NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 7th December 2023

Agenda and Papers

Excellence in Neuroscience

NHS
The Walton Centre
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING

Thursday 7 December 2023
Boardroom
09:30 – 12.40

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: • 5 October 2023 (d)	Chair	Approve
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive	Note
6	10.20	Charity Substrategy Update (d)	Chief People Officer	Assurance
7	10.30	People Substrategy Update (d)	Chief People Officer	Assurance
8	10.40	Quality Substrategy Update (d)	Chief Nurse	Assurance
9	10.50	Board Assurance Framework Report 2023/24 (d)	Chief Executive	Approve
COLLABORATION				
10	11.00	Joint Site Sub Committee (d) • Key Issues Report – 10 October 2023	Chair	Assurance
11	11.05	Liverpool Trusts Joint Committee: Key Issues Reports (d) • 21 September 2023	Chief Executive Officer	Assurance
11.10 BREAK				
INTEGRATED PERFORMANCE REPORT				
12	11.20	Business Performance Committee (d) Chair's Assurance Report: 28 November 2023	Committee Chair	Assurance
13	11.35	Quality Committee (d) Chair's Assurance Report: 16 November 2023	Committee Chair	Assurance
QUALITY & SAFETY				
14	11.50	Nurse Staffing Bi-Annual Acuity Report (d)	Chief Nurse	Assurance
15	12.00	Freedom to Speak Up Reflection Tool (d)	Chief Nurse	Approve
COMMITTEE CHAIR'S ASSURANCE REPORTS AND PAPERS				
16	12.10	Audit Committee - 18 October 2023 (d) • Standing Financial Instructions and Scheme of Reservation and Delegation (d)	Committee Chair	Approve
17	12.15	Charity Committee - 27 October 2023 (d)	Committee Chair	Approve

Item	Time	Item	Owner	Purpose
		• Charity Annual Report and Accounts 2022/23 (d)		
18	12.20	Research, Innovation and Medical Education Committee - 9 November 2023 (d)	Committee Chair	Assurance
19	12.25	Health Inequalities and Inclusion Committee (d) • 13 October 2023 • 27 November 2023	Committee Chair	Assurance
20	12.30	Neuroscience Programme Board - 9 November 2023 (d)	Committee Chair	Assurance
21	12.35	Remuneration Committee – 8 November 2023(d)	Committee Chair	Assurance
CONSENT AGENDA				
22. Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • *Learning from Deaths Policy (d)*				
CONCLUDING BUSINESS				
23	12.40	Any Other Business (v)	Chair	Note

Date and Time of Next Meeting: 9.30am, 1 February 2024, Boardroom, The Walton Centre

UNCONFIRMED
Minutes of the Public Trust Board Meeting
Board Room
5 October 2023

Present:

Max Steinberg (MS)	Chair
Mike Burns (MB)	Chief Financial Officer
Mike Gibney (MG)	Chief People Officer
Karen Heslop (KH)	Non-Executive Director
Debra Lawson (DL)	Associate Non-Executive Director
Nicky Martin (NM)	Acting Chief Nurse
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
Ray Walker (RW)	Non-Executive Director
Lindsey Vlasman (LV)	Chief Operating Officer

In attendance:

Mike Duffy (MD)	Head of Risk Management (*Item 8)*
Katharine Dowson (KD)	Corporate Secretary
Jennifer Ezeogu (JE)	Deputy Corporate Secretary *(for minutes)*
Louise Fasting (LF)	Advanced Neurology Nurse (*Item 1)*
Andy Green (AG)	Interim Deputy Chief Finance Officer (*Item 7)*
Lisa Judge (LJ)	Head of Patient Experience (*Item 1*)
Julie Kane (JK)	Freedom to Speak Up Guardian (*Item 17)*
Sally Butler Rice (SBR)	Health Safety and EPRR Manager (*item 18)*
Emma Sutton (ES)	Equality and Diversity Manager (*Item 15)*
Katie Tootill (KT)	Chief Procurement Officer (*Item 14)*

Observers

Caroline Hall (CH)	Executive Assistant
Chris Lake (CL)	Managing Director, Integrated Development
Belinda Shaw (BS)	Public Governor: Merseyside
Tom Stretch (TS)	Public Governor: Cheshire
Elaine Vaile (EV)	Communications and Marketing Manager

Apologies:

Paul May (PM)	Non-Executive Director
Irene Afful (IA)	Non-Executive Director

1 Staff Story

1.1 MS introduced the staff story which was in respect to how the Advanced Nurse Practitioner (ANP) supported a Motor Neurone Disease (MND) patient in the community with their long-term care plan.

1.2 LF explained that the patient had been admitted to a community hospital after a fall. The patient had severe communication challenges and was distressed. It had been thought by the

discharge team that the patient lacked capacity and had been difficult to manage as she had rejected the discharge options made to her.

1.3 A communication board was made available for the patient and an advocate was assigned to her to get her involved in the decision-making process for her long-term care plan and that of her husband. Through the intervention of the ANP the patient was also able to access funding for care at home and was able to visit her husband for the first time in six months.

1.4 MS asked about points of learning for the Trust. LF stated that having the right process and people in place who understand the patient group would help foster long term management of patients within the services as they have a better grasp of how the system integrates for the benefit of patients.

1.5 RW inquired about the size of the team and the areas covered by the team. LF answered that there were six Nurses and they provided care for the whole of Cheshire and Merseyside (C&M) with each assigned a particular geographical area. SR commented that the roles of advocates was significant, and this was an area that could be covered by the Health Inclusion and Inequalities Committee (HIIC).

1.6 MS thanked LF on behalf of the Board for going over and above in her role to ensure that the system worked with the patient and that the patients' needs were recognised.

The Board noted the staff story.

2 Welcome and apologies

2.1 Apologies were noted as above. The Chair welcomed everyone to the meeting.

3 Declaration of interest

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

4 Minutes of the meeting held on 7 September 2023

4.1 The following changes were suggested:

4.2 Paragraph 1.4 – "nationally" to be added to the end of the last sentence.

4.3 Paragraph 3.1 – Queens Court be amended to read "Queenscourt".

4.4 Paragraph 5.8 – reworded to read "JR stated that the participation of staff in the staff awards and celebration evening, the Trust's nomination for the HSJ Awards and the Trust's performance at the inpatient survey were a reflection *of the positivity felt across the Trust at this time.*"

4.5 Paragraph 8.3 – reworded to read "SR noted the ongoing commitment to Equality, Diversity and Inclusion which included the development of HIIC with a focus on health inequalities and the support provided to new international staff which was *being kept under review at HIIC*."

4.6 Paragraph 15.1 – the second sentence amended to read "*NHS Public Dividend Capital (NHSPDC) allocations* were being allocated late in the financial year … ."

4.7 Paragraph 16.1 – the second sentence amended to read "A draft *template of expenditure control* had been submitted to the ICB on behalf of the Board… ."

4.8 Following the completion of these amendments, the minutes of the meeting held on 7 September 2023 were approved as an accurate record of the meeting.

Action tracker

4.9 All actions had been completed and removal agreed from the action log.

5 Chair & Chief Executive's Report

5.1 MS advised the Board that the final interviews for a new Non-Executive Director (NED) were to be held on 6 October 2023. A visit to the Trust had been scheduled with a Dutch Medi-tech company by Liverpool City Council, in support of the Trust's innovation agenda. The Trust had been invited to reestablish its membership at Club Liverpool and MG would be in attendance on behalf of the Board. On 26 September 2023, MS and JR hosted a visit from Professor Tim Jones the Vice Chancellor of Liverpool University.

5.2 MS had, since the last Board Meeting, attended the Business Support and Inward Investment meeting, the Cheshire and Merseyside Acute Specialist Trusts (CMAST) Leadership Board meeting, the Liverpool Providers Joint Committee meeting. MS chaired the Council of Governors meeting and Annual Members Meeting (AMM) and the Annual Accounts were signed off at the AMM.

5.3 JR advised that there was a change in the expectation for Chairs and Non-Executive Directors with regards the level of operational activities they were engaged in. MS stated that at the Liverpool Trusts Joint Site Committee meeting the Chief Executives had been tasked with reviewing the various Joint Site Sub Committee meetings to ensure that the right people were in attendance.

5.4 MS noted that it had been hoped that a senior Labour shadow spokesperson for Health and Social Care could visit the Trust while the Labour conference took place in October, but this had not been possible due to busy agendas. It was hoped that a visit could be arranged in the not too distant future.

5.5 JR reported that during the recent industrial action, 14% of Consultants and 50% of Junior Doctors had participated in industrial action at the Trust.

5.6 JR alerted the Board that the Trust had been named in the Times newspaper for allegedly paying approximately £7,853 for a single neurosurgery shift during the recent consultant industrial action. JR clarified that the allegations were false and that the Trust had used the tariff approved by the integrated Care Board (ICB) for each shift covered within the strike period. The amount quoted was the total of what had been paid throughout the strike period. The true position had been communicated to stakeholders and the ICB.

5.7 KH asked about the system cost for the industrial action and if the Trust had a fixed rate to cover shifts during the strike periods and a methodology to measure the impact of the strike on patients. MB responded that the Trust used the tariff approved by the ICB to make payments. JR stated that it was difficult to measure the true impact of the industrial action with unscheduled as well as cancelled activities and the income therefore lost; there was no methodology of capturing the impact on patients.

5.8 AN advised that clinical risks were difficult to quantify and that NHS England (NHSE) had written to the British Medical Association (BMA) about their concerns with regard to the clinical risks that had arisen as a direct impact of the strike actions.

5.9 SR noted that a paper had been presented at the Business Performance Committee Meeting which provided assurance on the financial and clinical risk management during the recent periods of industrial action.

5.10 JR reported that the COVID 19 inquiry was still ongoing, and LV was now the Senior Responsible Officer for this. The Walton Centre Charity Snowdownia fundraising walk was held on 29 September 2023, JR, JE and a number of other staff were in attendance.

5.11 NHSE had released a sexual safety charter and the Trust was in the process of signing up to this. A task and finish group had been established to identify how the Trust could ensure the safety of female staff and support them to speak up and be listened to on gender related issues and concerns.

5.12 DT commented that it was another example of inappropriate behaviour hiding in plain view. He welcomed the task and finish group. JR stated that it was a societal issue and had been recognised as an issue prevalent within the NHS and that plans were underway to establish a staff network group and that lots of staff had indicated their interest to participate in the group. The Communications team would follow up on this to ensure staff at the right levels were involved in the group. JR suggested that discussions about the sexual charter be included in the Board Development sessions and this was welcomed.

5.13 SR enquired if there had been any cases of sexual harassment reported through the Freedom to Speak Up Guardian. JR answered that none had been received.

5.14 SR sought clarity with regards the new Stroke Emergency Assessment Centre (SEAC) that had been opened at the Aintree site and its impact on the Trust. JR stated that it was part of the Mid-Merseyside Collaboration on stroke services in the region and it was aimed at providing specialist care for stroke patients, thereby minimising the impact of strokes, and improving the chances of a good outcome following treatment. There was a likelihood that this would result in an increase in Thrombectomy cases. JR advised that the Trust was part of the planning team for the SEAC and that she was the Senior Responsible Officer for stroke in Cheshire and Merseyside.

The Board noted the Chair and Chief Executive reports.

6 Trust Strategy Update

6.1 LV presented an update on the Trust Strategy for quarter two (Q2) and highlighted that good progress had been made against the target areas for Q2 and that quarter three priorities had been mapped out. An update on the Trust Strategy at 12 months had also been presented at the Board Away Day in October.

6.2 LV stated that plans were underway for an extended Team Brief to mark one year of the strategy and that updates would now be presented thrice a year to Board. Going forward the report would be presented in the template used for the enabling Substrategies to better track and reflect what had been done.

6.3 JR stated that great progress had been made in year one because a lot of the target areas were areas that the Trust had been working on and noted that progress on the other target areas might not progress as quickly as the previous quarters.

ACTION: LV to send The Trust Strategy slides from the Board Away Day to DT and RW.

The Board noted the Trust Strategy Update

7 Finance and Commercial Development Substrategy Quarter 1 & 2 Update

7.1 MB presented the quarter 1 and 2 Finance and Commercial Development (FC&D) Substrategy update and highlighted that good progress had been made in quarters 1&2 and objectives had been set for quarter 3.

7.2 MB stated that regular presentation of the monthly finance position at the Staff Partnership Committee had begun and there had been an increase in the Trust's compliance against the Better Payment Practice Code (BPPC) from 82.9% in March 2023 to 89.3% in August however this remained below the target compliance level of 90%. Nevertheless, progress continued to be made.

7.3 It was noted that an initial model Service Level Agreement (SLA) had been designed by the Finance Team to ensure that all contracts were standardised, and the right level of income was generated for the services provided. A Priority Group had been set up to make decisions with regards the phasing and timing of capital investments and the shift in capital priorities.

7.4 MB presented an overview of risks to the delivery of the FC&D Substrategy and stated that more work was to be done by the Finance team towards the development of a stronger link between this and the Digital Substrategy to better understand future projects and any funding that could be available.

The Board noted the Finance and Commercial Development Substrategy Quarter 1 & 2 Update.

8 Violence and Aggression Strategy Update

8.1 MD presented the Violence and Aggression (V&A) Strategy Update and highlighted that the Trust was fully compliant against 30 of the 42 criteria of the Violence Prevention and Reduction (VPR) Standards. Since commencing in post, the Personal Safety Lead had developed an underpinning work plan to ensure the Trust was fully compliant with the National VPR Standards and delivering the objectives of the Trusts Violence and Aggression Strategy.

8.2 MD reported that some of the areas of non-compliance were with regards to data which had not been previously captured. The data would be gathered over several months to allow the team to generate a report that reflected the Trust's compliance rate. The Trust had now begun annual V&A training for staff, previously this was only every three years.

8.3 JR enquired if the workplan addressed all the gaps and areas of non-compliance and the governance of the workplan. MD stated that a detailed work plan for all gaps had been developed along with anticipated dates of completion for each non-compliant criterion and that the plan was monitored on a quarterly basis through the Health, Safety and Security Group.

8.4 JR asked if the information available provided enough data to tackle the issues highlighted. MD agreed and responded that good progress had been made in reducing the numbers of repeat offenders and highlighted that some of the incidents arose as a result of discharge delays for patients who were fit for discharge and were frustrated.

8.5 DT questioned if the tools adopted for the formal debriefing process were new. MD replied that the policy was that staff should always debrief following an incident and there had not been a formal way of recording this previously. The new formal debrief protocol was now in place and was captured on the Trust's risk management reporting system. The Trust had also put in place an incident management scheme in recent years; this had been monitored through the risk management system to record the extra support offered to staff after an incident has occurred.

8.6 NM stated that the investment into the V&A Advanced Nurse Practitioner (ANP) had been positive and that there had been significant improvement since the role had been developed.

8.7 RW asked if data was also captured on incidents from staff that were not directly employed by the Trust. MD stated that the data captured all incidents that happened within the Trust.

8.8 RW asked if it was a requirement that the V&A Strategy came to Board and if oversight of V&A should also be done through the Quality Committee for more scrutiny. KD confirmed that it was a requirement that the Board received updates on progress against the Strategy and that assurance was been given to the Quality Committee on V&A through the regular Clinical Governance reports. KD added that as part of the current review of Committee Structures health and safety would move to Business Performance Committee (BPC) and she would ensure that the V&A Strategy update was reviewed here before Board.

ACTION: KD to include the Violence and Aggression Strategy Update in the BPC Cycle of Business.

8.9 SR asked if the Trust had situations when the police were called and if there had been instances when the Trust had to exclude people form the premises. MD answered that there had been very few incidents that required the police and that although there were some instances when the Trust had to issue sanctions to patients with capacity and visitors, the Trust rarely excluded people.

8.10 SR inquired how often incidents of V&A had resulted in staff being off sick. MD stated that this did happen, this was captured within the report and the Human Resource team also received data on this area.

The Board noted the Violence and Aggression Strategy Update.

9 Liverpool Providers Joint Committee Key Issues Report

9.1 JR presented the key issues report from the Liverpool Providers Joint Committee (LPJC) meeting which was held on 27 July 2023 and highlighted that the Committee received an update on the activities of the individual Joint Site Sub-Committees and a presentation on the Liverpool Electronic Patient Record Review.

9.2 JR stated that the Chief Executives had been tasked to discuss the make-up of the Sub-Committees to ensure the right people were on them to ensure progress on the individual site workplans.

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

10 Integrated Performance Report

10.1 JR introduced the Integrated Performance Report (IPR) and highlighted that there had been an increase in mandatory training and appraisal compliance and that the Executive Team maintained oversight of these through monthly updates. JR noted that the number of 52 weeks waits and the industrial action had been areas of concern.

10.2 The Safe Care data had been included for the first time and it would continue to be amended to help the Board understand and provide assurance against safe staffing levels and incidents. The Trust had performed well financially to month 5, with a surplus in month of £273k and year to date of £2,285k. JR highlighted that check and challenge of the IPR had been undertaken at Board Committees and the Chairs of the relevant Committee would present this as part of their assurance reports.

The Board noted the Integrated Performance Report.

11 Business Performance Committee Chair's Assurance Report

11.1 DT, as Chair of the Business Performance Committee (BPC) presented the key issues report and stated that most of the items discussed at the meeting formed part of the Board meeting. DT highlighted that the Trust continued to perform well on cancer and diagnostics and reiterated that there was a risk that performance would be impacted as a result of the ongoing industrial action.

11.2 DT reported that the Committee had received a review of the measures taken to mitigate the impact of the recent industrial action to avoid patient harm and ensure safety, and it was highlighted that there had been a significant impact on activity, an increased strain on resources for those leading the mitigations which meant a reduction in capacity to accommodate for other priorities.

11.3 A report on the Trust's digital provision and maturity carried out by Public Digital was received by the Committee together with an action plan to follow up on the recommendations as endorsed at the private Board meeting in September.

11.4 DT stated that there continued to be a high turnover of non-clinical staff. One of the reasons was a lack of consistency as to how bandings were agreed across different Trusts. He asked if this could be looked into at the regional level. JR stated that although the Trust could highlight that other Trusts had been deviating from the nationally agreed guidelines, there were limited options as Trust's had some flexibility to pay differently in situations where they had difficulties recruiting into a role. JR noted that the variation in pay was mostly with regards to the medical workforce.

11.5 MG noted that this was recognised nationally and that there was ongoing work in the system with regard to this.

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

12 Quality Committee Chair's Assurance Report

12.1 RW as Chair of the Quality Committee (QC) presented the key issues report and noted that although safeguarding training had improved, it still remained below target and a trajectory plan for meeting targets had been requested by the Committee.

12.2 RW highlighted that sepsis compliance had been noted to be low on the Minerva system however it had been confirmed that the data was incorrect and a long-term IT solution to resolving issues relating to patient reviews not being recorded on the system was being explored. Manual mitigations were in place pending the resolution of the IT issues.

12.3 RW noted that there had been an increase in the number of patients falling, however there had been no increase in falls with harm, and the Committee had requested for a deep dive on to be presented at a future meeting. Venous Thromboembolism (VTE) rates for August were at 100% and given the rapid improvement in the figures the Committee had requested for a review to provide assurance that the data was accurate.

12.4 SR stated that at the last Audit Committee Chair's meeting, it had been suggested that the Audit committee be renamed as the Audit and Risk Committee. KD commented that the Audit Committee already had an oversight on the system of risk management but it did not manage risks and there was a danger that if it was renamed, other Committees might not consider that they need to provide oversight on risks which was a responsibility of all Committees and the Board.

12.5 MS commented that there did not appear to be a great deal of concerning movement on the IPR since the last meeting which supported the decision to move meetings to bi-monthly.

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

13 Freedom to Speak Up and Fit and Proper Persons: Learning from the Lucy Letby Trial

13.1 NM presented the Freedom to Speak Up and Fit and Proper Persons: Learning from the Lucy Letby Trial and highlighted the various speaking up platforms available within the Trust. A lot of work had been done to increase the number of Speak Up champions in the Trust and 25 staff had indicated their interest in this, three of whom were Consultants.

13.2 KH asked if the Trust knew if there was any noted cultural bias about speaking up, for example did internationally recruited staff speak up. NM stated that discussions were ongoing amongst Cheshire and Merseyside Chief Nurses about focusing on areas where staff were not speaking up and what could be done to address this. JR confirmed that the Trust monitored the FTSU report and periodic updates were presented at HIIC. SR asked how the Trust could overcome any cultural barriers to speaking up. NM stated that actions within the plan that had been put in place to address this. MG added that a training programme on the Culture of Conscious Inclusion was being rolled out and that approximately 60 staff had been trained to date, with plans to include more staff.

13.3 SR noted that the report showed that staff had started to utilise the various FTSU platforms put in place by the Trust, rather than raising concerns directly with the Care Quality Commission (CQC).

The Board noted the Freedom to Speak Up and Fit and Proper Persons: Learning from the Lucy Letby Trial report.

14 Liverpool Place Procurement Proposal: Strategic Outline Case

14.1 KT presented the Strategic Outline Case for the Liverpool Place Procurement Proposal (HPL) to expand the shared procurement service across all Liverpool Trusts. An overview of the background to the formation of HPL was provided along with some of the successes and efficiencies realised since the inception of the model.

14.2 KT noted that the service would potentially mean an additional 57 Procurement staff joining the team to create the shared function that would actively manage over £400m of non-pay expenditure and this equated to over 50% of the total Cheshire & Merseyside procurement influenceable expenditure. The HPL expansion would facilitate the improved use of resources to improve the current service, strengthen procurement and support the system.

14.3 A single business case was to be developed and presented for approval by all Trust Boards in December 2023/January 2024.

14.4 JR advised that there were risks associated with the implementation of the system, but that the HPL system was a point of success and exemplified the benefits of collaboration across the region. JR thanked KT and the procurement team for their work to get HPL in place and working.

The Board approved the Liverpool Place Procurement Proposal: Strategic Outline Case to progress to the due diligence stage.

15 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

15.1 MG introduced the report and stated that the WRES and WDES included perception-based indicators from the 2022/23 survey and that a new survey was currently being rolled out for 2023/24. Due to the ongoing industrial action, the report had not been presented at the Equality Diversity and Inclusion (ED&I) Group and at HIIC as the meetings had to be rescheduled but noted that the reports would be presented at the next Committee and ED&I Group meetings.

Workforce Disability Equality Standard (WDES)

15.2 ES presented the WDES report and highlighted that there had been a disparity between the number of staff that reported that they had a disability on the Trust system and those who had indicated that they had a long-term condition in the staff survey. The difference in wording may indicate a reluctance to register a disability. AN observed that there were a lot of staff with long-term conditions who did not identify as being disabled which could account for some of the difference.

Workforce Race Equality Standard (WRES)

15.3 The WRES report was presented by ES and it was highlighted that there had been some challenges and that the number of staff that felt discriminated against by their managers was a particular concern. An external review in this area had been carried out by the Trust in 2022/23 and two proposals had been accepted from the external reviewers to support the Trust.

15.4 The Trust had in place a train the trainer programme which was aligned with building a culture of conscious inclusion and it was proposed that this became mandatory for all line managers. A support package had been implemented to look at the retention, career progression and appraisal process for black and minority ethnic staff to ensure the Trust was giving support to all staff.

15.5 MS asked if the actions outlined in the plan were sufficient to tackle the issues highlighted, were there completion dates for all the actions in the plan and asked when the People Substrategy would be presented to the Board. MG stated that the People Substrategy had been presented at the last BPC and would be presented to the Board in December. The actions highlighted within the plan were designed to address all the issues and the actions from a number of sources had now been brought into a single ED&I plan.

15.6 JR stated that the ED&I lead gap had meant that the Trust had been limited to what it had been able to address, but it was anticipated that the new action plan would address this. Discussions were ongoing within the executive team on how oversight of the action plan would be maintained. RW suggested that the actions listed in the action plan be scrutinised and approved by the HIIC and ED&I Group.

15.7 KD suggested that it would be helpful to know the numbers of BAME staff that filled out the survey as the results were all in percentages and if the number of respondents were small some of the findings may not show the true picture. AN agreed, noting that more than 25% of black and minority ethnic staff were Consultants and many others were not computer based and often their participation rates in the staff survey were lower.

The Board noted the report and agreed the direction of action set out to drive improvement in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) report.

16 Trust Wide Mortality Report: Learning from Deaths, Quarter 1 Report, 2023/24

16.1 AN presented the 2023/24 Trust Wide Mortality and Learning from Deaths, Quarter 1 report and highlighted that additional processes had been put in place to scrutinise deaths and that all deaths were investigated by the Medical Examiner. Further processes were in place at the Mortality Surveillance Group which looked into all deaths and would recommend further detailed reviews where needed.

16.2 It was noted that the Learning from Deaths Policy was currently being reviewed to include details from the Patient Safety Incident Reporting Framework (PSIRF) policy and would be presented to the relevant groups, Committee and the Board.

16.3 AN stated that the Q1 data collected by the Intensive Care National Audit and Research Centre (ICNARC) had indicated that there had been an increase in the number of deaths for patients who were predicted to have a mortality risk of less than 20%. The Trust's overall mortality rate had been within the expected range. The Trust's Mortality Lead was leading a clinical panel to review the ICNARC/Mela Data together for those patients classified as less than 20% risk of death, with the initial mortality and in-depth reviews. This would be monitored through the Mortality Surveillance Group and the outcome, and any actions, would be included in the Q2 Mortality report.

16.4 SR asked if the information on people with learning disabilities and from a black and ethnic minority background (BAME) could be reflected in the report. AN stated that that the report could include BAME patients and those for patients with learning disability were reported separately as this was a requirement.

16.5 SR enquired if there had been any patterns noticed with regard to the deaths of patients. AN stated that these were looked for as part of the review process and would be highlighted where identified.

The Board noted the Trust Wide Mortality Report: Learning from Deaths Report 2023/24.

17 Freedom to Speak up Guardian Report

17.1 JK presented the Q1 Freedom to Speak Up (FTSU) Guardian report and highlighted that nine cases had been reported in Q1. Plans were underway for the Speak Up Month during October including additional drop-in sessions, Walkabouts, raffle draws, quizzes, the launch of additional Speak Up Champions and pop-up stands. The Trust had 85% compliance on the FTSU e-learning training module and 25 people had indicated interest to become FTSU champions, 10 of which had been trained.

17.2 RW asked what the benchmark score for the e-learning training compliance was. JK stated that there was no national benchmark, but the Trust had set its target at 80%.

17.3 DT noted one of the comments that stated that “it is very hard to speak up at the Walton Centre” and if it was a perception held by the majority of staff within the Trust. JK stated that those who raised concerns with her always gave positive feedback about the process, but there were instances were staff felt that their concerns had not been dealt with because there was not an opportunity to communicate back to them on what had been done where concerns had already been acted upon. This was usually due to confidentiality requirements.

17.4 LV asked what more the Trust could do to ensure leavers completed exit interviews. JK stated that there was a need for a review of the exit interview process to include the details of the FTSU Guardian and for paper copies to be filled out by most clinical and medical staff as they seldom logged on to their emails.

17.5 RW stated that the report did not provide an acceptable level of assurance and suggested that the assurance level be changed to partial as there was a lot of work to be done which remained in progress and this was agreed.

17.6 DL asked what plans had been put in place to launch the Listen Up e-learning training module which was the next module. JK stated that plans were in place to roll out the Listen Up module for everyone and noted that there would be a ‘follow up’ module to be undertaken by line managers.

The Board noted the Freedom to Speak up Guardian Report.

18. Health and Safety Awareness Report

18.1 SBR presented the Health and Safety Awareness Report and outlined the current arrangements put in place by the Trust to improve health and safety (H&S) awareness. A Health and Safety Group had been set up which was headed by the Acting Chief Nurse and received reports on the H&S audit tool.

18.2 It was noted that the Trust's current training compliance rate for H&S was at 96%. Mandatory training was delivered face to face for new starters and then moved to triennially to be completed via the Electronic Staff Records (ESR) platform.

18.3 SBR stated that departmental health and safety assurance visits had been conducted to determine if the Trust's H&S arrangements were sufficient and to identify areas for improvement. Following a full review of the audit tool, areas for improvement had been identified to ensure the effective monitoring of departmental health and safety arrangements.

18.4 KH enquired if the shortfalls found with processes and compliance was mostly due to lack of training or non-compliance with training. SBS responded that this was due to both non-compliance and lack of training.

The Board noted the Health and Safety Awareness Report.

19 Neuroscience Programmes Board Key Issues Report

19.1 AN presented the key issues report for the Neuroscience Programmes Board meeting held on 23 September 2023.

19.2 SR sought clarity with regard to the request by the ICB to pause the Cheshire and Merseyside Rehabilitation Network review. AN stated that it was a long-standing issue as the ICB had been unable to nominate a lead/responsible senior officer (SRO) sponsor but that alternative approaches were being developed.

The Board noted the Neuroscience Programmes Board Key Issues report.

20 Remuneration Committee Key Issues Report

20.1 MS presented the Renumeration Committee Key Issues report from the meeting held 4 September 2023 and highlighted that the Committee had approved the appointment of a new non-voting Executive Director for the Trust to lead on Digital, agreed to progress with the recruitment of a Chief Nurse and agreed in principle a Mutually Agreed Retirement Scheme (MARS) for 2023/24.

The Board noted the Remunerations Committee Key Issues Report.

21 Consent Agenda

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

- **NHS England Health Education Providers Annual Self-Assessment**
- **Modern Slavery Act Statement**
- **Medical Revalidation Annual Report**

22 Any Other Business

Guardian of Safe Working Annual Report 2022/23

22.1 CB presented the 2022/23 Guardian of Safe Working Hours Annual Report and noted that there had been 22 exception report in the year. Most of the exception reports were in respect to the mandatory overnight five hours of continuous rest for on call neurology registrars.

22.2 AN stated that the 22 exception reports were predominantly for one group of staff. The Trust could implement a shift working pattern for the group of doctors to resolve this, but it had been resisted as it would have a negative impact on their training. The Trust would continue to work to find a solution to ensure that the quality of their training was not impacted whilst ensuring that they complied with the minimum rest requirements.

22.3 AN advised that the issues were predominately with regard to the thrombectomy service. It was recognised that several measures had been put in place that helped but they had not been enough, additional SMART nurses had been provided but there was need for a more significant revision. There was a real concern from staff about the thrombectomy suitability criteria being widened and the potential impact of this on staff within the service. Short term measures would be put in place which might impact on other staff but a medium to long-term plan was needed to bring sustainable improvements for this group of doctors.

22.4 DT asked what the timeline for the completion of actions would be to improve the service. AN responded that there were several options being considered but it was recognised that change was needed at speed JR reiterated that there were some short-term plans in place to help resolve the issues and that an understanding and clarity on what each staff group does for a Thrombectomy would help.

The Board noted the 2022/23 Guardian of Safe Working Annual Report.

22.5 There was no other business to be discussed.

23 Review of Meeting

23.1 Those present agreed that the meeting had had a strategic focus, good debate and necessary assurance had been received. Although the information in some of the reports was not as the Board would wish it exemplified that the Board was transparent in all its dealings.

23.2 MS thanked KH on behalf of the Board for service to the Trust and input over the years as she retired from her role as Non-Executive Director in October.

There being no further business the meeting closed at 13:35

Date and time of next meeting - Thursday 7th December 2023 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	✓	✓	✓	✓	✓	✓		
Mike Gibney	✓	✓	✓	✓	✓	✓		
Karen Heslop	✓	✓	✓	✓	A	✓		
Debra Lawson	N/A	N/A	N/A	N/A	✓	✓		
Paul May	✓	✓	✓	✓	✓	A		
Andy Nicolson	✓	✓	✓	✓	A	✓		

Nicky Martin	N/A	N/A	N/A	N/A	✓	✓		
Su Rai	✓	✓	✓	✓	✓	✓		
Jan Ross	✓	A	✓	✓	✓	✓		
David Topliffe	✓	✓	✓	✓	✓	✓		
Lindsey Vlasman	✓	✓	✓	✓	✓	✓		
Ray Walker	✓	✓	✓	✓	A	✓		

PUBLIC TRUST BOARD
Action Log
December 2023

	Complete & for removal
	In progress
	Overdue

Open Actions

05/10/2023	Item 6	**Trust Strategy Update** LV to send The Trust Strategy slides from the Board Away Day to DT and RW	LV	Completed	October 2023	
05/10/2023	Item 8 Para 8.8	**Violence and Aggression Strategy Updates** KD to include the Violence and Aggression Strategy Update in the BPC Cycle of Business	KD	Complete. V&A Strategy update to be presented twice a year at BPC.	October 2023	

Actions for future meetings

06/07/2023	Item 7 Para 7.4	**Communications and Marketing Substrategy** Update on stakeholder engagement to be provided to Board.	JR	Stakeholder Mapping exercised completed at Board Away Day 1 November 2023.	~~7 December 2023~~ February 2024	
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.	MG		4 April 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		4 April 2024	

Report to Trust Board
7 December 2023

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

- Change of Health minister
- NHS England Letter re: Financial challenges
- Operational pressures across the system
- Ongoing system changes

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

National Update

1. On 8 November NHS England (NHSE) issued a letter to all Trusts requesting support to 'address the significant financial challenges created by industrial action in 2023/24, and immediate actions to take.' The Trust therefore was requested to forecast the activity and financial plan based on the requested action in the letter and changes to Elective Recovery Funding (ERF) thresholds. An extraordinary board took place on 17 November 2023 to agree the revised plan for submission to the ICS which was accepted without any further changes.

2. On 14 and 15 of November NHS Providers (NHSP) held their annual conference, this year's theme was ***Vital!***, representing the essential care the provider sector delivers, the deep commitment of staff, and the importance of ensuring our health service is sustainable for the future. We had a mixture of keynote speeches, panel discussions, interactive breakouts and networking opportunities, focussing on the key issues facing provider sector leaders. Both the chair and I attended.

3. November was politically a very busy month, with the Health Secretary the Rt Hon Steve Barclay MP being replaced by Rt Hon Victoria Atkins MP, who spoke at the NHSP conference about her commitment to resolve industrial action and deliver the current financial plan as well as funded workforce plan.

4. **Industrial Action:**
   The British Medical Association (BMA) re-ballot of consultants opened on Monday, 6 November and closes on 18 December 2023. In addition, the same process will apply to SAS doctors with the HSCA ballot of Junior Doctors closing on 20 December. Talks are continuing with Government to try to resolve the issues. However, the potential industrial action dates will be between January and June 2024.

Cheshire & Merseyside Integrated Care System

5. Jane Tomkinson was announced as the CEO of The Countess of Chester Hospital. She had been supporting the Trust since December 2022. This leaves a CEO vacancy at Liverpool Heart and Chester Hospital who are currently reviewing options.

6. Operational pressures across the system have increased with the key issues being an increase in the number of patients in acute hospital beds not meeting the criteria to reside, a deterioration in four-hour performance with over 17% of patients being in an accident and emergency department for over 12 hours.

CMAST Update

7. The Leadership Board of the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) have met twice, in October and November, since the last CEO report.

8. The October meeting was focused on delivery against the CMAST workplan and the following headlines were noted against the different work programmes.

9. **Diagnostics Programme**
    - Against a backdrop of an overall increase in activity there has been a reduction in waiting times across specialities, including 100% reduction in patients waiting 79 weeks+ and 74% reduction in patients waiting 26 weeks+.
    - Increased productivity has been achieved through the introduction of single guidelines and productivity tools meaning performance can be monitored more accurately across Cheshire and Merseyside (C&M)
    - A number of key decisions on significant direction of travel issues have been taken in the first part of the year to further the following workstreams within the diagnostics programme:
        - Pathology target operating model
        - Pathology LIMS (Laboratory Information System)
        - Endoscopy transformation

10. Anticipated 2023/4 next steps and delivery milestones were identified as:
        - enhanced mutual aid offer to harmonise waiting times
        - continued development of shared digital systems
        - workforce – interventional radiology, workforce growth and development
        - development and testing of risk and gain share mechanisms
        - increased use of Artificial Intelligence (AI) deployment across diagnostics

Elective programme

11. 2023/4 delivery headlines:
    - Waiting lists and Patient Tracking List (PTL) management:
        - C&M were one of the only ICBs in the country to eliminate 104 week waits in line with deadlines
        - C&M Elective Recovery Fund (ERF) performance has tracked 2% higher than the England average since May
    - Reducing variation in care:
        - Mutual aid for over 6,500 patients from eight different trusts throughout C&M has been facilitated
    - System resources:
        - C&M theatre utilisation performance started in the 2nd quartile a year ago, and rose to 4th best in the country during August
        - Over 2,600 patients have been treated in the shared elective hub

12. Anticipated 2023/4 delivery milestones:
    - Waiting lists and PTL management
        - C&M are on track to eliminate 65 week waits by the end of March 2024
        - Over 110,000 patients have been cleared from the potential breach cohort since April
    - System resources:
        - The second cohort of attendees will be starting Theatre Academy to ensure the spread of best practice techniques throughout C&M

Clinical Pathways Programme (CPP)

13. 2023/4 delivery headlines:
    - The CPP Programme continues to follow its established methodology while continuing to follow identified road maps for orthopaedics, dermatology and Ear, Nose and Throat
    - A current state assessment has been undertaken for gynaecology with the first workshop held over the summer

14. Anticipated 2023/4 next steps and delivery milestones:
    - Orthopaedics – the risk stratification project currently ongoing in all Trusts that deliver orthopaedic services will conclude and further pathway standardisation will be progressed
    - Dermatology – Continued focus on exploring the potential use of technology within the specialty, through establishment of pilots and stocktaking existing projects
    - Ear, Nose and Throat – Further development of the collaborative alliance with key focus on workforce with support from the workforce programme
    - Gynaecology – Prioritisation and evaluation of opportunities to agree an improvement roadmap
    - Connecting with other workstreams to maintain connection when identifying and scoping of further specialties for inclusion in the programme

Finance, Efficiency & Value – Efficiency at Scale

15. 2023/4 delivery headlines:
    - Programme Director is in place and funding for the programme has been secured for 2023/4 and 2024/5
    - Principles and a workplan for 2023/24 have been established for efficiency at scale. The workplan is aligned to the National Corporate Services Transformation Programme
    - Highlights from workstreams include:
        - Funding for the medicines optimisation workstream has been secured for 2023/4 and 2024/5, a single governance structure is now in place for medicines to support this
        - A full procurement governance structure is in place and the Integrated Care Board (ICB) Chief Procurement Officer commenced in September
        - An additional indemnity insurances review has been completed and £2.1m identified for review across C&M
        - A business case in under development for a single financial ledger and is supported by all trusts in C&M

16. Anticipated 2023/4 key targets include system delivery and contribution to:
    - Medicines management will deliver an estimated £10m of savings in 2023/4, subject to continuation of ICB investment in infrastructure
    - Procurement initiatives will deliver a £5m full year effect although the full value will not be realised until 2024/5
    - Planning to support finance and legal workstreams to potentially release up to £1m in savings in 2024/25

Workforce

17. 2023/4 delivery headlines:
    - A detailed analytical review of workforce and benchmarking exercise has been completed with all C&M providers in conjunction with the ICB and the efficiency at scale programme
    - Allied Health Professionals (AHP) Faculty has been established with a robust system wide workplan
    - Clear priorities and strategic workforce plan have been developed and aligned to support focus areas for the elective recovery and clinical pathway programmes
    - A number of pilot sites have been identified to facilitate testing of a career pathway aimed at Band 6 ward nurses to support retainment and career progression
    - After undertaking scoping exercises and in conjunction with system partners it has been agreed not to pursue projects at this time around developing a Healthcare Assistant (HCA) collaborative bank or midwifery trainee nursing associate role.

18. Anticipated 2023/4 delivery milestones will support delivery of objectives by:
    - Ongoing funding will not be provided for the workforce programme in 2024/5
    - A refocusing of the programme to identify commitments moving beyond 2023/4 has commenced.

19. In November the focus of the meeting was on emerging priorities and activities in digital and workforce. The need to prioritise and to target activity was discussed as was the opportunity for Trusts to consider the best way to maximise effort, secure improvements and, if possible, to achieve efficiency. The Board welcomed the presentations and identified the need for a facilitated exploratory and prioritisation discussion on these subjects at its next meeting.

Infection Prevention and Control

20. The winter Flu vaccination campaign continues with several internal initiatives to encourage staff to take up the vaccine. Uptake from medics remains low and continues to be encouraged. This appears to be a similar picture across the region.

21. COVID 19 vaccinations are available to all staff via the Aintree hub, again uptake numbers remain low.

Trust Update

Investors in People Re-accreditation

18. The Trust is in the process of undertaking its 3-year reaccreditation process for the Investors in People Gold Awards for the 'we invest in people' and 'we invest in wellbeing' standards. Further to the staff surveys undertaken in July and August, the onsite assessment commenced on 20 November and will continue until 1 December 2023. During this time, the assessor will speak to a range of staff from across the organisation through showcase presentations, focus groups and interviews. Initial informal feedback will be received on the 4 December with the full report being brought to Trust Board in February 2024.

Good News

Innovation Update:

19. £198k has been awarded by NHSE to support the next development phase of the Trust's Headache Chatbot the aim of which is to support the triage of headache patients resulting in reduced waiting times and enhanced patient experience.

20. £94k has been awarded by the National Institute for Health and Care Research (NIHR) to undertake a feasibility and acceptability study of VERA in a community-based setting. **V**irtual **E**ngagement **R**ehabilitation **A**ssistant is a mobile digital portal that has been co-designed by patients, their carers, clinicians and researchers. The research will be undertaken by the University of Central Lancashire.

Starters & Leavers

21. Following a robust recruitment process Nicola Martin was appointed as The Walton Centre's Chief Nurse. Recruitment is underway for a Deputy Chief Nurse.

22. Recruitment continues for our Chief Digital Information Officer (CDIO) with timelines established and interviews to take place in the new year.

Trust Strategy

23. The Trust continues to deliver on the Trust Strategy and the strategic ambitions, monitoring these through the Strategic Project Management Office (SPMO). A Quality Improvement (QI) away day has been held in the Lecture Theatre in Sid Watkins building with a focus on strategy, collaboration, and QI; there was several external partners, and the feedback has been very positive.

24. The One Liverpool Partnership Board will oversee the refresh of One Liverpool, the city's Health, and Care strategy. The Walton Centre will be engaging in this process and have shared our trust strategy with the team, workshops have been arranged to progress with this work.

Estates & Facilities

25. As part of ongoing work for Reinforced Autoclaved Aerated Concrete (RAAC), NHSE issued additional guidance in May 2023, asking all trusts to assess their estate based upon new this guidance. Although the Walton Centre or Sid Watkins Building do not fit into the criteria, a review of both buildings has been conducted following the guidance from the Royal Institute of Chartered Surveyors (RICS). These investigations have revealed that no RAAC is present within either building. This review was presented to the executive team in November 2023.

26. The Linen and Laundry Contract Recommendation paper is due to be presented today at closed board and will be progressed accordingly.

27. The PLACE inspection took place on 15 November and the results will be shared with the Trust Board once the final results have been received.

28. Plans for the replacement of the Air Handling Unit continue with a working group in place and mutual aid discussions are ongoing with LUHFT for theatre capacity.

29. The Heating and Pipework project is on track and in the final phase.

Business as Usual

Quality

30. The Trust remains below trajectory for all Hospital Acquired Infections, with exception of Clostridium Difficile (CDIFF) and Pseudomonas. The Trust Target for C Diff was 6 and is currently at 8 and 1 for pseudomonas and currently at 2. An investigation for all cases has taken place and actions identified.

31. Cairns ward accreditation has taken place with GOLD standard maintained.

32. The lead Epilepsy Specialist Nurse has had an abstract accepted for NHS England's Centre for Advancing Practice Conference 2023 relating to preconception healthcare for women with epilepsy.

33. The Cheshire and Merseyside Rehabilitation Network (CMRN) is celebrating its ten-year anniversary this year. There is a staff and patient event planned for 13 November 2023 which will include stakeholders and collaborative partners.

34. The newly developed Specialist Rehabilitation Nursing Competency Framework is due to be launched in November 2023 across all our CMRN rehabilitation inpatient units. A storyboard video regarding the framework, its development and purpose has just been completed we are just awaiting the final version from the design company.

35. The Lead Epilepsy Specialist Nurse was invited to Downing Street in October 2023 by the Minister for Science, Research and Innovation for a reception for the launch of Epilepsy Research Institute UK.

36. One of our Registered Nurses on Dott ward has been invited to Buckingham Palace to a reception with the King to celebrate the contribution of Internationally educated Nurses and Midwives working in the UK's health and social care sector.

Finance

37. Financial performance for October and year to date is in line with the plan. The Trust delivered a surplus in month of £267k. Year to date the Trust is showing a £2,8m surplus. The full year plan is a £4.1m surplus. There has been over performance in income mainly driven by Agenda for Change (AFC) pay award funding which is matched by the over performance in expenditure. Other income over-performance relates to overseas patients, Scottish and NI income, HEE funding and some over-performance against the NHSE elective threshold target. There are still areas of cost pressure, notably in homecare drugs and utilities though this pressure has reduced.

38. Capital continues to underspend year to date driven in the main by heating and pipework and the air handling units schemes being underspent against plan. It is hoped that the contract for the air handling units will be finalised soon and spend is expected to start on the scheme in quarter 4. The Cost Improvement Plan (CIP) has delivered in full year to date, however 73% has been delivered recurrently (when the ICS had informed all providers that 100% needed to be delivered).

39. The current Cheshire and Merseyside (C&M) financial position at month 7 (October) is a £143.9m deficit against a planned deficit position of £73.9m (£70.0m adverse to plan). This is driven by several factors including industrial action, prescribing pressures and continuing healthcare packages (CHC).

40. Recently it was announced that given the pressures due to industrial action, £1.1b would be provided to Integrated Care Systems (ICS)'s to manage the financial pressures throughout the country. This included £800m of expenditure within national budgets and funding announcements and £0.3m of additional income through further reducing the elective thresholds. As part of this investment, a balanced financial position was required from each ICS following the receipt of their share of the £1.1b.

41. Each provider in the ICS was requested to reforecast their position following this announcement given the current gap in C&M. The Trust were able to commit to an additional £2.8m surplus following this exercise which was driven by activity across the Specialised Commissioning and ICS contracts (helped by the lowering of the thresholds) offset by some reductions in high-cost drugs. The draft final re-forecast position approved by board on the 17/11/23 was £6.9m. We await confirmation from the ICS that this is an agreed financial plan update. Further information on the re-forecast process is included in the board paper from 17/11/23.

Emergency Preparedness, Resilience and Response (EPRR)

42. NHS England (NHSE) have reviewed the EPRR Annual Assurance process for 2023/24 and agreed a further enhanced assurance arrangement using the EPRR Core Standards by introducing an evidence-based check and challenge process, this is a new process for all trusts to achieve compliance of the standards and we are now required to submit evidence to support this self-assessment.

43. The Trust submitted a provisional self-assessment of partial assurance, and this was shared with the Business Performance Committee and the Trust Board, NHSE completed a full review of the evidence with a check and challenge process and compliance was assessed as non-compliant.

44. All Trusts within Chesire and Merseyside have been rated as non-compliant and this is due to the change in the enhanced assurance arrangements. The Trust EPRR lead has now gone on to maternity leave, and the Trust had arranged cover during this period unfortunately the cover has now been cancelled due to other commitments. The Trust has now gone out to an external agency to try and arrange cover to support the Health and Safety lead with EPRR and achieving the EPRR core standards. An updated paper will be brought to the next Business Performance Committee to update and provide assurance of next steps.

Performance

45. System wide preparations continue for winter planning and the trust continues to work closely with the ICB to devise the joint winter plan. The Walton Centre have submitted their winter plan.

46. 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 52 weeks, we have seen an increase in this area due to pain management patients.

47. 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 but have identified an issue in relation to the scanning capacity and the trust is working closely with the regional teams to look at the facilities for scanning in the Paddington Diagnostic Suite.

Recommendation

To note

Author: Jan Ross, Chief Executive Officer

Date: 30 November 2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
7 December 2023

Report Title	Charity Substrategy Update
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Madeleine Fletcher, Head of Fundraising
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)*

- This paper highlights achievements in the first 12 months of the Charity Substrategy
- Digital fundraising developing and embedding
- Charity funding supported and enabled achievements in the first 12 month of Trust strategy

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

- Set Priorities for 2024
- Progress against priorities to continue to be reported to the Committee and the Trust Board.

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)*

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**
The Walton Centre Charity Committee Meeting	27/10/2023	Madeleine Fletcher, Head of Fundraising	No issues raised, good progress made across all strategic objectives

Charity Substrategy Update

Introduction and Background

1. The Charity Substrategy was approved by the Charity Committee in October 2022 and ratified by the Board at its November meeting. This paper highlights the progress made in the first 12 months against the five main areas of focus, highlighting achievements in each area.

Analysis

2.

1. INCOME GENERATION

"In addition to ongoing and existing income streams, new fundraising opportunities and initiatives will aim to move more of the focus to digital, social media and virtual platforms, as well as offering hybrid event opportunities wherever possible. There will also be a focus on committed regular giving and legacy promotion"

Digital Fundraising

a. Donations from platforms such as Facebook, GoFundMe, Ebay and Thrift totalled £18,200 during the last 12 months, compared to £15,500 the previous 12 months.

b. Facebook fundraising continues to grow with supporters mainly using the platform to create Birthday Fundraisers. The platform has over 146 supporters for which we now have contact details. The aim is to build the number of supporters further over time and move them along the stewardship donor journey.

c. Digital Fundraising Manager has started a donor database mapping project to identify streams of contact data from different sources to create planned contact throughout the donor journey.

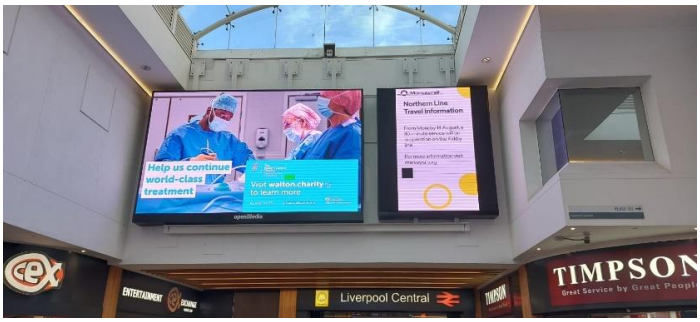
d. The option to create online tribute pages on the Charity website has been created. Pages set up via the Charity website instead of third-party platforms means that the fees are lower, and more income is received from each donation. The Digital Fundraising Manager is working with the Community Fundraiser to identify and liaise with local funeral directors in the community to showcase the benefits of this service.

e. The Digital Fundraising Manager has joined a digital fundraising group that consists of Alder Hey Children's Charity, Liverpool Heart and Chest Hospital Charity and The Walton Centre Charity. The group meet on a regular basis to discuss best practice in digital fundraising, share experiences of using different fundraising platforms and review current trends.

f. Social media campaign during 'Remember a Charity in your Will' week in September, saw two sign-ups to Bequethed, with both wills including a gift to the charity. A further social media campaign for 'Free Wills Month' will run throughout October.

g. A 'microsite' on the charity website was created, to coincide with the launch of the Trauma Room One series on Channel 5. The microsite details how the charity supports the hospital, the type of equipment we fund, and how best to support us.

This is also linked to the donation of screen time with Open Media digital advertising screens – liaised with comms on content and design – this ran for 2 weeks following the launch of the Trauma Room One series.



Central station Liverpool

h. New charity branded letterheads and leaflets have been developed.

Individual / Committed Giving

a) The Lottery scheme has been actively promoted on the Trust/Charity's social media platforms as well as the website during the last 12 months. There has also been some in person promotion in the hospital. Last October, there were 88 players signed up which by the end of September 2023 had risen to 160. This equates to approximately £500 per month.

Events

b) During the last 12 months Charity organised events has raised £111,000 net – they include:

- Jan Fairclough Ball 2022
- Walk for Walton 2023
- Golf Day 2023
- Ladies Lunch 2023
- Abseil 2023
- Snowdon Hike 2023.

2. GRANT MAKING

"A comprehensive policy will ensure a strategic approach to grant-making, evaluation, and impact reporting. Once implemented a project pipeline of potential grant/fundraising opportunities can be developed which will help diversify income opportunities. Regular impact reporting will also help promote the work of the Charity and ultimately the Trust"

a) A draft Grant Making Policy setting out the principles, criteria and processes was developed and approved at the April Charity Committee meeting. This will be followed by a suite of new application forms, guidelines, flowcharts and reporting templates to help support and promote the grant application process.

b) The application process will move online once the new intranet is up and functioning, and the Digital Fundraising Manager is developing the content in liaison with the intranet project lead.

3. IMPACT

"Working closely with the Trust's communications team, the Charity's positive impact will be shared both internally and externally to encourage further involvement and support for future fundraising."

Learning, Monitoring and Evaluation

a) Following the successful grant application to NHS Charities Together the Charity engaged a freelance evaluation consultant for 12 months to work with the Charity to review current grant-making data; co-create a Theory of Change with the Charity team; design a measurement framework with new tools, such as a re-designed application form, grant report form and template surveys.

b) A 6-month progress report is due to NHS Charities Together before the end of December, and the report will be shared with the Charity Committee at the January or April meeting.

4. PROJECT PIPELINE

"Establish a Project Pipeline in conjunction with the Trust, to identify, assess and prioritise projects for fundraising purposes."

a) An open-call for potential charitable funding needs across the Trust was sent out in January 2023. Information requested included a brief outline of the project; approximate capital/revenue cost; explanation of the benefit to patients; and any information which might strengthen the case for support to attract funders/donors (i.e. first of its kind etc). The projects must also of course be 'over and above' what should be provided by the NHS.

b) The initial expressions of interest/potential projects were considered by the Charity Committee and some applicants were invited to submit full applications, which were considered in the July meeting. Several other potential projects were subsequently included on a 'project pipeline' for future funding or fundraising and projects will continually be added to the list.

c) The project for the 2023 Jan Fairclough Ball was identified through this process.

d) Another open-call will take place in January 2024.

5. FUNDRAISING TEAM

"The Fundraising Team will be strengthened to add skills and allow a more focused approach for digital income generation and the aim for the next three years will be to further embed into the new Trust strategy to ensure the Charity can effectively contribute to the overall income of the Walton Centre NHS Foundation Trust, and thereby support and enable developments particularly in innovation and research."

Expand Team

a) A Digital Fundraising Manager was recruited and appointed in November 2022, with the responsibility to manage the planning and implementation of all digital fundraising activity for The Walton Centre Charity to increase support and maximise fundraising income for the Charity.

b) Community Fundraiser has requested a change to contract from 37.5 to 30 hours per week – 4 days. Impact of this on the team will be monitored for 3

months but it is anticipated that the member of staff will want to continue the arrangement.

6. TRUST STRATEGY

"The aim during the next three years will be to further embed into the corporate strategy of the Trust to ensure the Charity can effectively contribute to the overall income of the Walton Centre Foundation Trust, and thereby support and enable developments particularly in innovation & research and education, training and learning."

Education, Training & Learning

National neurosurgery training courses have been run for medical students and junior doctors, incorporating the charity funded NeuroVR simulator (virtual reality surgical teaching tool).

Research & Innovation

Thanks to pilot funding from the Charity, the Trust is in a position to bid to become one of the national centres to provide LITT (Laser Interstitial Thermal Therapy) for patients with epilepsy.

Conclusion

3. The last 12 months have seen some achievements and progress against the strategy.

Recommendation

4. To note

Author: Madeleine Fletcher, Head of Fundraising
Date: 28 November 2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
7 December 2023

Report Title	People Substrategy Update
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)*

- Progress review undertaken on strategy objectives and strategic implementation and assessment delivery plans for Q1 and Q2
- 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)*

- Continue with activity to achieve deliverables identified within the strategic implementation and assessment delivery plans for Q3.

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**
Business Performance Committee	26/09/23	Mike Gibney Chief People Officer	No issues raised, good progress made across all strategic objectives
People Group	02/10/23	Mike Gibney Chief People Officer	No issues raised, good progress made across all strategic objectives

People Substrategy 2022-25 Progress Report

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.

2. The report provides an overview of the progress made in Q1 and Q2 of 2023 and outlines Q3 objectives (**Appendix 1**).

Background and Analysis

1. The overarching aim of the Substrategy is to ensure a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background. This will be achieved through five strategic objectives:

    - **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.

2. The Substrategy is underpinned by six strategic implementation plans:

    - Health and Wellbeing
    - Staff Experience
    - Medical Education
    - Innovation
    - Research
    - Training and Development

3. And three assessment delivery plans:

    - Social Value Framework
    - Prevention Pledge Action Plan
    - Investors in People Action Plan.

Conclusion

4. Whilst there has been good progress on the delivery of the strategic objectives in Q1 and Q2, the environment within which the Trust operates has not improved since the launch of this Substrategy. The cost-of-living crisis is still intense resulting in labour market conditions that combine skill shortages with increasing pay.

5. The NHS Long Term Workforce Plan is the most significant contextual factor to emerge since the Substrategy was agreed. Its 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 Trust Board to note that these aspirations absolutely align with the Trust's local Substrategy.

Recommendation

6. Trust Board is asked to note the achievements to date and the objectives for Q3.

Author: Mike Gibney and Jane Mullin
Date: 24 November 2023

Appendix 1 – Overview of progress made in Q1 and Q2 of 2023 and Q3 objectives.

Executive Summary

The Trust Strategy was approved in September 2022, the strategy covers the three years from 2022-2025 and places patients at the heart of everything we do, and it sets out clear success statements against each ambition. The trusts enabling strategies have also all been approved.

Education Training and Learning Q1 & Q2

The Walton Centre NHS Foundation Trust

Achievements	Challenges
Increased uptake in apprenticeships by existing staff	The new Long Term Workforce Plan for the NHS signals a step change in apprenticeship as a route to grow the workforce
New pre-employment programme commenced	Maintaining mandatory training and appraisal compliance
Agreement from Executive Committee to explore nursing apprenticeships	Delivering a high-quality medical student placement with vastly increased student numbers alongside ongoing strike action
Agreement with Edge Hill University Medical School from 2023-24 academic year to provide undergraduate neurological medical education	
Initial draft of organisational cost of educational attachments shared with the Medical Educational Group in September 2023	
Initial draft of quality benchmarks for education attachments to standardise the outcomes for The Walton Centre affiliated placements shared with the Medical Education Group in September 2023.	

Leadership Q1 & Q2

The Walton Centre NHS Foundation Trust

Achievements	Challenges
Equality, Diversity and Inclusion Lead commenced in post	The Equality, Diversity and Inclusion agenda has seen a number of new initiatives for the NHS which require holistic understanding to enable practical action planning
The Board approved the Trust's first Anti-Racism statement on the 14 September 2023 which included a number of commitments directly attributable to Board members	Building Rapport internal leadership programme delayed due to resource provision within the Training and Development Department.
Trust Health Inequalities and Inclusion Committee established	
External Inclusive Consciousness Training commissioned	
Reassessment of Navajo kitemark undertaken and retained	
Investors in People staff surveys completed for both standards as part of reaccreditation assessment in preparation for onsite visit in November 2023.	

Research and Innovation Q1 & Q2

The Walton Centre NHS Foundation Trust

Achievements	Challenges
Draft strategic vision/Memorandum of Understanding developed to enable joint working between University of Liverpool and The Walton Centre with research priorities to be agreed at a joint workshop in October 2023	Research Financial Management Policy has been developed but awaiting discussion with Finance
Funding secured for a part-time research physiotherapist – new role to the Trust to expand in the physiotherapy area	Resource to support the continued development and growth of the Innovation function
Funding secured for 2 student research bursaries	Innovation active staff to have allocated capacity within their job plans/roles to undertake innovation activity/projects.
First Dietician as a Principal Investigator	
Stall for Clinical Trials Days	
Five out of eight submissions completed for the self-assessment element of the IKE Institute 3-year development programme to attain ISO innovation standards	

Research and Innovation Q1 & Q2 Continued…

The Walton Centre
NHS Foundation Trust

Achievements	Challenges
Innovation Communications plan implemented inclusive of: • Presentations included in external visits e.g. NHS Providers, LCR Platform, Innovation Agency North West Coast • Innovation activity publicised through Trust internal and external communication channels • Innovation included in corporate and medical student inductions • 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	
IKE Institute accredited training programmes undertaken at Board, leadership, practitioner and digital transformation level	
Innovation Governance processes established and implemented.	

Collaboration Q1 & Q2

The Walton Centre NHS Foundation Trust

Achievements	Challenges
Administration and clerical bank staff transferring to NHS Professionals – Historically, the bank had been managed in-house, however, to strengthen governance processes and procedures, the service has been transferred to a specialist organisation	Need to ensure that the opportunities provided by the NHS Long Term Workforce Plan are influenced appropriately in relation to training routes and role redesign
Delivering against all 14 Prevention Pledge 'Core Commitments' and Wellbeing Hub being showcased at the C&M ICB Prevention Pledge Summit at the end of September 2023	

Social Responsibility Q1 & Q2

The Walton Centre NHS Foundation Trust

Achievements	Challenges
Opening of staff Wellbeing Hub	Dedicated staff rest area – Area identified however, work not yet commenced as dependent on paper free digital project
Strong coaching culture	
Civility training offered	
Achieved aspiring status for Liverpool City Region Fair Employment Charter	
Achieved silver accreditation for Employee Recognition scheme for veterans	
Strong initial C&M ICB Anchor Institution Charter submission made in June 2023 with the first Assembly panel attended in July 2023	

Q3 Objectives

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Education Training and Learning

- Development of an apprentice levy transfer protocol
- Ensure pre-employment programmes are “communicated” to the Trust. Follow up with success stories

Leadership

- Develop Trust-wide action plan following 3-year reaccreditation assessment completion in November 2023
- Roll out of Building Conscious Inclusion following train-the-trainer programme in November 2023

Research and Innovation

- Develop business case for Innovation Officer Role and subsequent recruitment if approved
- Develop Role Description for Innovation Clinical Lead
- Approval of Innovation Clinical Lead role for Neurosurgery division and subsequent recruitment if approved

Recruitment of Research Quality Manager

- Establish Research Quality Sub-group
- Collaboration
- Progress against outstanding 2 Prevention Pledge Core Commitments
- Lead C&M Occupational Health and Wellbeing workstream

Social Responsibility

- To undertake first Liverpool Citizens Listening Campaign and to continue to participate in MP/Elective Member Engagement and Member Organisation Recruitment workstreams
- To plan for next C&M ICB Anchor Institution submission in January 2024

The Walton Centre NHS Foundation Trust

Report to Trust Board
7 December 2023

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**	✓ **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 Report highlights:

- Q2 Achievements and Highlights
- Q3 Objectives and initial progress
- Risks to delivery
- Items for escalation
- Key progress Metrics

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

- Meet with Divisions to discuss progress and engagement.
- Progress with Q3 objectives.
- Recruitment of new Health Roster lead

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	September 2023	Nicola Martin	Although template was agreed by executive team following SPMO producing it, it was felt more information was needed.

Quality Sub-Strategy Update 2023-24

Executive Summary

1. The purpose of this report is to provide Board of Directors with progress of delivery for the Quality Sub Strategy for Quarter two and objectives planned for Quarter three.

Progress Summary

2. Following the approval of the enabling Quality Sub-Strategy 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 Q2 and planned objectives for Q3 of 2023/24. The report also highlights key risks to delivery and escalation highlighted in Septembers SPMO meeting.

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. Examples of the dashboards have been agreed and will be presented as part of Q4 update to Quality Committee.

Conclusion

6. Good progress is demonstrated against the key priorities for Q2 2023-24, and further key priorities set for Q3 2023-24.

Recommendation

- To note

Author: Nicola Martin, Chief Nurse
Date: 22/11/23

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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 1&2 of 2023/24 and those set for delivery in Q3

Quality Sub strategy Q2

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Q2 Objectives	Q2 Progress Update
• Establish spinal outreach advice in 2 NHS Trusts	• Exceeded expectation and now in place at Southport, lufth and Bridgewater.
• Trial of Quality Improvement Boards on Caton ward	• Completed, well established engagement from all levels of staff, patients and families with tangible outputs realised, boards now designed and ordered for roll out Q3.
• 50+ members of senior teams to attend QI study day	• Completed, Feedback excellent, staff receiving certificates and future dates now over subscribed.
• To maintain national operational targets in long waits, diagnostics and cancer	• Exceeded, In addition achieved the 12 week validation target, and the national PIDMAS initiative.
• Mutual aid in and out of the region to ensure all patients, nationally are receiving equitable care	• Continues and increased to Salford and Birmingham.
• Continue to increase PIFU %	• PIFU Maintained and best performing trust in the region.
• Launch call for concern	• Launched and evidence of use by families but could be increased further, additional comms and advertisement material to be sourced.
• Investment in SWAN bereavement nurse	• Agreed, SLA being drawn up by LUFTH
• Roll out level 1 training to all staff	• 78 % of staff trained, to continue to increase training data
• Investment for increase in TVN Nurse, to support a trust vision and improvement programme	• Agreed and in process of recruitment, once recruited a vision, education and QI programme to be agreed.

Quality Sub strategy Q2

The Walton Centre NHS Foundation Trust

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Q2 Objectives	Q2 Progress Update
• Increase housekeepers to full time and 7 day cover in ITU and Theatres	• Business case completed, agreed and in recruitment process
• PSIRF Plan and policy to be approved	• Approved and roll out commenced, evidence of a number of SWARM huddles have also since taken place.
• Recruit x 3 Patient Safety Partners	• Recruited to and identified what groups they will attend.
• Maximise RANA activity	• Recirculated RANA criteria to LUFHT via the joint committee

Key Prog. Metrics	Baseline	Q3 23/24	Q4 23/24
• Reduction in catheter associated infections	Baseline total 35 in 22/23	Total YTD 5	
• Reduction in Category 2 pressure ulcers	Baseline total of 25 in 22/23	Total YTD 13	






Quality Sub strategy Q3

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Q3 Objectives	Q3 Progress Update
• To have implemented 'you said, we did' signage	• Funding of the boards approved, received and are in the process of completion.
• 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.
• Delivered x3 QI study day sessions	• Completed, reaching approximately 30 more staff
• Will have QI ward boards on all wards and operational areas	• Ordered following successful trial on Caton ward
• Established ad renewed PFCC working Group with clear lines of accountability	• Took place W/C 13/11/23
• Completed Sepsis QI programme	• In progress, IT solution commencing Nov 23
• Learning Disability Gap analysis	• Completed and approval of LD nurse, recruitment process
• Source solution to improve FFT response rate	• E-forms has been sourced as a potential FOC option
• To have evaluated and realised benefits from introducing e roster in theatres	• Commenced and some initial changes started, awaiting new roster lead to complete
• To have implemented text messages reminders for patient appointments	• IT integration complete, Patient Administration System (PAS) integration ongoing, however expected to be complete before the end of Q3

Quality Sub strategy Q3

The Walton Centre NHS Foundation Trust

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Q3 Objectives	Q3 Progress Update
• Continue to improve RANA utilisation	
• progress bid for LITT services	• Bid submitted, awaiting outcome
• 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 as part of the pilot
• 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
• Launch ‘noise at night’ campaign	• Commenced W/C 13/11/23
• Culture review in ITU	• Commenced, awaiting outcome and recommendations in Q4

Quality Sub strategy

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

Items for escalation

- Staff/Divisional Engagement
  - Due to staffing resource and operational pressures, there has been little to no engagement from divisional teams, which has the potential to jeopardise delivery of the sub-strategy

- Digital systems
  - Delivery of some programmes of work are reliant on digital delivery of projects and/or integration. Due to ongoing resource issues, risks remain an issue with clinical systems and workarounds in place.

Risks	Actions / Mitigations	Owner / Lead	Anticipated End Date
• Imminent departure of e roster lead	• Business case to fund permanent post moving forward • Recruitment process	N.Martin J.Mullin	• New post recruited to, commences Jan 24
• On going industrial action			
• Winter pressures and associated risk			



Any questions?

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Report to Trust Board
7 December 2023

Report Title	**Board Assurance Framework (BAF) Report 2 2023/24**
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 mid-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	8 Nov 2023	K Dowson Corporate Secretary	All risks reviewed by Executives and agreed
Quality Committee	16 Nov 2023	K Dowson Corporate Secretary	Reviewed and commented on the risks assigned to the Committee.
RIME Committee	Nov 2023	K Dowson Corporate Secretary	Reviewed via email due to meeting timing issues. No changes proposed
Health Inequalities & Inclusion Committee	27 Nov 2023	K Dowson Corporate Secretary	Reviewed and commented on the risk assigned to the Committee. No changes proposed.
Business Performance Committee	28 Nov 2023	K Dowson Corporate Secretary	Risk scoring for BAFs 003 and 11 debated due to the challenges inherent, no changes proposed given the current mitigations.

Board Assurance Framework (BAF) Report 2 2023/24

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 since been reviewed through the assigned Board Committees twice.

2. Through the Board Committee process there were no changes proposed at this review although it was recognised in BPC that the finance and activity challenges continued to be considerable. BPC also noted that much of the cyber security risk was externally controlled and that the risk could be rewritten for 2024/25 to focus on the areas that the Trust could control i.e. the security controls and processes, rather than the number and ferocity of the attacks themselves. This remains the highest scoring risk.

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

4. 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

BAF Heat Map

Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	5	10	15 011	20	25
Likely	4	8	006 12	16	20
Possible	3	6	002 004 007 9 003 008	001 009 005 12 012 010	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

Background and Analysis

5. 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.

6. 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

7. 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.

8. 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.

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

10. The BAF risks were assigned to Board Committees to review and provide assurance and this took place during November.

Changes

11. 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.

12. 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 will review the BAF at meetings in July this year (August from 2024), December and April with Committees reviewing in July, November and March.

13. 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.

14. The Board established its Risk Appetite Statement for 2023/24 at the April Board meeting and the changes made have been reflected in this BAF. There is variation in the risk appetite assigned to each risk across the BAF. This reflects that these risks are linked to the new 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**	

15. 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. For example, risks 135 and 934 on BAF001 System and Finance are new operational risks. Where risks have been closed or reviewed and the score has dropped below 12 these are down as crossed out.

16. 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 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 will be shown.

Conclusion

17. 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

18. To approve

Author: Katharine Dowson
Date: November 2023

Board Assurance Framework Glossary

ADO	Associate Director of Operations
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
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:	July 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:**	December 2023
		CQC Regulation:	Regulation 12 Safe Care and Treatment
		Ambition:	Quality of Care
		Assurance Committee:	Quality Committee
		Lead Executive:	Acting Chief Nurse

Linked Operational Risks (15+ or new risks only)		
1011	If poor compliance across all acute wards in relation to the adherence to sepsis protocol inline with escalation and treatment, continues then there is a risk to patient safety and care.	12
1043	If the SCS nursing team does not have adequate resource, then there is a risk that patients' appointments will be delayed as the current staffing levels will not be able to meet the demands of the service.	12
1044	If the DBS nursing team does not have adequate resource, then there is a risk that patients' appointments will be delayed as the current staffing levels will not be able to meet the demands of the service	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 now minimal) - 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. ~~Theatre Transformation~~ 3. IPC BAF reviewed at Quality Committee quarterly – January 2023 4. Ward Accreditation Programme (CARES) in place for 2023/24 5. Implementation of Tendable Audit System for ward-based Quality metrics from 2022/23 6. Board Walkabout Programme – reporting to Quality Committee 7. NICE Exception Report 8. CQC Mock Inspections 2023 ~~– May 2022~~ 9. Specialist Nurse Support in place e.g tissue viability and IPC 10. Patient and Family Centred Framework in place – relaunched January 2023 11. HCAI plan for 2022-23 approved by Board June 2022 update? 12. Pulse Survey reflecting staff morale 13. ANTT Training for nurses complete and established as a quality priority for 2023/24 14. 'Call for Concern' campaign launch February 2023 15. Neuropsychology specialist nursing team 16. PLACE mini review June 2023 – reporting to BPC 17. Patient Safety Incident Reporting Framework implemented from 1 September 2023 18. Safe care and e roster 19. Patient safety partners now recruited 20. Service reviews across each team 2023-24 21. External patient engagement events 22. SWAN Nurse appointed	1. Timely completion and reporting of NICE exception reports 2. Theatre utilisation programme not achieving its objectives as planned ~~3. Deteriorating performance on flushing audits~~ 4. Assessment criteria against Patient and Family Centred Plan (6 Steps) 5. ANTT Training for medics 6. Sepsis audits to include all relevant patients ~~7. NEWS criteria requires review~~ ~~8.~~ Limited progress on agreed End of Life Framework with LUHFT ~~not agreed~~ 9. Peer review plan requires roll out 10. Robust process for CQuINs 11. Response rate for Friends and Family Test – potential digital solution to be explored 12. Review of all nursing documentation to allow the delivery of the Digital Substrategy and to ensure is in line with NMC Code of Conduct 13. Safeguarding training compliance- All levels 14. IT System

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 ~~Serious Incident Group – monthly review~~ Patient Safety Incident Reporting Group Balance Score Cards – monthly review Hospital Management Group – monthly review Hand Hygiene Audits – monthly review Staff and Patient stories to Board at each meeting ~~monthly~~ 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 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 ~~May~~ 2023 Update on NICE assessment, including those outstanding quarterly, reported to Quality Committee **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meetings with Commissioners – Quarterly National Inpatient Survey Results – published ~~October 2022~~ 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 2021) Anaesthesia Clinical Services Accreditation (ACSA) visit 2022 Report following visit to check compliance with Human Tissue Act (March 2023) Trauma Audit and Research Network (TARN) peer review – February 2023	1. End of Life Care Strategy (available from February 2023) 2. ~~End of Life Care model not yet agreed by Trust~~ 3. Quality Impact Assessments e-system now in place, only one completed to date 4. Most recent PLACE assessment highlighted areas for improvement in food service and environment.

	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 May 2023: Most recent meeting cancelled by LUHFT, awaiting update and revised date. Business case for SWAN nurses is being progressed through Trust governance processes. UPDATE Dec 2023: Business case approved but Committee is consistently cancelled, to escalate to LUHFT as unable to give assurance re progress against strategy. Next meeting planned for 12 December 2023.	MD	~~September 2022~~ ~~October 2022~~ ~~March 2023~~	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	CN	June 2023	~~New Action~~ In progress
5	Delivery plan to fulfil the Quality Substrategy. UPDATE Dec 2023: Lack of engagement from Divisions, escalated to COO	CN	July 2023	New Action
6	Options for investment in electronic Friends and Family Test to be explored	CN	January 2024	New Action
7	IT amendments required in order to monitor Trust progress against Sepsis compliance	CN	March 2024	New Action
8	Explore options of e-learning package for doctors training of ANTT	CN	November 2023	New Action

Risk ID: 002	Date risk identified	April 2022 (*updated April 2023*)	Date of last review:	July 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:**	December 2023
			CQC Regulation:	Regulation 17 Good Governance
			Ambition:	Collaboration
			Assurance Committee:	**Quality Committee**
			Lead Executive:	Medical Director

Underlying Operational Risks		
~~966~~	~~If clinic room estate at the new Royal Liverpool hospital cannot be confirmed/guaranteed (as part of spinal service integration) then this will have an impact on spinal outpatient activity, radiology services, clinician morale and patient experience. There is also a risk to Trust reputation.~~	~~12~~
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
Risk Appetite	**Open**	

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

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Equality of care for patients due to variation in system delivery and capacity - Potential for increased morbidity and mortality rates - Patient safety incidents - Patient outcomes worsen - Length of stay increases - Resource impact of excess unnecessary investigations - Sustainability of Trust - Inadequate funding to support development and growth in line with strategic ambition - Deterioration of patient and family experience - 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 - ~~ICS Strategy not yet in 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. New Joint Site Committee established with LUHFT for the Aintree site to progress the Liverpool Services Clinical Review clinical priorities and investigate potential collaborations with delegated authority from the Board. 12. C&M Forward Plan 2022-28 includes Neurosciences, Epilepsy and Stroke as focus areas 13. Workplan and priorities for the Aintree Site Sub-Committee agreed as imaging, emergency clinical pathways and estates and digital.	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. ~~Workplan and priorities for the Aintree Joint Committee need to be agreed.~~ 7. Ability to meet widened criteria for thrombectomy - model of care needs review. 8. 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 Monthly reporting to Board on ICS development and development of strategy, processes and systems and also of operationalisation of 24/7 Thrombectomy and spinal surgery Weekly C&M ICS CEO meeting Regular ICS Chair meetings **Level 2** Monthly Chair and CEO reports to Board Project update e.g. Spinal Services to Executive Directors meeting on a regular basis Clinical Effectiveness and Services Group monthly meeting reviews and reports to Quality Committee through Chair's assurance report Regional Thrombectomy Meeting Spinal Provider Board with LUHFT Project Boards with partners 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	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR. 3. Lack of clarity on future of specialist commissioning – 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 exploring some short-term support to conduct a review. No current timescales. Paper going to Rehab Network meeting on 16 October.	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	COO	December 2023	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
9	Pathway for MRI for ventilated patients with LUHFT to be agreed.	MD	December 2023	New Action
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

Risk ID:	003	Date risk identified	April 2023	Date of last review:	July 2023
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:**	December 2023
				CQC Regulation:	Regulation 17 Good Governance
				Ambition:	Collaboration
				Assurance Committee:	**Business Performance Committee**
				Lead Executive:	Chief Finance Officer

Operational Risks		
135	If Specialised Commissioning element of income transfers to Population based commissioning allocations as planned, then there is a risk of this leading to reduced funding allocations for the Trust.	15
934	If 2019/20 out turn weighted activity plus growth (non specialised at 9% growth and specialised at 11%) is not delivered there is a risk that income may be clawed back 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 23/24 financial plan at risk as receipt of API income is assumed within the plan.	16
948	If SLA and contracts management cannot be maintained, then there is a Risk to financial control and service provision.	12
Risk Appetite	**Open**	

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

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of decision-making responsibilities / influence as move to system based working and financial targets with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance and finance - Loss of autonomy 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 - ~~Recent NHSE consultation on system funding models~~ - ~~Tariff consultation on population-based funding.~~ - 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 - ~~ICS Strategy not in place~~ - Larger acute trusts with underlying structural deficits in the ICS - Trust basis for funding based on historical local tariffs and disproportionate costs of delivery may not be taken into account for services leaving Trust with a financial gap - 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 ~~potential~~ 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.	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 be submitted in September 2023~~ 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

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 **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 monthly Business Performance Committee **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% CIP 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. ~~Waiting for ICS to agree 2023/24 plan~~	CFO	~~March 2023~~ ~~Tbc~~ ~~September~~ December 2023	~~New Action~~ In progress
5	ICS to develop a three year financial plan 2024-2027 to ~~evidence~~ 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.	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:	July 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:**	December 2023
		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)		
1042	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
1033	If the emergency referral system, ORION, doesn't provide timely alerts to the on-call team when new referrals or new updates are submitted by referring Trusts then this will lead to a delay in patients receiving advice and treatment.	12
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
Risk Appetite	**Cautious**	

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

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Patients will wait longer for 1st and follow up appointments – which could result in harm or lead to poor patient experience. - Referral to treatment standard (RTT) / average wait pilot standard will not be met. - Cancer standards will not be met. - Diagnostic standards will not be met. - +52 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 which 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 2. Performance Dashboard in real-time 3. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 4. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 5. Submission of Recovery and Restoration plans for 2022/23 6. Stretch recovery target set for 104% of 2019/20 activity 7. Daily COO-led performance catch up which focuses on performance targets and addressing issues that may impact on delivery such as operating list cancellations 8. Divisional recovery plans 9. +52 week recovery plan 10. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners. 11. All 52-week plus waiters have been clinically reviewed and validated (March 2022) 12. Rapid Access Neurological Assessment (RANA) supporting system partners 13. Staff wellbeing programme 14. Regular meetings with specialist commissioners and partners re Thrombectomy to escalate initial issues e.g. ambulance response times 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	1. Covid-19 Recovery Plan based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviours / compliance. 2. ~~National Shortage of ODP theatre staffing currently requiring agency staff to support this gap~~ 3. Reliance on other organisations capacity to provide services 4. Industrial action started in December 2022 and remains ongoing despite the agreement of a settlement by some unions 5. Lack of clarity regarding referral to treatment future targets 6. Impact of mutual support work not fully known. 7. Implementation of Patient Initiated Digital Mutual Aid System (PIDMAS) November 2023 may worsen RTT position. 8. EPRR arrangements judged as non-compliant by system (November 2023)

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily performance review with Divisions Weekly monitoring of performance of RTT – improvement in 52 and 104 week waits Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly	1. Thrombectomy demands on staff rotas 2. Transfer of Thrombectomy patients to and from the Trust in a timely manner 3. Sickness of critical staff 4. Recruitment and retention of key staff and succession planning 5. Challenging follow up outpatients target, to reduce by 25%

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 monthly in IPR to Board **Level 3** Meetings with Commissioners – monthly Internal Audit review of Waiting List Management - April 2022 System review of 52+ week waiters – April 2022 Check and challenge sessions with ICS on operational and workforce plans	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 Recovery Plan to increase activity – plan is in progress and progress monitored through BPC.	COO	~~Sept 2022~~ March 2023	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	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

Risk ID: 005	Date risk identified	April 2022 *(revised April 2023)*	Date of last review:	July 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:	December 2023
			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	Major	Likely	
			Initial: 4	4	16
			Major	Possible	
			Current: 4	3	12
			Major	Possible	
			Target: 4	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. ~~BAME Strategic Advisory Committee exercise~~ 7. Staff Survey /Action Plan 8. Partnership working with universities to recruit newly qualified staff 9. Regional collaborations e.g. International Recruitment 10. WCFT Health and Wellbeing Programme 11. National Nursing Bursary – 2020/21 12. Hybrid training models developed to enable ongoing delivery of training with social distancing 13. Monthly deputy's engagement sessions 14. Annual Training Needs Analysis 15. E-rostering 16. Senior Leadership Team meetings held in Neurology and Neurosurgery 17. Aspiring ward manager programme started ~~9 Sept~~ 2022 18. Building rapport for managers programme relaunched September 2022 and repeated annually 19. Triumvirate leads development programme to start early 2023 – restarted September 2023 through AQuA 20. Investors in People Action Plan 21. Mental Health First Aiders – support and training programme 22. ~~Civility Training Programme launched with initial focus on consultants~~ 23. New People Substrategy 2022-25 approved at Board February 2023 24. Catch up programme for Deputies who did not complete first cohort 25. Listening activities in place i.e. Join Jan, TEA engagement sessions, NED/Executive walkrounds. 26. Sickness Controls Internal Audit demonstrated good processes and policy in place. 27. Civility training Programme in place for all staff groups 28. Building a Culture of Conscious Inclusion. Train the trainer programme starting autumn 2023.	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.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Vacancy monitoring – weekly Staff training and development reports sent monthly to mangers Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events Staff Support sessions provided by NOSS as and when required HR\Finance\Nursing Vacancy renew meetings **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC (linked to People Plan) Quarterly Staff Pulse Survey Workforce report to People Group **Level 3** Outcomes of Staff Survey 2023. Investors in People Accreditation 2022 – Gold Status Investors in People Wellbeing Award 2022 – 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	1. Delivery of National People Plan 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	CPO	~~September 2022~~ ~~February 2023~~ ~~June 2023~~ ~~October 2023~~ January 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. A small number of teams have not yet submitted plans, verbal report to BPC by November 2023	CPO	~~April 2023~~ ~~July 2023~~ November 2023	~~New Action~~ Complete
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.	CPO	December 2023	~~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

Risk ID: 006	Date risk identified April 2022	Date of last review:	July 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:**	December 2023
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Social Value: Supporting local communities and staff
		Assurance Committee:	Health Inequalities & Inclusion Committee
		Lead Executive:	Chief Executive

Linked Operational Risks		
~~531/ 455~~	~~If controls are not put in place to manage the complexity of the patient caseload then there is a risk that staff will be subject to high incidences of situations involving violence and aggression from patients.~~	~~12~~ 8
~~990~~	~~If the Trust does not work collaboratively with partners in the community in which it is anchored to address health inequalities then it is less likely to prioritise effectively and there will be less positive impact on patient outcomes.~~	~~12~~ 9
Risk Appetite	**Open**	

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

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 ~~(includes Shiny Minds Resilience Training) – approved 2018~~ 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 now in place 19. Executive Lead for Health Inequalities confirmed as Chief People Officer	1. Health Inequalities and patient access strategic plan 2. ~~Identified Executive Lead for Health Inequalities~~ 3. National issue with complex long-standing causes that cannot be easily turned around 4. Liverpool population recognised as area of high deprivation 5. ~~Challenges in recruiting ED&I lead, now appointed awaiting start date.~~ 6. Strategic plan for health inequalities 7. Development of health inequalities performance data 8. Move to population-based commissioning may reduce funding available for some geographical areas 9. ~~Reporting structures for Health Inequalities and Social Value to be agreed~~ 10. 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 **Level 2** ~~Annual Governance Report – Quality Committee~~ Quality IPR – Quality Committee – 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

Workforce IPR – BPC – monthly Board oversight of progress against NHS Prevention Pledge Quarterly Pulse Survey Staff Partnership Group with Trade Unions Health Equalities programmes of work report into Business Performance Committee through The People Group Chair Report Bi-annual update on Violence and Aggression work to Board - October 2023 **Level 3** Staff Survey 2021 ~~1~~ 2 CQC Inspection Report 2019 Investors in People - Gold accreditation for 'we invest in wellbeing' standard - annual reaccreditation received in June 2022 Investors in People Gold accreditation for 'we invest in people' standard - annual reaccreditation received in January 2023. ~~Bronze~~ 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: Trust core group established with training to be undertaken in March and May 2023 in preparation for listening campaign (spring 2023). Founding Assembly delayed until September to enable member organisation recruitment target to be achieved. Trust ED&I Leads identified to support engagement work. Work progressing to recruit to the Community Organiser role **September 2023 Update**: Founding launch deferred until spring 2024 or until have recruited an additional 14 member organisations. Three workstreams have been established to support the Alliance progress to Founding stage. Listening Campaign to be held 18/10/23 – 29/11/23 and MP and Local Leader Engagement campaign planned.	CPO	~~October 2022~~ ~~March 2023~~ ~~Sept 2023~~ May 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. May 2023 Update**:** TOMs Framework portal live and staff training taken place. Working group established to populate portal and review metrics which will provide the baseline for applications for Social Value and Quality Mark (action 5) **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 May 2023 Update: As action 4 although accreditation likely to take longer to confirm following submission planned for September 2023 **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.	CPO	December 2023	In progress
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)	~~CEO~~ CPO	~~March 2023~~ March 2024	~~In progress~~ On Hold
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	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. February 2023 Updated:3-years lottery funding secured to support the project and Partner Project Steering Group established to take the work forward**. 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.	CPO/IM	March 2026	New Action
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:	July 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:**	December 2023
		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	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. ~~Key policies (Fire and~~ 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 – Bi-monthly Medical Devices, Estates and Facilities Group (6 per year) **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 ~~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 aware paper to be developed.	COO	~~January 2023~~ ~~July 2023~~ ??? LV to confirm	In progress
7	Proposals ready "on the shelf" for any additional capital funds that may become available in year based on Trust's priority criteria.	CFO	~~September~~ December 2023	New Action

Risk ID: 008	Date risk identified: April 2023	Date of last review:	July 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 ambition to offer a national medical education training programme in Neurosciences.		**Date of next review:**	December 2023
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

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

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.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Established Medical Education Committee and clear reporting line to the Board of Directors via to Research, Innovation and Medical Education (RIME) Committee 2. Lead educator roles established with Director of Medical Education (DME) engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and meets at least bi-monthly. Clinical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed 6. SOPs have been created to standardise and assure processes 7. New structure for delivery of education was consolidated in 2021 8. Consultants are now formally recognised for undergraduate educational supervision and remunerated through job planned activities 9. 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 September 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. ~~If initial interest from other medical schools progresses, there may not be sufficient capacity to deliver what would be required and negative impact on overall quality of provision & experience – discussion needs to be done collectively with multiple med schools to ensure optimum outcomes~~ 4. Workforce planning has to consider impact of AI and how doctors future roles/education needs will change 5. ~~Capacity to deliver potential doubling of medical students~~ 6. ~~Medical Education Strategic Implementation Plan in development.~~ 7. Plans to manage increased medical student numbers and implications of NHS Long-term Plan are being led by regional workforce leads

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Medical Education Committee minutes • Medical Education overarching Action Plan • Medical Undergraduate Working Group minutes • Junior Doctor Forum (held alongside Guardian of Safe Working)	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

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 and observers to support the national offering. Update September 2023: Task and finish group to be established to complete this action.	CPO	~~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 RIME December 2023	CPO	~~September 2023~~ December 2023	~~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.	CPO	~~August 2023~~ December 2023	~~New Action~~ In progress
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	CPO	~~September 2023~~ Ongoing	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:	July 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:**	December 2023
		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
	New operational risk is under development regarding national lack of commercial research.	
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	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• 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	• 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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Research and Development Strategy 2019/24 (under review) 2. CAPA audit (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 9. Research contracts now in Edge database 10. Key Performance Indicators for research in place 11. Standard operating procedure (SOP) for feasibility study process in place 12. Quality Manager for Research appointed (starts in January 2024)	~~1. Ongoing redesign of Neuroscience Research Centre (NRC) and associated implications for the human resource, including the teams capacity, capability and clarity of purpose to deliver strategic objectives~~ 2. Implications of the NRC redesign upon the development/ implementation of strategic objectives 3. Current R&D governance model unable to deliver research on a bigger scale. ~~4. Completion of audit action plans paused due to lack of resource~~ 5. Clarity of purpose and roles in the emerging system infrastructure 6. Income generation model approved but contracts to be negotiated 7. Review/development of principles for time dedicated to research 8. Prioritisation framework 9. Engagement with wider consultant body 10. Principal Investigators Training Plan

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 **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. ~~Feasibility study process needs to be improved~~ ~~3. Key Performance Indicators~~ 4. Standard Operating Procedure required for the set up of studies to ensure consistency 5. Expression of interest process does not chase responses where no interest 6. Time to explore quality issues with research projects 7. Understanding of ideal research portfolio mix for trials 8. Full understanding of money flows in and out of NRC

• University Hospital Status and membership of Associate Research Groups and Research and Development Directors University Hospitals Association Groups	

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	~~April 2022~~ ~~August 2022~~ ~~November 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	~~October 2022~~ ~~December 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.	Head of NRC	~~January 2023~~ ~~March 2023~~ December 2023	In progress
4	Develop SPAs framework for research activity using medical education model. Update September 2023: work is ongoing	CDRD	~~January 2023~~ ~~June 2023~~ ~~September 2023~~ January 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 September 2023: Internal flows are understood and progress is being made to identify and process invoices appropriately. External flows require further work	~~CFO~~ CFO	~~March 2023~~ ~~October 2023~~ March 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.	CPO	~~November 2023~~ December 2023	~~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.	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

Risk ID: 010	Date risk identified: April 2023	Date of last review:	July 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:**	December 2023
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief Executive

Linked Operational Risks			Consequence	Likelihood	Rating
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			
			Major	Likely	
			Initial 4	4	16
			Major	Possible	
			Current 4	3	12
			Major	Unlikely	
			Target 4	2	8
Risk Appetite	**Adventurous**				

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 - annual reaccreditation received in June 2022 6. Investors in People Gold accreditation for 'we invest in people' standard - annual reaccreditation assessment received in January 2023 (full three yearly reaccreditation due November 2023) 7. Pulse and National Staff Surveys 8. Staff 'TEA' (talk, engage, action) sessions with Executive Team June-July 2023 9. 'Join Jan' bi-monthly staff engagement sessions with CEO 10. Board Effectiveness Review April 2023 included response from staff. 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. ~~Wider engagement with Trust stakeholders and patient groups~~ 4. ~~Single project management office to be established~~ 5. Competitor Analysis to be completed 6. ~~Innovation Communication Plan to be revised as part of the Innovation Strategic Implementation Plan 2022-25~~ 7. 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. Benefit 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. Final submissions, stakeholder engagement and final presentation to be completed by Q4 following which two-year action plan will be developed.	CPO	~~June 2022~~ ~~Tbc~~ ~~May 2023~~ ~~September 2023~~ February 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.	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
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.	CFO	November 2023	New Action

Risk ID: 011	Date risk identified: April 2020	Date of last review:	July 2023
Risk Title: Cyber Security		Date of next review:	December 2023
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.		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

Month	2023	2022	2021
Jan	16	26	26
Feb	20	15	37
Mar	18	25	32
Apr	20	18	32
May	12	17	34
Jun	26	20	23
Jul	14	15	20
Aug	8	18	18

- **14 High Cyber alerts 2022**
- **8 ~~4~~ High Cyber Alerts 2023**

- Cyber security attacks remain an issue ~~are increasing~~, and ongoing work is required to keep up to date
- Heightened Cyber level due to Russian conflict.

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

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. ISO27001 Accreditation process – 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. 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 2022.
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. Some recommendations from MIAA Cyber Security Internal Audit will continue to be implemented throughout 2023/24 as legacy servers are moved into new Datacentre.
5. 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) Annual Cyber Security Awareness Presentation to Audit Committee 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 Committee ~~Board~~ 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 - reaccreditation Apr 23 MIAA audits of Data Security and Protection Toolkit –Substantial Assurance External Penetration Testing – 2022 completed / July 23 Regional Desktop Exercise – April 2022 Internal Desktop Cyber Exercise – Dec 2022 / May 23 Trust Board Cyber Security Training – Nov 2022 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	CDIO	~~April 2023~~ April 2024	~~In progress~~ 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 - Cyber lead appointed and undergoing training in October. Meetings to commence in Oct/Nov 23	CDIO	July 2023 November 2023	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

Risk ID: 012	Date risk identified	April 2023	Date of last review:	July 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:**	December 2023
			CQC Regulation:	Regulation 17 Good Governance
			Ambition:	Digital/ Cyber Security: To keep up with digital opportunities and threats
			Assurance Committee:	Business Performance Committee
			Lead Executive:	Chief People Officer

Linked Operational Risks				Consequence	Likelihood	Rating
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	Initial	Major 4	Likely 4	16
~~543~~	~~If delays in completion of IT projects continue, then there is a risk to patient safety, specifically the risk of a loss, duplication and inaccurate key data on reports generated by EPN system, resulting in a lack of clinical confidence in the accuracy of the reports.~~	~~15~~	Current	Major 4	Possible 3	12
866	If referrals are sent for clinical triage while on annual leave there is a risk that the referral could be missed or delayed depending on the length of time the clinician is away from the Trust. The result could impact timely access to treatment for patients, there is also a risk to performance targets in particular cancer targets.	12	Target	Major 4	Unlikely 2	8
Risk Appetite	**Moderate**					

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Investment does not result in anticipated benefits for patient care and safety - Missed objective - Reputational damage due to poor use of resources - Poor patient experience - Long term revenue commitments for under-par systems - Staff do not understand/use systems - Sanctions from regulators	- Trust bid successfully for Digital Aspirant funding approved by NHS Digital. This funding will help to deliver the EPR and wider Digital Strategy between 2021 and 2024 - Insufficient staff resource/sickness to deliver full performance - Impact of Covid on supply chain causing delays in delivery and equipment shortages

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. PMO Function underpinning the Digital Strategy 6. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 7. EPR rollout plan for 2021/22 completed, 2023/24 underway 8. Digital Transformation Programme (LoA/MoU NHSD/X) 9. Digital Aspirant status to allow Digital Transformation 10. HiMSS Level 5 achieved (working towards Level 6) 11. Digital Substrategy approved at Board April 2023 12. Representation on ICS Digital Programme Boards 13. Regular reporting to NHSE of progress against digital aspirant funding 14. Monthly report to Business Performance Committee 15. Monthly reporting to Executives 16. 2022/23 year end Digital Aspirant completed and signed off by NHSE 17. JIRA system bringing full overview to all projects 18. Board Development Day session on Digital Boards with NHS Providers, second session to be scheduled 19. External review on digital maturity completed August 2023 and recommendations accepted	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy 3. Change in national priorities around Digital post-Covid response may not be aligned to Trust digital priorities 4. Lack of digital expertise on board 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

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 Meeting HITU project meetings Clinical Systems Safety Group – 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	1. Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. 2. Digital Strategy Group is not meeting consistently.

National Chief Information Officer Weekly Meetings update on implementation of Digital Aspirant Fund shared with Executive and BPC October 2022 **Level 3** Critical Applications Audit – Jan 2020 Healthcare Information and Management System Level 5 achieved 2021/22 NHS Digital Maturity Minimum level achieved NHS EPR maturity achieved Information Security Management Systems Certification IS27001 accreditation full successful reaccreditation April 23 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 UPPDATE: 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~~	~~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 data to be released June 2023. GAP report for the organisation to underpin Digital Strategy to be completed. Update - All items now included in JIRA to map out prioritise with stakeholders NHSE playbook sessions now completed Oct 23 and data released. Organisational GAP meetings to be rescheduled now for Nov23 onwards.	CPO	March 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	CPO	~~September 2023~~ March 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

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

CHAIRS REPORT

Joint Site Sub-Committee meeting held on Tuesday 10 October 2023 at 14.00, Boardroom, TWC

Introduction

The meeting of the LUHFT and TWC Joint Site Committee took place on Tuesday 10th October 2023. 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 – 22nd August 2023	The Committee **approved** the minutes from the Joint Site Committee (JSC) held on 22nd August 2023.
Action Log	The Committee reviewed the rolling action tracker, from the meeting on 22nd August 2023. The Committee **agreed** to close all outstanding actions for October following the update.
Any Urgent Matters Arising	None
Joint Site Sub Committee Workplan Update • **Joint Partnership Group Exception Report**	The Committee received an update on the progress of the Joint Site Sub Committee workplan and the Joint Partnership Group (JPG). Key deliverables and key performance indicators (KPI) across the focus areas had been developed and good progress had been made on some of the target areas. Updates were provided on the progress and priorities of the agreed deliverables across the three agreed areas and: • Emergency Clinical Pathways • Imaging • Estates and Digital The risks identified were as follows: • Consensus on new ways of working • Clinical engagement and defining clinical pathways • Financial constraints • Equipment Utilisation • Interoperability of digital systems across both sites Discussions are ongoing across both sites on how best to better manage and utilise MRI services with regards demand capacity and patient assessment. It was recommended that where the Joint Site Sub Committee was unable to resolve issues due to organisational complexity, they be escalated to the Liverpool Trusts Joint Committee (LTJC).

Agenda Item	Key Discussions/ Decisions/ Actions
	The Committee **noted** the Joint Site Sub Committee Workplan Update and the Joint Partnership Group Exception Report
Liverpool Trusts Joint Committee Update	The Committee received the update from the Liverpool Trusts Joint Committee (LTJC) meeting held on 21st July 2023 where an update on the activities of the various Joint Site Sub Committees and a follow-up presentation from the Cheshire and Merseycare Health and Care Partnership with regards the system-wide review of the Electronic Patient Record (EPR) was received.
Draft Agenda for the next meeting	The Committee **agreed** the following items will be included on the October agenda: • Joint Site Sub-Committee Workplan Update • Liverpool Trusts Joint Committee Update
Next meeting date and venue: Friday 01 December, 09.00 to 10:00 at the Boardroom, TWC.	

Recommendations for the Board

The Board is asked to:

- note the contents of the report.

Board Committee Assurance Report

Report to	Board of Directors
Date	
Committee Name	Liverpool Trusts Joint Committee
Date of Committee Meeting	21 September 2023
Chair's Name & Title	David Flory, Chair Liverpool University Hospitals NHS Foundation Trust

Matters for Escalation

There are no matters for escalation.

Key Discussions

The Committee received an update on the activities from the following sub-committee as follows:

1. **The Walton Centre NHS Foundation Trust/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**

   Progress on the three priorities of work was provided which detailed progress within imaging pathway, emergency care pathway and estates and digital pathway.

   It was noted that the thrombectomy pathway has been identified as a priority following changes in clinical guidelines. The utilisation of the exiting pathway and a demand and capacity review aligned to the new clinical guidelines is being undertaken.

2. **Liverpool Heart & Chest/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**

   Progress on the four priorities of work was provided which detailed progress within diagnostics, ward development pharmacy and critical care. Work ongoing within the Liverpool Cardiology Partnership was also noted.

3. **Clatterbridge Cancer Centre NHS FT/Liverpool University Hospitals NHS FT Joint Committee Update**

   A reminder of the three priorities of work was provided which detailed progress within medicines optimisation, radiology and emergency pathways.

4. **Liverpool Women's Health NHS FT/Liverpool University Hospitals NHS FT Partnership Group Update**

   - Health Sub-Committee of the Cheshire & Merseyside Integrated Care Board
   - Interim Joint Chief Executive Officer Recruitment Update
   - Liverpool Womens Health & Alder Hey NHS Foundation Trust Partnership Board
   - Progress on the development of the Liverpool Joint Risk Register

The Joint Risk Register between LUHFT & LWH was presented following a review undertaken between the trusts.

An update on the PLACE work updates was also presented detailing Alder Hey, Merseyside and Liverpool University Hospitals NHS FT which covered key updates. The Committee also received an update on progress on the move the Merseycare Walk-In Centre to the Linda McCartney Building at LUHFT was successful.

Programme Management Arrangements

Members agreed to progress a review by Trust Chief Executive Officers in order to meet the need to identify a programme management methodology for the Committee and reporting sub-group joint committees in order to successfully progress the recommendations from the Liverpool Clinical Services Review and other areas of collaboration identified.

LUHFT Improvement Journey

The Committee received an overview of the Liverpool University Hospitals NHS Foundation Trust Improvement Plan, alongside governance arrangements with the System Improvement Board as a Trust in Segmentation 4 of the Strategic Oversight Framework (SOF4).

Efficiency at Scale Opportunities

An update on the Efficiency at Scale Opportunities Programme being undertaken at a system level was presented. The aim in the programme was to identify and reduce unwarranted variation across corporate services, increasing service resilience and improving value for money.

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 21 September 2023.

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 7/12/2023		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 28/11/23		**Membership Numbers: 5 (Quorate)**
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report • Digital Substrategy Update • Board Assurance Framework • Strategic Project Management Office (SPMO) Update • Quality Improvement Project Deep Dive – Outpatient Programme • Information Governance Bi-Annual Report • Digital Transformation Monthly Update • Year End Spend of Digital Aspirant • Emergency Preparedness, Resilience and Response (EPRR) Self-Assessment Update • Review of Committee Subgroup Structure • Linen and Laundry Contract Recommendation Report • Theatres Refurbishment Business Case • Replacement electroencephalogram (EEG) and Telemetry Equipment Business Case
2	**Alert**	• Waiting lists (notably 52-week waiters and new outpatients) and average waits after Referral to Treatment continue to rise. The forthcoming theatre refurbishment programme will make elective recovery of in-patient activity even more difficult. • In September, the Trust Board received assurance of 80% compliance with the NHS Core Standards for Emergency Planning Resilience & Response (EPRR) based on a self-assessment. This has subsequently been downgraded to only 15% compliant by the NHS central team. The difference is understood to relate to an absence of evidence supporting the assertions, rather than that the assertions themselves represent inadequate controls. It is understood that all trusts in the ICB have been similarly marked down, pointing to a lack of awareness that additional evidence was being sought this year. An action plan has been developed to resubmit within 3 months including the evidence now requested.
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) has increased slightly due to industrial action and remains a primary focus to eliminate by March 2024. There are no 78+week waits. Restoring improvement in average waits (Referral To Treatment) will become the focus after that. • Activity was under plan for elective and day cases and slightly above plan for new outpatients. 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 5.33% is now back within normal variation. • Mandatory training remains above target and Appraisal compliance remains below target at 82%. The improvement plan had aimed to exceed 85% sustainably by September, but this hasn't yet been achieved. • A new metric "Doctors in Training Core Skills" shows how on-track the specific cohort who are currently with us are with their overall training; it doesn't reflect how well their training has been advanced whilst on rotation at The Walton Centre. ***Finance*** • The Income & Expenditure surplus was on plan (£2.8m YTD). The YTD Quality Improvement Programme (QIP) target was delivered, there was an improved proportion of recurrent QIP however this remained below the plan of 100% (73% compared to 100% planned). • Better Payment Practice Code stands at 88.7% of invoices paid and 90.7% of value against target of 95%. • Capital is well behind trajectory; large spend items are end-year loaded and phasing is being monitored closely. *Other matters* • Good progress is shown against the digital sub-strategy plan as currently defined; when brought to Board, it will be re-formatted and connection with the action plan from the Public Digital review action plan will be made clearer. • The 6 relevant strategic risks of the Board Assurance Framework were reviewed. On 'Digital' there is concern that the exec-led Digital Strategy Group is still not yet appropriately attended. On 'Cybersecurity' improvement from some dedicated resource was noted which will be prudent to sustain; it was suggested to reframe the wording of the risk (next year) to focus on action to mitigate cyber threats (which themselves are inevitable) and consider additional mitigation actions, rather than on a focus on reducing the threats themselves. • A deep dive into transformation work on outpatient processes showed a wide-ranging and thorough approach. The scale of the opportunity for improvement in efficiency seems very large; the actual magnitude needs further validation. A programme of wide-ranging improvement actions is being formulated. • A briefing on all the improvements being overseen by the Strategic Project Management Office showed a mixture of progress with delays caused by disruption over the course of the year. • A continued excellent set of performance achievements in Information Governance was evidenced. There were, however, 2 externally reportable incidents in the recent period shared as alerts via the forum.
4.	**Advise**	• A proposal to restructure sub-groups was agreed. The current set of 13 will be replaced by 4 Exec-led sub-groups which largely map to the 4 sub-strategies which BPC oversees. This should facilitate the elevation of strategic-type matters, and

		less operational ones, to the committee, whilst strengthening Exec accountability for the more operational matters. • Key Issues reports from 11 (current) sub-groups were received and reviewed. • A business case to replace EEG and telemetry was approved, subject to the financials being clarified. • 2 other business cases were recommended for Board approval (within Private Board).		
5.	**Risks Identified**	• No new risks identified		
6.	**Report Compiled**	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Date of last meeting: 16/11//2023		**Report of: Quality Committee**
		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 • National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report • Clinical Governance and Risk Register • Patient Experience Update Report • Pathology Quality Assurance Dashboard • Infection Prevention and Control Report • Tissue Viability Report • Deep Dive – Patient Falls • Mortality and Morbidity Report • Pharmacy KPI Report • Review of Committee Sub-Groups • Visibility and Walkabout Report • Potential Health and Safety Executive Visit • Learning From Deaths Policy • Patient Safety Incident Review Group Terms of Reference
2.	**Alert**	**Integrated Performance Report** Referral To Treatment (RTT) performance was noted to have dropped to 58%. Validation and mitigations are in place to ensure safety, however delays will invariably impact patient experience. **Infection Prevention and Control Report** There has been slow progress against the flu campaign target with vaccination levels currently at 33% against a CQUIN target of 70%.
3.	**Assurance**	**Infection Prevention and Control Report** It was noted that the Trust had achieved level three GAMSAS (Global Antimicrobial Stewardship Accreditation Scheme) accreditation for its Antimicrobial Stewardship programme. **Integrated Performance Report**

		Regular manual monitoring of sepsis documentation continues until implementation of a long term IT solution (anticipated early 2024). **Patient Falls** There was now a formal Quality Improvement project regarding patient falls and a deep dive into patient falls on Chavasse Ward was presented. Lessons learned and actions would be rolled out across all areas. **Mortality and Morbidity Report** Robust processes were in place to ensure all deaths were reviewed and any significant issues escalated as appropriate. **Risk and Governance Report** All actions relating to Serious Incidents and Never Events have either been completed or were within timescales, information around embedding of learning was requested for inclusion in future reports.
4.	**Advise**	**Integrated Performance Report (IPR)** The Committee agreed to remove the Divisional report section from the IPR to enable a focus on the relevant data within the main report. However, this would require the correct balance of focused narrative within the IPR. **Infection Prevention and Control Report** There has been an increase in the number of Clostridium Difficile infections recorded with eight infections recorded against an internal trajectory of eight for 2023/24. There is a continued focus on the fundamentals of infection prevention and control. It was noted that good progress had been made regarding Aseptic Non-Touch Technique (ANTT) by Nursing staff and work to review the best way to engage medical staff was underway. Three External Ventricular Drain (EVD) infections had been recorded and full reviews had taken place via SWARM post incident huddles which are held after each incident. **Tissue Viability Update Report** A business case for additional resource had been approved and the recruitment process was underway which would enable progress against Quality Account priority areas however it was recognised that this would take time to realise. **Pharmacy KPI Report** The quality improvement savings for 2023/24 were likely to be under £42k and the Committee proposed that there should be higher expectations for Quality Improvement Projects in 2024/25. Discussions are underway with commissioners regarding additional resource for Homecare patients, this was due to the growing number of homecare drug prescriptions. **Learning from Deaths Policy** The Committee endorsed the learning from deaths policy for Board approval subject to a review of the Equality Impact Assessment form and embedding of protected characteristics within the policy. **Patient Safety Incident Review Group Terms of Reference** The Committee approved the Patient Safety Incident Review Group terms of reference.

		Review of Committee Sub-Groups The Committee agreed to support the proposed review of Committee subgroups. Clarity would be sought regarding the Human Tissue Act Group and the new subgroup structure would be reviewed in 6 months to ensure it was working effectively and had brought benefit.		
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
7 December 2023

Report Title	Nursing Safe Staffing Bi-Annual Report
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 the system of controls

Key Messages *(2/3 headlines only)*

- Acuity and Dependency review now takes place every shift through safe care with a focus on professional judgement.
- Staffing data is now reviewed alongside patient harms monthly as part of the IPR.
- Sickness remains low for Registered nurses.
- Turnover remains low for nurses and Allied Health Professionals.

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

- Continue to educate and embed the safe care system.
- Formal audit of safe care/acuity to take place to obtain full assurance re safe care acuity levels.
- Full formal yearly establishment review led by the chief nurse to be conducted May 2024.
- Commence nursing/Allied Health Profressionals recruitment and retention plan

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Leadership	Quality	Workforce	Choose an item.

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

004 Patient Care and Experience	005 Recruitment and Retention of Staff	

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**
NA			

Nursing Safe Staffing Bi-Annual Report

Executive Summary

1. The purpose of this report is to provide the Board of Directors with assurance regarding the nurse staffing levels during the months of May 2023 to November 2023. The Trust has a duty to ensure nurse staffing levels are sufficient to maintain safety and provide quality care.

2. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, and it fulfils the recommendations of the NHS Improvement 'Developing Workforce safeguards' guidance (October 2018). The guidance recommends that the Board of Directors receive a biannual report on staffing to comply with the Care Quality Commission (CQC) fundamental standards on staffing and compliance outlined in the well led framework.

Background and Analysis

3. Substantial evidence exists that demonstrates nurse staffing levels significantly contribute to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care, and the efficiency of care delivery and therefore essential that the Trust delivers the right staff, with the right skills, in the right place at the right time.

4. At The Walton Centre, we aim to provide excellent, efficient safe care for our patients every day and our nursing staffing levels are continually assessed to ensure that we achieve this.

5. All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return, which is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. In addition, assurance is provided to the Trust Board of Directors via the Chief Nurse.

6. During the months of May 2023 to November 2023 staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift-by-shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and within the Trust, when fill rates are below 90%, the ward staffing is reviewed at the daily staffing meeting and the late and night shift, considering acuity and dependency via the safe care tool, and where necessary staff are redeployed from other areas to support.

7. **Care Hours Per Patient Day (CHPPD)**

   Care Hours Per Patient Day (CHPPD) was developed, tested, and adopted to provide a single, consistent, and nationally comparable way of recording and reporting staff redeployment in all inpatient wards across all healthcare settings. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight.

8. The senior nursing team currently collects and reports CHPPD data monthly. The May 2023 to November 2023 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Lead Nurses. The Walton Centre is above the national target of 7.9.

Year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD	CHPPD	CHPPD
2023/24			Registered	Care staff	All
	May	4328	6.3	5.5	11.8
	June	4180	6.6	5.6	12.2
	July	4207	6.5	5.8	12.3
	August	4220	6.6	5.9	12.5
	September	3959	6.8	6	12.8
	October	4338	6.3	5.6	11.9

Table 1 illustrates the monthly CHPPD data.

9. Due to the speciality of the trust, it is important that acuity and dependency is reviewed in line with nurse to patient ratio. Additional shifts are requested via NHSP to support patients that require 1-1 care. See Appendix one for the volume of additional shifts required to support this, this is shifts requested over and above their establishments.

10. Following the implementation of safe care, acuity and dependency is now assessed 3 times a day. See appendix two which illustrates the required hours vs the actual hours vs occupancy. There isn't a particular area of concern currently in relation to staffing levels although further work is required in the Intensive Care Unit (ITU) as they are showing as having more staff on duty consistently than is required, staff are therefore regularly moved to ward areas to support areas acuity and dependency.

11. A formal 21-day audit of staffing levels vs harms, acuity, incidents and concerns is due May 2024 and to be led by the chief nurse to complete a full staffing establishment review. In addition to this, Staffing data is also reviewed monthly now in line with patient harms, see appendix three.

12. Red Flags and staffing levels are reviewed three times a day with safe care and in the staffing meeting with all areas attending. A process has been put in place where red flags are reviewed, and resolved at the staffing meetings, if possible, to do so to ensure appropriate action has been taken to ensure staff and patients are safe.

13. Staffing Data and patient harms are presented Monthly to the Quality committee as part of the Integrated Performance Report.
    - Falls – There has been 1 serious harm fall between May 2023 and November 2023 that occurred on Caton ward, a full review was completed.
    - Pressure ulcers – The trust has reported one category 4 pressure ulcer on Caton ward and 9 category 2 pressure ulcers May to date which is a decrease from 22/23. Of the 9, 2 theatre, 2 Dott, 2 Chavasse, 1 Caton and 2 Horsley. Full reviews have taken place and actions identified for learning. None have been related to staffing levels.
    - 1 Deep Tissue Injury reported during this time which is also a decrease and occurred on Horsley. The Tissue viability lead has spent clinical time on the unit working alongside the team and providing teaching sessions.
    - Infection prevention and control- The trust is currently below all the allocated trajectories for Hospital Acquired infections with exception of Clostridium difficile and

pseudomonas. A pro active improvement plan is currently in the process of development by the senior nursing team and IPC. Additional investment has been provided to increase housekeeper hours to support the cleaning of equipment, deep cleans of ITU and ward environments have taken place and a drive on hand washing and IPC precautions.

- Complaints, the table below shows the number of complaints per area for May 23 to Nov 23.

Cairns	4
Caton	1
CRU	0
Chavasse	1
Dott	2
Horsley	2*
Jefferson	0
Lipton	0
Sherry	0

- Quarterly data shows incidents of violence and aggression have significantly decreased from 65 in Q1 23/24 to 47 in Q2 23/24. There was 65 in Q4 and 62 in Q3 22/23, the recruitment and work of the violence and aggression lead is having a positive impact on incidents (see chart 2). The incidents of physical assault have also reduced from 24 in Q1 to 12 in Q2.
- RAG status in place to record the level of staffing.
- Three times a day acuity and dependency review by a senior nurse of RAG status and red flags
- 19 red flags unresolved from May to November 2023, all of which was reviewed by the ward manager and matron and no harm occurred following this.
- Unresolved red flags are monitored during the day and evening by senior nursing teams.

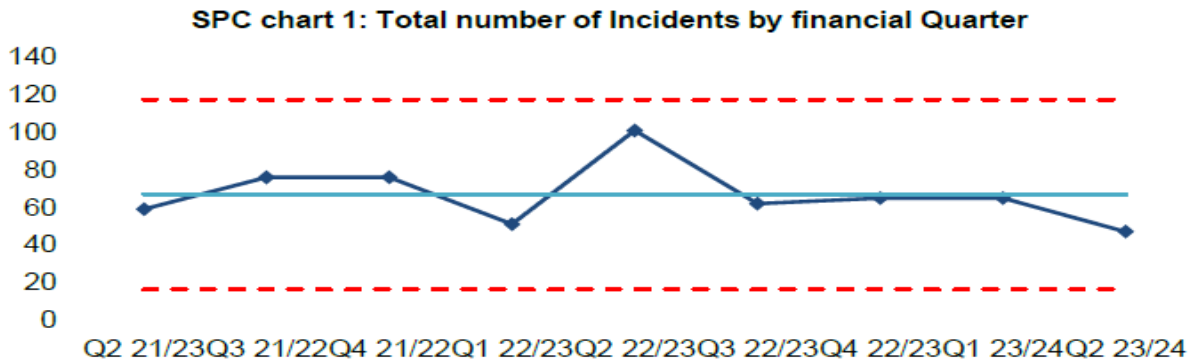


Chart 2: total number of Violence and aggression incidents.

14. Sickness

Sickness continues to vary and is currently at 4.61% for Registered Nurses (RN), this is the lowest it has been for the 6 months. Both divisions hold monthly sickness meetings to ensure a plan is in place for each individual and the trust sickness policy is followed and required individualised support is provided, as necessary. The sickness policy process is audited by HR and any concerns with timeframes are escalated.

15. Healthcare Assistant (HCA) sickness is at 9.43%, the senior nursing team plan to carry out a deep dive into this data to identify any themes/trends or areas that require any further support.

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
Add Prof Scientific and Technic	0.00%	0.81%	0.00%	2.51%	1.09%	1.74%
Additional Clinical Services	7.98%	8.74%	10.16%	9.49%	9.51%	9.23%
Administrative and Clerical	2.81%	3.82%	3.73%	3.98%	4.50%	4.98%
Allied Health Professionals	4.59%	4.94%	2.88%	2.97%	3.03%	4.23%
Estates and Ancillary	5.75%	19.22%	23.09%	10.82%	9.42%	10.35%
Healthcare Scientists	0.54%	0.00%	0.22%	1.09%	5.86%	1.70%
Medical and Dental	1.16%	0.82%	1.83%	1.68%	1.21%	1.52%
Nursing and Midwifery Registered	6.31%	6.21%	6.73%	7.05%	5.91%	4.61%
Grand Total	**4.64%**	**5.19%**	**5.44%**	**5.40%**	**5.21%**	**5.04%**

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
Healthcare Assistant	9.00%	9.23%	10.58%	10.31%	9.94%	9.43%

Table 3: RN and HCA sickness

16. Vacancies

Tables 4 indicates the number of RN and HCA vacancies as of November 2023. A total of 7 RNs were given to ITU to support the re-opening of HDU which has increased the vacancies, but recruitment is taking place. The trust completed their first pre-employment programme post covid where 5 staff were recruited.

Table 4: RN and HCA vacancies as of November 23

REGISTERED	Budget WTE	Actual WTE	Vacancy
Chavasse Ward	25.11	23.43	1.68
Complex Rehab Unit	24.36	19.82	4.54
Lipton Ward	15.12	11.03	4.09
Cairns Ward	20.52	21.54	-1.02
Caton Ward	20.53	15.78	4.75
Dott Ward	20.52	17.02	3.5
Horsley Ward	113.32	104.8	8.52
Theatres	49.24	46.8	2.44

UNREGISTERED	Budget WTE	Actual WTE	Vacancy
Chavasse Ward	29.23	25.49	3.74
CRU	40.93	41.58	-0.65
Lipton Ward	21.39	17.86	3.53
Outpatients	16.67	15.6	1.07
Cairns ward	18.84	15.3	3.54
Caton	16.06	16.28	-0.22
Dott	16.05	16.48	-0.43
Horsley	16.2	14.73	1.47

17. Turnover

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %
Add Prof Scientific and Technic	1.83%	0.00%	3.10%	0.00%	0.00%	5.07%
Additional Clinical Services	0.55%	1.35%	1.54%	1.27%	3.77%	2.61%
Administrative and Clerical	1.30%	1.94%	1.44%	2.10%	0.94%	0.25%
Allied Health Professionals	0.38%	0.41%	1.81%	1.34%	1.73%	0.40%
Estates and Ancillary	0.00%	0.00%	0.00%	0.00%	3.16%	0.00%
Healthcare Scientists	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Medical and Dental	0.39%	0.00%	1.37%	6.86%	0.67%	2.00%
Nursing and Midwifery Registered	0.14%	1.03%	1.90%	0.82%	1.29%	0.36%
Grand Total	**0.62%**	**1.10%**	**1.61%**	**1.89%**	**1.56%**	**0.97%**

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %
Healthcare Assistant	0.72%	0.88%	1.76%	1.61%	2.36%	1.75%

Table 5: Nursing and HCA Turnover

18. Turnover for nursing and HCA remains consistently low with no concerns, it has been noted via information to people group that Chavasse and CRU has seen an increase in leavers, but nothing specifically identified on exit reviews, the people group will continue to monitor this with the neurology division.

19. Overseas recruitment

The Trust successfully participated in a Pan-Mersey international recruitment project and recruited a total of 61 Internationally Educated Nurses across all areas. The Trust is not taking part in the next cohort of recruitment due to skill mix, lack of vacancies and turnover.

20. Temporary Staffing

The Trust utilises NHS Professionals (NHSP) for temporary staffing with a current fill rate of 85% RN and 80% HCA (see appendix four), in comparison with 21/22 of 79%. A further 6 CSWD have been recruited and are in the training phase to support winter NHSP fill rates for HCA shifts.

21. Apprenticeships

The trust has been successful in receiving funding from NHS England to support 3 of our nurse associates to progress to Registered Nurse Degree Apprenticeship programme 2023/24. A business case is currently in development for ODP apprenticeships and degree apprenticeships are in place in Therapies and physiotherapy.

22. Theatres

Theatre pathways have resumed back to pre-covid pathways and work is underway to increase theatre utilisation. Theatres has seen an increase in their vacancies with the following:
1 WTE band 5 scrub,
2 WTE band 5 anaesthetics,
1 WTE band 6 anaesthetics,
1 WTE band 6 recovery,
1 WTE band 3 HCA
1 housekeeper (12hrs) following investment.

23. Recruitment is underway with all the vacancies.

24. Funding has also been secured from NHS England to upskill Operating Department Practitioners (ODP) senior leadership educator who will undertake a PGC in Education to further support in house teaching, undergraduate clinical education and maintain CPD (continuing professional development) for theatre staff.

25. Allied Health Professionals (AHP)

The Walton Centre Therapies service consists of 5 AHP disciplines with valid Health and Care Professions Council (HCPC) registration: Occupational Therapy, Physiotherapy, Speech & Language Therapy, Dietetics, and Orthoptists. Together these teams provide specialist therapy intervention to acute wards, ITU, rehabilitation units Complex Rehabilitation Unit (CRU) & Lipton Hyperacute, community rehab, outpatients, Pain Management, Trauma, and Spinal services.

26. Recruitment for vacant posts has mostly been successful, although there remains a national shortage of Occupational therapists and speech and language therapists. To develop our future workforce therapies are currently supporting the new Degree Apprenticeship route for one occupational therapist and one physiotherapist on a three-year program.

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
Allied Health Professionals	4.59%	4.94%	2.88%	2.97%	3.03%	4.23%

Table 6: Illustrates AHP sickness.

	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10
	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %	Turnover FTE %
Allied Health Professionals	0.38%	0.41%	1.81%	1.34%	1.73%	0.40%

Table 7: AHP turnover.

Conclusion

27. The Walton Centre has a series of robust systems in place to consistently monitor safe staffing and utilise the nationally recommended tools to support the setting of establishments in line with the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018.

28. Safe staffing and staffing escalations are monitored and utilised and is always a priority for the clinical teams. These processes remain in place to support staff and protect the safety of patients at The Walton Centre.

29. A full formal establishment review is due May 2024 and is to be led by the Chief nurse.

30. Violence and aggression continue to be a theme in incidents but is clearly reducing following the work implemented by the new violence and aggression lead.

31. Turnover remains low for nursing and AHPs

32. Sickness remains low for Registered Nurses but a deep dive is required to understand Health Care Assistant sickness.

33. Progress with Apprenticeships must continue.

34. The Chief Nurse needs to progress with a trust nursing and AHP recruitment and retention plan.

Recommendation

To note

Author: **Nicola Martin, Chief Nurse**
Date: **26/11/2023**

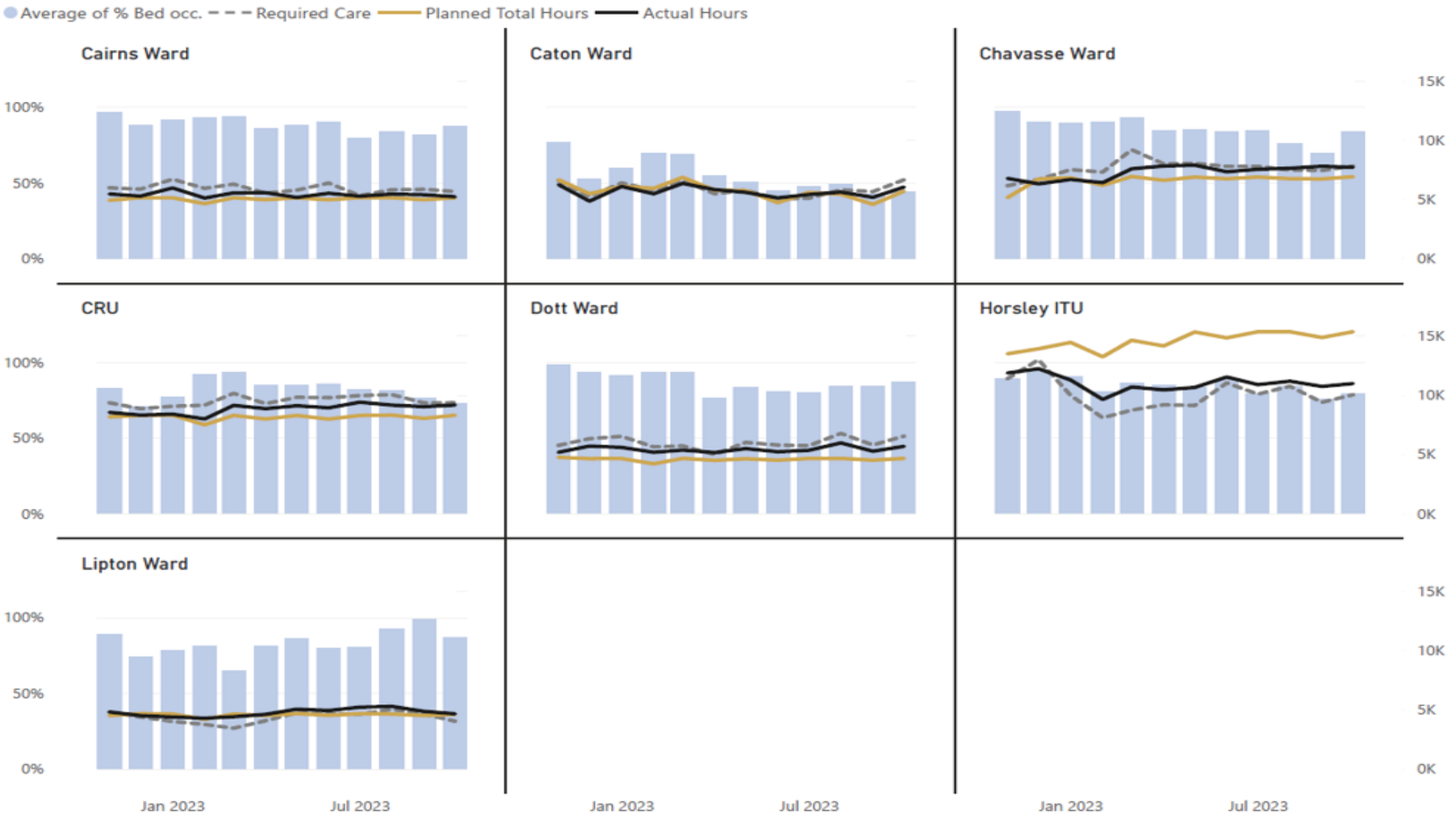
Appendix One

Unit Name	Shift Name	Planned RN Average	Actual RN Average	Planned HCA Average	Actual HCA Average	Total Additional RN Duties	Total Additional HCA Duties	Total Specials
Cairns Ward	Early	3.99	4.01	3.99	3.83	4.00	46.00	545.00
	Late	3.98	3.86	4.00	3.56	1.00	27.00	544.00
	Night	3.00	3.05	3.00	4.01	8.00	204.00	535.00
	Total					**13**	**277**	**1624**
Caton Short Stay	Early	1.81	0.67	1.44	0.19	1.00	0.00	0.00
	Late	1.79	0.65	1.63	0.23	0.00	0.00	0.00
	Night	1.20	0.61	1.30	0.39	1.00	0.00	0.00
	Total					**2**	**0**	**0**
Caton Ward	Early	4.12	4.18	3.10	3.64	4.00	127.00	487.00
	Late	4.12	4.09	3.11	3.46	4.00	112.00	482.00
	Night	3.10	3.18	3.08	3.96	8.00	196.00	497.00
	Total					**16**	**435**	**1466**
Chavasse Ward	Early	4.63	4.46	5.64	6.29	2.00	212.00	1125.00
	Late	4.63	4.34	5.64	5.61	3.00	148.00	1068.00
	Night	3.96	3.93	4.98	6.61	12.00	349.00	966.00
	Total					**17**	**709**	**3159**
CRU	Early	4.70	4.47	7.97	9.14	1.00	270.00	1488.00
	Late	4.00	3.97	7.98	8.71	0.00	228.00	1421.00
	Night	3.99	3.98	6.96	8.57	2.00	341.00	1232.00
	Total					**3**	**839**	**4141**
Dott Ward	Early	3.99	4.04	3.00	3.94	9.00	189.00	588.00
	Late	3.98	3.90	3.00	3.55	5.00	138.00	596.00
	Night	3.00	3.05	3.00	4.41	12.00	266.00	628.00
	Total					**26**	**593**	**1812**
Horsley ITU	Early	18.98	17.43	2.99	2.39	5.00	4.00	
	Late	18.99	17.34	3.00	2.32	6.00	3.00	
	Night	18.97	17.59	3.00	2.28	16.00	1.00	
	Total					**27**	**8**	**0**
Lipton Ward	Early	3.00	2.83	3.98	4.46	0.00	142.00	827.00
	Late	3.00	2.71	3.97	4.36	1.00	130.00	774.00
	Night	2.00	2.02	3.96	4.90	1.00	205.00	771.00
	Total					**2**	**477**	**2372**

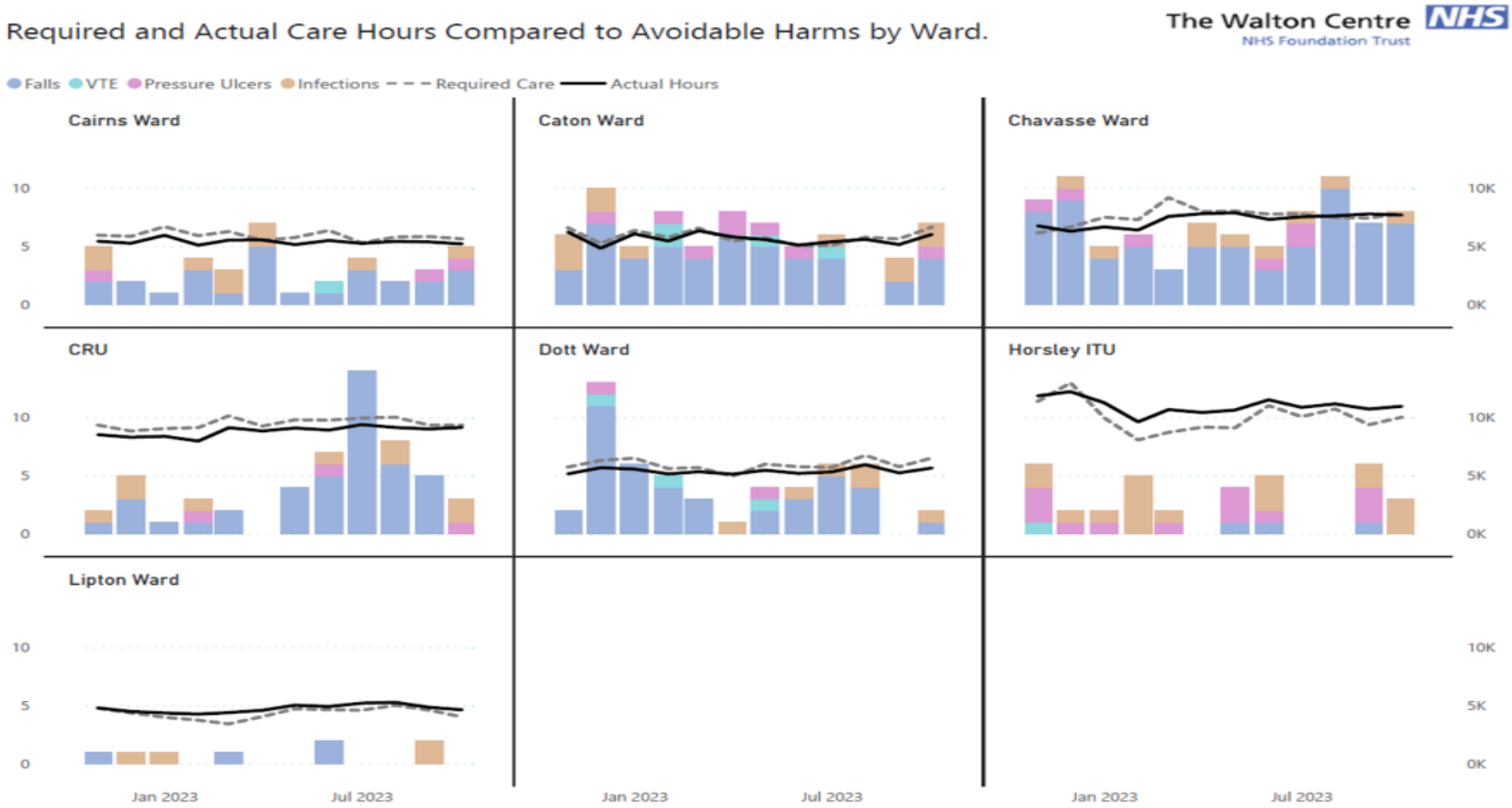
Appendix Two

Required and Actual Care Hours Compared to Occupancy and Establishment

The Walton Centre NHS Foundation Trust

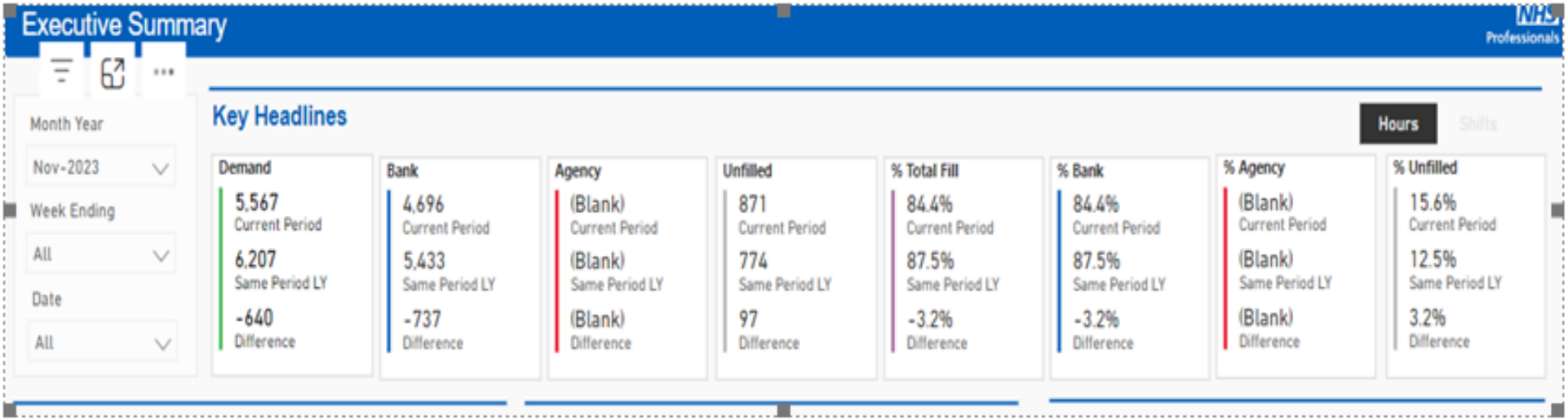


Appendix three.

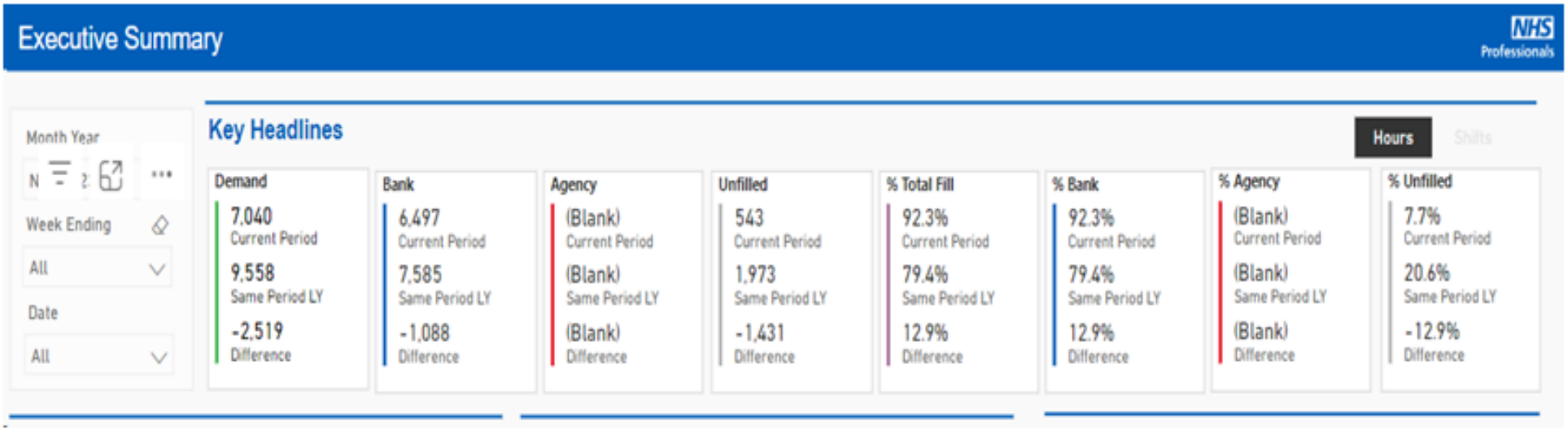


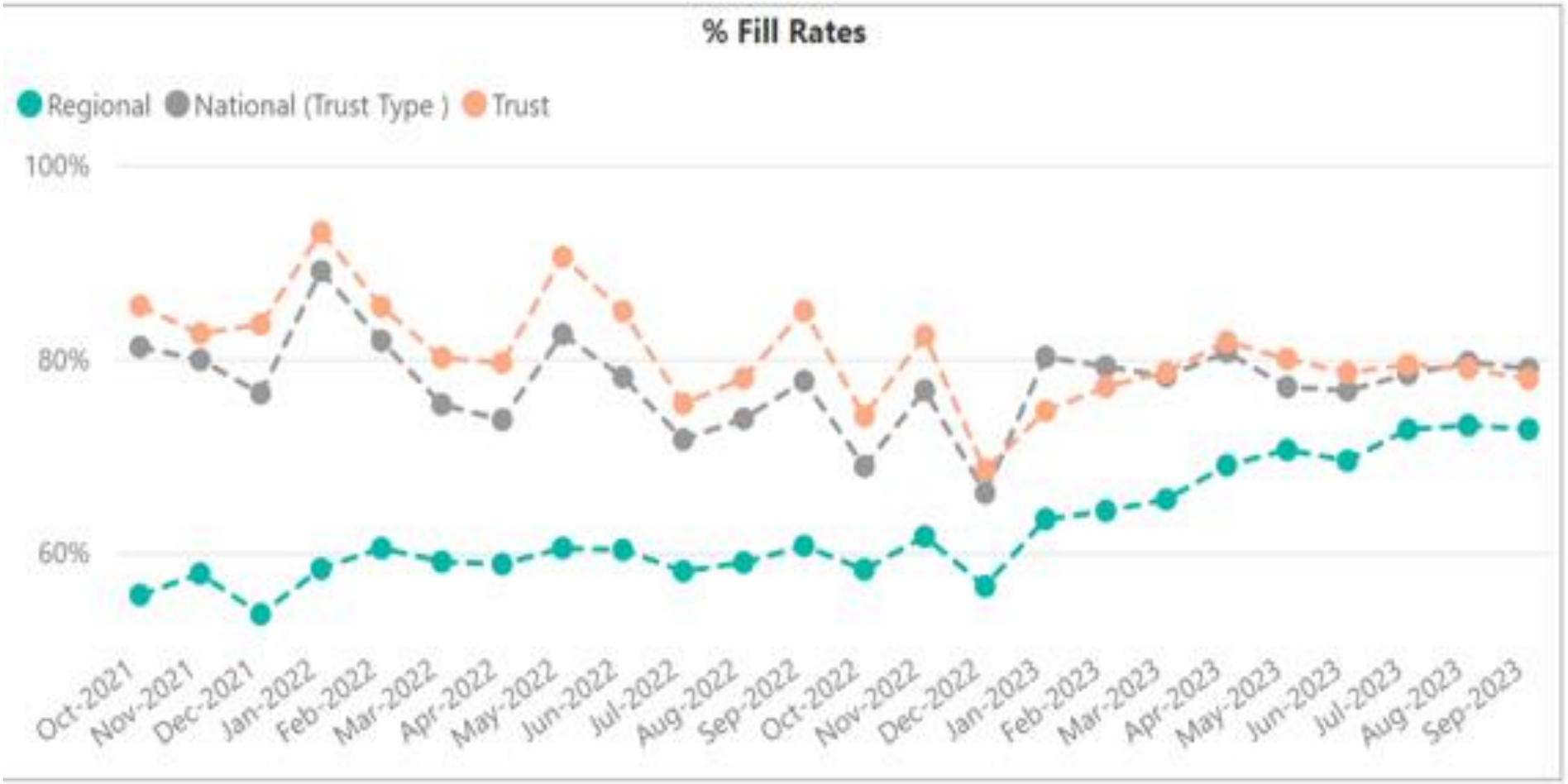
Appendix four

RN00 84.4%



CSW 92.3%




% Fill Rates
Regional
National (Trust Type)
Trust
100%
80%
60%
Oct-2021
Nov-2021
Dec-2021
Jan-2022
Feb-2022
Mar-2022
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Jul-2022
Aug-2022
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Mar-2023
Apr-2023
May-2023
Jun-2023
Jul-2023
Aug-2023
Sep-2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
07 December 2023

Report Title	Freedom to Speak Up – A Reflection and Planning Tool
Executive Lead	Nicola Martin, Chief Nurse
Author (s)	Nicola Martin, Chief Nurse Jane Mullin, Deputy Chief People Officer Julie Kane, Quality Manager and Freedom to Speak Up Guardian
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

- The National Guardians Office published a revised Freedom to Speak Up Reflection and Planning Tool which all organisations are required to complete.
- Senior Leaders, the Non-Executive Director for Raising Concerns and the FTSU Guardian are required to complete the tool.
- The purpose of this paper is to share the FTSU Reflection and Planning Tool with the Board of Directors following review by the Executive Team.

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

- The Board of Directors are asked to review and note the report.
- The high-level development actions will be progressed over a 6-24 month period as stated in the report.
- New Chief nurse will continue the role as FTSU executive lead.
- New NED for FTSU lead identified also.
- New NED to complete the NED section of review tool.

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

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

001 Quality Patient Care	004 Leadership Development	Not Applicable

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**
Execs	8/11/23	Nicola Martin	Reviewed and Approved.

Freedom to Speak Up – A Reflection and Planning Tool

Executive Summary

1. The purpose of this paper is to share the Freedom to Speak up Reflection and Planning Tool (see Appendix One) with the Board of Directors following approval from the Executive Team.

2. The tool is designed to help identify strengths in ourselves, the leadership team, the organisation and any gaps. The tool should be used alongside Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.
   Link to the guide: FTSU - A Guide for Leaders

3. The National Guardians Office confirmed all NHS Trusts and Foundation Trust Boards have been asked to update their local policy to reflect the new national template by the end of January 2024. By this time, Trusts should have also seen the outputs from using the self-reflection tool and provided at least one progress update.

4. We have revised our local speak up policy in line with the requirements set out by the National Guardians Office. This was approved at the Staff Partnership Committee in January 2023 and is available on the Trust intranet.

Background and Analysis

5. The senior lead for FTSU in the Trust to take responsibility for completing this reflection tool, at least every 2 years.

6. Completing the tool will demonstrate to the senior leadership team, Board and/or any oversight organisation on the progress we have made developing our Freedom to Speak Up arrangements.

Conclusion

7. The assessment has been completed by the Chief Nurse, Trust FTSU lead and Deputy Chief People Officer. The Executive team need to confirm what group and/or committee will monitor progress against the high-level actions during the forthcoming 6-24 months.

Recommendation

8. To approve the Freedom to Speak Up Reflection and Planning Tool.

Authors: Nicola Martin, Jane Mullin, and Julie Kane

Date: November 2023

Appendix One: Freedom to Speak Up reflection Toolkit

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	No
I am assured that our guardian(s) was recruited through fair and open competition	No
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes
Enter summarised commentary to support your score. The FTSUG was appointed over 5 years ago and not via a formal interview process as this was an addition to her substantive role	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 MIAA to undertake a review of the speak up arrangements as part of their annual plan for 2024/25	
2 Review the ringfenced time of the Freedom to Speak Up Guardian	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score. To be completed by Non-Executive Lead for Raising Concerns – When returns	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	No
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	Yes
We are confident that we have clear processes for identifying and addressing detriment	Yes
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	Yes
We regular discuss speaking-up matters in detail	Yes
Enter summarised evidence to support your score. To be completed by Executive Team	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 Comms plan for execs for FTSU vision	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	No
We support our guardian(s) to make effective links with our staff networks	No
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
Enter summarised evidence to support your score. The Trust has a People sub strategy and live action plans around staff experience and health and wellbeing, the Trust has regular surveys and staff engagement events throughout the year encouraging staff to speak up. Whist the Trust has not formally adopted a just and learning culture we do adhere to the principles. The Freedom to Speak Up Guardian attends local staff networks including LGBTQIA+, Equality Diversity and Inclusion and Race	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Support guardian to link with staff networks	
2 Consider adding a question to the next pulse survey re FTSU	
3 Align Speak Up Champions to staff networks	
4 Consider and AHP as a Speak Up Champion	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events	N/A
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	N/A
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes
Enter summarised evidence to support your score. To be completed following action/s taken within Principle 1	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	3
Enter summarised evidence to support your score. Raising Concerns Policy has been updated and reflects NGO changes	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Pulse Survey & Tendable to include a question about accessing the policy	
2 Friday round up Trust wide – Communications Team to include information/link to the policy	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	No
We tell positive stories about speaking up and the changes it can bring	Yes
We measure the effectiveness of our communications strategy for Freedom to Speak Up	No
Enter summarised evidence to support your score.	

FTSUG Office well signposted Drop-In sessions scheduled throughout the year Intranet page provides information on Speaking Up, the FTSU Guardian and Champions Quarterly report to Board by the FTSUG including feedback from those who have spoken up
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Devise Annual Plan to raise profile of FTSU
2 Question to be added to Pulse Survey and Communications Strategy re: FTSU

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	No
Enter summarised evidence to support your score. Mandatory training for all staff Level 1 FTSUG presents at Corporate Induction each month, attends Junior Doctors Forums and local meetings within the Trust	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 During 'Speak Up' Month in October additional question to be added to questionnaire re: impact of e-learning training	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	Yes – Compliant at time of completion
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. Daily huddles undertaken for all staff (clinical and non-clinical) to attend Senior Nursing Team Presentations at Corporate Induction	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Level 2 e-learning training to be launched Q2 2023	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes

We use triangulated data to inform our overall cultural and safety improvement programmes	3
Enter summarised evidence to support your score. Meetings occur with the Executive and Non-Executive Leads for Raising Concerns, the FTSUG and Deputy Chief People Officer	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Board Report to include updates from monthly meetings with those listed above	

Statements about learning for improvement	**Score 1–5 or yes/no**
We regularly identify good practice from others – for example, through self-assessment or gap analysis	No
We use this information to add to our Freedom to Speak Up improvement plan	No
We share the good practice we have generated both internally and externally to enable others to learn	Yes
Enter summarised evidence to support your score. The FTSUG has a dual role	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Improvement Plan to be devised	
2 Good practice, learning and gap analysis to be undertaken and shared	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	No
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. The FTSUG was appointed over 5 years ago and not via a formal interview process as this was an addition to her substantive role The FTSUG has been undertaken the training and registered with the NGO	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 If the FTSUG resigns from the role it will be advertised and appointed to in a fair and transparent way	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	No
There is an effective plan in place to cover the guardian's absence	No

Our guardian(s) provides data quarterly to the National Guardian's Office	Yes
Enter summarised evidence to support your score. FTSUG has an appraisal each year with clear objectives One to One support is readily available for the FTSUG. Monthly meetings take place with the FTSUG and Executive and Non-Executive Leads for Raising Concerns and the Deputy Chief People Officer. Quarterly meetings take place with the FTSUG, CEO and Chair Quarterly data is provided to the NGO by the FTSUG	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Review what support/supervision is accessible/made available	

Statements about our speaking up process	**Score 1–5 or yes/no**
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	3
Enter summarised evidence to support your score. The Raising Concerns Policy is up-to-date and in line with the National Guardians Office requirements	

The FTSUG escalates concerns in a timely manner Annual staff survey results
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Review if confidentiality is maintained effectively, progress is made timely and experience is positive from a HR perspective

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	No
We know who isn't speaking up and why	No
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	No
Enter summarised evidence to support your score. Champions undertake training and a case study during their training and are clear on their role	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Identify barriers: • Closed Culture Paper – Work to be initiated • Reviews undertaken within ITU, Therapies and Theatres	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	No
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	2
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	No
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Pulse Survey – Add questions in relation to detriment	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes

We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes
Our improvement plan is up to date and on track	No
Enter summarised evidence to support your score. The Trust has a People sub strategy and live action plans around staff experience and health and wellbeing, the Trust has regular surveys and staff engagement events throughout the year encouraging staff to speak up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Devise Improvement Plan	

Statements about evaluating speaking-up arrangements	**Score 1–5 or yes/no**
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	No
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	No
Our speaking-up arrangements have been evaluated within the last two years	No
Enter summarised evidence to support your score. A plan to be in place to measure confidence which follows PDSA Speak Up Arrangements to be evaluated	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

1 Evaluate speak up arrangements via Mersey Internal Audit Agency
2 Devise Improvement Plan

Statements about assurance	**Score 1–5 or yes/no**
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes
Enter summarised evidence to support your score. FTSUG presents a quarterly report to Board in person CIPs signed off by Chief Nurse and Medical Director	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Provide the Executive Team with the detail in relation to speaking up and the improvements to be presented to Board via the Annual Report	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Identify a Non-Executive Lead for Raising Concerns	Q3 2023/24	Interim Chief Nurse
2 Align Champions with Staff Networks	Q4 2023/24	FTSUG
3 Question to be added to Pulse Survey in relation to evidencing that our staff know how to find the speaking up policy	Q1 2024/25	Interim Chief Nurse and Deputy Chief People Officer
4 Tendable to include a question in relation to evidencing that our staff know how to find the speaking up policy	Q3 2023/24	Matron for Surgery
5 Communications Team to include in the Friday Round Up the link to the speak up policy	Q3 2023/24	FTSUG/Comms Team
6 Devise Annual Plan to raise profile of FTSUG	Q4 2023/24	FTSUG Interim Chief Nurse
7 Review supervision, support for FTSUG	Q4 2023/24	Interim Chief Nurse
8 Comms plan for execs for FTSU vision	Q1 2024/25	Communications Team

Development areas to address in the next 12–24 months	Target date	Action owner
1 MIAA to undertake a review of the speak up arrangements as part of their annual plan for 2024/25	April 2024	Interim Chief Nurse
2 Question to be added to Pulse Survey in relation to those who feel they have suffered detriment after speaking up	January 2024	Deputy Chief People Officer
3 Devise a Freedom to Speak Up Improvement Plan	Q2 2024/25	Interim Chief Nurse, FTSUG, Deputy Chief People Officer
4 Review timeframes from when concerns are raised with HR	Q4 2023/24	Deputy Chief People Officer
5 Identify barriers to speak up and the impact	Q4 2023/24	Interim Chief Nurse, FTSUG, Deputy Chief People Officer

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Board engagement and the response to board report	Reports to Board	Interim Chief Nurse, FTSUG
2 People Strategy	Q4 2023/24	Deputy Chief People Officer
3 Triangulation of data reported to board	Reports to Board	Interim Chief Nurse, FTSUG
4 TEA Sessions	Q1 2024/25	Deputy Chief People Officer
5 Join Jan	Ongoing	Deputy Chief People Officer
6 Senior Nursing Team 'walkabouts'	Ongoing	FTSUG
7 FTSUG 'Drop In' sessions including evening and weekend walkabouts	Ongoing	FTSUG

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Date of last meeting: 17/10/23		**Report of:** Audit Committee
		Membership Numbers: Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Recommendations Report • Infection Prevention and Control BAF Audit Report • External Audit Progress Report • Breach of Managing Conflicts of Interest Policy • Tender and Quotations Waivers Q2 Report 2023/24 • Review and Explanation of the 2021/22 National Cost Collection Index • Financial Compliance Report • Standing Financial Instructions and Scheme of Reservation and Delegation • Senior Information Risk Owner Annual Report 2022/23 • Raising Concerns Processes • Fit and Proper Person Test: The Role of the Audit Committee • Waiting List Management Checklist • Cyber Security Improvement Initiatives 6 Month Update • Audit Committee Cycle of Business • Anti-Fraud Bribery and Corruption Policy and Response Plan
2.	**Alert**	• The Committee received an update on the 2022/23 Infection Prevention and Control BAF Audit Report which provided "Limited Assurance" and noted the actions/measures in place to improve compliance. • The Trust had an overall National Cost Collection Index (NCCI) score of 119 which was an indication that the Trust was running at a higher average cost per patient in comparison to 2020/21. More work was being undertaken.

3.	**Assurance**	• Internal audits of Medical Revalidation had provided Substantial Assurance.
		• The Committee considered the Internal Audit Progress Report and noted that the following audits were underway:
		  ○ Fire Safety (fieldwork stage)
		  ○ Data Quality – IPR (reporting stage)
		  ○ Safe Staffing/eRostering (reporting stage)
		  ○ Key Financial Controls (fieldwork stage)
		  ○ Budgetary Control and management reporting (scoping stage)
		• The Internal Audit Recommendation Report was received by the committee, and it was highlighted that the Trust had closed eleven out of the twenty recommendations

		previously made and continued to make progress against the implementation of the open recommendations. • The Committee received the 2022/23 Senior Information Risk Owner Annual Report, and it was noted that the Trust received "Substantial Assurance" rating for the Data Security and Protection Toolkit (DSPT) self-assessment for the 13th year in succession and obtained "Standards Met" for the new DSPT for the fifth year. • The Committee received the Waiting List Management Report and noted the measures in place to improve areas where the Trust had underperformed. • The 2023/24 Q2 Tender Waivers Report was received, and the Committee noted the positive outcomes. • The 2023/24 Financial Compliance Report was received by the committee and the Committee noted the recovered debts and measures in place to recover aged debts. No bad debts had been approved or written off so far within the year. • The Committee received the External Audit progress report and noted the timeline for reporting and issuance of the 2023/24 external Audit plan. No significant risks had been identified. • The Committee received the Cyber Security Improvement Initiatives 6-month update and noted the completed initiatives within the period and updates on planned initiatives.		
4.	**Advise**	• The Committee noted that if Internal Audit Recommendations were not closed within the set deadlines and sufficient information not received when requested, it could impact negatively on the Auditor's Final Opinion for 2023/24. • The Committee received the Fit and Proper Person's Test (FPPT) compliance report, an update on the Trust compliance to the revised FPPT Framework to be presented to the Committee in 2024/25. • The Breach of Managing Conflict of Interest Policy was received by the Committee. There had been one breach within the year, and it had been managed in line with the policy. The policy has been updated in light of the breach. • The Committee received and approved the Anti-Fraud Bribery and Corruption Policy and Response Plan. • Annual updates on the Trust's National Cost Collection Index and a benchmarking report against other specialist Trust to be presented to the Business Performance Committee going forward. • The Committee received a report on the Raising Concerns Process and an internal audit on the Trust's Freedom to Speak Up process to be carried out in 2024/25. • The Committee endorsed the Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SoRD) for Board approval.		
5.	**Risks Identified**	• No new risks had been identified.		
6.	**Report Compiled by**	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
7th December 2023

Report Title	Review of Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)
Executive Lead	Mike Burns – Chief Finance Officer
Author (s)	Zoe Stevenson – Head of Financial Services
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)*

- Both the SFI and SORD have been reviewed to ensure that they remain up to date and in line with current financial regulations.
- The changes to the SFIs are detailed on page 3 of the document.
- The changes to the SoRD are detailed on page 4 of the document.

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

- Ensure updated SORD is put on Trust intranet
- Training to be provided to ensure staff are aware of their responsibilities.

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Value for Money	Finance	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**
Audit Committee	5th July 2023	Katie Tootill – Chief Procurement Officer Andy Green Deputy Chief Finance Officer	Given the number of business cases that were being presented / submitted for Chairs Approval at BPC it was suggested that the levels of delegation for approval were reviewed in the Trust.
Audit Committee	17th October 2023	Zoe Stevenson – Head of Financial Services	Annual review of the SFIs and SoRD

Review of Standing Financial Instructions and Scheme of Reservation and Delegation

Executive Summary

1. The current SFI's and SoRD are subject to an annal review which is reviewed at Audit Committee in October with recommendations to Trust Board in December.

Background and Analysis

2. This year an interim review was carried out in the summer and it was decided to increase the approval levels to aid process flow as it was noted that some capital business cases were being delayed (and some at relatively low values) given that Business Performance Committee (BPC) is a monthly process, when they could have been approved at another forum such as the executive team meeting, which happens weekly and is therefore able to be more agile in its approval cycle. As part of the Health Procurement Liverpool (HPL) governance it was appropriate to look at standardising the thresholds across all partner sites moving forwards.

3. The increased levels were approved and implemented immediately however, the Board are also required to approve any updates as part of the annual review.

Conclusion

4. The changes to the SFI's and the SoRD are detailed within each document including the approval limits that have been increased and the general requirement to streamline procurement and finance processes along with harmonising some processes in HPL.

Recommendation

5. Trust Board are requested to approve the changes to the SFIs and SoRD.

Author: Zoe Stevenson – Head of Financial Services
Date: 24th November 2023

Appendix 1: Standing Financial Instructions

Appendix 2: Scheme of Reservation and Delegation

The Walton Centre NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Reviewed by:

Zoe Stevenson, Head of Financial Services
October 2023

Authorised by:

Mike Burns, Chief Financial Officer

CONTENTS

SECTION

RECORD OF AMENDMENTS

SECTION	AMENDMENT	DATE
5	Replacement of OPG by GBS and electronic banking	25/03/2010
11	Replace references to Capital Accounting Manual with Reporting Manual	25/03/2010
16	Remove section on charitable funds and renumber	25/03/2010
16 (Formerly section 17)	Remove references to PASA which no longer exists	25/03/2010
12.8 and 16.7 (Formerly section 17.7)	Change name of NHS Logistics to NHS Supply Chain	25/03/2010
All sections	General review and updating re: legislative updates	01/12/2011
Section 16	Revised for introduction of electronic tendering	July 2012
All sections	General review and updating re: legislative updates (e.g. NHS Act 2012)	June 2013
11	Revised for Monitors amended Risk Assurance Framework	Oct 2014
16	Revised for electronic tendering	Oct 2014
All sections	General review for titles and legislative changes	Oct 2014
All sections	General review for typos and legislative changes	Nov 2015
All sections	General review for typos and legislative changes – including change from Monitor to NHS Improvement and the introduction of the Single Oversight Framework.	Oct 2016
1	Add in comments on Chair's actions, as requested by Nov 16 Board.	Jan 2017
All sections	Updated Director of Nursing, Operations and Quality job title	
All sections	General review for errors and legislative changes	Oct 2017
9	Details added regarding the Zero Cost Model ordering process (the ZCM process flow document is currently under review)	Oct 2017
All sections	General review for errors, names and legislative changes	Oct 2018
12	Details added regarding the authorisation of NHS Supply Chain Weekly Sales invoices	Oct 2018
9	Details added regarding travel for Executives	Oct 2018
All sections	General review for errors, names and legislative changes	Oct 2019
16	Exclude Liverpool Health Partners subscription from formal tendering procedures	Oct 2019
All sections	NHS Protect to NHS Counter fraud Authority	Oct 2020
All sections	NHS Improvement to NHS England/Improvement	Jan 2021
Section 13	Update responsibility from Medical Director to Board of Directors	Jan 2021
All sections	Changes to job titles as follows: Director of Finance and IT amended to Chief Financial Officer Deputy Director of Finance amended to Deputy Chief Financial Officer Director of Nursing and Governance amended to Chief Nurse Deputy Director of Nursing and Governance amended to Deputy Chief Nurse Director of Operations and Strategy amended to Chief Operating Officer Director of Workforce and Innovation amended to Chief People Officer	Oct 2021
Section 14	Responsibility OF the Trusts IT compatibility, compliance and risk changed from Director of Finance and IT to Chief People Officer	Oct 2021
All sections	NHSI to NHSE/I	Oct 2021
All sections	Change Head of Procurement to Chief Procurement Officer	Oct 2023
	Change NHSE/I to NHSE	Oct 2023
Section 8	Include job evaluation (agenda for change) under Staff Appointments	Oct 2023
All sections	Change Financial Accountant to Head of Financial Services	Oct 2023

General

NHS England (NHSE) sets the Terms and Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector and with any relevant code of practice and guidance issued by NHSE. The Code of Conduct and Accountability in the NHS issued by the Department of Health and Social Care requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions (SFIs) for the regulation of the conduct of its employees in relation to all financial matters with which they are concerned. These SFIs are issued in accordance with the Code and detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation (SoRD) adopted by the Foundation Trust and identify the financial responsibilities, which apply to everyone working for the Foundation Trust and its constituent organisations including hosted arrangements. They do not provide detailed procedural advice and should therefore be read in conjunction with the detailed departmental and financial procedure notes.

The Chief Financial Officer must approve all financial procedures and should any difficulties arise regarding the interpretation or application of any SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING.** The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's Governance Manual.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

Overriding SFIs:

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall reported to the next Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer as soon as possible.

In the Standing Financial Instructions the following definitions apply:

Term	Definition
The 2006 NHS Act	Means the 2006 National Health Service (NHS) Act as amended.
The Health and Social Care Act 2012	Means the Health and Social Care Act 2012.
Accounting Officer	Shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They shall be responsible for ensuring the proper stewardship of public funds and assets. The 2006 NHS Act designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.
Board of Directors	The Board of Directors of the Foundation Trust, as constituted in accordance with the Foundations Trust's constitution.
Budget	A plan, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust.
Budget Holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
The Chair	Means the Chair of the Foundation Trust, or such person, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution.
Chief Executive	The Chief Officer (and Accounting Officer) of the Foundation Trust.
Committee	A Committee or Sub-Committee created and appointed by the Foundation Trust.
Constitution	The Constitution of The Walton Centre NHS Foundation Trust.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	Means a member of the Board of Directors.
Auditor	Any auditor other than the external auditor appointed under the Constitution to review and report upon other aspects of the Foundation Trust's performance.
External Auditor	The independent organisation appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 NHS Act.
Financial Year	The period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March and each successive period of twelve months beginning with 1 April.
The Foundation Trust	The Walton Centre NHS Foundation Trust
Foundation Trust Contract	Agreement between the Foundation Trust and Commissioners for the provision and commissioning of health services.
Funds held on trust	Those funds which the Foundation Trust holds as its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under 2006 NHS Act. Such funds may or may not be charitable.
Monitor	Means the Independent Regulator of NHS Foundation Trusts until 1 April 2016 when Monitor became part of NHS Improvement. Guidance provided by Monitor remains valid until superseded by new publications from NHS Improvement.
Fraud	Reference to 'fraud' shall be used as an umbrella term to include financial crime, including bribery and other corruption offences.
Member	A member of the Foundation Trust.
NHS Improvement	Means the Independent Regulator of NHS Foundation Trusts. From 1 April 2016 Monitor, the former regulator, became part of NHS Improvement.

NHS Provider License	The Health and Social Care Act (2012) requires everyone who provides an NHS health care service to hold a license unless they are exempt under regulations made by the Department of Health and Social Care. Foundation Trusts are licensed from 1 April 2013. All other providers will be required to apply for a licence from April 2014. The Walton Centre NHS Foundation Trust license number is 130132.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and SFIs.
Officer	An employee of the Foundation Trust with specific nominated delegated powers.
Partner	In relation to another person, a member of the same household living together as a family unit.
Secretary	Means the Corporate Secretary of the Foundation Trust.
Scheme of Reservation and Delegation (SoRD)	The SoRD sets out the powers which the Board of Directors has reserved and those which have been delegated to committees, sub-committees, individual directors or officers.
Standing Financial Instructions (SFIs)	SFIs regulate the conduct of the Foundation Trust's financial matters.

Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

Wherever the term 'employee' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust.

Responsibilities and Delegation

The Foundation Trust shall at all times remain as a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

1. Formulating the financial strategy;

2. Requiring the submission and approval of budgets within overall income;

3. Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and

4. Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

The Constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Trust's SoRD.

The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Foundation Trust. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as the Accounting Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust's system of internal control.

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control. It is a duty of the Chief Executive to ensure that existing directors and employees and all appointees are notified of and understand their responsibilities within these instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, SFIs and financial procedures of the Foundation Trust.

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

The Chief Financial Officer is responsible for:

1. Implementing the Foundation Trust's financial policies and for co-ordinating any corrective action necessary to further these policies. The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes;

2. Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

3. Ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time;

4. Without prejudice to any other functions of directors and employees of the Foundation Trust, the duties of the Chief Financial Officer include:

    - the provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

    - the design, implementation and supervision of systems of internal financial control;

    - the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

All directors and employees, severally and collectively, are responsible for:

1. The security of the property of the Foundation Trust;

2. Avoiding loss;

3. Exercising economy and efficiency in the use of resources;

4. Conforming with the requirements of the Governance Manual, SFIs, financial procedures, NHSI procedures/directives and the SoRD.

Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

2. AUDIT

Audit Committee

The Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook and Foundation Trust governance requirements, which will provide an independent and objective view of internal control by:

1. Overseeing Internal and External Audit Services:

   (i) Internal Audit – to monitor and review the effectiveness of the internal audit function and to undertake a market testing exercise for the appointment of the auditor at least once every five years;

   (ii) External Audit:

   - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable;
   - to undertake a market testing exercise for the appointment of the auditor at least once every five years;
   - to make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor;
   - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements;
   - to develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance

2. Reviewing financial and information systems and monitoring the integrity of the financial statements, any formal announcements relating to the Foundation Trust's financial performance and reviewing significant financial reporting judgements;

3. The monitoring of compliance with the SoRD and SFIs;

4. Reviewing schedules of losses and compensation and ratifying on behalf of the Board of Directors;

5. Reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Annual Governance Statement and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors;

6. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that supports achievement of the organisation's objectives.

The Audit Committee may also review arrangements by which staff of the Trust may raise concerns about possible improprieties in matters of financial reporting and control, clinical quality and patient safety. All such concerns are to be treated in confidence and the Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.

The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience. Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Chief Financial Officer in the first instance).

Chief Financial Officer

The Chief Financial Officer is responsible for:

1. Ensuring adequate internal and external audit services are provided;

2. Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment and maintenance of an effective internal audit function and the coordination of other assurance arrangements;

3. Ensuring that the internal audit is effective and meets all relevant professional standards;

4. Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

5. Ensuring that a quarterly and annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

    - a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
    - major internal financial control weaknesses discovered;
    - progress on the implementation of internal audit recommendations;
    - progress against plan over the previous year;
    - the forward plan;
    - any updates / requirements as determined by NHSE or other regulators.

The Chief Financial Officer or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

1. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of confidential nature;

2. Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employees of the Foundation Trust;

3. The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or an employee's control;

4. Explanations concerning any matter under investigation.

Internal Audit

The NHS Foundation Trust Accounting Officer Memorandum requires the Foundation Trust to have an internal audit function.

The role of internal audit embraces two key areas:

1. The provision of an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives;

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Internal Audit will produce a strategic audit plan and a detailed plan for the coming year and will review, appraise and report upon:

- the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- the adequacy and application of financial and other related management controls;
- the suitability of financial and other related management data; and
- the extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  i) fraud and other offences; and
  ii) waste, extravagance, inefficient administration, poor value for money or other causes.

Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from NHSE.

Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately. The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Foundation Trust. The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for Internal Audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting systems

shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Foundation Trust's Audit Committee. Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed time-scales specified within the report. The Chief Financial Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Chief Financial Officer.

External Audit

The 2006 NHS Act states that the Foundation Trust is to have an External Auditor (defined in the Act as the Financial Auditor) and is to provide the External Auditor with every facility and all information which they may reasonably require for the purpose of their functions. The External Auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHSE on standards, procedures and techniques to be adopted. In auditing the accounts, the External Auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Foundation Trust is required to include an Annual Governance Statement within the financial statements. The financial auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements and other work.

Appointment of the External Auditor

The External Auditor is appointed by the Council of Governors. The *Audit Code for NHS Foundation Trusts* has been produced by the regulator under its powers under paragraph 24(5) of Schedule 7 of the 2008 Act which states that in auditing the accounts the External Auditor is to comply with any directions given by NHSE) as to the 'standards, procedures and techniques' to be adopted.

The Council of Governors of the Trust is responsible for appointing an External Auditor. NHS foundation trusts must ensure that the appointed

External Auditor meets the following criteria, at the date of appointment and on an on-going basis throughout the term of their appointment:

1. The External Auditor must satisfy the criteria for appointment as an auditor of an NHS foundation trust, as set out in paragraph 23(4) of Schedule 7 of the 2006 Act;

2. The External Auditor must have an established and demonstrable standing within the healthcare sector and be able to show a high level of experience and expertise. The work is of a specialised nature, and so general audit experience is not sufficient;

3. The External Auditor must comply with the *Audit Code for NHS Foundation Trust;* and

4. The External Auditor must subject the audit to internal quality control procedures which are sufficiently robust to monitor the compliance of the audit work with the *Audit Code for NHS Foundation Trusts.*

The Council of Governors shall appoint or remove the External Auditor at a general meeting of the Council of Governors. NHSE may require External Auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between NHSE, the External Auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators and Regulated Entities.

The External Auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the External Auditor.

Liaison with Internal Auditors

It is expected that the External Auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The External Auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the *Audit Code for NHS Foundation Trusts.* In particular the

External Auditors may wish to consider the work of internal audit when undertaking their procedures in relation to the Annual Governance Statement.

Access to Documents

External Auditors of NHS Foundation Trusts have a right of access at all reasonable times to every document relating to the NHS Foundation Trust which appears to them necessary for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

Public Interest Report

In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall send the public interest report to the Council of Governors, the Board of Directors and NHSE, at once if it is an immediate report; or not later than 14 days after conclusion of the audit, forward a report to NHSE within 30 days (or such shorted period as NHSE may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

Fraud, Bribery and Corruption

The Foundation Trust shall take all necessary steps to counter fraud and corruption relating to its functions and in accordance with the 'Foundation Trust Contract' and have regard to any reasonable guidance or advice from NHS Counter Fraud Authority. The Foundation Trust shall act in accordance with:

- the NHS Anti-Fraud, Bribery and Corruption policy; and
- the policy statement '*Applying appropriate sanctions consistently'* published by NHS Counter Fraud Authority.

The Chief Executive and Chief Financial Officer shall monitor and ensure compliance with Fraud and Corruption elements of the Foundation Trust Contract.

The Foundation Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

Manual and Guidance

The Local Counter Fraud Specialist shall report to the Foundation Trust's Chief Financial Officer and shall work with the staff in NHS Counter Fraud Authority in accordance with the requirements set out in the NHS Anti-Fraud,

Bribery and Corruption policy. The Local Counter Fraud Specialist will provide a written plan and report, at least annually on counter fraud work within the Foundation Trust.

Security Management

The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the Foundation Trust Contract, having regard to any other reasonable guidance or advice issued by NHS Counter Fraud Authority, or previously by the CFSMS. The Foundation Trust shall nominate and appoint a Local Security Management Specialist as per the Foundation Trust Contract. The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Security Management Director (SMD) (the Trust's Chief Operating Officer) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

Preparation and approval of operational plan and budgets

Operational planning

In accordance with the annual planning cycle, the Chief Executive will complile and submit to the Board of Directors and to the Council of Governors the annual Operational Plan which takes into account financial targets and forecast limits of available resources, The Trust Operational Plan will contain:

- A statement of the significant assumptions on which the plan is based;
- Details of major changes in workload, delivery of services or resources required to achieve the plan;
- The Financial Plan for the year;
- Such other contents as may be determined by the Integrated Care System (ICS) / NHSE.

The annual Operational Plan must be submitted to NHSE in accordance with NHSE requirements.

Budgets

Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

- be in accordance with the aims and objectives set out in the Foundation Trust's operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks and mitigations;
- be based on reasonable and realistic assumptions;
- be prepared on a basis to maximise value for money; and
- enable the Foundation Trust to comply with the requirements of the Single Oversight Framework set by NHSE.

The Chief Financial Officer shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variance should be reported by the Chief Financial Officer to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

All budget holders will be provided with delegated budgets which they will assess, review with their Divisional Accountant, suggest changes and then agree at the commencement of each financial year.

The Chief Financial Officer has a responsibility to ensure that adequate financial training is delivered on an on-going basis to all budget holders to help them manage budgets effectively.

Budget Delegation

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements. This delegation must be in writing and be accompanied by a clear definition of:

- The amount of the budget;
- The purpose(s) of each budget heading;

- Individual and group responsibilities;
- Authority to exercise virement;
- Achievement of planned levels of service; and
- The provision of regular reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

Budgetary Control and Reporting

The Chief Financial Officer will devise and maintain systems of budgetary control. These will include regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

1. Statement of Comprehensive Income to date showing trends and forecast year-end position;

2. Statement of Financial Position including movement in working capital;

3. Cash flow;

4. Capital project spend and projected out-turn against plan;

5. Explanations of any material variances from plan / budget;

6. Details of any corrective action where necessary and the Chief Executive's and / or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

7. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

8. Investigation and reporting of variances from financial, and workload budgets;

9. The monitoring of management action to correct variances;

10. Arrangements for the authorisation of budget transfers;

11. Advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall provide advice on the economic and financial impact of future plans and projects;

12. Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Financial Officer will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

Each budget holder is responsible for ensuring that:

1. Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

2. Officers shall not exceed the budget limit set;

3. The amount provided in the approval budget is not used in whole or in part for any purpose other than specifically authorised subject to the rules of virement;

4. Capital project spend and projected out-turn are managed against plan;

5. They can provide explanations of any material variances from plan / budget;

6. Details are provided of any corrective action where necessary and the Chief Executive's and / or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

7. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

8. Investigation and reporting of variances is undertaken for financial and workforce budgets;

9. They monitor management action to correct variances;

10. Arrangements for the authorisation of budget transfers are followed;

11. They advise the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall provide advice on the economic and financial impact of future plans and projects;

12. They review the bases and assumptions used to prepare the budgets; and

13. No permanent employees are appointed without the approval of the Chief Executive or Chief Financial Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Chief Operating Officer and the Chief Financial Officer are responsible for ensuring delivery of the Trust's long-term savings programme in line with agreed schemes and with appropriate quality impact assessment in accordance with the requirements of the operational and strategic plans.

Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. A project sponsor will be identified who will assume responsibility for the budget relating to each scheme.

Quarterly or Monthly Performance Returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSE within the specified time-scales.

4. ANNUAL ACCOUNTS AND REPORTS

Accounts

The Foundation Trust shall prepare accounts in respect of each financial year in such form as NHSE may, with the approval of HM Treasury, direct. The accounts are to be audited by the Foundation Trust's External Auditor. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

- the accounts;
- any records relating to them;
- any report of the External Auditor on them.

The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer. The Accounting Officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts in such form as NHSE may, with the approval of the HM Treasury, direct. The Accounting Officer will comply in preparing accounts with HM Treasury guidance as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts; and
- shall be responsible for the functions of the Foundation Trust as set out in the 2006 NHS Act.

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

- the annual report including the annual accounts; and

- any report of the External Auditor on them;

The Accounting Officer shall cause the Foundation Trust to lay a copy of the annual accounts, and any report of the External Auditor on them, before Parliament and once it has done so, send copies of those documents to NHSE.

Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

Annual Reports

The Foundation Trust shall prepare an Annual Report and send it to NHSE. The reports are to give information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership; and any other information NHSE requires.

The Foundation Trust is to comply with any decision NHSE makes as to the form of the reports; when the reports are to be sent to them; and the periods to which the reports are to relate.

The Financial Auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the External Audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

Annual Plans

The Foundation Trust shall provide information as to its forward planning in respect of each financial year to NHSE. The Foundation Trust must make clear which elements of the Annual Plan do not constitute forward planning information. The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors. The forward plan must be prepared with reference to documents published by NHSE which aid planning. In preparing the document, the directors shall have regard to the views of the Council of Governors.

The Annual Plan must be approved by the Board of Directors. The Foundation Trust is required to provide three types of in-year reports:

1. Regular reports on a quarterly basis;

2. Exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards;

3. Ad-hoc reports, following up specific issues identified either in the Annual Plan or in-year Eg. Monthly update of forecast annual outturn.

5. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

General

The Chief Financial Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. The Board of Directors shall approve the banking arrangements.

Bank and GBS Accounts

The Chief Financial Officer is responsible for:

1. Bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health and Social Care or commercial entity;

2. Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;

3. Ensuring payments made from bank or GBS accounts do not exceed the amount credited to the accounts except where arrangements have been made;

4. Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn.

All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Financial Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

Banking Procedures

The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts, which must include:

1. The conditions under which each bank and GBS accounts are to be operated;

2. The limit to be applied to any overdraft;

3. Those authorised to make payments drawn on the Foundation Trust's accounts.

The Chief Financial Officer must ensure the accounts are operated in accordance with the conditions agreed with the Trust's bankers and shall approve security procedures for payments made without a hand-written signature. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate. All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

Trust Credit Cards

The Chief Financial Officer is responsible for the authorising of Trust Corporate Credit Cards to named individuals. Expenditure will only be made on these credit cards as a payment of last resort or where a financial saving can be obtained by usage.

Tendering and Review

The Chief Financial Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking. Competitive tenders should be sought at least every 5 years and the results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Income Systems

The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties. The Chief Financial Officer is also responsible for the prompt banking of all monies received.

Fees and Charges other than Foundation Trust Contract

The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care, NHSE or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed. All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

Debt Recovery

The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts. Overpayments should be detected (or preferably prevented) and recovery initiated. Income not received should be dealt with in accordance with losses procedures.

Security of cash, cheques and other negotiable instruments

The Chief Financial Officer is responsible for:

1. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable. No form of receipt which has not been specifically authorised by the Chief Financial Officer should be issued;

2. Ordering and securely controlling any such stationery;

3. The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

4. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

Officially money shall not under any circumstances be used for the encashment of private cheques, nor IOUs. Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc. All cheques, postal orders, cash etc., shall be banked promptly, intact, under arrangements approved by the Chief Financial Officer. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss. Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Financial Officer and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud, bribery or corruption this should follow the form of the Foundation Trust's Anti-Fraud, Bribery and Corruption Policy/Response Plan and guidance provided by NHS Counter Fraud Authority. Where there is no evidence of fraud, bribery

or corruption the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures.

7. FOUNDATION TRUST CONTRACTS

Provision of Services

The Board of Directors of the Foundation Trust shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide the services referred to in the Trust's contracts.

Foundation Trust Contracts

The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTC) with commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national performance metrics;
- the provision of reliable information on cost and volume of activity;
- ability to provide timely and accurate information / reports relating to agreed CQUIN targets;
- the provision of agreed information regarding outcome measures.

A good FTC will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the FTC. This will include appropriate payment by results performance information.

Non-Commercial Contract

Where the Foundation Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels;
- The term of the agreement;
- The value of the agreement;
- The lead officer;
- Performance and dispute resolution procedures;
- Risk management and clinical governance arrangements; and
- Exit provisions.

Non-commercial contracts should be reviewed and agreed on an annual basis or as determined by the term of agreement so as to ensure value for money and to minimise the potential loss of income.

8. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

Remuneration Committee

In accordance with the Constitution, the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive and Corporate Directors (and other senior employees), including:

- all aspects of salary (including any performance-related elements and bonuses);
- provisions for other benefits, including pensions and cars, arrangements for termination of employment and other contractual terms;
- review recommendations to the Board of Directors on the remuneration and terms of service of Executive and Corporate Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust – having proper regard to the Foundation Trust's circumstances and performance and to the

provisions of any national arrangements for such staff where appropriate;
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board of Directors meetings should record such decisions.

The Council of Governors, at a general meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors.

Funded Establishment

The workforce plans incorporated within the annual budget will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive. The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the SoRD. The Divisional Accountant is responsible for verifying that funding is available.

Staff Appointments

No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

1. Unless authorised to do so by the Chief Executive; and

2. Within the limit of their approved budget and funded establishment as defined in the SoRD.

The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, job evaluation (Agenda for Change) etc., for employees.

Processing of the payroll

The processing of the Foundation Trust's payroll is a contracted-out service. The Chief Financial Officer remains responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;
- the financial determination of pay and allowances, including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
- making payment on agreed dates; and
- agreeing method of payment.

The Chief Financial Officer will issue instructions regarding:

1. verification and documentation of data;

2. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

3. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

4. security and confidentiality of payroll information;

5. checks to be applied to completed payroll before and after payment;

6. authority to release payroll data under the provisions of the Data Protection Act;

7. methods of payment available to various categories of employee;

8. procedures for payment by cheque, bank credit, or cash to employees; procedures for the recall of cheques and bank credits;

9. pay advances and their recovery;

10. maintenance of regular and independent reconciliation of pay control accounts;

11. separation of duties of preparing records and handling cash; and

12. a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

Appropriately nominated managers have delegated responsibility for:

1. processing a signed copy of the contract / appointment form and such other documentation as may be required immediately upon an employee commencing duty;

2. submitting time records, and other notifications in accordance with agreed timetables;

3. completing time records and other notifications in accordance with the Chief Financial Officer's Instructions and in the form prescribed by the Chief Financial Officer; and

4. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Financial Officer.

The Chief Financial Officer shall ensure that the chosen method of providing the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

Contracts of Employment

The Board of Directors shall delegate responsibility to a manager for:

- ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health and Safety legislation; and
- dealing with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

Delegation of Authority

The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

The Chief Executive will set out:

- the list of managers who are authorised to place requisitions for the supply of goods and services which should be updated and reviewed on an on-going basis and annually by the Finance and Procurement Departments;
- where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system; and
- the maximum level of each requisition and the system for authorisation above that level.

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Choice, requisitioning, ordering, receipt and payment for goods and services

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust. In so doing, the advice of the Foundation Trust's advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted. The Chief Financial Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Chief Financial Officer will:

- advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in SoRD and regularly reviewed;

- prepare procedural instructions where not already provided in the SoRD or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;
- be responsible for the prompt payment of all properly authorised accounts and claims;
- be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

The system shall provide for:

1. a list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised, the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

2. Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standards and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained and examined;
- the account is arithmetically correct; and
- the account is in order for payment.

3. A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

4. Instructions to employees regarding the handling and payment of accounts within the Finance Department;

5. Responsibility for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

- prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate);
- the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and
- the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must:

- Be consecutively numbered;
- Be in a form approved by the Chief Financial Officer;
- State the Foundation Trust terms and conditions of trade; and
- Only be issued to, and used by, those duly authorised by the Chief Executive.

Managers must ensure that they comply with the guidance and limits specified by the Chief Financial Officer and that:

1. All contracts other than for a simple purchase permitted within the SoRD or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

2. Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

3. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

4. Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

5. No order shall knowingly be issued for any item or items to any firm which has provided/offered/promised gifts, rewards, benefits or inducements to either directors or employees other than;

    - isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
    - conventional hospitality, such as lunches in the course of working visits.

6. No requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

7. All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

8. Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked '*Confirmation Order'*;

9. Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

10. Goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future un-competitive purchase;

11. Changes to the list of directors / employees authorised to certify invoices are notified to the Chief Financial Officer;

12. Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

13. Petty cash records are maintained in a form as determined by the Chief Financial Officer; and

14. Orders are not required to be raised for utility bills and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non-pay.

15. Online orders for Executives' travel ordered by Personal Assistants due to system time constraints are later checked and approved by the Chief Executive or Chief Financial Officer/Deputy Chief Financial Officer*.

The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant EU and IFRS accounting guidance.

Under no circumstances should goods be ordered through the Foundation Trust for personal or private use with the exception of permitted schemes such as lease cars or the cycle to work initiative.

Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under statutory powers shall comply with procedures laid down by the Chief Financial Officer.

*The Chief Executive to authorise travel for the Chief Financial Officer; the Chief Financial Officer to authorise travel for the Chief Executive; the Chief Executive/ Chief Financial Officer/Deputy Chief Financial Officer to authorise travel for all other Executives.

10. EXTERNAL BORROWING AND INVESTMENTS

Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors (delegated to the Trust's Business Performance Committee).

The Business Performance Committee is responsible for establishing and monitoring an appropriate investment strategy. The Chief Financial Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held and will prepare detailed procedural instructions on

investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will incorporate guidance from NHSEas appropriate.

11. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

Capital Investment

The Chief Executive:

1. Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

2. Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges and other recurrent costs;

3. Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

4. That NHSE is notified if the Foundation Trust has plans for material transactions in accordance with the thresholds defined in NHSE Single Oversight Framework. NHSE will determine whether they class the transaction as material or significant. Material investments can, under specific conditions set out in NHSE Compliance Framework, be approved by the Foundation Trust's Board of Directors. Significant investments must be assessed by NHSE before the Foundation Trust can proceed. In addition, all transactions which potentially impact the Financial Sustainability Risk Rating must also be notified to NHSE. All PFI transactions require NHSE assessment. All decisions to borrow money, from any source, will be rigorously reviewed by the Board of Directors and the Foundation Trust will undertake its own financial due diligence using independent financial experts prior to making any decision.

For capital expenditure proposals the Chief Executive shall ensure (in accordance with the limits outlined in the SoRD):

1. That a business case is produced setting out:

    - an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

- appropriate project management and control arrangements; and
- the involvement of appropriate Foundation Trust personnel and external agencies.

2. That the Chief Financial Officer has sought professional advice and assurance regarding the capital costs and has assessed and verified the revenue consequences detailed in the business case.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management. The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

- specific authority to commit expenditure;
- authority to proceed to tender; and
- approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management which will be detailed in the Foundation Trust's Governance Manual.

The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract of capital investment projects and valuation for accounting purposes.

Private Finance

The Foundation Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers an appropriate proportion of risk to the private sector;
- A business case must be referred to the appropriate DH and NHSE for approval or treated as per current guidelines;
- The proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires; and

- The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

Asset Registers

The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the Asset Register to be conducted once a year. The Foundation trust shall maintain an Asset Register recording fixed assets and additions to the fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour including appropriate overheads;
- lease agreements in respect of assets held under a finance lease and capitalised; and
- independent valuation of assets.

Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed Asset Registers. The value of each asset shall be adjusted to current values in accordance with the principles outlined in the Group Accounting Manual issued by the Department of Health and Social Care and the value of each asset shall be depreciated also using with the principles outlined in the Annual Reporting Manual.

Any disposal of fixed assets must be in a compliance with the Terms of the Trust Licence specifically section 5 condition COS2 – restriction on the disposal of assets.

Security of Assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Financial Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

- recording managerial responsibility for each asset;
- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All significant discrepancies revealed by verification of physical assets to the Fixed Asset Register shall be notified to the Chief Financial Officer. Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all departments to apply appropriate routine security practices in relation to NHS property as determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions. Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses and where practical, assets should be marked as Foundation Trust property.

12. STOCK, STORES AND RECEIPT OF GOODS

Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

1. controlled stores – specific areas designated for the holding and control of goods;

2. wards and departments – goods required for immediate usage to support operational services; and

3. manufactured items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

Such stocks should be kept to a minimum and for:

- controlled stores and other significant stores (as determined by the Chief Financial Officer) should be subjected to an annual stocktake or perpetual inventory procedures; and
- valued at the lower of cost and net realisable value.

Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer. The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practical, stocks should be marked as NHS property. The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores and losses.

Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer. The designated manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposable, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 13 – Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Receipt of Goods

A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and / or weight and inspected as to quality and specification. Instructions shall be issued to

staff covering the procedures to be adopted in those cases where a delivery note is not available. All goods received shall be entered onto an appropriate goods received / stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately. For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The Head/Deputy Head of Procurement shall check receipt against delivery to satisfy themselves that the goods have been received and will then authorise payment of NHS Supply Chain weekly sales invoices. The Finance Department will make payment on receipt of an invoice. This may also apply for high volume low value items such as stationery.

Issue of Stocks

The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Financial Officer. Regular comparisons shall be made of the quantities issued to wards / departments etc. and explanations recorded of significant variations. All transfers and returns shall be recorded on forms / systems provided for the purpose and approved by the Chief Financial Officer.

13. DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and Condemnations

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate. For protected assets see Section 11 of these SFIs. All unserviceable articles shall be:

- condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer; and

- recorded by the condemning officer in a form approved by the Chief Financial Officer which will indicate whether articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

Losses and Special Payments

Losses

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, and losses. The Chief Financial Officer must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Financial Officer who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer who will liaise with the Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud, bribery or corruption, the Chief Financial Officer must inform their Local Counter Fraud Specialist who will inform the relevant NHS Counter
Fraud Authority regional team **before** any action is taken and reach agreement as to how the case is to be handled. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

- The Board of Directors;
- The External Auditor; and
- NHS Counter Fraud Authority (through the Local Counter Fraud Specialist).

The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations. For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

Write-Offs and Special Payments

The writing-off of debts, the abandonment of claims and the making of any kind of special or ex-gratia payments will be approved in accordance with the scheme of delegation. In approving the write-off of debts consideration will be made of the nature of the monies owed and the likelihood of the receipt of monies against any costs which may be incurred in attempting to recover the debt. In approving special payments account will be taken of national guidance, any precedents and any potential for admitting liability for further claims.
The Chief Financial Officer shall maintain a Losses and Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

Compensation Claims

The Foundation Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of the Department of Health and Social Care, and NHS Resolution in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim. The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review;
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants;
- Adopting a systematic approach to claims handling in line with the best current and cost-effective practice;
- Following guidance issued by NHS Resolution relating to clinical negligence;
- Achieving Standards for Care Quality Commission essential standards of quality and safety; and
- Implementing an effective system of Clinical Governance.

The Board of Directors are collectively responsible for ensuring the proper reporting, recording, and management of all claims. The Board of Directors delegates responsibility for receiving, assessing and acting upon claims in two key Board sub-committees, namely the Quality Committee and the Business and Performance Committee.

14. INFORMATION TECHNOLOGY

Responsibilities and Duties of the Chief Financial Officer

The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

- devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (update 2000) and the Computer Misuse Act 1990;

- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

- ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

- ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

The Chief Financial Officer shall satisfy them self that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

Freedom of Information

The Chief Financial Officer shall also publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It described that classes or types of information about our Foundation Trust that we make publicly available.

Responsibilities and Duties of other Directors and Officers in relation to IM&T and Information Governance

General

In order to ensure compatibility and compliance with the Trust's IM&T Strategy, no computer hardware, software or facility will be procured without authorisation of the Chief People Officer and Head of IM&T.

Information Governance

The Head of Information Governance together with the Chief Procurement Officer are to ensure that all Trust contracts and SLAs have appropriate clauses to protect the Trust and its staff, patients and other stakeholders from any risk of breach of confidentiality of breach of Information Governance standards.

Risk Assessment

The Chief People Officer shall ensure that risks to the Foundation Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans. The Foundation Trust shall disclose to NHSE and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the Terms of Authorisation, Schedule 6. Other information, as requested, shall be provided to NHSE.

15. PATIENT'S PROPERTY

The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. The Chief Nurse is responsible for ensuring that patients or their guardians, as appropriate, are informed of appropriate procedures for storing such items before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records; and
- the advice of administrative and nursing staff responsible for admissions.

The Foundation Trust will not accept responsibility or liability for patients' property brought into its premises unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt. The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient's property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions shall cover the necessary arrangements for withdrawal of cash or disbursements of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

A patient's property record, in a form determined by the Chief Financial Officer shall be completed in respect of the following:

1. Property handed in for safe custody by any patient (or guardian as appropriate); and

2. Property taken into safe custody having been found in the possession of:

- mentally disordered patients;
- confused and/or disorientated patients;
- unconscious patients;
- patients dying in hospital; and
- patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (2) including a nil return if no property is taken into safe custody.

The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record. Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies; these shall be opened and operated under arrangements agreed by the Chief Financial Officer. Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department for Work and Pension instructions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances

accruing. Refunds of cash handed in for safe custody will be dealt with in accordance with current Department for Work and Pensions instructions. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

Disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Chief Financial Officer, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Financial Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question. In all cases where property of a deceased patient is a total of value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Grant of Representation shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Property handed over for safe custody shall be placed into the care of appropriate administration staff. Where there are no administrative staff present, in which case the property shall be placed in the secure care of the most senior member of nursing staff on duty. In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor. Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon authorisation of the Chief Financial Officer. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients. Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16. TENDERING AND CONTRACT PROCEDURE

Duty to comply with Standing Orders and SFIs

The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Standing Orders and SFIs (except where Suspension of Standing Orders is applied).

EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and SFIs. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust.

Formal Competitive Tendering

The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care); and
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

Where the Foundation Trust elects to invite tenders for the supply of healthcare these SFIs shall apply as far as they are applicable to the tendering procedure.

Formal tendering procedures are not required where:

- the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the SoRD, (this figure to be reviewed annually); or
- the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with; or
- the expenditure relates to the annual member subscription of Liverpool Health Partners, which the Foundation Trust must incur as a founding partner of this limited company; or
- regarding disposals as set out in SFIs 'Disposals and Condemnations.'

Formal tendering procedures **may be waived** in the following circumstances:

1. In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable, or the estimated expenditure or income would not warrant formal tendering

procedures, and the circumstances are detailed in an appropriate Foundation Trust record;

2. Where the requirement is covered by an existing contract;

3. Where public sector agreements are in place and have been approved by the Board of Directors;

4. Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

5. Where the timescale genuinely precludes competitive tendering. However, failure to plan the work properly would not be regarded as a justification for a single tender;

6. Where specialist expertise is required and is available from only one source;

7. When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

8. There is a clear benefit to be gained from maintaining continuity with an earlier project; however, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and

9. For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and all generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work. The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and

recorded in an appropriate Foundation Trust and reported to the Audit Committee at each meeting.

Fair and Adequate Competition

Where applicable the Foundation Trust shall ensure that invitations to tender are sent to a sufficient number of firms / individuals to provide fair and adequate competition as appropriate, and in no case less than three firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with EU regulations) without Department of Health and Social Care approval.

Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Audit Committee and be recorded in an appropriate Foundation Trust record.

Contracting / Tendering Procedure

All tenders for services with a value greater than £50,000 (inc VAT) must be published on the national contracts' finder website.

Invitation to tender

1. all invitations to tender shall state the date and time as being the latest time for the receipt of tenders;

2. all invitations to tender shall state the procedures to be followed in submitting the tender;

3. every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable;

4. every tender for building or engineering works should be subject to the appropriate form of contract.

Receipt and Safe custody of Tenders

The Chief Executive or their nominated representative will be responsible for the system to track the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be recorded. Tenders will be carried out using an electronic tendering system. Access to the electronic tendering system will be by username and password and a full audit trail will be maintained. The system will ensure that submitted tenders, apart from in-house bids, cannot be accessed by any member of the Trust until after the closing date.

Opening Tenders and Register of Tenders

1. As soon as possible after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the manager designated by the Chief Executive and not from the originating department;

2. The 'originating' Department will be taken to mean the department sponsoring or commissioning the tender. The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Department from serving as one of the managers to open tenders;

3. The date and person opening every tender should be recorded;

4. A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

    - the name of all firms/individuals invited;
    - the names of firms/individuals from which tenders have been received;
    - the date tenders were opened;
    - the person opening the tenders;
    - the price shown on each tender; and
    - a note where price alterations have been made on the tender;

5. incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders, i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other

tenders, should be dealt with in the same way as late tenders. (see below).

Admissibility

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient, or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive. Where only one tender is sought and / or received, the Chief Executive and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

Late Tenders

Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decided that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer. Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started. While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

Acceptance of formal tenders

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of contract will not disqualify the tender. The tender which is the most economically advantageous to the Trust will be accepted. The weighting of finance, quality and other measures in determining the most economically advantageous tender will be consistent with the invitation to tender.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

All tenders should be treated as confidential and should be retained for inspection.

Tender reports to the Board of Directors

Reports to the Board of Directors will be made on an exceptional circumstance basis only.

Quotations: Competitive and non-competitive

General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to exceed the sum defined in the SoRD.

Competitive Quotations

Quotations should be obtained from at least three firms / individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust. Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. For the avoidance of doubt, writing includes electronic means which can be permanently recorded. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record. All quotations should be treated as confidential and should be retained for inspection. The Chief Executive or their nominated officer should evaluate the quotation and select the quote which is the most economically advantageous to the Trust. The factors used to determine economic advantage should be recorded in a permanent record.

Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

- the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts; and
- where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (1) and (2) of this SFI) apply.

Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation trust and which is not accordance with SFIs except with the authorisation of either the Chief Executive or Chief Financial Officer.

Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the SoRD. These levels of authorisation may be varied or changed. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Foundation Trust should adopt one of the following alternatives;

- the Foundation Trust shall use the NHS Supply Chain or other national contracts/frameworks for procurement of all goods and services unless the Chief Executive or nominated officer deems it inappropriate. The decision to use alternative sources must be documented; and
- If the Foundation Trust does not use the NHS Supply Chain or other national contracts/frameworks – where tenders or quotations are not required, because expenditure is below the levels defined in the SoRD, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

Private Finance for Capital Procurement

The Foundation Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers an appropriate proportion of risk to the private sector;

- Where the sum exceeds delegated limits, a business case must be referred to NHSE in accordance with guidelines in the Single Oversight Framework;
- The proposal must be specifically agreed by the Board of the Foundation Trust; and
- The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

Compliance requirement for all contracts

The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- The Foundation Trust's SOs and SFIs;
- EU Directives and other statutory provisions;
- Such clauses of the NHS Standard Contract Conditions as are applicable;
- Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
- Where appropriate contracts shall be in or embody the same terms of conditions of contract as was the basis on which tenders or quotations were invited; and
- NHSE principles / regulations.

In all contracts made by the Foundation Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Foundation Trust.

Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. All contracts should be compliant with DHSC / HMRC tax rules and mitigate the Trust's liability for individual non-compliance accordingly.

Foundation Trust Contracts / Healthcare Service Agreements

Service agreements with NHS providers for the supply of healthcare services are not contracts in law and therefore not enforceable by the courts. However,

a contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to SoRD).

Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
- obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;
- items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;
- items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and
- land or buildings connected with DHSC guidance that has been issued but subject to compliance with such guidance.

All contractors should be compliant with DHSC / HMRC tax rules and mitigate to Trust's liability for individual non-compliance accordingly;

For any of the conditions noted above, check with the Head of Financial Services prior to progressing.

In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Foundation Trust may also determine from time to time that in-house services should be market tested by competitive tendering. In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification Group, comprising the Chief Executive or nominated officer/s and a Specialist Officer;

- In-house tender group, compromising a nominee of the Chief Executive and technical support; and
- Evaluation team, comprising normally a specialist officer, a supplier's officer and a Chief Financial Officer representative.

All groups should work independently of each other and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders. The evaluation team shall make recommendations to the Board of Directors and the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

Where the Trust is considering providing a service in-house which is currently contracted-out the same groups should be set up to evaluate the service and make recommendations to the Board of Directors.

Applicability of SFIs on Tendering and Contracting to funds held in trust

These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's Charity and private resources. There may be times when instructions may be waived e.g. when there is an opportunity to purchase an asset of strategic importance / benefit to the Trust.

17. ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

The Chief Financial Officer shall ensure that all staff and any other interested and applicable parties are made aware of the Foundation Trust policy – Standards of Business and Personal Conduct. This policy makes due provision to the Bribery Act 2010. The policy is deemed to be an integral part of the Trust's Governance Manual and SFIs.

18. RETENTION OF DOCUMENTS

Context

All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

Accountability

The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the record legacy of predecessor organisations and / or obsolete services. Under the Public Records Act all NHS employees are responsible for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in Department of Health and Social Care guidance, Records Management Code of Practice.

Types of Record Covered by the Code of Practice

The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based);
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;
- Theatre registers and minor operations (and other related) registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with compliant-handling);
- X-ray and imaging reports, output and other images;
- Photographs, slides and other images;
- Microform (i.e. fiche / film);
- Audio and video tapes, cassettes, CD-ROM etc.;
- Emails;
- Computerised records;
- Scanned records;
- Text messages (both out-going from the NHS and in-coming responses from the patient).

Documents held in archives shall be capable of retrieval by authorised persons and documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19. RISK MANAGEMENT

Programme of Risk Management

The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, which must be approved and monitored by the Board of Directors. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including; Internal Audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured; and
- arrangements to review the Risk Management Programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

Insurance Arrangements

The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by NHS Resolution, use commercial insurance or self-insure for some or all of the risks to which the Trust is exposed. A combination of the three options may be used. If the Board decides not to use the NHS Resolution risk pooling schemes for any of the risk areas (clinical, property and employers / third party liability) covered by the scheme, this decision shall be reviewed annually.

In addition, the Board of Directors will need to consider the implications of leaving the NHS Resolution scheme upon its quality profile as determined by Monitor / NHS England/Improvement and the CQC.

Arrangements to be followed by the Board of Directors in agreeing Insurance Cover

The Chief Financial Officer shall examine the options in regard to insurance cover and make a recommendation to the Board on which arrangements, or combination of arrangements, represent the best value for money for the Trust. In coming to their decision, the Board will take account of the impact of a major incident / loss on the operation and reputation of the Trust.

Where the Board decides to use commercial insurance the insurance contract will be let subject to the normal procurement rules set out in Section 16. The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments behind the deductions in each case and will maintain records of the policies and insurance certificates in line with the retention of records policy.

Areas not covered by the NHS Resolution schemes

The following areas are not covered by the NHS Resolution schemes and therefore need to be covered by commercial insurance or self-insurance:

- Motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;
- Where the Foundation Trust is involved with a consortium in a Private Finance Initiative (PFI) contract and the other consortium members require that commercial insurance arrangements are entered into; and
- Income generation schemes are not covered by the NHS Resolution schemes. If the income generation activity is also an activity normally carried out by the Foundation Trust for an NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

The Walton Centre NHS
NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION

Reviewed by:

Zoe Stevenson, Head of Financial Services
October 2023

Authorised by:

Mike Burns, Chief Financial Officer

CONTENTS

RECORD OF AMENDMENTS

NO	SECTION	DATE
1	Updated document issues for implementation	
2	3.9 adjusted to reflect Walton Neurosciences responsibility for charity accounts	25/03/2010
3	4.1.2 Walton Neurosciences funds committee's role as Trustee of Walton Neurosciences Fund	25/03/2010
4	Table A section 20 relating to charitable funds removed and remainder renumbered	25/03/2010
5	Table B section 1 relating to charitable funds removed and remainder renumbered	25/03/2010
6	Table A section 39 add in tariff setting responsibility for Bistro	25/03/2010
7	General update throughout document	01/12/2011
8	General update throughout document	08/01/2013
9	Annual review and amendment following	23/05/2013
10	Amend to reflect change in executive team duties, amend expenditure limits for Chief Executive and Director of Finance and IT and give Other Executive Directors authority to spend up to £50K and update for changes in EU limits	Oct 2014
11	Amend to amend Chief Executive expenditure approval lower level from £70,000 to £75,000 and general review for consistency, changes to titles and Director responsibilities	Nov 2015
12	Amend references to Monitor to reflect NHS Improvement as the new regulator. Amend values given on p7 regarding proposals on individual contracts to reflect expenditure limits in table B. Update table A and B for minor typos and job title changes. Include in table B a threshold of £500 for Deputy Director of Finance and IT to approve ex gratia payments.	Oct 2016
13	Amend references to Director of Nursing and Modernisation to cover revised job title: Director of Nursing, Operations and Quality. Include paragraph on Chair's action as requested at November 2016 Board meeting.	Jan 2017
14	Update tables A and B for the authorisation of credit notes. Update the financial limits in table B to exclude VAT where appropriate. Update tables A and B – quotations and tenders to reflect Trust procurement and tendering policy.	Apr 2017
15	Minor corrections and job title changes; update table B to include £15k (excl VAT) threshold for Deputy Director of Nursing and Lead Nurse for Neurosurgery to approve other expenditure; updated table B to include Zero Cost Model (ZCM) expenditure.	Oct 2017
16	Minor corrections and job title changes (Director of Nursing and Governance); over EU threshold tender limits updated in table B; consignment stock added to table B; authorisation limits for NHS Supply Chain weekly sales invoices added; details regarding travel for Executives added.	Oct 2018
17	Changes to job titles as follows: Director of Finance amended to Director of Finance & IT Director of Strategy and Operations now included Deputy Director of Governance duties now covered by Director of Nursing & Governance Inclusion of the Corporate Secretary title Removal of a section from the Code of Accountability Formatting amended to include numbered paragraphs throughout Approval of polies reserved to the Board as per national guidance. Specifically • approval of the Trust's *Freedom to Speak Up Policy*; • approval of the Trust's *Risk Management Strategy*; • approval of the Trust's *Health, Safety and Welfare Policy*; • approval of the Trust's *Major Incident Plan*; • approval of the Trust's *Learning from Deaths Policy*;	Oct 2019

	• approval of the Trust's *Fit and Proper Persons Policy*.	
18	Over EU threshold tender limits updated in table B Amend reference to NHS Protect to NHS Counter Fraud Authority	Oct 2020
19	Table B – Delegated Financial Limits – Updated following benchmarking exercise. Amend reference to NHS Improvement to reflect name change to NHS England/Improvement	Jan 2021
20	**Changes to job titles as follows:** Director of Finance and IT amended to Chief Financial Officer Deputy Director of Finance amended to Deputy Chief Financial Officer Director of Nursing and Governance amended to Chief Nurse Deputy Director of Nursing and Governance amended to Deputy Chief Nurse Director of Operations and Strategy amended to Chief Operating Officer Director of Workforce and Innovation amended to Chief People Officer Head of Procurement amended to Associate Director of Procurement Deputy Head of Procurement amended to Head of Procurement Deputy Director of Human Resources amended to Deputy Chief People Officer Head of Finance, Income and Contracting amended to Head of Financial Services, Income and Planning Deputy Director of Nursing and lead nurse for Neurosurgery amended to Divisional Nurse Director for Neurosurgery Table A section 36 Risk Management responsibility amended from Director of Nursing and Governance to Chief Operating Officer Table B section 6 EU threshold updated Table B section 9 updated for new consignment contracts to go to BPC and Board of Directors NHSI to NHSE/I Added Deputy CEO and CFO to requisition limit £25k - £35k	Oct 2021
21	Associate Director of Procurement to Chief Procurement Officer Expenditure Approval Levels: CMG from £50k to £100k; Executive Team from £50k-£150k to £100k-£250k; Business Performance Committee from £150k-£500k to £250k-£1m; Trust Board from £500k and above to £1m and above Zero Cost Model changed to Specialised Services Devices programme (SSDP) Credit note approval limit increased from £25k to £35k Other managers approval limit increased from £5k to £10k P2P and Supply Chain Manager added to check weekly order transactions Section 36 – Risk Management Updated the delegated officer to Chief Nurse Financial Accountant to Head of Financial Services	Oct 2023

1.0 INTRODUCTION

1.1 Background

1.1.1 This Scheme of Reservation and Delegation of Powers details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the Walton Centre NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the *Constitution* and the *Standing Financial Instructions* which have been adopted by the Trust. The Trust's *Constitution* and the *Foundation Trust Code of Governance* from NHS England.

1.1.2 The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions; even those delegated to committees, sub committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.2 Role of the Chief Executive

1.2.1 All powers of the Foundation Trust which have not been retained as reserved by the Council of Governors, Board of Directors, or delegated to an executive committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation (SoRD) identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

1.2.2 All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

2.3 Caution over the Use of Delegated Powers

2.31 Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

2.4 Absence of Directors or Officer to Whom Powers have been Delegated

2.4.1 In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

2.4.2 If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Deputy Chief Executive, pending the Accounting Officers return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

3.0 RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

3.1. Accountability

3.1.1 The Code of Accountability which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 3.2 to 3.9 below:

3.2 General Enabling Provision

3.2.1 The Board of Directors may determine any matter it wishes in full session within its statutory powers and taking account of the Trust's Constitution and any guidance issued by NHS England.

3.3 Regulations and Control

The Board of Directors remains accountable for all of its functions; even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The Board of Directors exercises this delegation of regulation and control by the:

a) approval of *Standing Orders for the Board of Directors* which form Annex 8 of the Trust's Constitution;

b) a schedule of matters reserved to the Board of Directors and *Standing Financial Instructions* (SFIs) for the regulation of its proceedings and business;

c) approval of a *Scheme of Reservation and Delegation of Powers* (SoRD) of powers from the Board of Directors to managers;

d) requirement to receive the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration;

e) requirement to receive the declaration of interests from officers which may conflict with those of the Trust;

f) disciplining of Directors who are in breach of Statutory Requirements or the Trust's Constitution and governance documents;

g) adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to;

h) requirement to receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon;

i) confirmation of the recommendations of the Foundation Trust's committees;

j) where the committees do not have executive powers;
    a. requirement to establish terms of reference and reporting arrangements of all committees;

k) ratification of any urgent decisions through use of emergency powers in accordance with paragraph 5.2 (Emergency Powers) of the *Standing Orders for the Board of Directors* as described in Annex 8 of the Trust's *Constitution*;

l) approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on Trust by The Walton Centre Charity;

m) approval of arrangements for dealing with complaints;

n) approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property;

o) authorisation of use of the seal;

p) ratification or otherwise, instances of failure to comply with SOs brought to the Chief Executive's attention; and

q) approval and monitoring of the Foundation Trust's policies and procedures for the management of risk;

r) approval of the Trust's *Freedom to Speak Up Policy*;

s) approval of the Trust's *Health, Safety and Welfare Policy*;

t) approval of the Trust's *Major Incident Plan*;

u) with the Council of Governors, and in accorda*nce with the* Trust's *Constitution,* approve changes to the Trust's *Constitution*;

v) approval of the Trust's *Learning from Deaths Policy*;

w) approval of the Trust's *Fit and Proper Persons Policy*.

3.4 Appointments/Remuneration and Dismissals

3.4.1 The Board of Directors exercises this delegation of appointments by:

a) the appointment and dismissal of committees;
b) the appointment, appraisal, disciplining and dismissal of Executive Directors;
c) approval of proposals received from the Remuneration Committee regarding the remuneration of the Chief Executive, Executive Directors and senior employees.

3.4.2 In accordance with the Trust's *Constitution*, the Council of Governors will appoint the Chairman, the Non-Executive Directors and approve the appointment of the Chief Executive.

3.5 Policy determination

3.5.1 The Board of Directors exercises this delegation of policy determination by: (a) the approval of Trust management policies where not specifically delegated to Committee(s) to approve.

3.6 Strategy and Business Plans and Budgets

3.6.1 The Board of Directors exercises this delegation of strategy, business plans and budgets by:

a) defining the strategic aims and objectives of the Foundation Trust;

b) approval annually of the Foundation Trust's proposed business plan / service development strategy;
c) approval of the Trust's annual budget and long-term financial plans;
d) approval of Outline and Final Business Cases for capital investment for values greater than£1,000,000;
e) approval annually of the Foundation Trust's proposed business plan / service development strategy;
f) ratification of proposals for acquisition, disposal or change of use of land and/or buildings;
g) approval of PFI proposals;
h) approval of the creation of corporate bodies by the Trust;
i) approval of the participation in joint ventures and the creation of joint entities;
j) approval of proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital level above £1,000,000or revenue amounting to, or likely to amount to over £1,000,000 over the life of the contract;
k) approval of proposals in individual cases for the write-off of debt or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer;
l) approval of proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes;
m) review of the use of NHS risk pooling schemes;
n) approval of the opening of bank accounts; and
o) approval of individual compensation payments.

3.8 Financial and Performance Reporting Arrangements

3.8.1 The Board of Directors exercises this delegation of financial and performance reporting arrangements by:

a) continuous appraisal of the affairs of the Foundation Trust through receipt of management reports and policy statements;

b) receiving reports from committees in respect of their exercise of powers delegated;

c) receive reports from Chief Financial Officer on financial performance against budget and business plan / service development strategy;

d) receive reports from the Chief Financial Officer on actual and forecast income from service level agreements and contracts.

e) receive and approve of the Foundation Trust's Annual Report and Annual Accounts prior to:
   - being laid before Parliament; and
   - presentation to the Council of Governors at the Annual Members Meeting.

f) the receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive;

g) the receipt and approval of the Annual Report(s) for funds held on Trust.

3.9 Audit Arrangements

3.9.1 The Board of Directors exercises this delegation of audit arrangements by:

a) approving audit arrangements (including arrangements for the separate audit of funds held on Trust) and to receive reports of the Audit Committee meetings and take appropriate action;
b) the receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee;
c) the receipt of the Annual Internal Audit Report from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit Committee.

d) The Board of Directors note, in accordance with the Trust's *Constitution*, that the Council of Governors is responsible for the appointment, re-appointment and removal of the External Auditor, advised by the Board of Directors' Audit Committee.

4.0 DELEGATION OF POWERS

4.1 Delegation to Committees

4.1.1 The Board of Directors may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors who shall also determine the committee's reporting requirements. Committees may not delegate executive powers to sub-committees.

4.2 Delegation to Officers
(From the Accounting Officer Memorandum for Foundation Trusts 2015)

4.2.1 **The general responsibilities of an NHS foundation trust accounting officer**

The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the NHS Foundation Trust as a whole;
- financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS Foundation Trust; and
- financial considerations are fully taken into account in decisions on NHS Foundation Trust policy proposals.

4.2.2 **The specific responsibilities of an NHS Foundation Trust Accounting Officer**

The essence of the Accounting Officer's role is personal responsibility for:

- the propriety and regularity of the public finances for which he or she is answerable;
- the keeping of proper accounts;
- prudent and economical administration; and
- the avoidance of waste and extravagance; and the efficient and effective use of all the resources in their charge.

4.2.3. The Accounting Officer must:

- personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content as prescribed by NHS England in accordance with the Act;
- comply with the financial requirements of the terms of authorisation;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS Foundation Trust);
- ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which they are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; and
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Board of Governors or in the actions or advice of the NHS Foundation Trust's staff and ensure that, in the consideration of policy proposals relating to the expenditure for which the Accounting Officer is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

4.2.4 The Accounting Officer should ensure that effective management systems are appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems have been put in place. An Accounting Officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made

available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; and

- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

4.2.5 Accounting Officers must make sure that their arrangements for delegation promotes good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in NHS Internal Audit Standards.

4.3

Chairs Actions

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

TABLE A - DELEGATED AUTHORITY

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders (SOs) / Standing Financial Instructions (SFIs)		
a) Final authority in interpretation of SOs.	Chair	Chief Executive
b) Notifying Directors and employees of their responsibilities within the SOs and SFIs and ensuring that they understand the responsibilities.	Chief Executive	Deputy Chief Financial Officer and Budget Managers
c) Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with SOs, Standing Financial Instructions and financial procedures.	Chief Executive	All Directors and Employees
d) Suspension of SOs	Board of Directors	Board of Directors
e) Review suspension of SOs	Audit Committee	Audit Committee
f) Variation or amendment to SOs	Board of Directors	Board of Directors
g) Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two Non-Executive Directors	Chair and Chief Executive with two Non-Executive Directors
h) Disclosure of non-compliance with SOs to the Chief Executive (report to the Board of Directors).	All Staff	All Staff
i) Disclosure of non-compliance with SFIs to the Chief Financial Officer(report to the Audit Committee).	All Staff	All Staff
j) Advice on interpretation or application of SFIs and this Scheme of Delegation.	Chief Financial Officer	Deputy Chief Financial Officer

TABLE A – DELEGATED MATTERS

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Audit Arrangements		
a) To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the External Auditor and to approve the remuneration in respect of the External Auditor.	Audit Committee (for recommendation to the Council of Governors for approval).	Chief Financial Officer
b) Monitor and review the effectiveness of the internal audit function.	Audit Committee	Director of Internal Audit / Chief Financial Officer
c) Review, appraise and report in accordance with international Internal Audit Standards and best practice.	Audit Committee	Director of Internal Audit
d) Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e) Ensure cost-effective audit service.	Audit Committee	Chief Financial Officer
f) Implement recommendations.	Chief Executive	Relevant Officers
2. Clinical Trials and Research Projects		
a) Authorisation of Clinical Trials and Research Projects.	Chief Executive	Research, Development and Innovation (RDI) Operations Group
b) Financial Management of Clinical Trials and Research Projects in accordance with all Trust financial policies and procedures.	Chief Financial Officer	Deputy Chief Financial Officer with Chief Operating Officer
3. Authorisation of New Drugs		
4. Bank / GBS Accounts / Cash		
a) **Operation** • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements).	Chief Financial Officer	Head of Financial Services
• Opening bank accounts.	Chief Financial Officer	Deputy Chief Financial Officer
• Authorisation of transfers between the Foundation Trust's bank accounts.	Chief Financial Officer	In accordance with the bank mandate

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Approve and apply arrangements for the electronic transfer of funds.	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures.
• Authorisation of: – GBS schedules; – BACS schedules; – Automated cheque schedules; – Manual cheques.	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures.
b) **Investments** • Investment of surplus funds in accordance with the Foundation Trusts Treasury Management policy (based on NHSE/I requirements / guidance). • Preparation of investment procedures.	Chief Financial Officer	Head of Financial Services
c) **Petty Cash**	Chief Financial Officer	Refer to Table B Delegated Limits
5. Capital Investment		
a) Programme: • Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the impact on business plans / service development strategy.	Chief Executive	Chief Financial Officer/
• Preparation of Capital Investment Programme.	Chief Executive	Chief Financial Officer/ Chief Operating Officer
• Preparation of a business case.	Chief Financial Officer/ Chief Operating Officer	Relevant operational manager – Refer to Table B
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract.	Chief Financial Officer	Deputy Chief Financial Officer
• Contracting: Selection of architects, quantity surveyors, consultant engineers and other professional advisors within the EU regulations and Trust tender procedures.	Chief Executive	Chief Financial Officer/ Chief Operating Officer with external advice as required
• Authorisation of capital requisitions.	Chief Executive	Refer to Table B Delegated Limits
• Responsible for the management of capital schemes and for ensuring that they are	Chief Executive	Chief Financial Officer/Chief

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
delivered on time and within cost.		Operating Officer.
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	Chief Financial Officer/ Chief Operating Officer
• Issue procedures to support: (i) capital investment; (ii) staged payments.	Chief Financial Officer/ Chief Operating Officer	Deputy Chief Financial Officer
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Chief Financial Officer	Deputy Chief Financial Officer
• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's.	Chief Executive	Chief Financial Officer
b) **Private Finance:**		
• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive	Chief Financial Officer
c) **Leases (property and equipment):**		
• Review of type of lease to determine whether an operating lease or finance lease implication on the Financial Sustainability Rating prior to being signed	Chief Financial Officer	Head of Financial Services
• Granting and termination of leases with Annual rent < £50k.	Chief Financial Officer	Head of Financial Services
• Granting and termination of leases with Annual rent of £50k - £100k.	Chief Executive	Chief Financial Officer
• Granting and termination of leases with Annual rent > £100k.	Board of Directors	Chief Executive
6. Clinical Audit	Chief Executive	Medical Director / Chief Nurse
7. Commercial Sponsorship		
Agreement to proposal.	Chief Executive	Chief Financial Officer with reference to the Standards of Business and

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Personal Conduct Policy
8. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively.	Chief Executive	Chief Nurse
b) Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Chief Nurse
9. Confidential Information		
• Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS;	Chief Executive	Medical Director
• Freedom of Information Act compliance code;	Chief Executive	Chief Financial Officer
• Data Security Arrangements.	Chief Executive	Chief Financial Officer
10. Data Protection Act		
Assurance of the Foundation Trust's Compliance.	Chief Executive	Chief Financial Officer
11. Declaration of Interest		
Maintaining a register of interests of the Board of Directors.	Chair	Corporate Secretary
To ensure Senior Managers / Senior Clinicians / Department Heads / all Senior Staff have declared relevant and material interest.	Chief Executive	Chief Financial Officer
12. Disposal and Condemnations		
• Items obsolete, redundant, irreparable or cannot be repaired cost effectively.	Chief Financial Officer	Head of Department in accordance with agreed policy
• Develop arrangements for the sale of assets.	Chief Financial Officer	Deputy Chief Financial Officer
13. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal.	Chief Executive	Chief Operating Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
14. External Borrowing		
a) Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Chief Financial Officer	Deputy Chief Financial Officer
b) Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board of Directors	In accordance with relevant mandate
c) Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive	Chief Financial Officer
d) Preparation of procedural instructions concerning applications for loans and overdrafts.	Chief Financial Officer	Head of Financial Services
15. Financial Planning / Budgetary Responsibility		
a) **Setting:**		
• Submit budgets to the Trust Board	Chief Executive	Chief Financial Officer
• Submit to Board financial estimates and forecasts	Chief Executive	Chief Financial Officer
• Compile and submit to the Board operational and strategic plans which take into account financial targets, forecast limits and available resources.	Chief Executive	Chief Operating Officer
b) **Monitoring:**		
• Devise and maintain systems of budgetary control.	Chief Financial Officer	Deputy Chief Financial Officer
• Monitor performance against budget.	Chief Financial Officer	Divisional Accountant / Budget Holders
• Delegate budgets to budget holders	Chief Executive	Chief Financial Officer
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Financial Officer	Deputy Chief Financial Officer
• Submit in accordance with the Monitor's requirements for financial monitoring returns.	Chief Executive	Chief Financial Officer
• Identify and implement cost improvements and income generation activities in line with the Business Plan.	Chief Executive	Executive Team/Divisional Management

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Preparation of: • Annual Accounts • Annual Reports	Chief Financial Officer Chief Executive	Teams Deputy Chief Financial Officer Corporate Secretary
c) Budget Responsibilities: Ensure that: • no overspend or reduction of income (that cannot be met from virement) should be incurred without authorisation from the Divisional Manager or lead Executive in the case of corporate budgets. All overspending budgets or unfavourable variances are reported to the Board on a monthly basis. • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.	Chief Financial Officer	Budget Holders
d) Authorisation of Virement: It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties.	Chief Executive / Chief Financial Officer	Refer to Table B Delegated Limits
16. Financial Procedures and Systems		
a) Maintenance and update on Foundation Trust Financial Procedures	Chief Financial Officer	Deputy Chief Financial Officer
b) Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action; • Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position; • Providing financial advice to members of the Board of Directors and staff; • Ensure that appropriate statutory records are maintained; and • Designing and maintaining compliance with all financial systems.	Chief Financial Officer	Deputy Chief Financial Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
17. Fire Precautions		
Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Chief Operating Officer
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Executive	Chief Financial Officer
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current accounting requirements.	Chief Financial Officer	Deputy Chief Financial Officer
c) Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Chief Financial Officer and reporting losses in accordance with Foundation Trust's procedures.	Chief Executive	All Staff
19. Fraud (See also 25,35)		
a) Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Local Counter Fraud Specialist
b) Notify NHS Counter Fraud Authority and External Audit of all suspected Frauds.	Chief Financial Officer	Local Counter Fraud Specialist
20. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements.	Chief Executive	Chief Operating Officer
21. Hospitality / Gifts		
Keeping of hospitality register.	Chief Executive	Corporate Secretary
22. Infectious Diseases & Notifiable Outbreaks		
	Chief Executive	Chief Nurse
23. Information Management & Technology		
Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T strategy; • Implementing new systems and ensure they are developed in a controlled manner and thoroughly tested; • Seeking third party assurances regarding financial systems operated externally; and • Ensure that contracts for computer services for	Chief Financial Officer	Deputy Chief Financial Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
financial applications define responsibility for: security; privacy; accuracy; completeness and timeliness of data during processing and storage.		
IT Systems • Developing IT systems in accordance with the Foundation Trust's IM&T Strategy and Trust objectives; • Implementing new systems and ensure they are developed in a controlled manner and thoroughly tested; • Seeking third party assurances regarding IT systems operated externally; • Ensure that contracts for computer services for IT applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage; • Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Chief People Officer	Head of IM&T
24. Legal Proceedings		
• Engagement of Foundation Trust's Solicitors / Legal Advisors • Approve and sign all documents which will be necessary in legal proceedings i.e. executed as a deed; • Sign on behalf of the Foundation Trust any agreement or document not requested to be executive as a deed.	Chief Executive Chief Executive Chief Executive	All Executive and Corporate Directors Chief Financial Officer Chief Financial Officer
25. Losses, Write-off & Compensation		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing NHS Counter Fraud Authority of fraud / alleged fraud. **Losses:** – Losses of cash due to theft, fraud, overpayment & others; – Fruitless payments (including abandoned Capital Schemes); – Bad debts and claims abandoned; and – Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g.	Chief Executive	Chief Financial Officer Refer to Table B Delegated Limits

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
fraud, theft, arson).		
b) Reviewing appropriate requirement for insurance claims.	Chief Financial Officer	Deputy Chief Financial Officer
c) A register of all of the payments should be maintained by the Finance Department and made available for inspection / audit.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Financial Services
d) A report of all of the above payments should be presented to the Audit Committee on an annual basis.	Chief Financial Officer	Deputy Chief Financial Officer/ Head of Financial Services
Special Payments: Compensation payments by Court order **Exgratia Payments:** • To patients/staff for loss of personal effects; • For clinical negligence after legal advice; • For personal injury after legal Advice; • Other clinical negligence and personal injury; • Other ex-gratia payments.	Chief Executive Chief Executive	Refer to Table B Delegated Limits Refer to Table B Delegated Limits
Write-offs: • Write-off of Debtors. • Report all bad debt write-offs to the Audit Committee at least annually	Chief Executive	Deputy Chief Financial Officer(Refer to Table B Delegated Limits)
26. Meetings		
a) Calling meetings of the Foundation Trust Board.	Chair	Corporate Secretary
b) Chair all Foundation Trust Board meetings and associated responsibilities.	Chair	Chair
27. Medical		
• Clinical Governance arrangements	Medical Director / Chief Nurse	Chief Nurse
• Medical Leadership	Medical Director	Medical Director / Divisional Clinical Directors
• Programmes of medical education	Medical Director	Director of Medical Education
• Medical staffing plans	Medical Director	Divisional Clinical Directors / Divisional General Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Medical Research	Medical Director	Clinical Director of Research /
28. Non-Pay Expenditure		
a) Maintenance of a list of managers authorised to place requisitions / orders and accept goods in accordance with Table B	Chief Executive	Chief Financial Officer
b) Obtain the best value for money when requisitioning goods / services	Chief Executive	Chief Procurement Officer
c) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)).	Chief Executive	Chief Financial Officer
d) Develop systems for the payment of accounts.	Chief Financial Officer	Deputy Chief Financial Officer
e) Prompt payment of accounts.	Chief Financial Officer	Head of Financial Services
f) Financial Limits for ordering / requisitioning goods and services	Chief Financial Officer	Refer to Table B Delegated Limits
g) Approve prepayment arrangements	Chief Financial Officer	Head of Financial Services
h) Financial limits for authorising internal credit notes	Chief Financial Officer	Refer to Table B Delegated Limits
i) Financial limits for authorising NHS Supply Chain and other third-party distributors weekly sales invoices	Chief Financial Officer	Refer to Table B Delegated Limits
29. Nursing		
• Compliance with statutory and regulatory arrangements relating to professional nursing practice.	Chief Nurse	Deputy Chief Nurse
• Matters involving individual professional competence of nursing staff.	Chief Nurse	Deputy Chief Nurse
• Compliance with professional training and development of nursing staff.	Chief Nurse	Deputy Chief Nurse
• Quality assessment of nursing processes.	Chief Nurse	Deputy Chief Nurse
30. Patient Services Agreements		
a) Negotiation of Foundation Trust Contract and Non-Commercial Contracts.	Chief Executive	Chief Financial Officer/
b) Quantifying and monitoring non-contract activity.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Financial

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Services, Income and Planning
c) Reporting actual and forecast income.	Chief Financial Officer	Chief Financial Officer / Head of Financial Services, Income and Planning
d) Costing Foundation Trust Contract and Non-Commercial Contracts.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Financial Services, Income and Planning
e) Reference costing / Payment by Results. • Production of annual reference costs in accordance with national guidance and best practice.	Chief Financial Officer	Deputy Chief Financial Officer/Head of Financial Management.
f) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding.	Chief Financial Officer	Senior Finance Team Members
31. Patients' Property		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission.	Chief Financial Officer	Ward Managers
b) Prepare detailed written instructions for the administration of patients' property.	Chief Financial Officer	Deputy Chief Financial Officer / Divisional Nurse Director for Neurosurgery
c) Informing staff of their duties in respect of patients' property.	Chief Financial Officer	Divisional General Manager / Department Manager / Clinical Managers / Ward Manager
d) Issuing property of deceased patients • <£4,999 in accordance with agreed Foundation Trust policies; • >£5,000 only on production of a probate letter of administration.	Chief Financial Officer Chief Financial Officer	Head of Financial Services Head of Financial Services
32. Personnel & Pay		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts.	Chief Executive	Chief People Officer
b) Develop Human Resource policies and strategies for approval by the Board including training, industrial relations.	Chief People Officer	Deputy Chief People Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Authority to fill funded post on the establishment with permanent staff.	Chief People Officer	Budget Managers and Divisional Accountants
d) The granting of additional increments to staff within budget.	Chief People Officer	Budget Managers and Deputy Chief Financial Officer
e) The granting of additional increments to staff outside of budget limits.	Chief Executive	Budget Managers and Divisional Accountants with Executive Team Approval
f) All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Chief People Officer	Deputy Chief People Officer
g) Establishments		
• Additional staff to the agreed establishment with specifically allocated finance;	Chief Financial Officer	Budget Managers and Divisional Accountants with Executive Team Approval
• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Budget Managers and Divisional Accountants with Executive Team Approval
• Self-financing changes to an establishment	Chief Financial Officer	Budget Managers / Divisional Accountant
h) Pay		
• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Executive	Chief People Officer
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Chief People Officer	Budget Managers
• Authority to complete and authorise Staff Variation Lists (SVLS)	Chief Financial Officer	Budget Managers or authorised deputy
• Authority to authorise overtime	Chief People Officer/ Chief Financial Officer	Budget Managers
• Authority to authorise travel and subsistence expenses	Chief Financial Officer	Budget Managers
• Authority to authorise travel orders for	Chief Executive/	Personal

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Executives	Chief Financial Officer/ Deputy Chief Financial Officer	Assistants
i) Leave *(note entitlement may be taken in hours)*	Chief People Officer	Refer to Annual Leave Policy / Divisional Manager / Head of Department
<u>Annual Leave</u> • Approval of annual leave	Chief People Officer	Line / Departmental Manager (as per departmental procedure)
• Annual leave – approval of carry forward (up to maximum of 5 days)	Chief People Officer	Line/Departmental Manager
• Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only).	Chief People Officer	Clinical Directors / Departmental Manager / Department Heads
<u>Special Leave (paid and unpaid)</u> For example • Parental Leave ▪ Leave for Family Emergencies ▪ Bereavement Leave ▪ IVF and other fertility treatments ▪ Domestic Emergencies ▪ Participation in Elections ▪ Public Duties ▪ Jury Service ▪ Appearance as a Witness/Expert Witness ▪ Special Forces ▪ Additional Professional Duties ▪ Participation in Sporting Events ▪ Adverse Weather Conditions ▪ Travel Delays following Annual Leave ▪ Time off for Job Interviews To be applied in accordance with Foundation Trust Policy.	Chief People Officer	Departmental Manager / Head of Service / Clinical Managers
• Leave without pay.	Chief People Officer	Clinical Director / Directorate
• Medical Staff Leave of Absence – paid and unpaid.	Chief People Officer	Clinical Director with advice from the Medical Director
• Time off in lieu.	Chief People Officer	Line / Departmental

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Manager
• Maternity Leave - paid and unpaid.	Chief People Officer	Automatic approval with guidance
<u>Sick Leave</u> j) Extension of sick leave and pay.	Chief People Officer	Clinical Director / Directorate Manager / Department Heads in conjunction with the Chief People Officer
ii) Return to work part-time on full pay to assist recovery.	Chief People Officer	Clinical Director / Directorate Manager / Department Heads in conjunction with the Chief People Officer
<u>Study Leave</u> • Study leave outside the UK.	Chief Executive	Relevant Executive Director
• Medical staff study leave (UK) – Consultant / Non-Career Guide – Career Guide	Medical Director Medical Director	Medical Director / Clinical Directors Post Graduate Tutor
• All other study leave (UK)	Chief People Officer	Budget Manager (in budget) and Training and Development Manager
k) Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief People Officer must be sought when the grievance reaches the level of Divisional General Managers / Heads of Department.	Chief People Officer	Departmental Manager / Line Manager / Appeals Committee
l) Authorised – Car Users • Regular users allowance.	Chief Financial Officer	To be applied as per Trust Policy
m) Mobile Phone Users / Blackberry's / iPad's/laptops	Chief Financial Officer	To be applied as per local Trust policy

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
n) Renewal of Fixed Term Contract.	Chief People Officer	Budget Holder / Finance Approval plus relevant Executive Director
o) Redundancy.	Chief Executive	Chief People Officer/ Chief Financial Officer
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief People Officer	Deputy Chief People Officer
q) Early retirement.	Chief Executive	Chief People Officer/ Chief Financial Officer
r) Disciplinary Procedure (excluding Executive Directors).	Chief People Officer	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
s) Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Chief People Officer	Deputy Chief People Officer
t) Engagement of staff not on the establishment: • Authorisation of bank staff and temporary nursing staff, including agency	Chief Nurse	Refer to Table B In Hours – Budget Manager Out of Hours – On Call Manager (silver)
• Management Consultants and Other	Executive Team	Budget Manager Refer to Table B Delegated Limits
33. Quotation, Tendering & Contract Procedures		
a) Services: • Best value for money is demonstrated for all services provided under contract or in-house;	Chief Executive	Chief Financial Officer/ Deputy Chief Financial Officer/ Associate Chief Procurement Officer
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Chief Financial Officer/ Deputy Chief Financial

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Officer/ Associate / Divisional Director / Head of Department
b) Competitive Tenders		
• Authorisation Limits	Chief Executive	Refer to Table B Delegated Limits
• Maintain a register to show each set of competitive tender invitations despatched;	Chief Executive	Chief Procurement Officer
• Receipt and custody of tenders prior to opening	Chief Executive	Chief Procurement Officer Corporate Secretary
• Opening Tenders	Chief Executive	
• Decide if late tenders should be considered	Chief Executive	Chief Procurement Officer
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Chief Procurement Officer
c) Quotations / Authorisation Limits:	Chief Executive	Refer to Table B Delegated Limits
d) Waiving the requirement to request: • Tenders; • Quotes.	Chief Executive	Chief Financial Officer Refer to Table B Delegated Limits
34. Records		
a) Review Foundation Trust's compliance with the Records Management Code of Practice.	Chief Executive	Chief Nurse
b) Ensuring the form and adequacy of the financial records of all departments.	Chief Financial Officer	Deputy Chief Financial Officer
35. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected • Criminal offence of a violent nature; • Arson or theft; • Other.	Chief Executive	Senior Manager On-Call Directorate Manager / Department Heads / Security with reference to Chief Operating Officer
b) Where a fraud is suspected (reporting to NHS Counter Fraud Authority).	Chief Financial Officer	Local Counter Fraud Specialist
c) Deciding at what stage to involve the police in cases of misappropriation and other	Chief Financial Officer	Executive Director / Senior Manager

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
irregularities not involving fraud or corruption.		On Call (silver)
36. Risk Management		
• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management.	Chief Executive	Chief Nurse
• Developing systems for the management of risk.	Chief Nurse	Deputy Chief Nurse
• Developing incident and accident reporting systems • Compliance with the reporting of incidents and accidents	Chief Nurse	Deputy Chief Nurse All Staff
37. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Corporate Secretary
b) Attestation of seal in accordance with SOs	Chair / Chief Executive	Trust Board
c) Property transactions and any other legal requirement for the use of the seal.	Chair / Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Director
38. Security Management		
a) Monitor and ensure compliance with Clause 43 and Schedule 13 of the standard NHS contract (which mirror Secretary of State Directions) on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Chief Financial Officer
39. Setting of Fees and Charges (Income)		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Chief Financial Officer	Head of Financial Services, Income and Planning
b) Non-patient care income	Chief Financial Officer	Head of Financial Services, Income and Planning
c) Information to the Board of Directors of monies due to the Foundation Trust	Chief Financial Officer	Head of Financial Services, Income and Planning
d) Recovery of debt	Chief Financial Officer	Head of Financial Services
e) Security of cash and other negotiable instruments	Chief Financial Officer	Head of Financial Services

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
f) Financial limits for authorising credit notes	Chief Financial Officer	Refer to Table B Delegated Limits
40. Stores and Receipt of Goods		
a) Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Financial Officer	Chief Procurement Officer
b) Stocktaking arrangements	Chief Financial Officer	Heads of Departments and Divisional Accountants
c) Responsibility for controls of pharmaceutical stock.	Designated Pharmaceutical officer	Under SLA – senior designated Pharmaceutical Officer
41. Medicines Inspectorate Regulations		
Review Regulations.	Chief Executive	Medical Director (with operational support from Divisional General Manager) and contractor under SLA
42. Consignment Stock		
Responsibility for approving consignment stock agreements.	Chief Executive/ Chief Financial Officer/ Deputy Chief Financial Officer	Chief Procurement Officer/ Head of Procurement

TABLE B – DELEGATED FINANCIAL LIMITS

Unless otherwise stated, all thresholds are inclusive of VAT irrespective of recovery arrangements.

If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executives thresholds.

Financial Limits (subject to funding available in budget)		
	Value	**Delegated to:-**
1. GIFTS AND HOSPITALITY		
Any gifts or hospitality or offers of gifts or hospitality which exceed the £50 threshold must be declared.	£50	Chief Financial Officer in line with hospitality policy.
2. LITIGATION CLAIMS		
Payments made on advice of NHS Resolution, insurance company.	<excess on policy	Chief Financial Officer/ Chief Nurse - Report to Audit Committee
Payments made on advice of legal advisor	>excess	Chief Financial Officer/ Chief Nurse - Report to Board of Directors
Decision to contest/initiate other litigation claims	>£10k or contentious case <£10k and not contentious	Board of Directors Chief Financial Officer
3. LOSSES AND SPECIAL PAYMENTS – Reported to Audit Committee		
<u>Losses</u> Fruitless payments (including abandoned capital schemes)	>£10,000 <£10,000 <£5,000	Chief Executive (reported to audit committee) Chief Executive Chief Financial Officer
<u>Other Losses</u> Losses of cash due to theft, fraud, overpayment and others	>£10,000 <£10,000 <£5,000	Chief Executive (reported to the Board of Directors) Chief Executive Chief Financial Officer
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson etc.).	> £10,000 <£10,000	Chief Executive Chief Financial Officer
Exgratia Payments	>£10,000 £5,000 to £10,000	Chief Executive (reported to the Board of Directors) Chief Executive

Financial Limits (subject to funding available in budget)		
	<£5,000	Chief Financial Officer
Write-offs, Bad debts and claims abandoned. Private patients, overseas visitors & other.	>£50,000 <£50,000 <£1,000	Board of Directors Chief Executive/ Chief Financial Officer (reported to the Board of Directors) Deputy Chief Financial Officer
Compensation Payments		Deputy Chief Financial Officer in accordance with NHS Resolution/ legal advice
4. PETTY CASH DISBURSEMENTS (authority to pay)		
Small incidental items of expenditure.	< £100	Budget Holder / Head of Financial Services
5. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
5.1 Agency Staff: Any individual booking of agency staff, including medical locums, subject to NHSE/I guidelines	>£100,000 <£100,000 <£10,000 <£5,000	Board of Directors Chief Executive Executive Directors Divisional General Managers / Senior Manager On Call / Deputy Chief People Officer/ Medical Staffing Manager ***No other managers can authorise the use of agency staff***
5.2 Removal Expenses	<£8,000	Chief People Officer/ Chief Financial Officer
5.3 All Other Expenditure All pay and non-pay expenditure including software and IT equipment, maintenance contracts, goods and services contracts, management consultants and call off orders. The limit is the total value over the life of the contract. (Please see below for NHS Supply Chain and other third-party distributors weekly sales invoices).	All figures excl, VAT >£1m £250k-£1m £100k-£250k £60,000 to £100k £35k to £60k	 Board of Directors Business Performance Committee Chief Executive (EMT) Chief Financial Officer Other Executive Directors

Financial Limits (subject to funding available in budget)		
	£25k to £35k <£25k <£10k	Deputy Chief Financial Officer/Chief Financial Officer /Deputy Chief Executive Divisional Directors/Deputy Chief Nursing Officer Other Managers
5.4 NHS Supply Chain and other third-party distributors expenditure Authorisation of weekly sales invoices	>£25,000 (excl VAT) <£25,000 (excl VAT)	Chief Procurement Officer Head of Procurement/P2P and Supply Chain Manager
5.5 Specialised Services Devices programme (SSDP)	£0	Chief Financial Officer/ Deputy Chief Financial Officer/Chief Procurement Officer
5.6 Capital Expenditure • General • Strategic Investment Plan	>£1m £250k-£1m £100k-£250k <£100k	Board of Directors Business performance Committee EMT Capital Management Group
6. QUOTATIONS AND TENDERS		
Obtain competitive price for goods/services	<£19,999 (Inc. VAT)	Budget Managers in conjunction with Procurement Team
Quotations: Obtain a minimum of 3 written competitive quotations for goods/services.	£20,000 to £49,999 (Inc. VAT)	Budget Manager in conjunction with Procurement Team To note that regular reviews of cumulative expenditure for individual suppliers (on the same project) will be undertaken to ensure that SoRD limits are adhered to.
Under Threshold Tenders: Undertake a competitive tendering exercise for goods/services. Over EU Threshold Tenders: Undertake a competitive tendering exercise for goods/services.	>£50,000 (Inc. VAT) (Local tendering procedures) £139,688 (excl VAT) Goods/Services Contracts £5,372,609 (excl VAT) Works Contracts £663,540 (excl VAT) Social & other specific services (Light Touch)	Chief Procurement Officer evaluated by a member of the procurement team and at least three stakeholders from the evaluation panel

Financial Limits (subject to funding available in budget)		
7. VIREMENT		**Conditions:-**
Chief Executive Chief Financial Officer Budget Holder and Deputy Chief Financial Officer	 >£50,000 p.a. < £50,000 p.a. <£25,000 p.a.	Trust must still meet Financial Targets Total Trust budget remains underspent Chief Executive Chief Financial Officer Budget Holder & Deputy Chief Financial Officer
8. CREDIT NOTES		
Authorisation of credit notes, including internal credit notes used to adjust expenditure	>£35,000(excl VAT) <£35,000 (excl VAT)	Chief Financial Officer Deputy Chief Financial Officer
9. CONSIGNMENT STOCK		
Responsibility for approving consignment stock agreements. Chief Procurement Officer/ Head of Procurement to review terms and conditions prior to financial approval. Any existing contracts that increase in value to the next threshold need relevant approval	 >£500k (new consignment contracts) £150k-£500k(new consignment contracts) £100k- £150k £60k -£100k £35k-£60k £25k - £35k <£25k	Chief Procurement Officert/ Head of Procurement to review T&C's prior to financial approval. All figures excl.VAT Board of Directors Business & Performance Committee Chief Executive (EMT) Chief Financial Officer Other Executive Directors Deputy Chief Financial Officer Divisional Directors/Deputy Chief Nurse

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Date of meeting: 27/10/23		**Report of:** The Walton Centre Charity Committee Meeting
		Membership Numbers: Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Finance Report as at 30 September 2023 • CCLA and Ruffer Quarterly Investment Reports • Independent Investment Report to 30 June 2023 (Jagger & Associates) Independent Advisors • Independent Review Statement • Fundraising Activity Report • Fundraising Strategy Bi-annual Update • Charity Risk Register • Cycle of Business 2023/24 • Training and Development Department Applications Towards Staff Professional Development • Long Service Award Recognition • Consumables and Clinician Time for Pudendal SSEP for BESCSES Trial • Relatives Accommodation Policy Update • Pipeline of Potential Projects Update • Annual Report and Accounts 2022/23 • Charity Investment Policy Review • Draft Walton Centre Charity Governance Arrangements & Financial Instructions
2	**Alert**	• The Committee received quarterly statements from Fund Managers CCLA and Ruffer noting investment balances had reduced slightly from £1,180,000 in June 2022 to £1,176,000 in June 2023. • The independent advisor's annual investment report from Jagger & Associates provided an analysis on the Charity's investments. CCLA had faced some challenges in Q3 of 2023/24, funds were well behind the CPI+5% from June 2022 to June 2023, the absolute returns were volatile and there was a 8% switch from Cash into Fixed Interest. The Ruffer CAT return was behind the Ruffer ARF return over the last 12 months but was ahead over the 5-year period. Given the volatility of the markets the Committee would receive an additional independent investment report from Jaggers at the next meeting.
3	**Assurance**	• The Committee received a progress update on the Fundraising activities, and it was noted that good progress was being made towards the Jan Fairclough (JF) Ball in November. • The Committee received and noted the Cycle of Business for 2023/24.

		• The Committee received the Fundraising Strategy Bi-Annual Update, and it was noted that good progress had been made on the target areas. Update on the Strategy will be presented at the Board meeting in December 2023. • The Head of Fundraising presented the Charity Risk Register, no new risks were identified, and the Committee assessed appropriateness of risk ratings. • A verbal update on the pipeline of potential projects was received and noted by the Committee. • The Committee received an independent examiner's report on the 2022/23 Walton Centre Charity Annual Reports and Accounts from BWM Chartered Accountants and it was reported that there were no concerns and the Annual Reports and Accounts had been completed in accordance with FRS102 and the Charities SORP. A copy of the independent Examiners statement to be included in the WCC Annual Reports and Accounts		
4	**Advise**	• The Finance Report as at 30 September was presented to the Committee which showed that the fund balances had decreased from £1,381,843 to £1,287,091 as at 30 September 2023 and current investments were valued at £1,144,085. • The Committee gave formal approval for £12,700 to be used for recognition gifts to be awarded to staff with long service at The Walton Centre. • The Committee approved additional funding requests for 10 study leave applications from staff for part funding (25%) towards professional development. • The Committee received and ratified an application for £2,701 for Consumables and clinician time for Pudendal Somatosensory Evoked Potentia (SSEP) for BESCSES trial. • The Relatives Accommodation Policy was received by the Committee and changes to the policy were approved by the Committee. • The Committee received and approved the Draft Walton Centre Charity Governance Arrangements and Standing Financial Instructions. • The Committee received and recommended the 2022/23 Walton Centre Charity (WCC) Annual Report and Accounts to the Trust Board for approval subject to minor amendments suggested. • The Committee received and approved the Charity Investment Policy. A copy of the updated policy to be included in the WCC Annual Reports and Accounts.		
5	Risks Identified	• None		
6	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre
NHS Foundation Trust

Report to Trust Board
07 December 2023

Report Title	The Walton Centre Charity Annual Reports & Accounts 2022/2023
Executive Lead	Mike Burns Chief Financial Officer
Author (s)	Chris Gough, Financial Accountant
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- The Annual Report & Accounts were considered and agreed by the Charity Committee on October 27 2023.
- No errors were identified during the independent examination by BWM.
- The 2022/2023 Annual Report & Accounts for The Walton Centre Charity are presented for approval by the Board in its capacity as Corporate Trustee.

Next Steps

- Chair to sign Annual Report & Accounts and return to BWM for their records.
- Update the final print version of the report with the electronic signatures of the Chair and the independent examiner.
- Submit Annual Report & Accounts to the Charity Commission by 31 January 2024

Related Trust Strategic Ambitions and Themes	**Impact**		
Choose an item	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

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

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
The Walton Centre Charity Committee	21 July 2023	Chris Gough Financial Accountant	Draft version considered by the WCCC – no issues raised.
The Walton Centre Charity Committee	27 October 2023	Chris Gough Financial Accountant	Final version presented to the WCCC by the independent examiner BWM. No issues raised. WCCC approved report & accounts.

The Walton Centre Charity Annual Report & Accounts 2022/2023

Introduction

1. The 2022/2023 Annual Report and Accounts for The Walton Centre Charity are presented to the Board for approval in its capacity as Corporate Trustee.

Background and Analysis

2. The Annual Report and Accounts were considered in draft format at the Walton Centre Charity Committee meeting on 21 July 2023.

3. Final version of the report and accounts were presented by the independent examiner BWM at the October meeting of the Walton Centre Charity Committee. No issues were reported, and the report/accounts were approved by the Committee.

Conclusion

4. An independent examination of The Walton Centre Charity's Annual Report and Accounts raised no issues – the final version, already approved by the Walton Centre Charity Committee on 27 October 2023, is presented to the Board for final approval in its capacity as Corporate Trustee of the Charity.

Recommendation

To approve

Author: **Chris Gough, Financial Accountant**
Date: **24 November 2023**

Appendix 1

The Walton Centre Charity Annual Report & Accounts

Appendix 2

Signed letter of Representation

The Walton Centre Charity
Annual Report and Accounts 2022/23

The Walton Centre Charity
Supporting Excellence in Neuroscience

A charity supporter taking part in the Walk for Walton event.

Welcome to The Walton Centre Charity Annual Report for 2022/23

As the world began to emerge from the Covid-19 pandemic The Walton Centre Charity was delighted to be able to start to return to more normal fundraising activities, and see more of our fundraisers in person!

As the world began to emerge from the Covid-19 pandemic The Walton Centre Charity was delighted to be able to start to return to more normal fundraising activities, and see more of our fundraisers in person!

The past few years have been incredibly difficult for so many people and we appreciate the support our fundraisers, donors and volunteers have given us during this time as we know it's been very hard for people in different ways.

In 2022 we were able to bring back our annual Charity Golf Day at Formby Golf Club, in May, and once again hold the annual Jan Fairclough Ball in November, raising £62,200 from both events which will really make a difference to our patients and their families. Money raised from the Jan Fairclough Ball has contributed to the funding of the Hocoma Erigo tilt table, a piece of rehabilitation equipment which will be the only one in an NHS hospital – transforming the recovery of some of our patients.

However, we also retained some virtual fundraising opportunities to ensure people can support us in a variety of ways, particularly important considering how far some of our patients and their families can travel from.

Also in May 2022, we launched a new event, Walk for Walton. This encouraged supporters to walk 100,000 steps in the month of May, anywhere in the world! We raised £12,500 which was amazing and we look forward to continuing with this event in future years.

Walk for Walton supported the Home from Home relatives' accommodation which continued to provide an enormous benefit to the families of patients who value enormously the ability to stay close to their loved ones at such a difficult time.

We value however and whenever people support us, the kindness and generosity means so much to everyone at The Walton Centre and makes an enormous difference to patients and their families, now and in the future. Thank you.

Su Rai
Chair, The Walton Centre Charity Committee and Non-Executive Director, The Walton Centre NHS Foundation Trust

Cover image
Surgeons using the new charitably acquired Neuro VR, which simulates complex neurosurgical procedures, to train.

Objective

For any charitable purpose or purposes relating to The Walton Centre NHS Foundation Trust and such other places as the Trustee shall from time to time determine.

The Charity includes 29 earmarked funds which have been set up to enable the Trustee to meet the wishes of donors who have indicated that they would wish to have their money spent to benefit a specific ward/ department or area of research. A full list of the funds is provided on page 26 of this report. Details of the fund managers and aims and objectives for each fund are provided on page 27.

A patient showing their support for the charity.

Public benefit statement

The Walton Centre NHS Foundation Trust is the main beneficiary of the Charity and is a related party by virtue of being Corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to best effect for the benefit of the public served by the Trust.

When deciding on the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main objective, strategies, and plans of the Trust, whilst ensuring that the grants reflect the wishes of the donors, patients and staff.

The focus of the Charity's activities is to benefit the public who utilise the services of The Walton Centre NHS Foundation Trust. The hospital mainly services the community of Cheshire, Merseyside, North Wales and the Isle of Man, all of whom have equal access to its facilities. Charitable expenditure is made by way of direct grants to The Walton Centre NHS Foundation Trust, to enhance the patient care already provided.

The agents of the Corporate Trustee have complied with their duty to have due regard to the guidance on the public benefit published by the Charity Commission in exercising their powers of duty.

Fundraising regulation

The Charity strives to give the best possible donor care to ensure supporters are treated fairly and with respect. The Charity is regulated by the Charity Commission and Fundraising Regulator, the self-regulatory scheme for fundraising in the UK. In addition to this, the Charity is a member of NHS Charities Together and the Chartered Institute of Fundraising.

Fundraising activities, donations and legacies

During the year the total donations, legacies and income from fundraising events (shown as 'Other Trading Activities' in the Statement of Financial Activities) came to £415,000 (total income including return on investments £443,000).

Despite the continued challenges of this year there were still amazing fundraising efforts made by supporters of the Charity. Individuals took up their own personal challenges to fundraise - whether that was running, cycling or walking - and there were a number of 'virtual' events using social media and other online platforms.

The Charity website and other digital platforms played a particularly significant role during this year, to help facilitate fundraising in different ways.

Community fundraisers taking part in our Christmas Appeal.

Examples of activities carried out to raise funds during the year under review include:

Fundraising activities and donations

- Walk for Walton - £12,500
- Walton Centre Charity Golf Day - £14,800
- Abseil from the Anglican Cathedral - £2,700
- Jan Fairclough Ball - £47,400
- Christmas Appeal - £7,700
- League of Friends donation - £10,000

Grant making trusts and foundations

- NHS Charities Together - £16,500
- The Peel Trust - £13,215

Legacies

During the year under review the Charity received a total of £14,510 in legacy income.

To facilitate supporters wishing to leave gifts in their wills, the Charity also continued their partnership with an on-line will writing service, to support legacy marketing and giving.

The Charity is grateful to all our donors and supporters for all they do to raise funds and awareness for The Walton Centre Charity, to help us make a difference to patients and their families both now and in the future.

Review of the year

During the year the Charity received a total income of £443,000 (2021/22: £380,000) which is an increase of £63,000. The overall increase can in the main be attributed to an increase in fundraising activities and events following relaxation of the previous years Covid-19 restrictions, resulting in a £37,000 increase in fundraising activities income and a £31,000 increase in donations income compared to 2021/22.

Fundraising in the community saw an increase in activity with many supporters once again returning to mass-participation events as well as face to face fundraising. This is reflected in the increase of donations compared to last year.

The Charity's corporate partners and supporters continued to support its in-house organised events. The Golf Day at Formby Golf Club made a welcome return to the events calendar after a two-year break due to Covid-19 restrictions; and in November the annual Jan Fairclough Ball once again attracted huge support. At the event an appeal for a Hocoma Erigo tilt table was launched, and more than half of the funds required was raised during the evening. The tilt table will transform the patient rehabilitation journey by enabling patients to safely start intense physiotherapy in the earliest stages of acute care, and The Walton Centre will become the first NHS hospital in the UK to offer this innovative technology for the benefit of our patients.

During the year under review, the Charity's three-year strategy was launched. It was developed taking into consideration a very different landscape post-covid, in which there is a shift in how people work, and where most aspects of the economy are severely affected. The strategy has a stronger focus on digital income generation, including adding relevant skills to the fundraising team; increasing individual regular giving and developing a more proactive legacy marketing campaign. The overall aim is to embed the Charity into the corporate strategy of the Trust to ensure that the Charity can effectively contribute to the overall income of the Trust.

A Digital Fundraising Manager was recruited and appointed in November 2022, with the responsibility to manage the planning and implementation of all digital fundraising activity for The Walton Centre Charity to increase support and maximise fundraising income for the Charity.

During the year under review, the Charity spent £496,000 in 2022/23 (2021/22: £638,000). The Charity's expenditure covers its charitable objectives, fundraising and governance support costs.

In 2022/23 expenditure on charitable activities was £251,000 (2021/2022 £394,000) covering three main areas:

- Patient welfare and amenities: £110,000 (2021/22: £169,000) – this included the Home from Home relatives' accommodation; the Laser Interstitial Thermal Therapy (LITT) project - cutting edge technology to support epilepsy surgery; and animal therapy to support patients in the Complex Rehabilitation Unit.

- Staff welfare and amenities: £54,000 (2021/22: £50,000) In addition to welfare and amenities, funding was also made available for professional development, such as enhanced study courses, training and conferences, to ensure staff remain at the forefront of clinical, research and personal developments.

- Research: £37,000 (2021/22: £127,000) – this included funding for research posts, equipment, training, books and journals.

Including the £35,000 net loss on investments, (which is treated as a component of net income), the total expenditure for the Charity exceeded income by £88,000 for the year.

A former patient completing a skydive to fundraise for the charity.

Volunteers

The Trust currently has approximately 45 registered Volunteers working in various departments throughout the Trust.

The volunteers provide a much-needed trolley service for the inpatients and staff. Other volunteer activity covers the Meet and Greet; Infection Control; Neuro Buddies; Gardening; Pain Management Programme and Neurophysiology Outpatient services. The Volunteer service is supported by the Charity.

Volunteer along with therapy dog Lemmy, visit a patient.

Forward look

The Charity aims to continue its work to fund a variety of projects which will help improve patient care and services. These include new technology and innovations; research; as well as improved facilities for our patients and families. The Charity will also continue to support staff with health and wellbeing initiatives, as well as enhanced training opportunities to ensure they can remain at the forefront of clinical and research developments to the benefit of patients today and in the future.

The implementation of the 2022-2025 Fundraising Substrategy will be the focus of the next two years. This includes increasing individual regular giving and digital fundraising opportunities as well as developing a more proactive legacy marketing campaign.

Working closely with the Trust's Communications and Marketing Team, the Charity's positive impact will be shared both internally and externally to encourage further involvement and support for future fundraising. A monitoring, learning and evaluation process will be implemented in order to efficiently measure and share the impact.

Finally, the Charity will continue to implement and promote the process through which future fundraising projects can be identified. This will ensure that wider engagement with clinical staff occurs and includes relevant levels of approval to make sure that any potential major charitable investments are in-line with and support the overall corporate strategic direction of the organisation.

Structure, governance and management

The Charity was established in 1992 using the model declaration of trust for NHS charities and all of the funds held on trust at the date of registration were registered under the umbrella Charity.

Following discussions with the Charity Commission it was determined that ward and departmental funds should be registered as part of the General Purpose fund as would any monies received for purposes which had a finite life. This is on the basis that hospitals are continually evolving organisations and the bureaucratic impact on the Charity and the Charity Commission would be significant if the ward funds were registered as separate charities. This is because of the legal requirements surrounding changing fund objectives or the winding up of funds. Subsequent donations and gifts are added to the appropriate earmarked fund balance within the existing Charity or a new earmarked fund is created.

The Charity has procedures in place to ensure that it fulfils its legal duty of ensuring that funds are spent in accordance with the objects of each fund. The use of earmarked funds also allows the Charity to respect the wishes of donors in indicating how they would like their donation spent without imposing a material administrative burden. A full list of the funds, fund advisors and objectives for each fund are provided in Appendix 2 on page 27.

All expenditure is recorded as grant expenditure as the recipient organisation (normally The Walton Centre NHS Foundation Trust) requires beneficial ownership of any assets. Applications for expenditure are submitted to the Charitable Funds Administrator who ensures that they are properly authorised and in accordance with the relevant fund's objectives.

Each separate fund has a fund advisor who is an authorised signatory and has delegated authority to approve expenditure in line with the objective of the fund up to £1,000. Items of expenditure between £1,000 and £5,000 must also be authorised by the Director of Finance. Any expenditure in excess of £5,000 is approved by the Committee.

Non-Executive members of the Trust Board are appointed by the Foundation Trust Governors and Executive members of the Board are subject to recruitment by the NHS Foundation Trust. Members of the Trust Board and the Committee are not individual trustees under charity law but act as agents on behalf of the Trustee.

Day-to-day administration of the funds is dealt with by the Financial Accounts section of the Finance Department.

Specialist clinicians reviewing patient observations.

Reference and administration details

Name

The Walton Centre Charity

Charity Commission number

1050050

HM Revenue and Customs number

XR4801

The principal contact of the Charity

Mike Burns
Chief Finance Officer
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

T 0151 556 3482
E mike.burns3@nhs.net

Bankers

Royal Bank of Scotland
Liverpool Group of Branches
1 Dale Street
Liverpool L2 2PP

Independent examiner

Anita Mason BA(Hons) BFP FCA
BWM Chartered Accountants
Tempest, Suite 5.1, 12 Tithebarn Street,
Liverpool, L2 2DT.

Investment advisors

CCLA
Senator House
85 Queen Victoria Street
London EC4V 4ET

Ruffer LLP
80 Victoria Street
London SW1E 5JL

Charity supporters celebrating after completing their fundraising event.

Trustee

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. For the purpose of this annual report and these accounts the sole corporate trustee is referred to as The Walton Centre NHS Foundation Trust ("the Trust").

The Board of the aforementioned Trust has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee ("the Committee") which administers the funding on behalf of the Trustee. In the year ended 31 March 23 the following people served as directors of the Trustee:

Max Steinberg CBE
Chair

Janet Ross
Chief Executive

Dr Andrew Nicolson
Medical Director

Ray Walker
Non-Executive Director

Irene Afful
Non-Executive Director (from 01/01/23)

Prof Paul May
Non-Executive Director

Su Rai
Non-Executive Director

Karen Bentley
Non-Executive Director

David Topliffe
Non-Executive Director

Mike Burns
Chief Finance Officer

Mike Gibney
Chief People Officer

Lisa Salter
Chief Nurse

Morag Olsen
Interim Chief Nurse (from 01/01/23)

Lindsey Vlasman
Chief Operating Officer

In the year ended 31 March 2023 the following people served on the Committee as agents for the Trustee, as permitted under Regulation 16 of the NHS Trust's (Membership and Procedures) Regulations 1990:

Su Rai
Non-Executive Director (Chair)

Irene Afful
Non-Executive Director (from 01/01/23)

Prof Paul May
Non-Executive Director

Mike Burns:
Chief Finance Officer

Lisa Salter
Chief Nurse

Dr Sacha Niven
Consultant Neuroradiologist and Deputy Medical Director

Mr Neil Buxton
Consultant Neurosurgeon

Dr Peter Moore
Consultant Neurologist

Risk management

The Committee has examined the major risks affecting the Charity and identified the system and mechanisms in place to mitigate these risks.

The most significant risk identified is the potential loss incurred by a fall in the value of the Charity's investments. The Committee believe that the higher returns available from the stock market over the longer-term means that this is an acceptable risk, and the Charity has balanced its investment portfolio to safeguard against a material loss in value and has concluded that there is no material risk to the fund at present.

The close relationship between the Charity and the Trust means that the Charity benefits from the same controls designed to manage risk as the Trust. The Trust has developed various controls designed to mitigate the risk of loss through fraud or maladministration which have been applied to the Charity. Mersey Internal Audit Agency has developed a risk-based approach which reviews the operation and effectiveness of these controls. The various controls are examined on a cyclical basis and the frequency is determined by the level of risk relating to that area of control.

Reserves

The Charity has a reserves policy that is reviewed every year. Reserves are part of the Charity's funds that are available for its general purpose after meeting its commitments and other planned expenditure. Reserves include unrestricted funds or income that can be expended at the Trustee's discretion in furtherance of the Charity's aims and objectives.

Such funds can be earmarked for a particular project, but such a designation has an administration purpose only and does not legally restrict the Trustee's discretion to apply the fund. The Trustee has adopted a policy which states that reserves will not be permitted to fall below the total available of unrestricted funds for the General Purpose Fund at March 2023 less approved committed expenditure and running costs of the charity it is recommended that reserves of £300,000 be held for a 12 month period.

At 31 March 2023 the Charity held £1,601,000 in reserves, all of which related to unrestricted funds.

Fundraiser celebrating after completing multiple marathons.

Investments

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. The Trust Board therefore has overall responsibility for the investment of the Charity's funds.

The Board has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee. In turn, full discretion has been given to external investment managers in the day-to-day management of the assets. The Trustee believes that the investment strategy inherent in the investment managers' discretionary actions is appropriate for controlling risk.

The main assets of the Charity were previously held in a segregated portfolio of investments managed by Investec Wealth and Investment Ltd. The Charity Committee, supported by the Trust Board, transferred the Charity's investments to two multi-asset pooled charity funds in July 2018: CCLA Ethical Investment Fund (50%) and Ruffer LLP Charity Assets Trust (50%).

The aim was to create greater diversification (minimising risk) and improved performance over the longer-term, as well as generating potentially lower fees.

Ethical investment describes a way of making financial investments which reflects the Charity's values and ethos and does not run counter to its aims. A Charity can decide to invest ethically, even if the investment might provide a lower rate of return than an alternative investment. The law permits the following reasons:

— A particular investment conflicts with the aims of the Charity,

— The Charity might lose supporters or beneficiaries if it does not invest ethically, and

— There is no significant financial detriment.

As an NHS Charity, The Walton Centre Charity has determined that it should not invest in tobacco companies because of the proven link between smoking and poor health which would make such investments contrary to its charitable aims.

The pooled funds operated by CCLA and Ruffer LLP satisfy this requirement. Any other restrictions applied by the investment managers should not limit the operations of the Charity.

During the year ending the 31 March 2023 the stock market continued the fairly volatile trend of the past few years. The market value of the funds at the 31 March 2023 was £1,213,000 which is £35,000 lower than the market value at the 31 March 2022. The Charity benefited from dividends and interest of £28,000 which represents a positive result, given the low risk nature of the investment portfolio.

Statement of Trustee responsibilities

It is a pleasure to present the Annual Report for The Walton Centre Charity ("the Charity"), together with the financial statements for the year ended 31 March 2023 which have been subject to an independent examination.

The annual report and accounts have been prepared in accordance with Part 8 of the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (as amended for accounting periods commencing from 1 January 2019). The Charity's report and accounts include all of the separate funds for which The Walton Centre NHS Foundation Trust is the sole corporate trustee (the "Trustee").

All of the separate funds are designated parts of the Charity registered with the Charity Commission under the umbrella of The Walton Centre Charity with the registered Charity Number 1050050 in accordance with the Charities Act 2011.

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the charity's financial activities during the year and of its financial position at the end of the year. In preparing financial statements giving a true and fair view, the Trustee should follow best practice and:

- Select suitable accounting policies and then apply them consistently,
- Make judgements and estimates that are reasonable and prudent,
- State whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements, and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.
- Observe the methods and principles in the Charities Statement of Recommended Practice (SORP)

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enable them to ascertain the financial position of the charity and which enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed. The Trustee is responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements and notes set out on pages 16 to 25 have been compiled from and are in accordance with the financial records maintained by the Trustee.

Signed on behalf of the Trustee

Su Rai
Chair of the Charity Committee

A Radiographer welcomes patients into clinic.

A Staff Nurse helping a patient.

Independent examiner's report to the corporate trustee of The Walton Centre Charity

I report to the Trustees on my examination of the accounts of The Walton Centre Charity (the charity) for the year ended 31 March 2023.

This report is made solely to the charity's trustee, as a body, in accordance with Section 145 of the Charities Act 2011. My examination has been undertaken so that I might state to the charity's trustee those matters I am required to state to them in an Independent Examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my examination, for this report, or for the opinions I have formed.

Responsibilities and basis of report

As the trustees of the charity you are responsible for the preparation of the financial statements in accordance with the requirements of the Charities Act 2011 (the 2011 Act).

I report in respect of my examination of the charity's financial statements carried out under section 145 of the 2011 Act. In carrying out my examination I have followed all the applicable directions given by the Charity Commission under section 145(5)(b) of the 2011 Act.

Independent examiner's statement

Your attention is drawn to the fact that the charity has prepared financial statements in accordance with Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to the Accounting and Reporting by Charities: Statement of Recommended Practice issued on 1 April 2005 which is referred to in the extant regulations but has now been withdrawn.

I understand that this has been done in order for financial statements to provide a true and fair view in accordance with Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the Act; or

2. the financial statements do not accord with those records; or

3. the financial statements do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a true and fair view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the financial statements to be reached

Anita C Mason BA(Hons) FCA BFP
Independent Examiner

BWM Chartered Accountants
Tempest, Suite 5.1, 12 Tithebarn Street, Liverpool, L22DT

Statement of financial activities

For the year ended 31 March 2023

	Note	2022/23	2021/22
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Income and endowments from:			
Donations and legacies		285	257
Other trading activities		130	93
Investments		28	30
Total income and endowments	3	**443**	**380**
Expenditure on:			
Raising funds		245	244
Charitable activities		251	394
Total expenditure	4	**496**	**638**
Net gains/(losses) on investments	6	(35)	86
Net income/(expenditure) and net movement in funds		**(88)**	**(172)**
Reconciliation of funds:			
Fund balances brought forward		1,689	1,861
Fund balances carried forward		**1,601**	**1,689**

All of the Charity's funds are unrestricted. The net expenditure for the year arises from the Charity's continuing operations. The notes on pages 19 to 25 form part of these accounts.

Balance Sheet

As at 31 March 2023

	Note	2022/23	2021/22
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Fixed assets			
Investments	6	1,213	1,248
Total fixed assets		**1,213**	**1,248**
Current assets			
Debtors	7	5	3
Cash at bank and in hand	8	530	650
Total current assets		**535**	**653**
Creditors: amounts falling due within one year	9	147	212
Net current assets/(liabilities)		**388**	**441**
Total assets less current liabilities		**1,601**	**1,689**
Total net assets		**1,601**	**1,689**
Funds of the Charity			
Unrestricted	10	1,601	1,689
Total funds		**1,601**	**1,689**

The notes on pages 19 to 25 form part of these accounts.

Signed on behalf of the Trustee

Su Rai
Chair

Statement of cash flows

For the year ended 31 March 2023

	Note	2022/23	2021/22
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**(148)**	**(60)**
Cash flows from investing activities:			
Dividends and interest from investments		28	30
Proceeds from sale of investments		0	0
Purchase of investments		0	0
Net cash provided by (used in) investing activities		**28**	**30**
Change in cash and cash equivalents in the reporting period		(120)	(30)
Cash and cash equivalents at the beginning of the reporting period		650	680
Cash and cash equivalents at the end of the reporting period	8	**530**	**650**
Reconciliation of net income/(expenditure) to net cash flow from operating activities:			
Net income/(expenditure) for the reporting period (as per the statement of financial activities)		(88)	(172)
Adjustments for:			
(Gains)/losses on investments		35	(86)
Dividends and interest from investments		(28)	(30)
(Increase)/decrease in debtors		(2)	77
Increase/(decrease) in creditors		(65)	151
Net cash provided by (used in) operating activities		**(148)**	**(60)**

Notes to the financial statements

For the year ended 31 March 2023

1. Accounting Policies

1a. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments. The financial statements have also been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (as amended for accounting periods commencing from 1 January 2019) and applicable UK Accounting Standards and the Charities Act 2011.

The financial statements have been prepared in compliance with the Charities Statement of Recommended Practice (FRS 102). A Statement of Cash Flows has also been included.

1b. Incoming Resources

a. All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

   i. Entitlement – arises when control over the rights or other access to the economic benefit has passed to the Charity;

   ii. Probable – when it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity; and

   iii. Measurement – when the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

b. Legacies are accounted for as incoming resources when it is probable that they will be received. Receipt is normally probable when:

   i. There has been grant of probate;

   ii. The executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and

   iii. Any conditions attached to the legacy are either within the control of the Charity or have been met.

1c. Resource Expended

a. The funds held on Trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised when all of the following criteria are met:

   i. Obligation – a present legal or constructive obligation exists at the reporting date as a result of a past event;

   ii. Probable – it is more likely than not that a transfer of economic benefits, often cash, will be required in settlement; and

   iii. Measurement – the amount of the obligation can be measured or estimated reliably.

b. Cost of generating funds comprises the costs associated with attracting voluntary income.

c. Charitable expenditure comprises those costs incurred by the Charity in the delivery of its activities and services for its beneficiaries. It includes both costs that can be allocated directly to such activities and any costs of an indirect nature necessary to support them.

d. Governance costs include those costs associated with meeting the constitutional and statutory requirements of the Charity and include accountancy fees and costs linked to the strategic management of the Charity.

1d. Structure of Funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Other funds are classified as unrestricted funds. These are funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes as classified funds. The major funds held within these categories are disclosed in note 10.

1e. Investment Fixed Assets

Stocks and shares are shown at market value.

1f. Realised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between marked value at the year-end and opening market value or date of purchase if later.

1g. Foreign Currency transactions

All expenditure and income arising from transactions denominated in a foreign currency are translated into sterling at the exchange rate in operation on the date on which the transactions occurred.

1h. Change in the Basis of Accounting

This is the seventh year that financial statements have been prepared in compliance with the Charities SORP (FRS 102). There has been no material change in the basis of accounting during the year.

1i. Prior Year Adjustments

There has been no change to the accounts of prior years.

1j. Going Concern Assumption

The accounts have been prepared on a going concern basis and the Trustee has no plans to wind up the Charity, or concerns that it cannot continue as a viable entity.

2. Dividends and interests

Dividends are received for all stocks and shares in beneficial ownership of the Charity and are shown after recovery of tax where allowed. Interest is recorded for all bank accounts and short-term deposits made by the Charity.

3. Details of Income

	2022/23	2021/22
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Income and endowments		
Donations	270	239
Legacies	15	18
Fundraising activities and events	130	93
Investment income	28	30
Total income and endowments	**443**	**380**

4. Details of Expenditure

	2022/23	2021/22
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Raising Funds:		
Fundraising staff costs	195	176
Fundraising activities and events	50	68
	245	**244**
Charitable Activities:		
Patients welfare and amenities	110	169
Staff welfare and amenities	54	50
Research	37	127
Independent examination	3	3
Administrative support	47	45
	251	**394**
Total	**496**	**638**

All of the expenditure is accounted for as grants to benefit the staff and patients of The Walton Centre in line with the Charity's objectives.

5. Analysis of Staff Costs

	2022/23	2021/22
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Fundraising Staff Costs		
Salaries and wages	155	142
Social security costs	18	15
Employers pension contribution	22	19
Total Fundraising Staff Costs	**195**	**176**

The average number of employees during the year was 4 (2021/22: 4). One employee received emoluments in excess of £60,000 in the current year in the salary band £70,000 - £80,000 (2021/22: one, in the salary band £60,000 - £70,000).

No Trustee remuneration or any other benefits have been paid from an employment with the Charity and no Trustee expenses have been incurred.

6. Analysis of Fixed Asset Investments

The investment portfolio is managed by CCLA and Ruffer LLP and the total amount invested with each manager was £500,000. The movement in the portfolio can be analysed as follows:

	2022/23	2021/22
	£000	£000
Market value at the beginning of the reporting period	1,248	1,162
Less Disposals at carrying value	0	0
Aquisitions at cost	0	0
Unrealised gains/(losses)	(35)	86
Market value at the end of the reporting period	**1,213**	**1,248**
Book cost at the end of the reporting period	1,000	1,000

All investments are held in the UK and the market value can be analysed as follows:

	2022/23	2021/22
	£000	£000
Listed investments	1,213	1,248
Total	**1,213**	**1,248**

7. Debtors

Debtors in respect of the following are represented in the accounts:

	2022/23	2021/22
	£000	£000
Prepayments and accrued income	5	3
Total	**5**	**3**

There were no debtors falling due over one year.

8. Cash and Cash Equivalents

Cash at bank and in hand is held to meet the day-to-day running costs of the Charity as they fall due. Cash equivalents are short-term, highly liquid investments, usually in 90 day notice interest bearing savings accounts:

	2022/23	2021/22
	£000	£000
Cash at bank and in hand	530	650
Total cash and cash equivalents	**530**	**650**

9. Creditors

The creditor position can be summarised as follows:

	2022/23	2021/22
	£000	£000
Amounts due to NHS Foundation Trust	3	23
Accruals	144	189
Total	**147**	**212**

There were no creditors falling due over one year.

10. Analysis of Funds

The movement in the funds during the year can be analysed as follows

	Balance as at 31 March 2022	Income	Expenditure	Revaluation of investments	Balance as at 31 March 2023
	£000	£000	£000	£000	£000
Unrestricted Funds	1,435	443	(496)	0	1,382
Revaluation Reserve	254	0	0	(35)	219
Total	**1,689**	**443**	**(496)**	**(35)**	**1,601**

A list of the unrestricted funds and their balances as at 31 March 2023 is shown in Appendix 1.

11. Related Party Transactions

During the year the Trustee, members of The Walton Centre Charity Committee and the key management staff, and parties related to them, had no personal interest in any contract, nor undertook any material transactions with The Walton Centre Charity.

The Charity delivers its charitable objectives by making grants to The Walton Centre NHS Foundation Trust. Grants made amounted to £201,000 (2021/22: £346,000). This included £40,000 for cutting edge technology which included the MRI guided laser ablation system, also an individual grant of £38,000 from the Home from Home appeal to cover the running costs of the relatives' accommodation in the Trust's Sid Watkins Building.

The Walton Centre NHS Foundation Trust provides administrative support to the Charity and in 2022/23 charged a fee of £47,000 at arm's length (2021/22: £45,000).

At the year end The Walton Centre Charity owed £3,000 to The Walton Centre NHS Foundation Trust (2021/22: £23,000)

12. Events after the Reporting Date

The Trustee is not aware of any events after 31 March 2023 and up to the date the financial statements have been approved which will affect the accounts.

Appendix 1

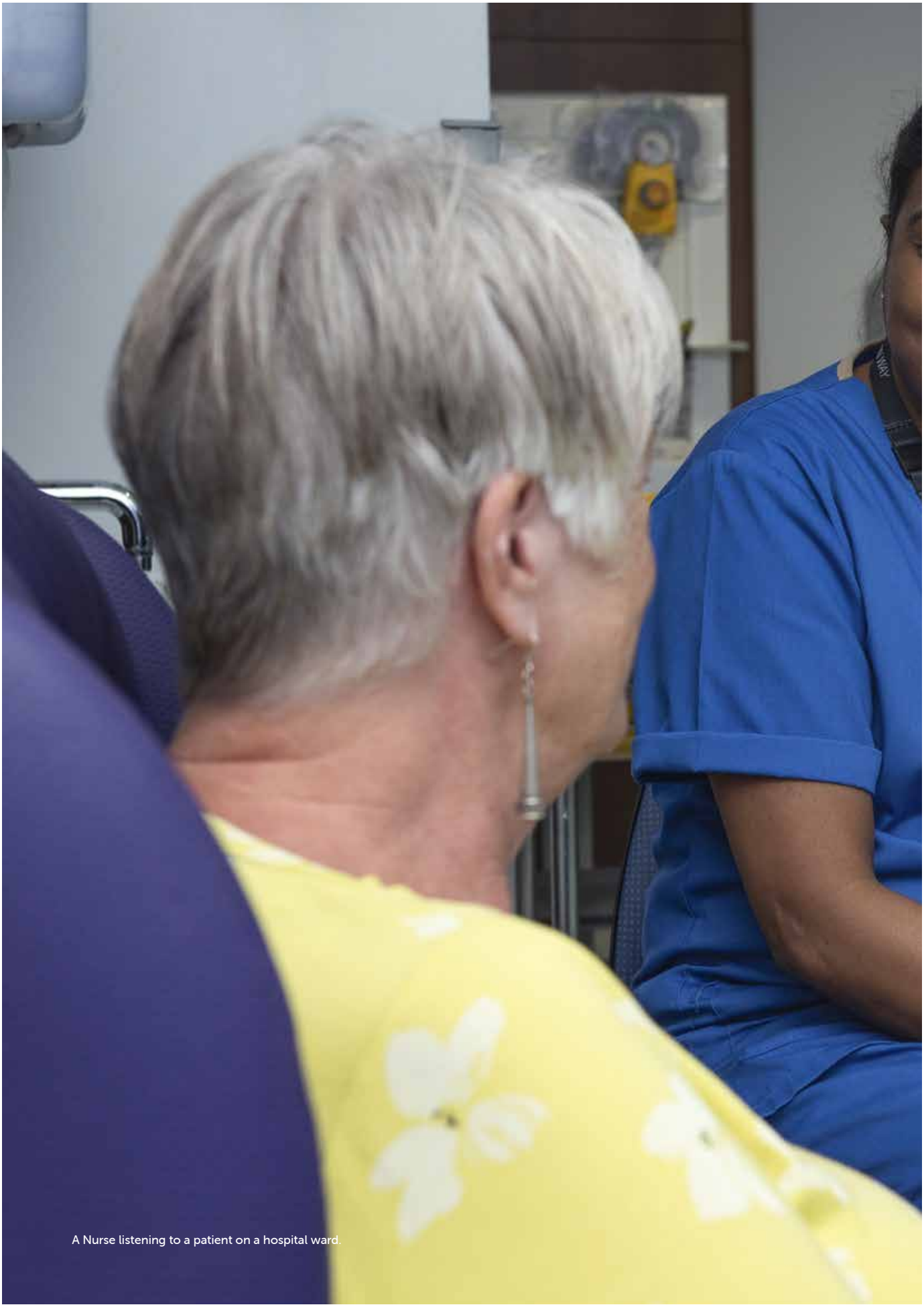
List of Funds and Fund Balances as at 31 March 2023

Fund Name		Fund Balance	
		2022/23	2021/22
		£000	£000
4009	General Fund	819	801
4010	NRU Fund	29	17
4015	Wards Fund	16	17
4017	Roy Ferguson Compassionate Care Fund	70	70
4019	Headache and Neurology Fund	1	1
4422	Pain Relief Research Fund	3	4
4442	Neuro General Research Fund	8	8
4457	Neuro Muscular Diseases Fund	1	1
4464	Cerebro Vascular Fund	27	27
4465	Home From Home	0	11
4481	Neurosurgical General Fund	22	28
4487	Horsley ITU Fund	76	76
4499	Epilepsy Fund	24	27
4527	R&D & Higher Study	6	7
4528	Neurophysiology Train. & Educ.	0	0
4530	Neurological Disability Fund	32	65
4532	L Loudrey Mvmt Disorders Fund	8	9
4533	Alan Sutcliffe Kerr Lecture Fund	1	1
4537	Cognitive Research Fund	0	0
4538	Stereotactic Fund	9	9
4541	Neurobiochemistry Fund	6	6
4543	Disorders Of Movement Gen Fund	58	59
4550	Research Fellowship	1	1
4552	Parkinsons Disease	8	8
4900	Neuro X-Ray Research	15	16
4905	Neurosurgical Neuro-Oncology	32	21
4910	Brain Infections Research	6	6
4911	Nmo And Atypical Disorders	17	18
4915	The Sid Watkins Innovation Fund	87	122
		1,382	**1,435**

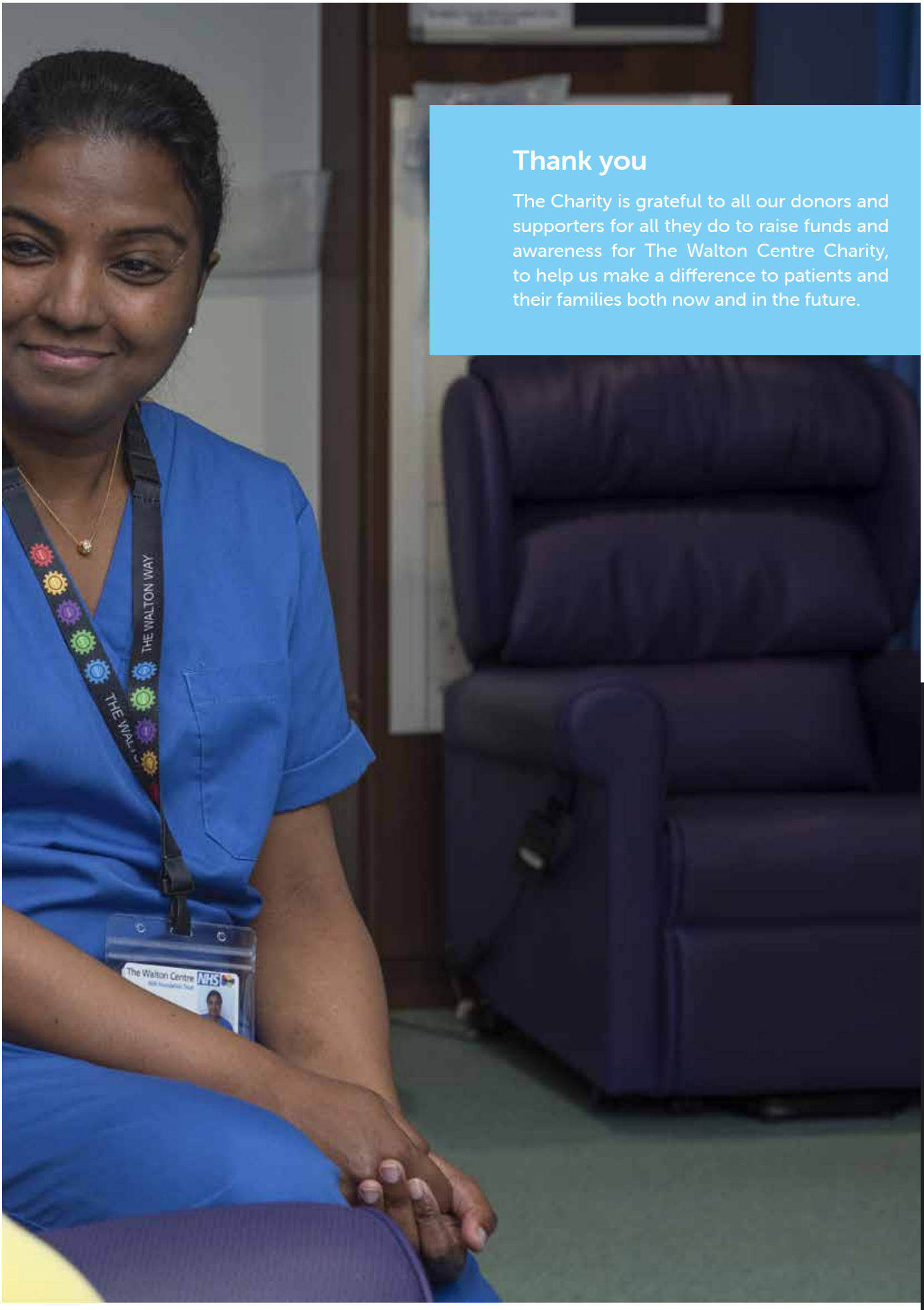
Appendix 2

List of Funds, Fund Managers and Objectives

Fund	Fund Name	Fund Manager	Aims and Objectives
4009	General Fund	Chief Finance Officer/Quorum of Panel	Any charitable purpose relating to The Walton Centre
4010	NRU	E Cottier/R Moreton	Social and recreational facilities for inpatients, improving quality of life
4015	Wards Fund	L Salter /N Martin	Items for wards to benefit patients, carers and staff; staff study support
4017	Roy Ferguson Comp Care Award	L Salter	Annual compassionate care project
4019	Headache And Neurology Fund	Dr Silver	Research into headache and allied disorders; support presentations
4422	Pain Relief Research Fund	Dr M Gupta/J Tetlow	Research and education
4442	Neuro General Research Fund	Dr Nicolson	Research projects relating to any aspect of clinical science
4457	Neuro Muscular Diseases Fund	Dr C Dougan	Research and teaching in the field of neuromuscular diseases
4464	Cerebro Vascular Fund	Dr Nicolson	Research, education, training and equipment
4465	Home From Home	Chief Finance Officer/Quorum of Panel	Maintain the relatives' accommodation
4481	Neurosurgical General Fund	Dr S Niven	Research, education, training and equipment
4487	Horsley ITU Fund	Dr Lakhani/M Rackham	Improve standard of care to patients and their relatives; study support
4499	Epilepsy Fund	Prof T Marson	Research
4527	R&D & Higher Study	C Chadwick	Research, education, training and equipment
4528	Neurophysiology Train. & Educ.	C Finnegan	Training/education for Neurophysiology staff
4530	Neurological Disability Fund	Prof C Young	Research/service development activities in disabling conditions
4532	L Loudrey Mvmt Disorders Fund	Dr M Doran	Research and development
4533	Alan Sutcliffe Kerr Lecture Fund	Chief Finance Officer	Specialist research and education
4537	Cognitive Research Fund	Dr M Doran	Research and development
4538	Stereotactic Fund	Mr J Farah/ Ms D Bhargava	Research and training
4541	Neurobiochemistry Fund	C Chadwick/N Moxham	Research, education, training and equipment
4543	Disorders Of Movement Gen Fund	Dr AP Moore	Research, education, development of new service initiatives
4550	Neuropsychology Fund	J Martlew	Research, patient education and equipment to benefit patients
4552	Parkinson's Disease	Dr M Steiger	Research, education and training
4900	Neuro X-Ray Research	Dr S Niven	Advancement of Neuroradiology
4905	Neurosurgical Neuro-Oncology	Mr A Brodbelt/ Prof M Jenkinson	Research, education, training and equipment
4910	Brain Infections Research	Prof T Solomon	Research
4911	Nmo and Atypical Disorders	Dr A Jacob	Research and patient care
4915	The Sid Watkins Innovation Fund	Chief Finance Officer/Quorum of Panel	Support innovation through The Walton Centre in research, prevention, diagnosis, treatment and the overall care of people with diseases or injury of the nervous system



A Nurse listening to a patient on a hospital ward.



Thank you

The Charity is grateful to all our donors and supporters for all they do to raise funds and awareness for The Walton Centre Charity, to help us make a difference to patients and their families both now and in the future.

Contact us

If you would like to contact us about fundraising, events or volunteering please get in touch.

Call
0151 556 3466

Write
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

Visit
thewaltoncentrecharity.org

The Walton Centre Charity
Supporting Excellence in Neuroscience

25 October 2023

AM/JB/WA034/623992

The Trustees
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
The Walton Centre
Lower Lane
Liverpool
L9 7LJ

Dear Trustees

During the course of the independent examination of the accounts for the year ended 31 March 2023, the following representations were made to us by management and trustees. Please read these representations carefully and if you agree with our understanding please sign and return a copy of this letter to us as confirmation of this.

1 You acknowledge as trustees that you have fulfilled your responsibilities under the Charities Act 2011 for making accurate representations to us and you confirm that the accounts for the charity are in accordance with the applicable financial reporting framework FRS 102.

You confirm that in your opinion the financial statements give a true and fair view and in particular that where any additional information must be disclosed in order to give a true and fair view that information has in fact been disclosed.

2 You confirm that all accounting records have been made available to us for the purposes of our independent examination and that all transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings, have been made available to us.

3 You confirm that significant assumptions used by you in making accounting estimates, including those measured at fair value, are reasonable, as set out in the attached list.

4 You confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the accounts have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

5 You confirm that there have been no events since the balance sheet date which require disclosing or which would materially affect the amounts in the accounts, other than those already disclosed or included in the accounts.

6 You confirm that you are aware that a related party of the charity is a person or organisation which either (directly or indirectly) controls, has joint control of, or significantly influences the charity or vice versa and as a result will include shareholders (as a guide with more than 20% of the voting rights), directors, trustees, other key management, close family and other business interests of the previous. You confirm that the related party relationships and transactions set out as

attached are a complete list of such relationships and transactions and that you are not aware of any further related parties or transactions.

7 You confirm that all related party relationships and transactions have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

8 You confirm that the charity has not contracted for any capital expenditure other than as disclosed in the accounts.

9 You have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the accounts.

10 The charity has satisfactory title to all assets, and there are no liens or encumbrances on the assets except for those disclosed in the accounts.

11 There are no liabilities or provisions other than those recognised and no contingent liabilities or guarantees to third parties other than those disclosed in the accounts.

12 You confirm that you are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its business, and which are central to the charity's ability to conduct its business (as set out in the attached list) except as explained to us and as disclosed in the accounts. The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance.

13 You acknowledge your responsibility for the design, implementation and maintenance of controls to prevent and detect fraud. You confirm that you have disclosed to us the results of your assessment of the risk that the financial statements may be materially misstated as a result of fraud.

14 You confirm that there have been no actual or suspected instances of fraud involving management or employees who have a significant role in internal control or that could have a material effect on the accounts. You also confirm that you are not aware of any allegations of fraud by employees, former employees, regulators or others.

15 You confirm that, having considered your expectations and intentions for the next twelve months, and the availability of unrestricted reserves, the charity is a going concern. You also confirm that the period that you have considered covers a minimum of twelve months from the date of this letter.

16 You confirm the accounts are free of material misstatements, including omissions. In your opinion, the effects of unadjusted misstatements are immaterial, both individually and in aggregate, to the accounts as a whole.

17 You confirm the following specific representations made to us during the course of preparing your accounts:

You confirm that you make use of internet banking and that adequate and appropriate controls over your internet banking facility/access were operational and effective throughout the year.

You confirm that your IT back up procedures and off-site cyber security are adequate, regularly tested, current and appropriate and that an up to date back up is available. You confirm that disaster recovery planning is conducted and reviewed periodically, and that adequate and appropriate insurance is carried.

You confirm that historic records are maintained for the minimum required (that is for the current and previous six years) to ensure, for example, that any future HMRC gift aid audit will proceed without irregularity.

You confirm that all grants, donations and other income, including any subject to special terms or conditions or received for restricted purposes, have been notified to us. There have been no breaches of terms or conditions regarding the application of such income.

You confirm that you are not aware of any matters of material significance that should be reported to the Charity Commission.

You confirm that all donated funds are correctly classified as unrestricted funds within the accounts and are correctly recorded within their separate funds.

Yours faithfully

BWM

The Walton Centre Charity

I confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and expertise (and, where appropriate of supporting documentation) sufficient to satisfy myself that I can properly make these representations to you and that to the best of my knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your work.

Signed on behalf of the Board of Trustees.

..... Date 27 October 2023

Su Rai

Chair of The Walton Centre Charity Committee

17.1.2. Letter of Representation signed 27.10.23

The Walton Centre Charity
Year ended 31 March 2023

Related party details

	Related party	Transactions
Corporate Trustee	The Walton Centre NHS Foundation Trust	Grants made to the Trust amounting to £201,000 Admin support provided by the Trust - £47,000 Inter-company balanced owing to the Trust - £3,000

Directors of the Corporate Trustee:

Type	Name of party	Transaction type (please state if none)
Chair	Mr M Steinberg (Appointed 1 April 2022)	None
Chief Executive		None
Chief Executive	Ms J Ross	None
Medical Director and Deputy Chief Executive	Mr A Nicolson	None
Non-Executive Director	Ms I Afful (Appointed 1 January 2023)	None
Non-Executive Director	Ms Su Rai (Deputy Chair)	None
Non-Executive Director	Ms K Heslop	None
Non-Executive Director	Mr D Topliffe	None
Non-Executive Director	Mr R Walker (*Appointed 1 January 2022*)	None
Non-Executive Director	Mr P May (*Appointed 1 January 2022*)	None
Chief Finance Officer	Mr M Burns	None
Chief People Officer	Mr M Gibney	None
Chief Operating Officer	Ms L Vlasman	None
Chief Nurse	Ms L Salter	None
Interim Chief Nurse	Ms M Olsen (Appointed 1 January 2023)	

Management of the Corporate Trustee:

Key Management	Dr S Niven - Consultant Neuroradiologist and Deputy Medical Director	None
Key Management	Dr N Buxton - Consultant Neurosurgeon	None
Key Management	Dr P Moore - Consultant Neurologist	None
Key Management	Mr C Gough – Financial Accountant	None
Other	The Walton Centre Charity Committee	None

And their close families

Laws and regulations

Charities Act 2011
Charities SORP
General Data Protection Regulations - GDPR
Money Laundering Regulations

Accounting estimates

Estimate	How identified	Estimation method	Level of uncertainty
Year end accruals	Review invoices and payments after the year end	A provision is made in the year end accounts for any goods / service received in the year where the invoices / payments are not processed until after the year end date.	Low
Accrued income	Review of past income remittances received	Review post year end invoices for goods/ services provided pre year end and adjust accordingly.	Low
Year end prepayments	Review invoices and payments around the year end	Review invoices for goods / services provided post year end and adjust accordingly	Low

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Date of last meeting: 09/11/23		**Report of:** Research, Innovation and Medical Education (RIME) Committee
		Membership Numbers: Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • 2023 GMC National Training Survey Report • Library Quality Outcomes Improvement Framework Update Report • MHRA Corrective and Preventative Action Plan Update • Research and Development Financial and Performance Update
2.	**Alert**	None
3.	**Assurance**	None
4.	**Advise**	**2023 GMC National Training Survey Report** – The 2023 survey had fewer positive highlights than in previous years with 4 upper quartile outliers and 16 lower quartile negative outliers which were primarily attributed to Anaesthetics and Neurology higher training programmes. The Committee was informed on the actions being taken in response to the survey outcomes. **Library Quality Outcomes Improvement** - Four areas of improvement from the 2022 Quality and Improvement Outcomes Framework had been addressed. The Library and Knowledge Service would now be monitored through an NHS England (NHSE) Service Improvement Plan, the first submission for which would be made by October 2024. **Medicines and Healthcare products Regulatory Agency (MHRA) Corrective and Preventative Action Plan Update** - A Research Quality Improvement Plan had been produced which superseded the MHRA Corrective and Preventative Action Plan and addressed the findings from previous inspections and external audits. The plan had been approved by the Research Group (whose remit was to oversee its implementation) and was being implemented by the newly formed Research Quality Subgroup. The procurement and tendering process to identify a provider to lead the Trust through the accreditation process for the ISO9001 Quality Management Systems had commenced. This would ensure that the Trust was able to sponsor interventional research. The first action plan was anticipated to be available in February 2024. An appointment had been made to the Research Quality Manager position who would commence in post in January 2024.

		Research and Development Financial and Performance Update - An overview of activity for month 6 of the 2023/24 financial year was provided to the Committee. However, the Committee was unable to accurately interpret the financial statement which would be addressed at the Committee meeting in December 2023.		
5.	Risks Identified	• None of note.		
6.	Report Compiled by	Professor Paul May, Non-Executive Director and RIME Committee Chair	Minutes available from:	Corporate Secretary

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Date of last meeting: 13th October 2023		**Report of: Health Inequalities and Inclusion Committee**
		Membership Numbers: 11 (Quorate)
1.	**Agenda**	The Committee considered an agenda which included the following: • Digital Exclusion Strategic Implementation Plan • Equality, Diversity and Inclusion (ED&I) Master Action Plan • Workforce Race Equality Standard Report • Workforce Disability Equality Standard Report • ED&I Solutions Support Report • Trust Anti-Racism Statement • North West SBAC Key Issues Report • ED&I Steering Group Key Issues Report • @RACE Forum Update • Disability Network Forum Update • LGBTQIA+ Network Update • Veterans Network Update • Sexual Safety at Work Update • Anchor Institute Group Key Issues Report • Socio-Economic Duty Report • Did Not Attend (DNA) Report
2.	**Alert**	There were no specific alerts to be escalated to Board.
	Assurance	• Staff networks are becoming embedded and growing stronger with more networks launching. Network Leads are also sharing learning and best practice to further improve the networks. • Improvement actions identified from the Workforce Race Equality Standard (WRES) report and Workforce Disability Equality Standard (WDES) report would be included within a master Equality, Diversity and Inclusion (ED&I) action plan that would be monitored by the Executive Directors and this Committee. • The Trust had gained reaccreditation for a two year period for the Navajo award. • The Trust had been awarded the silver award for the Defence Employer Recognition Scheme (ERS) and was not far from achieving the gold award.
	Advise	• The potential for delivery of neurodiversity training facilitated by the Brain Charity to Board at a future Trust Board will be explored. • A review of Did Not Attend (DNA) appointments was presented based on

		indices of deprivation data. This identified a number of reasons for non-attendance at appointments and a number of workstream were in tarin to mitigate against DNAs. The DrDoctor system was planned to be rolled out during quarter four and this would enable profiling of appointments to provide data in a number of metrics. The system also has functionality for a text messaging reminder system. The data around reasons for DNA appointments could now also inform clinical validation and enable improved utilisation of the Patient Initiated Follow Up (PIFU) waiting list. Work was also underway to explore how services could be delivered locally and build upon the current satellite model within Neurology.		
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

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 27th November 2023		**Report of: Health Inequalities and Inclusion Committee**
Date of last meeting: 13th October 2023		**Membership Numbers: 12 (Quorate)**
1.	**Agenda**	The Committee considered an agenda which included the following: • Equality, Diversity and Inclusion (ED&I) Master Action Plan • Board Assurance Framework • Equality Delivery Scheme • North West BAME Assembly Key Issues Report • ED&I Steering Group Key Issues Report • @RACE Forum Update • Disability Network Forum Update • LGBTQIA+ Network Update • Veterans Network Update • Women's Network Update • Anchor Institute Group Key Issues Report • Prevention Pledge Update • Waiting List Review Report
2.	**Alert**	There were no specific alerts to be escalated to Board.
	Assurance	• Staff networks are becoming embedded and growing stronger with more networks launching. Network Leads are also sharing learning and best practice to further improve the networks. Support is available for all Network Leads to facilitate the running of each network. • The updated Board Assurance Framework (BAF) was presented for review and there were no proposed changes to risk scoring and risk appetite. An overview of updates to controls, mitigations and corrective actions was provided and it was highlighted that the two linked operational risks were now both below their target scoring so had been removed from the BAF. • An update on work against the Prevention Pledge was provided and it was highlighted that the Trust was now making progress in all 14 core commitments. An overview of progress against each commitment was provided and it was noted that the main interim challenges to progressing delivery were around ownership of action plans and inconsistency of Making Every Contact Count (MECC) leadership. Meetings are underway with the Chief Nurse regarding MECC leadership and progress against the Trust action plans was monitored at the Trust's Anchor Institution Group.

	Advise	• A review of waiting lists was presented based on indices of deprivation data. This review did not identify any areas of major disparity regarding indices of deprivation and patients with protected characteristics and this was due to the current focus on long waits. The Trust would be moving towards a Referral to Treatment (RTT) model from April 2024 so this would continue to be monitored. • An Equality, Diversity and Inclusion (ED&I) master action plan has been compiled which brings actions from all ED&I workstreams together into one place. The master action plan would be monitored via Equality, Diversity and Inclusion Steering Group and Health Inequalities and Inclusion Committee. • The Committee received an update relating to the Equality Delivery Scheme. A new national scoring system had been implemented titled EDS2022 which was significantly different to the system used in EDS2. The Trust is due to submit and publish the EDS report by 28th February 2024 and it was recognised that work around this was yet to commence. Discussions had been held with NHS England who confirmed that completion of EDS2 would fulfil all public sector duties for the Trust. The Committee agreed to defer adoption of EDS2022 to 2024/25 and complete the usual EDS2 report for 2023/24 to enable planning and establishment of a working group for a robust completion of EDS2022 reporting requirements going forward.		
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

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 27/11/23		**Report of: Neuroscience Network Programme Board**
Date of last meeting: 09/11/23		**Membership Numbers:7**
1.	**Agenda**	The Neuroscience Programme Board considered the agenda below:- • Getting it Right First Time (GiRFT) Spinal Update • Thrombectomy Update • ICB/System Update • Feedback from Cheshire & Merseyside Community Continence Partnership • Patient Representatives for NSPB • Hot topics from other Trusts.
2.	**Alert**	**ICB update** Delegation of Specialist Services from the National Specialised Commissioner to the ICBs is due to take place in April 2024. It is anticipated that the way these services are delivered would not see any immediate impact with changes being implemented slowly over time. Meetings with Integrated Care Boards (ICBs) are being held with regards to decision making and governance. In relation to the Neuro Rehabilitation Review (which had been paused due to lack of resource within the ICB), a paper was being presented to the Executive team of the Walton Centre NHS Foundation Trust (WCFT) with the view to using non-recurrent specialised funding for a dedicated resource to lead this review. In the meantime, meetings have been held to discuss priority areas within the wider programme of Neuro Rehabilitation so that plans can be written as soon as possible. Events to celebrate the 10-year anniversary of the Cheshire & Merseyside Rehabilitation Network (CMRN) are being held in November 2023.
	Assurance	**GiRFT Spinal Update** It was noted that all actions are up to date with only one outstanding which relates to adding spinal injections onto the British Spine Registry (BSR). Work is currently on-going with BSR and Spine Tango in order to reduce duplication of data entry. Regional inconsistencies for services for patients presenting with spinal pain were acknowledged and discussed. **Feedback from Cheshire & Merseyside Community Continence Partnership** The partnership is helping to provide ways of sharing information within communities which is important for patients with neurological conditions and suffering with

		incontinence. The aim is to take the work into secondary care/providers and to link with national projects.		
	Advise	**Thrombectomy Service** The 24 hour/7-day service has been implemented for some time and numbers are increasing. New guidance with regards to Thrombectomy eligibility has been published which is envisaged to have an impact on the current resource. Next steps include an away day to ensure that the correct staffing model is put in place. **Patient Representative Update** The group members continue to work in order to find patient representatives to provide patient voice to the meetings, representing a number of neurological conditions. **Hot topics from other Trusts** It was noted that a meeting had been held with WCFT and the Musculoskeletal (MSK) Lead with regards to the blueprint for Spinal Multidisciplinary Team (MDT) case discussion. Further details are required with regards to costings but once signed off, this would be sent to the ICS. Whilst not able to mandate requirements, recommendations would be made so that variation in services across Cheshire & Merseyside is reduced. External meetings are also being held to discuss MSK/spinal pathways across the region. A document providing guidance to secondary care to advise on appropriate referrals to WCFT for spinal pain and possible Cauda Equina is to be updated to provide advice and to support a system-wide approach for patients presenting with back problems at Accident and Emergency (A&E) departments		
3	**Risks Identified**	None		
4.	**Report Compiled by**	Medical Director, WCFT	Minutes available from:	Corporate Secretary

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 7 December 2023		**Report of:** Remuneration Committee (RemCom)		
Date of last meeting: 8 November 2023		**Membership Numbers:** Quorate		
1	**Agenda**	The Committee considered an agenda of one item which was the approval of the appointment of the Chief Nurse.		
2	**Alert**	• None		
3	**Assurance**	• The Committee agreed the recommendation of the interview panel, following an open and robust process, which was to appoint Nicola Martin to the role of Chief Nurse. As she is already in the post in an interim capacity this would be with immediate effect from 8 November 2023 • Remuneration of the role was confirmed as in line with interim arrangements.		
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 Trust Board
7 December 2023

Report Title	Learning From Deaths Policy
Executive Lead	Andy Nicolson, Medical Director
Author (s) *Name and Job Title*	Patricia Crofton, Governance Lead for Mortality Mike Duffy, Head of Risk and Governance
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Learning from Deaths policy has been reviewed in light of the implementation of the national Patient Safety Incident Response Framework (PSIRF)
- Approval route for the policy was amended following a recommendation made from the external Well Led Review

Next Steps

- Following Board approval, the policy will be updated on the Trust Intranet.

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Quality	Not Applicable	Not Applicable

Strategic Risks

001 Quality Patient Care	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ✓	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Clinical Effectiveness and Services Group	26th October 2023	Andy Nicolson – Medical Director	CESG endorsed the policy for submission to Quality Committee for endorsement,
Quality Committee	18 November 2023	Mike Duffy, Head of Risk and Governance	The Committee endorsed the policy and recommended it to the Board for approval and a few typos and comments were suggested.

Learning From Deaths Policy

Executive Summary

1. Following completion of the recent external Well Led Review one of the recommendations made was for the Learning from Deaths policy to be approved by the Trust Board.

2. The policy was previously approved by the Clinical Effectiveness and Services Group (CESG) in October 2022.

3. The policy was reviewed following implementation of the national Patient Safety Incident Response Framework (PSIRF) in September to ensure compliance with PSIRF requirements and was then presented to CESG for endorsement in October 2023.

Conclusion

4. The policy had been reviewed to ensure it reflects the requirements of PSIRF and was endorsed by CESG for submission to Committee to seek endorsement for Board approval.

Recommendation

- To approve

Author: Mike Duffy - Head of Risk and Governance
Date: 29 November 2023

Appendix 1 – Learning From Deaths Policy

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Learning from Deaths Standardised Mortality Review Process

Author and Contact details:	**Patricia Crofton, Governance Lead for Mortality** **Tel:** (0151) 556 3289 **Email: Patricia.crofton@nhs.net**	
Responsible Director:	**Dr A Nicolson Medical Director**	
Approved by and date:	**Clinical Effectiveness and Services Group (CESG).**	**26/10/2023**
Document Type:	**POLICY**	**Version 2.0**
Target Audience:	All Clinical teams.	
Document Approval, History/Changes	**See Appendix 9** For further information contact the Governance Department on **Tel:** (0151) 556 3082	

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

Executive Summary

The Care Quality Commission (CQC) (2016) in their report 'Learning, Candour and Accountability reviewed the way that NHS Trusts review and investigate deaths in England. The report found that there was limited understanding of deaths and in some organisations learning from deaths was not being given sufficient priority; valuable opportunities for improvements were being missed. The CQC suggest that there is much more the NHS can do to engage families and carers and recognise their insights and experiences as being vital to our learning. In line with the National Quality Board (NQB) guidance on Learning from Deaths, this policy will set out how the Walton Centre Foundation Trust (WCFT) will identify, report, investigate and learn from a patient's death. This will include the care leading up to the patient's death, considering if this could have been improved, even when the care may have had no direct link with the patient's death. The Walton Centre Foundation Trust (WCFT) will make it a priority to work more closely with families/carers of patients who have died. WCFT is also working closely with partner trusts supporting the approach to learning from deaths.

This Trust-wide approach to learning from death has been developed with the aim of ensuring a standardised format and process. This will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning.

Contents

1. Introduction

The National Guidance Framework states “Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die whilst under their management and care.” Standardised processes should be in place to review inpatient deaths, identify deficiencies in care, and have systems and/or processes for improvement.
Key aspects of this policy include the introduction of a Multidisciplinary Mortality Surveillance Group (MRG) where specific criteria exists and proposals for ensuring concerns of families are heard. Bereaved families and carers will be given the opportunity to raise questions or share concerns in relation to the quality of care received.

Learning from mortality will be used to drive service improvement and offer assurance to our patients, stakeholders, and the Trust Board that any problems in care which might have contributed to the death of a patient have been considered and appropriately responded to in an open and transparent manner.

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented. Our engagement with patients, families and carers following a patient death must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process. Mortality reviews are also completed for every person from a minority ethnic background.

The Care Quality Commission (CQC) (2016) in their report ‘Learning, Candour and Accountability reviewed the way that NHS Trusts review and investigate deaths in England. The report found that there was limited understanding of deaths and in some organisations learning from deaths was not being given sufficient priority; valuable opportunities for improvements were being missed. The CQC suggest that there is much more the NHS can do to engage families and carers and recognise their insights and experiences as being vital to our learning. In line with the National Quality Board (NQB) guidance

2. Purpose

- The purpose of this policy is to describe the process by which all deaths are identified, reported, and investigated. It aims to strengthen arrangements, where appropriate, to ensure learning is shared and acted upon. on how it responds to deaths in our care and identifies the scope of review for each death and how the trust will learn from them.
- The trust will engage meaningfully and compassionately with bereaved families and carers with the opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones.
- The trust will support staff to explore all opportunities to improve the care we offer.
- To ensure Trust level data on inpatient deaths is complete and accurate. Deaths occurring outside the organisation are excluded.

3. Scope

This policy applies to all in hospital deaths, deaths occurring outside the organisation are excluded.
This policy is applicable to all clinical staff who may be involved in the provision of care or service. To patients within the WCFT on a permanent or fixed-term contract or on the bank or subcontracted to work in the Trust.

4. Definitions

Expected Death. A death where the individual is diagnosed with a terminal illness or condition whose health status, based on current medical knowledge, is not expected to improve but likely to deteriorate. The illness or condition is expected to be fatal, and the determination is supported by the individual’s treatment record and course of treatment.

Unexpected natural death: A death from a natural cause e.g., a sudden cardiac condition or pulmonary embolus that happens outside of an expected timeframe. These deaths will be reviewed and may be subject to an investigation. Some of these deaths may have been avoidable.

Unexpected unnatural death: A death from unnatural causes which will be subject to a coroner referral. These deaths will be reviewed for consideration of a serious incident in line with guidance from NHS England.

Death due to a problem in care: This is a death that has been clinically assessed using a recognised methodology of case note review and may have been potentially avoidable.

Sudden unexpected death in infancy/childhood, (SUDIC): this term is used at the point of presentation for the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. At the conclusion of an investigation, they will divide into those for which we have a clear diagnosis (explained SUDI/SUDC) and those for which we do not have a diagnosis (SIDS up to 12 months of age, and sudden unexplained death in childhood for children over 12 months).

Initial mortality review: A structured review of a case note records carried out by clinicians to determine whether there were any problems in the care provided to a patient, or any identified learning suitable for learning and sharing with clinical colleagues. An initial mortality review uses a generic template with a core data set. (Appendix 1).

Structured Judgement Review (SJR) Senior clinical teams assess the healthcare record in a critical manner and comment on specific phases of clinical care and treatment using the Royal College of Physicians data collection tool. (Appendix 2).

Mortality Meeting: regular meeting held by clinical teams to discuss potential problems in care provision and learning following deaths, complications, or unexpected clinical events. The actions from the meeting and where learning is to be applied should be clearly documented.

Mortality Surveillance Group: Mortality Surveillance Group is a group of senior clinicians that meet monthly, chaired by the Deputy Medical Director. This group acts as the Trust's strategic hospital mortality overview group to support the Trust in providing assurance that all hospital associated death are proactively reviewed, monitored, reported and where necessary, investigated.

Avoidability;'The assessment of avoid ability is framed by a six-point scale (6 = no evidence of avoidability; 1 = definitely avoidable). This scale has been used in several recent national mortality review studies in Canada, the Netherlands and England. Making an overall summary judgement on whether death is avoidable (at least to some extent) is often a challenging process that goes beyond judging safety and quality by also considering comorbidities and estimated life expectancy.

5. Duties

Chief Executive

The Chief Executive has overall responsibility and accountability for: ensuring the Trust has appropriate learning from death procedures in place.

Medical Director

The Medical Director will assure the Trust Board how the learning from deaths process if functioning effectively and ensure that arrangements are in place to provide collated Trust level data on mortality rates, reviews of deaths, and that appropriate actions and lessons learnt are taken to address deficiencies in care and/or processes.

Designated Non-Executive Director

The Designated Non-Executive Director, (Chair of Quality Committee) will be responsible for ensuring that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the Board in order that the Executives remain aware and non-Executives can provide appropriate challenge.

Deputy Medical Director

The Deputy Medical Director is the designated Clinical Mortality Lead and is responsible for:
ensuring key governance outcomes are supported by the Learning from Deaths (LFD) process by:

- Chairing the Mortality Surveillance Group (MSG)
- Receiving assurance at MSG of Divisional engagement with the LFD process and where necessary, escalate any issues to appropriate forums.
- Providing minutes from MSG and escalating concerns raised to the Clinical Effectiveness and Services Group.
- Escalating urgent remedial actions or concerns to the Executive Management Team.

The Divisional Triumvirates

The Divisional Triumvirates are responsible for ensuring the LFD processes are implemented within their divisions by:

- Ensuring there are suitable governance structures in place in each division to facilitate LFD in accordance with this policy and providing that assurance to the Trust Mortality Surveillance Group Quality Committee and Board.
- Ensuring staff reporting deaths have the skills and training to engage with families/carers.
- Ensuring that staff carrying out the review process that have the necessary skills through training e.g.PSIRF , Human Factors, Structured Judgement Case Note Review (SJR).

Divisional Clinical Directors

The Divisional Clinical Directors for neurology and, neurosurgery critical care and pain are core members of the Mortality Surveillance Group and are responsible for:

- Overseeing the mortality review process within their clinical area of responsibility within the divisions.
- Supporting and advising colleagues involved with the mortality review process, ensuring they have the time to carry this process out in a skilled way to a high standard.
- Ensuring mortality data is included at governance forums within the divisions to outline and ensuring any actions identified in relation to mortality reviews are recorded, progressed, and monitored appropriately until closed.

The Nominated Divisional Mortality Leads

Are senior clinicians with the responsibility to oversee the mortality process within their division and will:

- Coordinate and chair the Divisional Mortality Review Group, ensuring oversight and monitoring of their mortality data, with support for the processes set out in this policy and providing assurance to the Trust Mortality Surveillance Group.
- Ensure deaths aligned to the Specialty are reviewed and discussed by a multidisciplinary team.
- Supporting and advising colleagues involved with the mortality review process to conduct timely/ effective case reviews.
- Ensuring any actions identified in relation to mortality review are recorded, progressed, and monitored appropriately.
- Identifying any opportunities for learning for teams and ensuring that these are acted upon.

- Identifying areas of concern from the reviews that require feedback to referring hospitals and sharing opportunities to identify learning and promote changes in practice or policy.

The Mortality Surveillance Group (MSG)

The Mortality Surveillance Group will:

- Provide assurance to quality Committee regarding patient mortality.
- Monitor and consider mortality data / analysis from internal and external sources. .
- Assign clinical leads to address key trends / issues and monitor actions.
- Oversee actions arising from alerts received from the Care Quality Commission or identified by other mortality monitoring information systems (e.g., SHMI, ICNARC) and direct mortality reviews as required.
- Support cross Divisional learning from death.

Governance Lead for Mortality

Governance Lead for Mortality is responsible for:

- Collating divisional mortality reviews and mortality performance data. This will enable mortality reporting for the Divisional Risk and Governance group via the monthly divisional mortality reports. The Governance Lead for Mortality will monitor those cases identified for full mortality review and monitor the reviews, ensuring they closed within the required timeframe.
- Alerting appropriate leads when mortality screening and review are overdue and escalate where appropriate.
- Providing training and support of specialty teams in respect to the mortality review process
- Supporting the review of cases of potential sub-optimal care at the Divisional Mortality Review Groups, with escalation through to the incident process if necessary.
- Assisting the Medical Director in producing the quarterly mortality reports.
- Assisting clinicians undertaking any Structured Judgement Reviews where appropriate.

Consultants

Consultants are responsible for:

- Completing mortality reviews in line with Trust policy when requested.
- Ensuring that any actions or learning points identified from mortality reviews are shared and escalated through the divisional structure (in the form of an action plan) to facilitate wider organisational learning. These action plans will be collated within an action tracker, monitored through the Divisional Governance processes, and reported to the Mortality Surveillance Group.

Junior doctors

Junior doctors are responsible for:

- Completing the Medical Examiner referral form on the Trust Intranet (appendix 2) and completion of the Medical Certificate of Cause of Death (MCCD) and cremation form in a timely manner (within 24 hours) following approval by the ME.
- Completing the coroner referral form on the external Coroner portal.

6. Medical Examiner Scrutiny

The Medical Examiner's Office was established to improve the quality of death certification, to improve the experience of bereaved relatives, and to ensure appropriate referrals are made to HM Coroner. The

Medical Examiner scrutiny process also gives rise to the opportunity to potential identify learning from deaths. As part of the Medical Examiner's scrutiny the following will be identified:

- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision.
- All deaths where the Medical Examiner identifies the potential for learning.

7. Mortality Process

Expected deaths will be reported by the informatics team using the MINERVA dashboard. Any unexpected or unintended incident that directly resulted in a patient death will be reported to the Medical Director Chief Nures immediately and reported via Datix.
These reports will be routinely uploaded to the national data base (Learning from Patient Safety Events-LFPSE) to support national learning.

7.1. Responding to cross-system incidents/issues.

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and actions. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

8. Expected Death (see appendix 2)

An expected death is usually referred to the Medical Examiner, there are occasions where although expected the original referral to the Walton Centre NHS Foundation Trust was due to trauma (including falls) or a diagnosis has not been confirmed, those deaths will be reportable to HM Coroner.

All expected deaths will be reviewed by a consultant from the subspeciality but who was not involved in the patient's care, using the initial mortality review template. This will determine whether a more in-depth review is required. Completed initial mortality reviews will be presented to the Mortality Surveillance Group (MSG) monthly for secondary scrutiny. A further review, SJR may be requested by the MSG.

9. Unexpected Deaths

Unexpected deaths may fall into the category of serious incidents investigated using the Patient Safety Incident Reporting Framework (PSIRF). The medical team may not be able to advise a cause of death and the death will need to be referred to HM Coroner and a Datix report completed. If requested, a Rapid Review should be completed within 72 hours of the death and sent to the Deputy Medical Director for Scrutiny. They will decide if the death should be considered a Serious incident and escalated via the Patient Safety Serious Incident Investigation (PSSI) process or can be dealt with through the expected death pathway and initial mortality review process.
The Next of Kin or their representative should be informed as soon as possible of the issues that require further investigation and given advice on how to raise any concerns with the investigation team.

If required, the PSSI should be completed using a recommended structured methodology, the Royal College of Physicians Structured Judgement review, data collection tool, (SJR). This should be completed by a second consultant who was not directly involved in the patient's care.

9.1. Timing for learning responses.

The investigation will commence as soon as possible after the event. The Trust will aim to complete all PSII's within one to three months.

In some incidences, longer timeframes may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

10. Selecting deaths for further investigation using the Structured Judgment Review (SJR) methodology

Structured Judgement Review should be undertaken, by the relevant specialty if the death meets the following mandated criteria:

- A death following an elective procedure.
- Mortality Screening by the Medical Examiner identifies potential problems in care in line with the ME process.
- Where problems in end-of-life care or patient experience are identified, by bereaved relatives/carers feedback.
- Staff have raised a significant concern about the quality-of-care provision.
- Severe mental illness, defined as schizophrenia; schizoaffective disorders; bipolar affective disorder; severe depression with psychosis.
- Members of the Mortality Surveillance Group select cases for SJR, either due to concerns raised directly to the team or for potential learning.
- Inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths.
- A further sample of other deaths will be selected that do not fit the identified categories, to ensure that the Trust can take an overview of where learning and improvement is needed.
- Where a safeguarding concern has been raised.
- Where a LeDeR review has been identified.

10.1. Learning Disability

All deaths of people with learning disabilities or autism aged four years and older should be escalated to the trust Safeguarding Leads and will be registered with the national Learning Disabilities Review Programme (LeDeR).

10.2. Sudden or unexpected Collapse and Death in Infancy or Childhood – 0-18 years (SUDIC).

All deaths up to the age of 18 should be reported to the Trust Safeguarding Leads.
The SUDIC protocol should be applied to all initially unexpected and/or unexplained deaths of infants, children, and adolescents up to their 18th birthday.
The SUDIC protocol triggers a joint agency investigation known as a SUDIC Strategy meeting chaired by a Senior Social Care Manager. This meeting will be attended by a group of professionals who can provide information to assist with the investigation.
HM Coroner must be informed at the earliest opportunity of any unnatural or sudden death of unknown cause. HM Coroner has control of what happens to the child's body and decides if a post-mortem is required, and which pathologist will complete the examination.
Individual cases can always be discussed with a Coroner's Officer or, in an emergency, with HM Coroner directly. HM Coroner should normally be contacted via the Coroner's Office.

10.3. Sudden collapse (Near Death Presentation)

A SUDIC response should also be triggered if a child is brought to hospital near death, is successfully resuscitated, but is expected to die in the following days/weeks. In such circumstances the SUDIC protocol should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.

11. Reporting to HM Coroner (see appendix 4)

When a death occurs the consultant responsible for care has a duty to decide whether the coroner needs to be informed, if coronial referral is required this decision should be communicated sensitively to the bereaved relatives to avoid any unnecessary distress.

12. Supporting and involving families and Carers

The Trust should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles:

- Bereaved families and carers should be treated as equal partners following a bereavement.
- they must always receive a clear, honest, compassionate, and sensitive response in a sympathetic environment.
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture, and beliefs, including being offered appropriate support.
- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one.
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed. If an investigation is commissioned, bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Bereaved families and carers should then be partners in an investigation to the extent, and at whichever stages, at they wish to be involved as they offer a unique and equally valid source of information and evidence that can better inform investigation.
- Bereaved families and carers who have experienced the investigation process should be supported to work in partnership with the Trust in delivering feedback to staff where they want to. This can be in the form of a Lived Experience Story that can be shared at Trust Board and/or with clinic staff.

12.1. Opportunities for bereaved families and carers to raise concerns.

Bereaved families and carers can raise concerns directly with the clinical team, by discussions concerns with the Medical Examiners Officer or by contacting the Patient Experience Team.
A complaint can trigger an investigation if it brings to light previously unknown problems in care. However, if both the complaint and investigation are looking at similar issues, a complaint could be paused until the investigation is complete.

13. Supporting and involving staff

Staff wellbeing is of utmost importance and staff support will be available for staff; affected by the death of a patient in the Trust's care, from both senior medical and nursing staff. Debriefs following a death can be facilitated by Resuscitation and SMART teams, Specialist Nurses for Organ Donation, and palliative care teams.

Staff can also access counselling via NOSS the Network of staff Supporters either by Self, Occupational Health or Management referral. Contact details are on the Trust health and Wellbeing pages.

14. Training

The Governance Lead for Mortality will facilitate briefing sessions in each division to support clinical staff embedding this policy into clinical practice.

15. Reporting

The Trust is required to collect and publish its outcomes and data on a quarterly basis specified information on deaths. This data should include the total number of hospital in-patient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, the Trust will be required to provide data relating to how many deaths were judged more likely than not to have been due to problems in care.

The data is also summarised in the Trust Quality Accounts, including evidence of learning and an assessment of the impact of the actions that the Trust has taken.

16. Monitoring

What is being Monitored:	How is it monitored	By whom and When:	Minimum Standard	Reporting to:
Number of reviews versus deaths in each Division,	Review of quarterly divisional mortality reports	Mortality Lead for |Governance	All deaths reviewed within 8 weeks of occurrence	Divisional Mortality Groups
Appropriate level of review	Random sample of 10% cases reviewed to determine whether the level of review (Level 1, or Structured Review) was appropriate		10% cases reviewed	Divisional Mortality Groups

17. References

- Learning, candour, and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England, Care Quality Commission, December 2016.
- National Guidance on Learning from Deaths, National Quality Board, March 2017. By National Mortality Case Record Review Programme (England version). Royal College of Physicians (RCP), 2017.
- Learning Disability Mortality review process (LeDeR).
- Sudden Unexpected Death in Infants and Children (SUDIC) Protocol.

18. Supporting Policies

- Guideline for internal notification of death, completion of death certificates and referral to HM Coroner's following adult deaths.
- Incident Reporting, Investigation and Management Policy.
- Undertaking Mortality Case Record Reviews SOP.
- Duty of candour policy.
- Patient Safety Incident Response Policy

19. Appendix 1 – Initial Mortality review Form

To be completed following any inpatient death

1 DEMOGRAPHICS -

Name	
DOB	
Ward	
Consultant	
Hospital No.	
Ethnicity	
Reviewer	
Date of initial review	

2. ADMISSION DETAIL

Date of Admission.		**Referring Hospital**	**Comments**
Emergency			
Elective			
Sub -speciality			
Diagnosis			
Date of Death.			
Coroner referral			
Medical Examiner referral (ME).			
Queries from the ME.			
MCCD approved by the ME (Date).			
MCCD Completed (Date).			

3. COPY OF THE MEDICAL EXAMINEROR CORONER REFERRAL, including Medical Cause of Death.

4. DID THE PATIENT FULFIL ANY OF THE FOLLOWING CRITERIA:

Criteria	**YES / NO**	**Comments**
Learning Difficulties		
Under a DoL's order.		

Recent Surgery		
Patient or family had raised concerns/complained?		
Staff had raised concerns?		
ME raised on concerns?		

5. INCIDENT REPORTS:

Datix	**Detail**
Had there been any DATIX records concerning this patient?	
Compliments	**Detail**
Had there been any compliments from relatives or carers related to this patient?	

6. RISK ASSESSMENTS:

Risk assessment	**Completed**	**Accurate**
Falls		
VTE		
MUST		
Infection		
Frailty score		

7. AHP/ SPECIALIST REFERRAL

Referral to:	**Reason**	**Outcome**

8. END OF LIFE CARE:

Care of the dying pathway	**YES / NO**	**Involvement of specialist palliative care team / Specialist Nurses for organ Donation**
Was there evidence of good communication with the patient's family?		
Was the death expected?		
Was the patient on a care for the dying pathway?		

9. CONCLUSION Level 1 review of the death

Score	Avoidability	Reason
Score 1	Definitely avoidable	
Score 2	Strong evidence of avoidability	
Score 3	Probably avoidable (more than 50:50)	
Score 4	Possibly avoidable but not very likely (less than 50:50)	
Score 5	Slight evidence of avoidability	
Score 6	Definitely not avoidable	

10. **LEARNING POINTS:**

Learning points.

11. **ACTION** :

Is a further review (structured judgment review) required.

Date:

Mortality Surveillance Group Sign off.

Date- outcome / recommendations.

20. Appendix 2 Royal College of Physicians , Structured judgement review. (Data Collection Tool).

Name:

NHS NO:

Age at death (years):

Gender: M/F

First 3/4 digits of the patient's postcode:

Day of admission/attendance:

Time of arrival:

Day of death:

Time of death:

Number of days between arrival and death:

Month cluster during which the patient died:

Specialty team at time of death:

Specific location of death:

Type of admission:

The certified cause of death (if known):

Phases of Care.

The reviewer is requested to record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on, then please do so. (Applies to each phase of care).

Phase of care: Admission and initial management.

Please rate the care received by the patient during this phase. 1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score

Phase of care: Operative procedure

Please rate the care received by the patient during this phase. 1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care Please circle only one score

Phase of care: Ongoing care.

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score

Phase of care: End of Life care.

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score

Phase of care: Overall assessment.

Please rate the care received by the patient during this phase.
1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = Excellent care
Please circle only one score

Please rate the quality of the patient health care record.

1 = very poor 2 = poor 3 = adequate 4 = good 5 = Excellent

Problems in the patient's care.

Appendix 1 – Assessment of problems in healthcare in this section, the reviewer is asked to **comment on whether one or more specific types of problem(s) were identified and, if so, to** indicate whether any led to harm. Were there any problems with the care of the patient? (Please tick) No ☐ (please stop here) Yes ☐ (please continue below) .
If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation, or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls):**

   Did the problem lead to harm? Yes / No ☐
   In which phase(s) did the problem occur?

   Admission and initial assessment ☐ Ongoing care. ☐

   Care during procedure. ☐ Perioperative care. ☐

   End of life care. ☐

2 Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic): No

Did the problem lead to harm? No ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

2. **Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE):**
Did the problem lead to harm? No ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

3. Problem with infection control: No ☐ Yes ☐-
Did the problem lead to harm?
In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

4. Problem related to operation/invasive procedure (other than infection control): Yes

Did the problem lead to harm? No ☐ Yes ☐
In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

5. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes): No ☐ Yes ☐-

Did the problem lead to harm? No ☐ Yes ☐
In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

8 Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)): No ☐ Yes ☐

9 In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

10 Problem of any other type not fitting the categories above: Yes ☐

Did the problem lead to harm? No ☐ Yes ☐

In which phase(s) did the problem occur?

Admission and initial assessment ☐ Ongoing care. ☐

Care during procedure. ☐ Perioperative care. ☐

End of life care. ☐

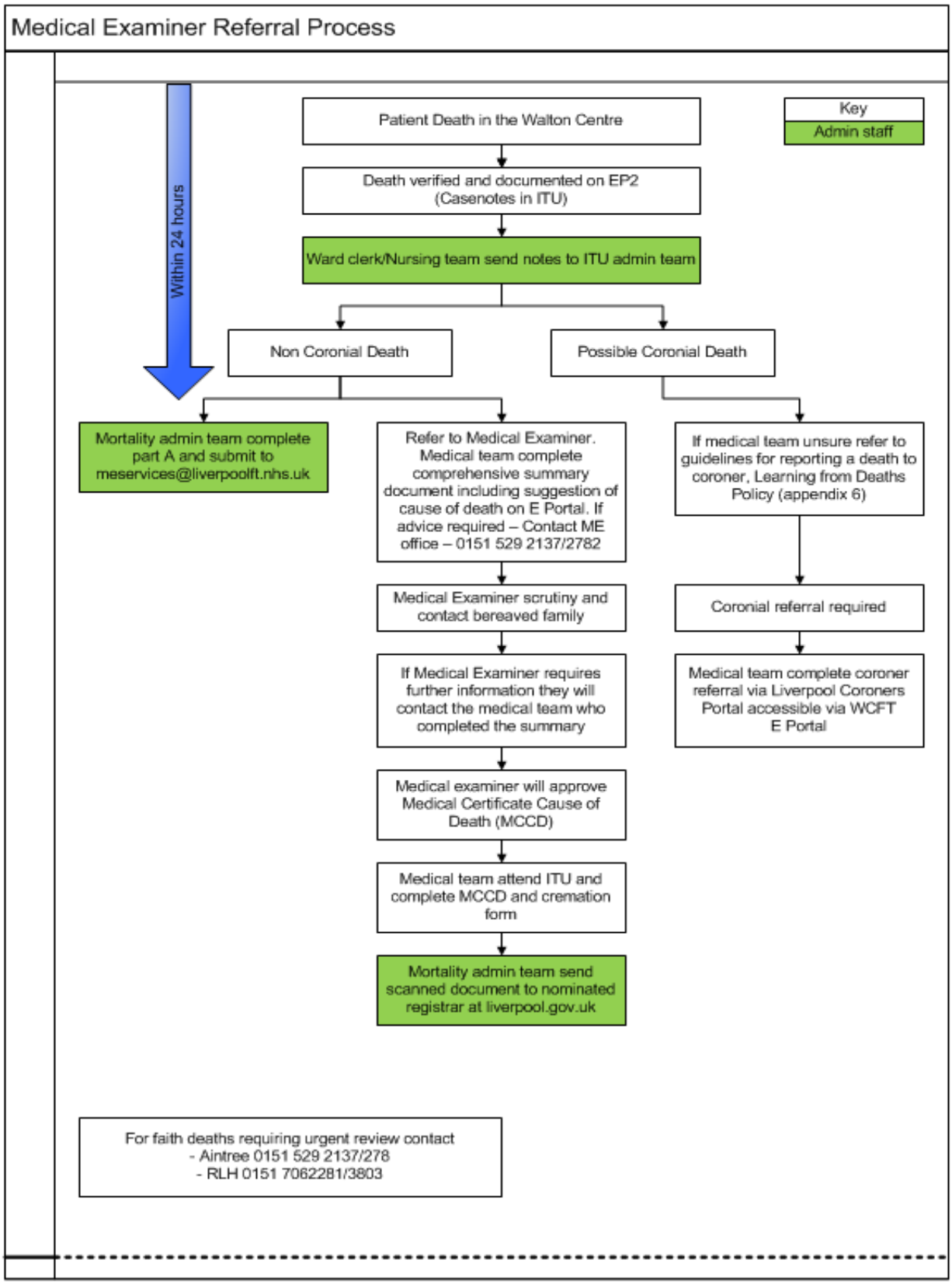
Avoidability of death judgement score *(most appropriately used at second stage review, if required)*

We are interested in your view on the avoidability of death in this case. Please choose from the following scale.

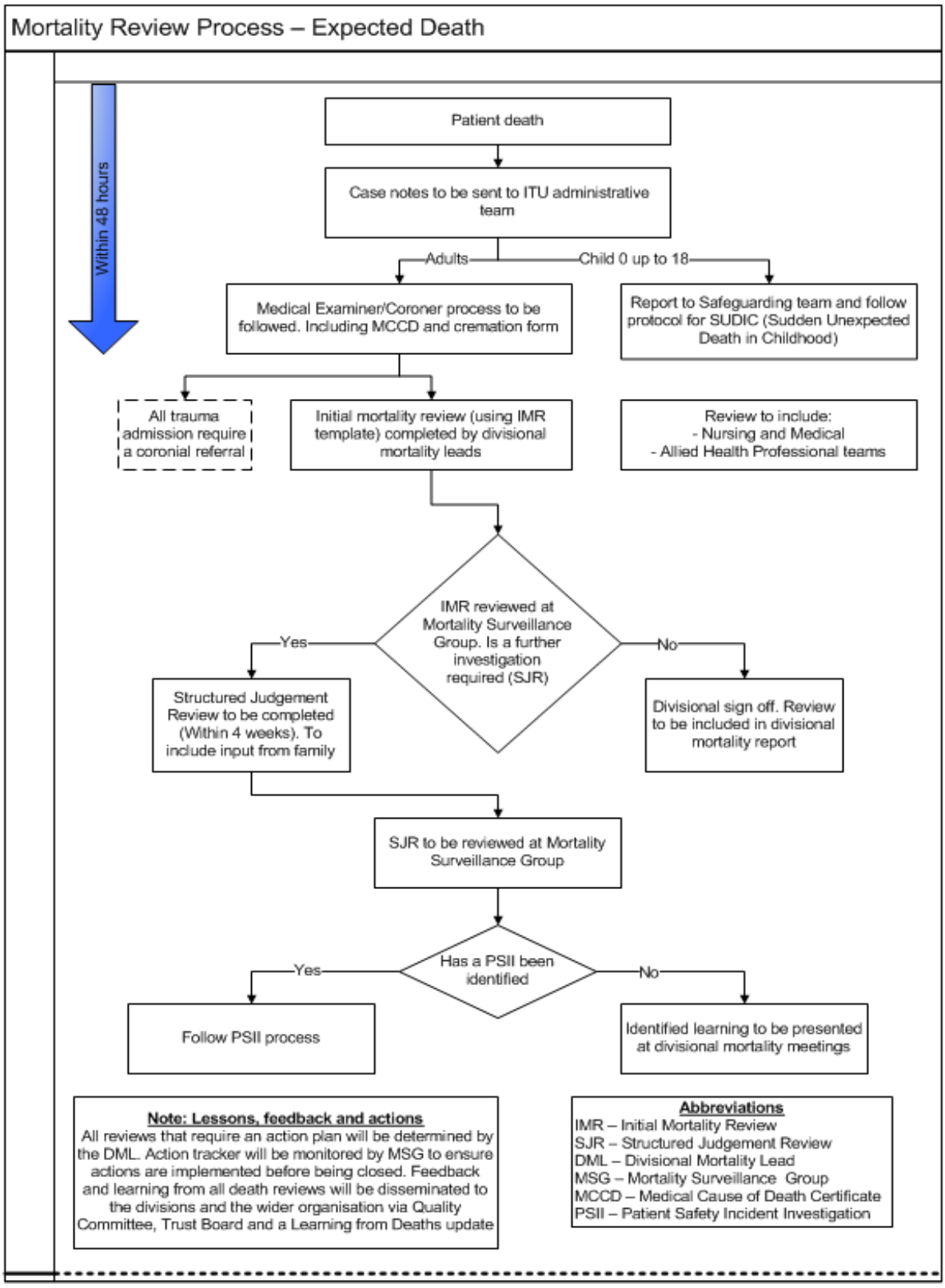
1 Definitely avoidable
2 Strong evidence of avoidability
3 Probable avoidance (more than 50:50)
4 Possible avoidances but not very likely (less than 50:50)
5 Slight evidence of avoidability
6 Definitely not avoidable.

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.

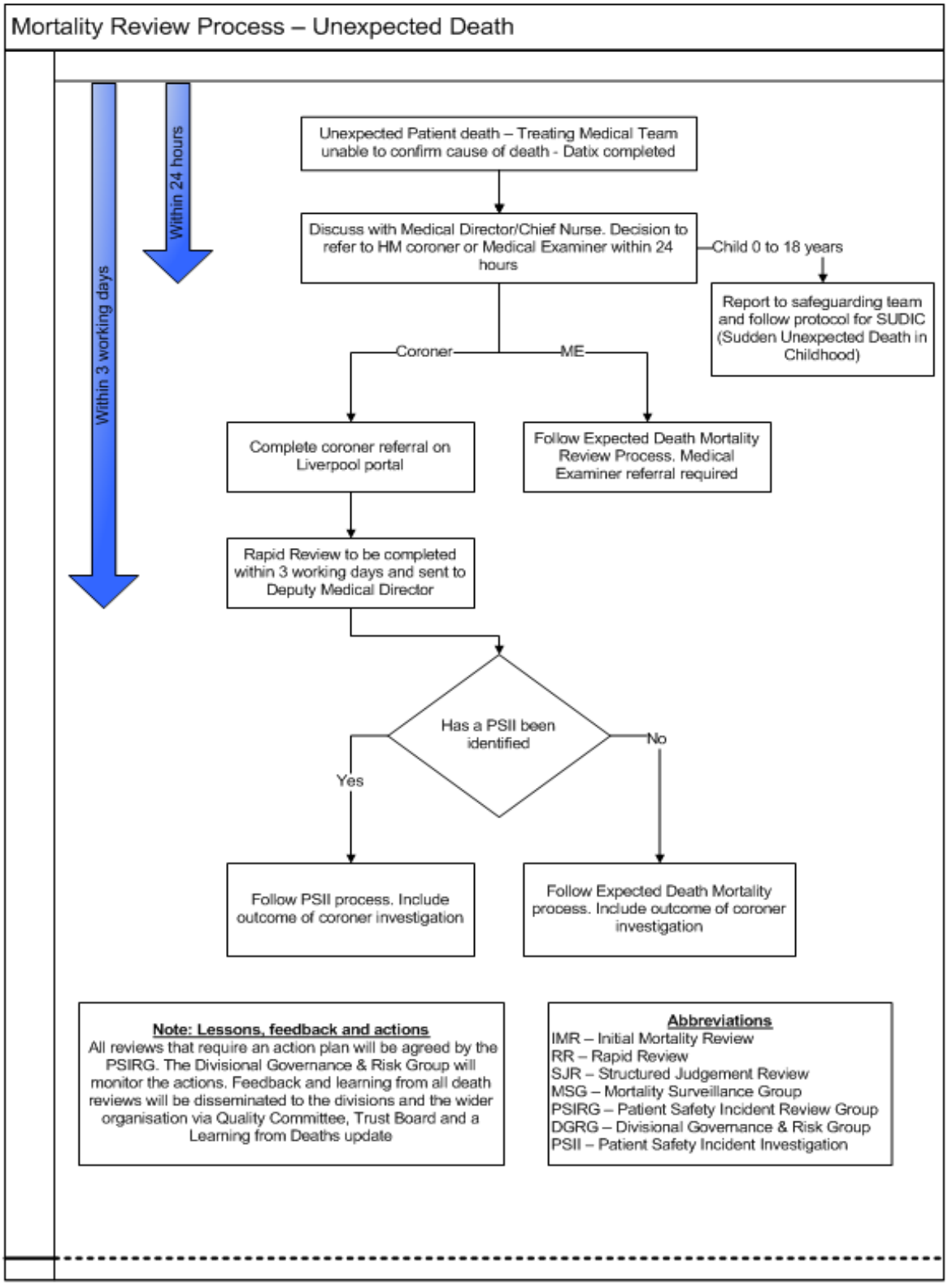
21. Appendix 3 - Medical Examiner Referral Process



22. Appendix 4 - Expected Death



23. Appendix 5 - Unexpected Death



Appendix 6 – Medical Examiner / Coroner Referral Process- Guidance for Clinicians

General principles

When a patient dies who has been under your care (you being either the consultant leading the team or a member of the team) When a patient dies who has been under your care (you being either a member of a clinical team or the consultant leading the team) there are certain legal obligations placed upon you. if you are certain of the cause of death, you are required to complete a medical Examiner (ME) referral. following approval from the ME), you will need to complete a Medical Certificate of Cause of Death certificate (MCCD).

On occasions you will need to report a case to the coroner and this guidance is intended to support you in the latter circumstance.

This is not a duty that can be delegated to non-medical staff.

23.1. Death certification by doctors

A licensed qualified medical practitioner can COMPLETE a MCCD in respect of a death from wholly natural causes when:

- He / she has attended (meaning assessed and/or treated) the patient during within 14 days before death.
- Is satisfied as to the cause of death.
- Is satisfied that the death is wholly due to natural cause.
- Is satisfied the death is not otherwise reportable to the coroner.

Completion of the Medical Certificate of Cause of Death

The Registrar of Deaths is required by law to refuse registration and to report a death to the coroner if the MCCD does not comply with Legal requirements. It is ultimately the responsibility of the Consultant in charge of the patients care to ensure the death is certified correctly.

If junior staff are in any doubt regarding the cause of a patient death, they should discuss his with their consultant in the first instance, the Medical Examiner is also available for discussion.

It is important when completing the MCCD that you avoid inadequate or vague causes of death, the use of symbols or abbreviations. There is further guidance on completing the MCCD on the front of the book of MCCDs.

23.2. Reporting deaths to the coroner

A death must be reported to HM Coroner if:

- the cause of death is unknown or if there is any doubt as to the cause of death.
- it cannot readily be certified as being entirely due to natural causes.
- the death was during an operation / as a consequence of the operation, or before full recovery from the effects of the anaesthetic or was in anyway related to the anaesthetic (whether the patient dies on the table or afterwards, irrespective of the length of time involved after anaesthesia e.g., a cerebral anoxia case dying six months later). Normally, a death within 24 hours of surgery should always be referred.
- the death may be related to a medical / nursing procedure and / or treatment whether invasive or not, even if the procedure was necessary, appropriate and properly executed.
- the death may be due to a crime.
- there is any element of suspicious circumstances; o there is any element of sudden or unexplained circumstances.
- there is any element of suspicious circumstances.

- there is an element of sudden or unexplained circumstances.
- there is any history of violence, or the death may be due to or contributed to by violence.
- the death may be linked to an accident (whenever it occurred, even if prior to admission)
- there is any question of self-neglect or neglect by others contributing to or causing the death (this includes medical/ nursing mishaps)
- the death has occurred, or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at the police station).
- the death might have been caused or contributed to by the actions of the deceased him/herself (such as a history of drug or solvent abuse, self-injury or overdose, or other suicide attempts) either intentionally or unintentionally.
- the death could be due to or contributed to by industrial disease, poisoning or occupational injury, or related in any way to the deceased's employment (e.g., mesothelioma, bladder cancer etc);
- the death is due to or contributed to by drugs, including therapeutic and prescribed drugs, where there is overdose, poisoning, idiosyncrasy, or addiction involved.
- the death may be due to or contributed to by a fall or fracture.
- the body is unidentified.
- the death is due to malnutrition or exposure / hypothermia; o the death may be due to acute alcohol poisoning (but not chronic addiction).
- the death may be due to lack of medical care.
- the death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care).
- the deceased was receiving any form of war pension or industrial disability pension (however irrelevant the disability may appear to be) unless the death can be shown to be wholly unconnected.
- there are any other unusual or disturbing features to the case.

Careful consideration should be given to reporting a death where there is, or is likely to be, an allegation or complaint of:

- medical / nursing mismanagement.
- inappropriate treatment.
- the death is the subject of a (serious) untoward incident investigation.
- There is no legal requirement to report a death in this situation, but careful thought should be given as to whether the coroner needs to be made aware of the circumstances surrounding the death.

The above is not an exhaustive list of the circumstances under which a death should be reported to the coroner but rather is intended as a guide for hospital based medical staff.

Useful reminders:

It is an offence to move or otherwise interfere with a body or surrounding evidence, without leave of the coroner, where death has occurred in circumstances which may lead him to hold an Inquest:

(i) For deaths occurring during or as a result of anaesthesia or any operative procedure or invasive technique involving any clinical support equipment (e.g., intubation tubes, catheters, probes, intravenous lines etc.), this should be left in situ for post mortem observation.

(ii) If there is any doubt as to whether a death is to be referred to the coroner, clinical support equipment should not be removed. (iii) Where needles or other sharps are present in the body at death and are left in situ the Consultant Histopathologist performing the postmortem should be notified. Reference MDG001 Date of issue 29/10/09

(iii) Staff are reminded that certain religions will need the body to be released very quickly. Difficulties can be encountered where the death must be reported to the coroner. It is, therefore, important that the coroner is made aware of any such requirement and in turn that the next of kin are kept fully informed of any likely delays.

It is vital that all discussions with the coroner are fully recorded in the patient's medical records including reasons for the referral.

24. Appendix 7 - Equality Impact Assessment (EIA) Form

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

Part 1

1. Person(s) Responsible for Assessment: P Crofton
2. Contact Number: 63289

3. Department(s): Governance.
4. Date of Assessment: 16/10/23

5. Name of the policy/procedure being assessed: Learning from Deaths , Standardised Mortality Review Process.

6. Is the policy new or existing?

New

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

Staff X Patients X Visitors X

8. How will these groups/key stakeholders be consulted with?

Communication with Consultant Medical staff, Senior Nursing team, Allied Health Professional leads.
National guidance related to Learning from Deaths

9. What is the main purpose of the policy?

This policy details the Trust wide process of retrospective case review that is to be implemented following an in-hospital death, identify any learning

10. What are the benefits of the policy and how will these be measured?

This Trust-wide approach to learning from deaths ensures the Trust has a standardised format for retrospective care reviews following an inpatient death. This standardised process will ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning.

Compliance with this policy will provide assurance that Mortality Governance meets the standards set within National Guidance.
Learning from mortality will be used to drive service improvement and offer assurance to our patients, stakeholders, and the Board that the causes and contributory factors of patient deaths have been considered and appropriately responded to in an open and transparent manner.
The Governance Lead will complete audits as detailed in the monitoring section of this policy.

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? *If yes, please give brief details*
Guidelines for Doctors on reporting deaths to the coroner.
Care of the deceased patient
End of Life and Bereavement strategy

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please specify specifically who would be affected (e.g., patients with a hearing impairment or staff aged over 50). Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*

Protected Characteristic	**Positive Impact *(benefit)***	**Negative *(disadvantage or potential disadvantage)***	**No Impact**	**Reasons to support your decision and evidence sought**	**Mitigation/adjustments already put in place**
Age			X		
Sex			X		
Race			X		
Religion or Belief			X		
Disability			X		
Sexual Orientation			X		

Pregnancy/maternity			X		
Gender Reassignment			X		
Marriage & Civil Partnership			X		
Other			X		

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)
All inpatient deaths are subject to Initial Mortality review and presentation at Trustwide Mortality Surveillance Group.

6 Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? *See Guidance for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal).*
No

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to the HR ED&I Lead for further support.

Action	Lead	Timescales	Review Date

Declaration

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

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

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality. ***You must ensure the policy has been amended before it can be ratified.***

Adverse impact but continue with policy – EIA has identified an adverse impact, but it is felt the policy cannot be amended. ***You must complete Part 2 of the EIA before this policy can be ratified***.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination, and the policy has been removed

Name: P Crofton Date:16/10/23

Signed: P Crofton

25. Appendix 8 - Policy approval checklist

The Learning from Deaths Standardised Mortality Review Process Policy is presented to the _CESG Committee/Group for Approval.

In order for this policy to be approved, the reviewing group must confirm in table 1 below that the following criteria is included within the policy. Any policy which does not meet these criterion should not be submitted to an approving group/committee, the policy author must be asked to make the necessary changes prior to resubmission.

Policy review stage

Table 1

The reviewing group should ensure the following has been undertaken:	**Approved?**
The author has consulted relevant people as necessary including relevant service users and stakeholders.	Y
The objectives and reasons for developing the documents are clearly stated in the minutes and have been considered by the reviewing group.	Y
Duties and responsibilities are clearly defined and can be fulfilled within the relevant divisions and teams.	Y
The policy fits within the wider organisational context and does not duplicate other documents.	Y
An Equality Impact Assessment has been completed and approved by the HR Team.	N/A
A Training Needs Analysis has been undertaken (as applicable) and T&D have been consulted and support the implementation	N/A
The document clearly details how compliance will be monitored, by who and how often.	N
The timescale for reviewing the policy has been set and are realistic.	Y
The reviewing group has signed off that the policy has met the requirements above.	Y

Reviewing group chairs name: Dr S Niven	**Date:20/10/2023**

Policy approval stage

X The approving committee/group approves this policy.

☐ **The approving committee/group does not approve the policy.**

Actions to be taken by the policy author:None	
Approving committee/group chairs name:Dr A Nicholson (MD)	**Date: 26/10/2022**

26. Appendix 9 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
2.0	1	Introduction updated to include reference to diversity and inclusivity. Learning disability or Autism and patients from a minority ethnic background	30/11/10/2023	P Crofton
2.0	4	End of Life Care removed from definition section.	30/11/2023	P Crofton
2.0	9	Paragraph updated to include Patient Safety Incident Reporting framework guidance	26/10/2023	P Crofton
2.0	10.1	Updated to include patients with autism requiring further investigation via a LEDER review.	30/11/2023	P Crofton
2.0	Appendix 1	Ethnicity added to demographic section.	30/11/2023	
2.0	Appendix 3	Updated algorithm	26/10/2023	P Crofton
2.0	Appendix 4	Updated algorithm	26/10/2023	P Crofton
2.0	Appendix 5	Updated algorithm	26/10/2023	P Crofton
2.0	Appendix 6	Medical Examiner / Coroner Referral Process- Guidance for Clinicians, added as appendix.	26/10/2023	P Crofton

Translation Service

If you require this leaflet in any other language or format, please contact the Patient Experience Team on 0151 556 3091 or 3093, or email wcft.patientexperienceteam@nhs.net stating the leaflet name, code and format you require.

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Chinese	如果你想索取本传单的任何其他语言或格式版本，请致电0151 556 3091或3093联络「病人经历组」，或发电邮至wcft.patientexperienceteam@nhs.net，说明所需要的传单名称、代码和格式。
Farsi	۰۱۵۱۵۵۶۳۰۹۱ شماره با بیمار تجربه تیم با لطفا,دیگری زبان یا هرفرم به بروشور این به نیاز صورت در بگیرد زیرتماس ایمیل با یا یا۳۰۹۳ wcft.patientexperienceteam@nhs.net خود نیاز مورد قالب و کد ، بروشور نام ذکر با
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