside chair's self-assessment.

↓

Stage 4:

Appraisal output

Chair;

appraisal facilitator;

regional director;

NHS England

Chief Operating

Officer

Appraisal discussion framed around collective evaluation of multi-source assessment; consideration given to in-year performance, identification of development or support needs, and consideration of current year's key objectives.

Key points from appraisal discussion formally recorded by appraisal facilitator and agreed by the chair. Completed appraisal reporting template sent to the Senior Appointments and Assessment team (SAAT) at england.chairsappraisal@nhs.net to facilitate regional director review.

Once approved by the regional director, SAAT will send it to NHS England's Chief Operating Officer for review (and for NHS trusts and ICBs, endorsement). NHS England's Chief Operating Officer will exercise discretion in seeking further information and/or moderating the appraisal outcomes if such action is deemed necessary.

Appendix 2: NHS chair multisource assessment template

Overview

This template is for those asked to contribute to the annual appraisal of NHS chairs, a principal component of which is multisource assessment. In addition to inviting responses from identified stakeholders to the statements and questions in the template, chairs will be asked to reflect on the same statements and questions as a means of self-assessment. The collective evaluation of all responses, including those provided by chairs, will form the basis of an appraisal discussion conducted by the appraisal facilitator.

The outcomes arising from the appraisal discussion will be formally recorded and, for ICBs and NHS trusts, reviewed at regional level (by respective regional directors) and national level (by NHS England's Chief Operating Officer).

The annual appraisal process should be a valuable and valued undertaking that honestly and objectively assesses a chair's impact and effectiveness, while enabling potential support and development needs to be recognised and fully considered.

The Leadership Competency Framework contains six domains:

1. Driving high-quality, and sustainable outcomes
2. Setting strategy and delivering long-term transformation
3. Promoting equality and inclusion, and reducing health inequalities
4. Providing robust governance and assurance
5. Creating a compassionate, just and positive culture
6. Building a trusted relationship with partners and communities

Collectively, the competencies associated with each domain represent a success profile against which chairs' impact and effectiveness should be annually assessed.

The multisource assessment template consists of themed statements grouped according to the six competency clusters. Based on their direct knowledge of the chair, assessors are asked to provide a response to each statement (ie strongly

agree, agree, disagree, or strongly disagree) or to a smaller number of specific statements that will have been indicated by the appraisal facilitator.

Assessors are further invited to provide commentary in response to 2 questions: “what does the chair do particularly well?” and “how might the chair’s impact and effectiveness be improved?” Responses will be particularly valuable in highlighting areas of high impact and good practice, and opportunities for development and support.

Completed templates should be submitted (anonymously or otherwise) direct to the appraisal facilitator.

Multisource assessment - impact and effectiveness

Confidential when completed

Name of organisation:	
Name of chair:	
Name and role of appraisal facilitator:	
Assessment period:	

Part 1: Responses to statements relating to the NHS Leadership Competency Framework

The following themed statements relate to the chair's impact and effectiveness in their role.

Please respond to as many of the statements as possible.

Domain 1: Driving high quality, sustainable outcomes						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to ensure that my organisation delivers the best possible care for patients					
1b	to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
2	**I assess and understand:**					
2a	the performance of my organisation and ensure that, where required, actions are taken to improve					
2b	the importance of efficient use of limited resources and seek to maximise: i. productivity and value for money ii. delivery of high quality and safe services at population level					
2c	the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
3	**I recognise and champion the importance of:**					
3a	attracting, developing and retaining an excellent and motivated workforce					
3b	building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					

3c	retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
4	**I personally:**					
4a	seek out and act on performance feedback and review, and continually build my own skills and capability					
4b	model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					

Domain 2: Setting strategy and delivering long term transformation

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b	ensure there is a long-term strategic focus while delivering short-term objectives					
1c	ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d	ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2	**I assess and understand:**					
2a	the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b	the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					
2c	clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans					

3	**I recognise and champion the importance of long-term transformation that:**					
3a	benefits the whole system					
3b	promotes workforce reform					
3c	incorporates the adoption of proven improvement and safety approaches					
3d	takes data and digital innovation and other technology developments into account					
4	**I personally:**					
4a	listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					
4b	seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

Domain 3: Promoting equality and inclusion, and reducing health inequalities

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b	ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c	reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2	**I assess and understand:**					

2a	the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)					
3	**I recognise and champion:**					
3a	the need for the board to consider population health risks as well as organisational and system risks					
4	**I personally:**					
4a	demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b	encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

Domain 4: Providing robust governance and assurance

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	working collaboratively on the implementation of agreed strategies					
1b	participating in robust and respectful debate and constructive challenge to other board members					
1c	being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
1d	contributing to effective governance and risk management arrangements					
1e	contributing to evaluation and development of board effectiveness					

2	**I understand board member responsibilities and my individual contribution in relation to:**					
2a	financial performance					
2b	establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
2c	delivery of high quality and safe care					
2d	continuous, measurable improvement					
3	**I assess and understand:**					
3a	the level and quality of assurance from the board's committees and other sources					
3b	where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making					
3c	how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
3d	the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					
4	**I recognise and champion:**					
4a	the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
4b	working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
5	**I personally:**					
5a	understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same					

Domain 5: Creating a compassionate, just and positive culture						
	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b	to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c	to improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d	to ensure there is a safe culture of speaking up for our workforce					
2	**I assess and understand:**					
2a	my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3	**I recognise and champion:**					
3a	being respectful and I promote diversity and inclusion in my work					
3b	the ability to respond effectively in times of crisis or uncertainty					
4	**I personally:**					
4a	demonstrate visible, compassionate and inclusive leadership					
4b	speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					

4c	challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe; or staff or people being excluded in any way or treated unfairly					
4d	promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

Domain 6: Building trusted relationships with partners and communities

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader by:**					
1a	fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
1b	identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
2	**I assess and understand:**					
2a	the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
2b	the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
3	**I recognise and champion:**					
3a	management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					
3b	open and constructive communication with all system partners to share a common purpose, vision and strategy					

Part 2: Strengths and opportunities

Reflecting on your responses to the above competency statements, please highlight the chair's particular strengths and suggest any areas in which there are opportunities for increasing their impact and effectiveness.

Field sizes are adjustable.

Strengths: What does the chair do particularly well?

Opportunities: How might the chair increase their impact and effectiveness?

Part 3: Additional commentary

Please provide any additional commentary relating to any aspects of the chair's conduct, impact and effectiveness in their role.

The field size is adjustable.

Additional commentary

Thank you for participating. Please now send your completed template to the appraisal facilitator, who will treat your responses in strict confidence. If you wish to discuss any of your responses with the appraisal facilitator, again in strict confidence, please request to do so.

Appendix 3: NHS chair appraisal reporting template

This template should be used to formally record a summary of the key outcomes from the appraisal discussion between chairs and appraisal facilitators.

Name of organisation:	
Name of chair:	
Name and role of appraisal facilitator:	
Appraisal period:	

Part 1: Multisource stakeholder assessment outcomes (for completion by appraisal facilitator)

a. Summary of significant emergent themes from stakeholder assessments:

b. Highlighted areas of strength:

c. Identified opportunities to increase impact and effectiveness:

Part 2: Self-reflection (for completion by chair)

Summary of self-reflection on multisource stakeholder assessment outcomes:

Part 3: Personal development and support (for completion by chair and appraisal facilitator)

Personal development and/or support needs identified:			
Description	Proposed intervention	Indicative timescale	Anticipated benefit/ measure of success

Part 4: Principal objectives (for completion by chair and appraisal facilitator)

3 principal objectives identified for next 12 months:

Objective	Anticipated benefit/ measure of success	Anticipated constraints/ barriers to achievement

Part 5: Suitability for appointment (for completion by chair and appraisal facilitator)

The appraisee has been assessed in the last 12 months under the NHS England FPPT Framework and it is confirmed that they continue to be a 'fit and proper person' as outlined in regulation 5 and there are no pending proceedings or other matters which may affect their suitability for appointment. Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)
YES/NO – If NO please provide details.

Part 6: Overall Assessment Rating and Confirmation

1. Assessment ratings:

    1) **Satisfactory** (they are meeting their formal expectations)
    2) **Cause for concern** (they are not meeting their formal expectations and will be formally logged and addressed)

Confirmation of overall assessment rating and confirmation (please circle and sign below)	
1) Satisfactory	2) Cause for concern

Confirmed by	Signature	Date
Chair		
Senior Independent Director, Deputy Chair or Regional Director		

Part 7: Confirmation

Confirmation of key outcomes of appraisal discussion:		
Confirmed by	Signature	Date
Chair		
Appraisal facilitator		

Part 8: Submission

a. Copy submitted to england.chairsappraisal@nhs.net who will forward to your regional director for review

Name of regional director	Date

b. Endorsement by NHS England Chief Operating Officer (NHS England will action)

Name	Date
Name	**Date**

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NHS Chair Multisource Assessment

Multisource assessment - impact and effectiveness

Confidential when completed

Name of organisation:	
Name of chair:	
Name and role of appraisal facilitator:	
Assessment period:	

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Part 1: Responses to statements relating to the NHS Leadership Competency Frameworks

The following themed statements relate to the chair's impact and effectiveness in their role.

Please respond to as many of the statements as possible.

Domain 1: Driving high quality, sustainable outcomes					
Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
I contribute as a leader:					
to ensure that my organisation delivers the best possible care for patients					
to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
I assess and understand:					
the performance of my organisation and ensure that, where required, actions are taken to improve					
the importance of efficient use of limited resources and seek to maximise: i. productivity and value for money **ii.** delivery of high quality and safe services at population level					
the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
I recognise and champion the importance of:					

attracting, developing and retaining an excellent and motivated workforce					
building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					
retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
I personally:					
seek out and act on performance feedback and review, and continually build my own skills and capability					
model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					

Domain 2: Setting strategy and delivering long term transformation

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b	ensure there is a long-term strategic focus while delivering short-term objectives					
1c	ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d	ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2	**I assess and understand:**					
2a	the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b	the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					

2c	clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans					
3	**I recognise and champion the importance of long-term transformation that:**					
3a	benefits the whole system					
3b	promotes workforce reform					
3c	incorporates the adoption of proven improvement and safety approaches					
3d	takes data and digital innovation and other technology developments into account					
4	**I personally:**					
4a	listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					
4b	seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

Domain 3: Promoting equality and inclusion, and reducing health inequalities

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader to:**					
1a	improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b	ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c	reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2	**I assess and understand:**					
2a	the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)					
3	**I recognise and champion:**					
3a	the need for the board to consider population health risks as well as organisational and system risks					
4	**I personally:**					
4a	demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b	encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

Domain 4: Providing robust governance and assurance

Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate

I contribute as a leader by:					
working collaboratively on the implementation of agreed strategies					
participating in robust and respectful debate and constructive challenge to other board members					
being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
contributing to effective governance and risk management arrangements					
contributing to evaluation and development of board effectiveness					
I understand board member responsibilities and my individual contribution in relation to:					
financial performance					
establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
delivery of high quality and safe care					
continuous, measurable improvement					
I assess and understand:					
the level and quality of assurance from the board's committees and other sources					
where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making					
how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					
I recognise and champion:					

the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
I personally:					
understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same					

Domain 5: Creating a compassionate, just and positive culture

	Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
1	**I contribute as a leader:**					
1a	to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b	to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c	to improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d	to ensure there is a safe culture of speaking up for our workforce					
2	**I assess and understand:**					
2a	my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3	**I recognise and champion:**					
3a	being respectful and I promote diversity and inclusion in my work					
3b	the ability to respond effectively in times of crisis or uncertainty					

4	I personally:					
4a	demonstrate visible, compassionate and inclusive leadership					
4b	speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					
4c	challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe; or staff or people being excluded in any way or treated unfairly					
4d	promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

Domain 6: Building trusted relationships with partners and communities

Competencies	Almost always	Frequently	Occasionally	Rarely or never	No chance to demonstrate
I contribute as a leader by:					
fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
I assess and understand:					
the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
I recognise and champion:					
management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					
open and constructive communication with all system partners to share a common purpose, vision and strategy					

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Part 2: Strengths and opportunities

Reflecting on your responses to the above competency statements, please highlight the chair's particular strengths and suggest any areas in which there are opportunities for increasing their impact and effectiveness.

Field sizes are adjustable.

Strengths: What does the chair do particularly well?

Opportunities: How might the chair increase their impact and effectiveness?

Part 3: Additional commentary

Please provide any additional commentary relating to any aspects of the chair's conduct, impact and effectiveness in their role.

The field size is adjustable.

Additional commentary

Thanks you for participating. Please now send your completed template to the appraisal facilitator, who will treat your responses in strict confidence. If you wish to discuss any of your responses with the appraisal facilitator, again in strict confidence, please request to do so.

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Leadership Competency Framework Board Member Self-Assessment

Domain 1: Driving High Quality, Sustainable Outcomes

What does good look like?

I am a member of a unitary board which is committed to ensuring excellence in the delivery of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader:					
1a. to ensure that my organisation delivers the best possible care for patients					
1b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation					
2. I assess and understand:					
2a. the performance of my organisation and ensure that, where required, actions are taken to improve					
2b. the importance of efficient use of limited resources and seek to maximise productivity and value for money and delivery of high quality and safe services at population level					
2c. the need for a balanced and evidence-based approach in the context of the board's risk appetite when considering innovative solutions and improvements					
3. I recognise and champion the importance of:					
3a. attracting, developing and retaining an excellent and motivated workforce					
3b. building diverse talent pipelines and ensuring appropriate succession plans are in place for critical roles					
3c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate					
4. I personally:					
4a. seek out and act on performance feedback and review, and continually build my own skills and capability					

4b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training					

Domain 2: Setting Strategy and Delivering Long Term Transformation

What does good look like?

I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader to:					
1a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities					
1b. ensure there is a long-term strategic focus while delivering short-term objectives					
1c. ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates					
1d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same					
2. I assess and understand:					
2a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments					
2b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy					
2c. clinical best practice, regulation, national and local priorities, risk and financial implications when developing strategies and delivery plans					
3. I recognise and champion the importance of long-term transformation that:					
3a. benefits the whole system					
3b. promotes workforce reform					
3c. incorporates the adoption of proven improvement and safety approaches					
3d. takes data and digital innovation and other technology developments into account					
4. I personally:					
4a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same					

4b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies					

Domain 3: Promoting Equality and Inclusion, and Reducing Health Inequalities

What does good look like?

I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and communities, including our workforce, and continued improvements to health and workforce inequalities.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader to:					
1a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care					
1b. ensure that resource development takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes					
1c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups					
2. I assess and understand:					
2a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (link to Domain 6)					
3. I recognise and champion:					
3a. the need for the Board to consider population health risks as well as organisational and system risks					
4. I personally:					
4a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds					
4b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities					

Domain 4: Providing Robust Governance and Assurance

What does good look like?

I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader by:					
1a. working collaboratively on the implementation of agreed strategies					
1b. participating in robust and respectful debate and constructive challenge to other Board Members					
1c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options					
1d. contributing to effective governance and risk management arrangements					
1e. contributing to evaluation and development of board effectiveness					
2. I understand board member responsibilities and my individual contribution in relation to:					
2a. financial performance					
2b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities					
2c. delivery of high quality and safe care					
2d. continuous, measurable improvement					
3. I assess and understand:					
3a. the level and quality of assurance from the Board's Committees and other sources					
3b. where I need to challenge other Board Members to provide evidence and assurance on risks and how they impact decision making					
3c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements					
3d. the use of intelligence and data from a variety of sources to recognise and identify early warning signals and risks					
4. I recognise and champion:					
4a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders					
4b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement					
5. I personally:					

5a. understand the individual and collective strengths of the Board, and I use my personal and professional knowledge and experience to contribute at the Board and support others to do the same					

Domain 5: Creating a Compassionate, Just and Positive Culture

What does good look like?

As a board member I contribute to the development and ongoing maintenance of a compassionate and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader by:					
1a. to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues					
1b. to ensure that all staff can take ownership of their work and contribute to meaningful decision making and improvement					
1c. to improve staff engagement, experience and wellbeing in line with our NHS People Promise					
1d. to ensure there is a safe culture of speaking up for our workforce					
2. I assess and understand:					
2a. My role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture					
3. I recognise and champion:					
3a. being respectful and I promote diversity and inclusion in my work					
3b. the ability to respond effectively in times of crisis or uncertainty					
4. I personally:					
4a. demonstrate visible, compassionate and inclusive leadership					
4b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice					
4c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly					
4d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention					

Domain 6: Building Trusted Relationships with Partners and Communities

What does good look like?

I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.

Competency	Almost Always	Frequently	Occasionally	Rarely or Never	No Chance to Demonstrate
1. I contribute as a leader by:					
1a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners					
1b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest					
2. I assess and understand:					
2a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems					
2b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners					
3. I recognise and champion:					
3a. management and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues					
3b. open and constructive communication with all system partners to share a common purpose, vision and strategy					

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 4 April 2024		**Report of:** Remuneration Committee (RemCom)		
Date of last meeting: 26 January 2024		**Membership Numbers:** Quorate		
1	**Agenda**	The Committee considered an agenda which included the following: • Chief Digital Information Officer Appointment		
2	**Alert**	• None		
3	**Assurance**	• A robust and open recruitment process took place and the recommendation of the appointment panel for the role of Chief Digital Information Officer was approved with remuneration within the agreed range.		
4.	**Advise**	• None		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	Max Steinberg, Chair	Minutes available from:	Corporate Secretary

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 4 April 2024		**Report of:** Remuneration Committee (RemCom)		
Date of last meeting: 7 March 2024		**Membership Numbers:** Quorate		
1	**Agenda**	The Committee considered an agenda which included the following: • Pension Contribution Alternative Reward Scheme Policy • Very Senior Manager Pay Policy • Annual Committee Effectiveness Review • Terms of Reference		
2	**Alert**	• None		
3	**Assurance**	• Pension Contribution Alternative Reward Scheme Policy and Very Senior Manager Pay Policy were approved • Committee performance and effectiveness over the past year was reviewed and noted as meeting the agreed terms of reference • Terms of Reference were recommended for approval by Board		
4.	**Advise**	• None		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	Max Steinberg, Chair	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Board of Directors
4 April 2024

Report Title	Remuneration Committee Terms of Reference
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

☐ **Acceptable assurance**	☐ **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)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness agreed that the Committee has fulfilled its duties as set out in the Terms of Reference
- One addition is proposed to bring the Trust into line with the Code of Governance for NHS Provider Trusts

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2023/24.

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

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**
Remuneration Committee	7 March 2024	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Remuneration Committee (RemCom) Terms of Reference

Executive Summary

1. The purpose of this report is to present the RemCom Terms of Reference (ToR) for approval following the annual effectiveness review.

2. Key Achievements for the Committee in 2023/24 were:
   - Approval of Pension Contribution Alternative Reward Policy
   - Approval of cost of living increase for Executive Directors
   - Review of Executive Director Performance
   - Approval of Mutually Agreed Resignation Scheme (MARS) for 2024/25 and review of 2023/24 scheme
   - Agreement and appointment of Chief Digital Information Officer role
   - Appointment of Chief Nurse
   - Review of Succession plan for Board Directors

Changes to ToR

3. The ToR sets out the responsibilities that the Trust Board have delegated to the Committee. There are no substantial proposed changes to the Terms of Reference (Appendix 2). One addition is suggested in order to reflect more explicit guidance in paragraph 16 from the new Code of Governance for NHS Providers [1] regarding the role the Committee should have to review and monitor the remuneration for the next level of management sitting below Executive Directors. The following sentence in red has been drafted to fulfil this duty.

   > Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. This should include monitoring and making recommendations on the remuneration of the first layer of management below board level.

4. This was agreed by the Remuneration Committee at their last meeting on 7 March 2024. The additional requirement is expected to be submitted to the next meeting of Remuneration Committee in June 2024.

Conclusion

4. The Board is asked to approve the revised Terms of Reference.

Recommendation

To approve

Author: Katharine Dowson
Date: 20 March 2024
Appendix 1 – RemCom Draft Terms of Reference April 2024

[1] NHS England » Code of governance for NHS provider trusts

Appendix 1

REMUNERATION COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Remuneration 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 appointment and remuneration of Executive Directors is conducted in line with statutory and regulatory requirements in order to make the most appropriate appointments to the senior leadership of the Trust. The committee will determine the approach to be taken to appoint Executive Directors and approve any such appointments, taking into account the skills gaps within the Board of Directors. The Committee will also have oversight of any policies or processes that impact on the terms and conditions of remuneration of Very Senior Managers (VSM) who are not subject to agenda for changes terms and conditions.

Membership

7. The Committee shall be comprised of the following voting members:
   - Trust Chair
   - All other Non-Executive Directors

8. The Corporate Secretary is required to attend on a regular basis.

9. The Committee will be deemed quorate when four members are present.

10. In the event that the Chair of the Committee is unable to attend a meeting, the Deputy Chair shall be the Chair for that meeting. In their absence the 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. There is no provision for deputies to represent members at meetings of the Committee.

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

Requirements of Membership

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

14. 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

15. Review the leadership needs of the Trust at Executive Director level, to ensure the continued ability of the Trust to operate effectively in the local and regional health economy, taking into consideration the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors. To use any outputs from any Board evaluation process as appropriate and make recommendations to the Board of Directors with regard to any changes.

16. Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. This should include monitoring and making recommendations on the remuneration of the first layer of management below board level.

17. Oversee the appointment process for Executive Directors by approving the appointment process, agreeing the job description and skills mix required by the Board of Directors, and agreeing the advertised remuneration package. Making the final approval decision on appointment (excluding Chief Executive).

18. Ensure that proposed candidates are a 'fit and proper person' in accordance with the Trust's Fit and Proper Persons Policy and that any significant commitments are considered before appointment.

19. Establish and keep under review a remuneration policy in respect of VSM.

20. Consult the Chief Executive about proposals relating to the remuneration of VSM.

21. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of VSM including:
    - salary, including any performance-related pay or bonus or earn-back arrangements (none currently in place)
    - provisions for other benefits, including pensions and cars
    - allowances
    - payable expenses
    - compensation payments

22. Establish levels of remuneration which are sufficient to attract, retain and motivate high-quality Executive Directors with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

23. Use national guidance and market benchmarking analysis in the review of Executive Director remuneration (and any senior managers on locally-determined pay), whilst ensuring that increases are not applied where either Trust or individual performance do not justify them, and be sensitive to pay and employment conditions elsewhere in the Trust.

24. Review and assess the output of evaluation of the performance of individual Executive Directors and consider this output when reviewing remuneration levels.

25. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments, to avoid rewarding poor performance.

26. Consider and approve matters regarding extraordinary and additional payments to staff employed by the Trust in relation to Mutually Agreed Resignation Schemes and/or Voluntary/Compulsory Redundancy programmes.

Data Privacy

27. The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

28. 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

29. 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.

Administration of Meetings

30. Meetings shall be held as required with a minimum of one per year, with additional meetings held as required at the request of the Chair or any three voting members of the Committee.

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

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

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

Review

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

35. 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: 4 April 2024
Review Date: April 2025

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 01/03/24		**Report of: Neuroscience Network Programme Board (NSPB)**
Date of last meeting: 29/02/24		**Membership Numbers:7**
1.	**Agenda**	The Neuroscience Programme Board considered the agenda below:- • Getting it Right First Time (GiRFT) Cranial Update • ICB/System Update • Decision Aid to support clinical review of use of *Keppra*® • Cheshire & Merseyside (C&M) Rehabilitation Review • Innovation Update • St Helens Project Update • Hot topics from other Trusts.
2.	**Alert**	**Decision Aid to support clinical review of use of *Keppra*®** • The NSPB provided initial approval for the decision guide to support clinical review for switching to generic Levetiracetam. Further contact is to be made with the medical director for further endorsement after which the guide will be discussed further at the relevant external meetings. Once fully approved, protocols would be circulated out to primary care colleagues. It is envisaged that switch could provide up to £1m in cost saving. **ICB/System Update** • Delegation of Specialist Services from the National Specialised Commissioner to the ICB is due to take place on 01/04/24 and the plan is on-going. **Cheshire & Merseyside Rehabilitation Review** • Funding has been secured to recruit a Programme Manager for 12 months with interviews anticipated to be held mid-April. Six key priorities have been identified for which working groups will be created once the Programme Manager is in post. **Neurological Conditions & Secondary Care** • The Chair of the C&M Neurological Society highlighted that frequently, the experiences and outcomes for those living with neurological conditions when admitted to secondary care is poor with symptoms of the condition often worsening. The Chair is contacting secondary care providers with the request to implement champions for this group of patients and for assurances that patients' neurological conditions are fully considered. This is to be a regular NSPB agenda item.

	Assurance	**GiRFT Cranial Update** • It was noted that most recommendations have been successfully completed apart from two which are partially complete. • The first recommendation, partially completed, relates to the increase the proportion of procedures undertaken in the day-case setting and increase the rate of short stay admissions. The same day admission ward and discharge lounge are now open and initially focused on spinal patients. More work to be done to embed this practise and increase numbers in cranial cases for those which are clinically appropriate. • The second recommendation, partially completed, relates to ensuring a timely transfer to rehabilitation centres or major procedures and timely repatriation to referring hospitals. Issues have arisen due to pressures and shortage of beds in referring hospitals and at rehabilitation centres. A Rehabilitation Consultant has been in post at WCFT to ensure that patients awaiting a rehabilitation bed received the appropriate treatment. • Two recommendations are not completed as external updates are awaited.		
	Advise	**Innovation update – Access to Exercise & Well-being** • Sheffield Hallam University are monitoring the results and should have an interim report in October. Initial results are positive. • Exercise and Well-Being Open Day is being held on 8th March at Greenbank Gym in Liverpool from 11am - 3pm. Various partners in the programme are attending to provide information and advice.		
3	**Risks Identified**	None		
4.	**Report Compiled by**	Chief Finance Officer Mike Burns	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Meeting Date: 23/02/24		**Report of:** The Walton Centre Charity Committee Meeting
Report Date: 04/04/24		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Finance Report to 31 January 2024 • Quarterly Investment Reports from CCLA and Ruffer • Three Year Suitability Review - Ruffer • Independent Investment Report • Preparation of the Financial Statements 2022/23: Proposed Accounting Policies • Fundraising Benchmarking Report • Cycle of Business 2024-25 • Head of Fundraising Report • Fund Manager Handbook • Digital Fundraiser Impact Report • Awake Craniotomy Business Case • PhD Application: Understanding long term cognitive impairment following COVID-19 through structural and functional neuroimaging • Application to Support the Purchase of OCT Machine • Staff Awards • Training and Development Department Annual Report and Charitable Application • Charity Risk Register
2	**Alert**	• None
3	**Assurance**	• The Committee received the independent advisor's investment report from Jagger and Associates and were provided with a benchmark performance against other fundholders. On balance, the Trust's fund holders benchmarked well against their peers. • The Committee received a presentation from the CCLA Fund Manager and noted the performance of the investment portfolio in light of the current market conditions. • The Committee received the Fundraising Benchmarking Report, and it was noted that the fundraising costs associated with the Walton Centre Charity ranked second highest compared to other local NHS Charities. • The Committee noted that the Fundraising Benchmarking Report did not provide a comprehensive overview of the fundraising cost and activities sponsored by the various (charities even when similar accounting polies were applied). • The Committee received the Training and Development Department Annual Report and Impact presentation and approved the Charitable Applications for quarter four. • The Committee approved the Fund Manager Handbook to be circulated to Fund Managers. • The Committee received the Digital Fundraiser Impact Report and the impact of the Digital Fundraiser postholder was commended and progress was noted.

4	**Advise**	• The Committee approved the Awake Craniotomy Business Case to help enhance the service and improve patient experience. • The Quarterly Investment Reports from CCLA and Ruffer were presented to the Committee and the Committee noted the volatility of the market and the performance of the investment portfolios. • The Finance Report as at 31 January 2024 was presented to the Committee which showed that the fund balances had increased from £1,381,843 to £1,383,162 and current investments were valued at £1,151,974. • The Committee received the draft 2024/25 Charity Plan and noted the planned outturn and incremental income increase. • The Committee received the Three-Year Suitability Report for Ruffer and the Committee agreed that the best approach was to continue receiving income from the fund rather than adding interest to the fund balance. • The Head of Fundraising report was received by the Committee and the Committee noted the good progress being made. • The Committee approved the 2023/24 Preparation of the Financial Statements and the Proposed Accounting Policies. • The Committee received an application to fully fund PhD, and it was suggested that the application be referred to the Research, Innovation and Medical Education Committee for further discussion. • The application to Support the Purchase of OCT Machine was received and ratified by the Committee. • The Committee approved the application for funds to cover expenditure and underwriting the costs of the 2024 Staff Awards on the basis that ticket sales and sponsorships would cover most of the event cost. • The Charity Risk Register was presented to the Committee, and it was noted that no new risks had been identified. • The Committee approved the 2024/25 Charity Committee Cycle of Business.		
5	**Risks Identified**	• None		
6	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Meeting Date: 06/02/24		**Report of:** Audit Committee
Report Date: 14/03/24		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Review of Internal and External Audit Functions and Counter-Fraud • Internal Audit Progress Report • Internal Audit Recommendation Report • Draft Internal Audit Plan 2024/25 • Clinical Audit Plan Progress Report • External Audit Services - Contract Award • External Audit Update and Progress Report • Counter Fraud Progress Report • Tender Waivers Q3 • Financial Compliance Report • Timetable for the Preparation of the Financial Statements 2023/24 • Risk Management Framework 2023 – 2026 Update • External Visits and Inspections Update Report • CQC Assurance Report • Annual Cycle of Business 2024/25
2.	**Alert**	• None Identified
	Assurance	• The Committee considered the Internal Audit Progress Report and noted that the following audits were underway: o Fire Safety (reporting stage) o Key Financial Controls (reporting stage) o Budgetary Control and management reporting (fieldwork stage) o Electronic Staff Records (fieldwork stage) o Data Security and Protection Toolkit (fieldwork stage) o Cyber Assessment Framework (fieldwork) • The Internal Audit Progress Report also informed that the following audits had been finalised: o Safer Staffing/eRostering (Substantial Assurance) o Data Quality – IPR (Substantial Assurance) • The Internal Audit Recommendation Report was received by the committee, and it was highlighted that the Trust had closed seventeen out of the twenty-four

		recommendations previously made and continued to make positive progress against the implementation of the recommendations. • The 2024/25 Draft Internal Audit Plan was received by the Committee and a final version would be presented to the Committee in April 2024. • Progress update on the Clinical Audit Plan was received by the Committee, it was noted that good progress had been made. The Committee would receive bi-annual updates on the Clinical Audit Plan going forward. • The Committee received an update on the extension of the External Audit Services contract that had been approved by the Council of Governors. • The Committee received the External Audit progress report and no significant risks had been raised. • The Committee received the Counter Fraud Progress Report and noted that no investigations had been referred and no issues had been identified with the delivery of the plan. • The Committee received an update of the 2023-26 Risk Management Framework followings its approval by the Board in March 2023. • The 2023/24 External Visits and Inspections Update report was received by the Committee and the Committee noted the plans in place to close the outstanding recommendations.		
	Advise	• There were no issues or concerns identified following the Annual Review of Effectiveness of the Internal and External Audit services and anti-fraud services. • The 2023/24 Q3 Tender Waivers Report was received, and the Committee noted that there were four waivers raised within the period of the report. • The Financial Compliance Report was received by the committee and the Committee noted the recovered debts and measures in place to recover aged debts. • The committee approved the Timetable for the Preparation of the Financial Statements and the Revised Accounting Policies. • The Committee reviewed the consolidation of the charity funds and recommend to the Board that the Trust continued to consolidate the charitable funds and that this would be reviewed on an annual basis. • The Committee received the Care Quality Commission (CQC) Assurance Report and noted that an action plan had been developed and reviewed regularly. • The Committee approved the 2024/25 Audit Committee Cycle of Business.		
2.	**Risks Identified**	None		
3.	**Report Compiled by**	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 April 2024

Report Title	Use of the Trust Seal 2023-24
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary Jennifer Ezeogu, Deputy Corporate Secretary
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- The Trust Seal was not used in 2023/24

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

None

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

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Use of the Trust Seal 2023/24

Executive Summary

1. The Board is required to receive an annual report on the use of the Trust Seal in accordance with the Constitution and the Standing Financial Instructions.

2. There had been no use of the Trust Seal in 2023/24 since it was last used on 9 June 2022.

Requirement for the Affixing of the Seal

3. The Trust Seal is the instrument by which the Trust affixes its signature to legal documents and as such its use is subject to a strict process.

4. The Constitution (Standing Order 42) requires the Trust to have a seal and specifies that only the Board of Directors shall authorise its use. Every year the Board receives a report on the use of the Board Seal through the year. In practice this is seldom used except on legal documents such as contracts.

Conclusion

5. The Board should have sight of the use of the Trust Seal and be advised that only they may approve the use of the seal.

Recommendation

To note

Author: Jennifer Ezeogu
Date: March 2024

Report to Trust Board
4 April 2024

Report Title	Eliminating Mixed Sex Accommodation: Annual Statement of Compliance
Executive Lead	Nicola Martin, Chief Nurse
Author (s)	Nicola Martin, Chief Nurse
Action Required	To note

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

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

Key Messages

- The Trust is required to provide an annual declaration against 'eliminating mixed sex accommodation'.
- At the time of preparing this report, the Trust was compliant with the Eliminating Mixed Sex Accommodation requirements for the period 1 April 2023 to 31 March 2024.

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

- To publish the annual statement of compliance.

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

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

004 Operational Performance	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**
Nil			

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. 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.

2. The report shows that the Trust is compliant with the Eliminating mixed sex accommodation requirements and that no mixed sex breaches have occurred within the period of the report from 1April 2023 to 31 March 2024.

3. The Chief Nurse will advise the Board accordingly at the meeting in April 2024 should this situation change during the remaining days of March 2024.

Progress Summary

4. 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.

5. 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 bay where they sleep with members of the same sex and 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.

6. 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.

7. 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

8. There were no breaches of same sex accommodation across the Trust in 2023 / 2024.

Recommendation

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

Author: Nicola Martin, Chief Nurse
Date: 26 March 2024

Appendix 1

Eliminating Mixed Sex Accommodation
Declaration of Compliance 01/04/23 - 31/03/24

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 2023 / 2024 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.

Nicola Martin
Chief Nurse
March 2024