NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 3rd February 2022

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
Thursday, 3 February 2022

Microsoft Teams

09:30 - 12:00

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies (v)	Acting Chair	N/A
2	09.30	Declaration of Interests (v)	Acting Chair	N/A
3	09.35	Minutes and actions of meeting held on 2nd December 2021 (d)	Acting Chair	Decision
4	09.40	Patient Story (v)	Chief Nurse	Information
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update (v)	Acting Chair / Chief Executive Officer	Information
PERFORMANCE				
6	10.10	Recovery & Restoration Update (v)	Acting Chief Operating Officer	Information
7	10.20	Integrated Performance Report (d)	Chief Executive Officer / Execs	Assurance
QUALITY & SAFETY				
8	10.40	Mortality and Morbidity Report Quarter 2 and Quarter 3 2021/22 (d)	Medical Director	Assurance
GOVERNANCE				
9	10.50	Board Assurance Framework Quarter 3 2021/22 (d)	Corporate Secretary	Assurance
10	11.00	Key Assumptions and Operational Planning (p)	Chief Finance Officer	Approval
11	11.10	Reducing the Burden and Releasing Capacity (d)	Corporate Secretary	Approval
REPORTS FROM BOARD COMMITTEES				
12	11.20	Quality Committee Key Issues Report (d)	Committee Chair	Assurance
13	11.25	Business Performance Committee Key Issues Report (d)	Committee Chair	Assurance
14	11.30	RIME Committee Key Issues Report (v)	Committee Chair	Assurance
15	11.35	Audit Committee Key Issues Report (d)	Committee Chair	Assurance
16	11.40	Walton Centre Charity Committee Key Issues Report (d)	Committee Chair	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Quarterly Governance, Risk and Patient Experience Report (d) • Quality Account Priorities 2022/23 (d) • Board Development Programme (d)				
CONCLUDING BUSINESS				
17	11.45	Any Other Business (v)	Acting Chair	Information

Date and Time of Next Meeting: 3rd March 2022 commencing at 9.30am

UNCONFIRMED

Minutes of the Public Trust Board Meeting

Meeting held in Board Room

2nd December 2021

Present:

Seth Crofts	Non-Executive Director – Acting Chair (AC)
Karen Bentley	Non-Executive Director (NED-KB)
Su Rai	Senior Independent Director (SID)
Nalin Thakkar	Non-Executive Director (NED-NT)
David Topliffe	Non-Executive Director (NED-DT)
Jan Ross	Chief Executive (CEO)
Andy Nicolson	Medical Director (MD)
Mike Burns	Chief Financial Officer (CFO)
Lisa Salter	Chief Nurse (CN)
Mike Gibney	Chief People Officer (CPO)
Lindsey Vlasman	Interim Chief Operating Officer (ICOO)

In attendance:

John Baxter	Executive Assistant (EA)
Katharine Dowson	Corporate Secretary (CS)
Lisa Judge	Head of Patient and Family Experience (HPFE) (item 4 only)
Elaine Vaile	Communications and Marketing Manager (CMM) (item 4 only)
Tina Davies	Head of Facilities (HF) (item 10 only)
Steve Holland	Head of Estates (HE) (item 10 only)

1 Welcome and apologies

1.1 AC welcomed those present to the meeting.

2 Declarations of interest

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

3 Minutes of the meeting held on 4th November 2021

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

4 Patient Story

4.1 A patient joined the meeting to present their story and informed that they had been a patient in 2019 and had originally been admitted to Aintree Hospital following a stroke and then transferred to the Walton Centre for a short stay to undergo level one rehabilitation before then being transferred to the Seddon Suite for more intensive rehabilitation. The patient noted that all staff that she had encountered were very friendly and professional however her only issue was when a physio informed her that she would never regain the full use of her arm. This was a shock and the patient felt this could have been communicated better with a more refined approach. The patient was now accessing private physiotherapy to continue their recovery and noted it would be a long and slow process.

4.2 CN queried what the impact had been on the patient's family and how the communication had been from the Trust. The patient reported that there had been a big impact on her family and they had not understood that the hard rehabilitation work would begin following their discharge home.

The Board thanked the patient for sharing their story.

5 Chair & Chief Executive's Report

5.1 AC updated that a new Neuropsychiatry Consultant and a new Consultant Neurologist had been appointed since the previous meeting. Discussions regarding the Partnership Collaborative were ongoing at the recent Integrated Care System (ICS) meeting. It was highlighted that Graham Urwin had been appointed to the Chief Executive position in the Cheshire and Merseyside Health Care Partnership (HCP) and recruitment for place-based partnership leads was underway with appointments aiming to be made before the end of the year.

5.2 Non-Executive Director recruitment was progressing and it was stated that shortlisting had been completed by the Council of Governors at their meeting on 11th November and interviews had taken place on 1st December. An update would be provided when the outcome was known.

5.3 AC attended the recent NHS Providers conference which had been focussed on diversity and the levelling up agenda. Audit and finance forums organised and facilitated by NHS England had taken place on 18th and 19th November to address the winding up of Clinical Commissioning Groups (CCG) and transfer to the ICS structure along with the associated governance around this.

5.4 A presentation had been provided at the regional Chair's meeting hosted by the Northern Care Alliance, showcasing how data could be used differently using a metric of deprivation based on postcode which was very helpful and would help to focus efforts in this area going forward; it was recognised that this was a key driver for the system. There had also been a lot of discussion regarding the recent incident at Liverpool Women's Hospital and the experience of staff there, along with the system response.

5.5 CEO reported that there had been a lot of focus on changes in practice due to Covid and the new Omicron variant from a staffing and messaging point of view. It had been agreed to postpone the staff Christmas party to the end of January and tickets could be rolled over to the new date or refunds provided. There continued to be a big push on the vaccination programme and the Trust continued to work closely with Liverpool University Hospitals NHS Foundation Trust (LUFT) regarding this. 89% of staff were currently double vaccinated and 68% of eligible staff had also received the booster vaccine. There would be an increase in targeted encouragement to receive the vaccine from line managers for staff to be fully vaccinated ahead of the nationally mandated date of 1st April 2022 and the Trust was working to sign up to a set of principles with trade unions to support these efforts. The annual flu vaccination programme was also underway with approximately 44% of staff currently having received the flu vaccine.

5.6 The Trust had received a letter from the Care Quality Commission (CQC) further to the recent review of Ionising Radiation (Medical Exposure) Regulations (IRMER) stating that they were happy with the completion of the action plan and the review would now be

closed.

5.7 The regional debrief following the recent incident at Liverpool Women's Hospital had not yet taken place and feedback would be provided after this had been held.

The Board noted the verbal update reports.

6 Recovery and Restoration Update

6.1 ICOO provided an update on the Trust's recovery and restoration programme noting that all diagnostic and cancer related targets had been achieved. H2 (October 2021 – March 2022) guidance had been published which contained some differences from the H1 (April – September 2021) guidance. It was highlighted that there were continued staffing pressures within critical care and theatres along with infection prevention and control pathway pressures and incentivised payments wold be implemented for December to try and mitigate staffing pressures.

6.2 Elective activity performance was currently at 91.64% of 2019/20 levels and it was reported that day case performance had decreased due to the ongoing national shortage of IVIG (intravenous immunoglobulin). There had also been a decrease in outpatient activity and this was linked to the half term break which had resulted in increased levels of annual leave.

6.3 There were 74 patients waiting 52 weeks or more in November and a plan was in place to reduce this further by March 2022.

6.4 Activity targets to access ERF (Elective Recovery Fund) had been met by the Trust during October and November, however it was noted that these targets needed to be met across the system to enable the ERF to be accessed.

The Board noted the progress made against the Trusts recovery and restoration programme.

7 Integrated Performance Report

7.1 CEO provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Committee meetings as noted in the relevant key issues reports. It was highlighted that cancer and diagnostic targets continued to be met by the Trust however both targets were a challenge across the wider system. Challenges regarding the delivery of elective activity within theatres remain due to staffing pressures and infection prevention and control pathways and therefore incentive schemes were in place for December.

7.2 ICOO noted that there had been one breach of cancer waiting times as the patient had required an additional test.

Quality

7.3 CN highlighted that work to increase Friends and Family Test responses was ongoing and QR (quick response) codes had been displayed at patient bedsides that could be scanned via the patient's smartphone to enable feedback to be provided in real time. Two new Matrons were now in post and both had settled in well. Work was underway to improve the number of completed appraisals and it had been noted that a number had

been completed but not reported to the Training and Development team in a timely manner.

7.4 There were two cases of MSSA recorded in October 2021 and one further infection noted in November. A reduction in the cases of pressure ulcers reported had been noted. Anew Tissue Viability Nurse had joined the Trust which would support ongoing work to reduce this further.

7.5 SID queried if a deep dive had been completed regarding the recent Never Event and CN confirmed that this related to an incidence of wrong route medication. The staff member did not have all their competencies signed off and a new system of monitoring was in place that would feed into online learning which would be able to identify staff progress regarding competency sign off. It was also confirmed that duty of candour had been completed with the patient.

7.6 **Workforce**

CPO advised that recruitment levels remained steady and the international recruitment programme was ongoing. Staff absence was currently 8.75%, 1% of this was Covid related and 3% was due to maternity leave. Staff were feeling the pressure of the high absence figures and capacity continued to have an impact on performance against appraisal targets. It was also expected that there would be a knock on effect on mandatory training performance.

7.7 SID queried if staff recruited via the international recruitment programme were recruited on fixed term contracts and it was confirmed that this was not the case and all were recruited on permanent contracts however visa renewals would be required following a certain length of time. The calibre of staffing recruited as part of this programme had been excellent with staff having a very high level of knowledge and expertise. CN noted that good pastoral support was in place and ward managers had been given an objective of identifying future leaders from this cohort.

Finance

7.8 CFO noted that in-month performance had been above plan and the version 6 financial plan submission had been made which measured performance against a breakeven position. ERF had been included in the latest financial plan as the Trust had been informed to include an element of ERF. Covid costs continued to reduce and would be removed going forward however there would be some recurrent costs due to the expansion of the infection prevention and control team.

7.9 CFO updated that Trust performance regarding the better payment practice programme was 92.3% against a target of 95% and work was ongoing to improve this further.

The Board noted the Integrated Performance Report.

8 Guardian of Safe Working Hours Report Quarter 2 2021/21

8.1 MD presented the Guardian of Safe Working hours report and highlighted that there continued to be a low number of exception reports. However there had been a slight increase during quarter two and this was mostly due to the implementation of the 24/7 thrombectomy service. This service implementation had resulted in some breaches of mandated rest periods which had been resolved within the Division. It was predicted that

there would be further breaches in the coming months. MD highlighted that 25% of thrombectomy referrals had taken place out of hours with 75% of referrals happening after 5pm. This level of activity had occurred much sooner than anticipated and the Trust had implemented a solution in response with a plan in place for the resident SMART (Surgical and Medical Acute Response Team) team to be trained to provide medical assessment. This approach would be in place by January 2022 and the Neurology Registrar on call was still available to attend if required on a case by case basis. Exception reports would continue to be made where required and these would be resolved as breaches occurred.

8.2 It was also reported that the Junior Doctors mess was now fully usable with all equipment installed.

The Board noted the Guardian of Safe Working Hours report for Quarter two of 2021/21.

9 National Public Covid-19 Inquiry Update

9.1 CN informed the Board that the focus of the upcoming inquiry would be in regard to health, business and education sectors. It was expected that a Chair would be appointed in December with terms of reference set to be published in January prior to the inquiry beginning in Spring 2022. It was anticipated that the terms of reference would be expanded following public feedback and the inquiry was expected to run for three to four years.

9.2 A stop notice had been issued on 28th October 2021 advising the Trust that they must keep all information and documentation relating to Covid and decision making. If any member of staff leaves the Trust a discussion is required around the location of information and up to date contact information must be kept.

9.3 An overview of current requirements was provided and assurances provided that work around each was underway. A team had been formed to take the requirements of the inquiry forward and additional staff would be co-opted in as required.

9.4 NED-DT queried the practicalities regarding safeguarding personal emails and CEO highlighted that the Trust had moved quickly at the start of the pandemic to a central command and control inbox as a single point of contact and the bulk of decisions made had been recorded in log books. Good documentation and communication channels had been in place and the command and control inbox continued to be managed via the on call structure. It was not known what level of investigation would take place and this would be detailed in the terms of reference. Policies were amended during the pandemic and the Trust has documented evidence of all amendments.

The Board noted the national public Covid-19 inquiry update.

10 Sustainable Development Plan

10.1 HF and HE joined the meeting.

10.2 ICOO presented the draft sustainable development plan and highlighted that this had been discussed at Business Performance Committee (BPC) and was a working document that would be updated as more areas became involved. The draft policy would be submitted to NHS England in January as required and further work would take palce as

required, including formation of an action plan. The current draft plan was a high level plan and would initially be submitted to the Integrated Care System (ICS) who would collate all regional plans into one system plan for submission to NHS England in March 2022.

10.3 Work on a sustainable development plan first started in 2012 when the Trust explored the potential for renewable energies and a paper would be compiled to explore this further as a number of newer advanced technologies were available.

10.4 The annual year on year reduction required to meet the government target of zero carbon emissions by 2040 was not known and would require additional work to understand however it was recognised that this target would be challenging to meet.

10.5 CPO stated that the ICS provided the opportunity to drive the sustainability agenda forward and understand what could be done at a local level.

The Board approved the draft sustainable development plan for submission to the ICS to include a caveat stating that it was not the final plan.

10.6 HF and HE left the meeting.

11 Health and Wellbeing Pledge

11.1 CPO provided a presentation regarding the health and wellbeing pledge that all Trusts had been asked to sign up to by NHS Employers. There were three main areas of enabling work to be undertaken:

- reviewing the national refreshed framework published by NHS England and NHS Improvement (NHSE/I)
- understanding the new person centred wellbeing and attendance management policy framework
- reviewing the implemented toolkit when this becomes available to understand what could be done to support managers.

11.2 CPO advised that these frameworks represented a person-centred approach and a more coaching style of leadership and management. Managers required a rapport with staff and tactics in place where no rapport was possible. Building rapport training was offered by the Trust and this now included a session around civility. This agenda was also being driven by staff side and would be achieved by strengthening and embedding a culture of wellbeing, the development of a wellbeing policy and development of line managers and leadership qualities.

11.3 An overview of the objectives of the project was provided and it was recognised that the emergence of agile working provided a potential for an increase in cases of domestic abuse. A health and wellbeing staff survey had been undertaken and the results from this were being awaited. It was anticipated that Trusts would have a minimum of one health and wellbeing advocate for every 50 members of staff. There were currently 29 mental health first aiders across the Trust and further training for additional staff would be offered in February 2022.

11.4 Work was underway to understand what the associated KPIs (key performance indicators) would be and it was expected that this would include soft indicators such as staff surveys

and hard indicators such as the national indicators recorded in the IPR.

11.5 CFO queried if any funding was available for implementation as this was a national initiative and CPO confirmed that no additional funding was available however there was funding to support health and wellbeing on a national level which would support the pledge.

11.6 SID questioned if there was anything in the framework specific to Black, Asian and Minority Ethnic (BAME) staff. CPO noted that the two strands were not yet connected however this would have to happen moving forward.

11.7 CPO and NED-KB, as Wellbeing NED, were planning to meet with Matt Holt-Rogers, Health and Wellbeing Consultant at Wellbeing 4 Business, to move this work forward.

The Board noted health and wellbeing pledge.

12 Investors in People Annual Review

12.1 CPO presented the report following the annual update review of the Investors in People: We Invest in People accreditation and reported that two observations had been made. The first was that the Trust did not feel any different to before the pandemic and the second observation made was the ongoing challenge regarding visible leadership. There had been further impact on this due to the pandemic however it was recognised that an action plan was in place and further work had been identified to make improvements . A visibility strategy had been compiled by the communications team which included a number of approaches that would be trialled to identify which approach worked best.

The Board noted the Investors in People annual review.

13 Strategic BAME Advisory Committee (SBAC) **Key Issues Report**

13.1 SID provided an update from the meeting of the held on 16th August 2021 and highlighted that the Trust continued to move ahead with this agenda. It was reported that the Informatics Team now had the capability to filter individual patient based metrics by ethnicity which would enable the Trust to evidence areas of variance in a number of indicators between ethnic groups.

13.2 A safeguarding case presentation had been provided by the Safeguarding Matron which highlighted how staff were able to identify red flags and family behaviours early on which had protected a patient at risk.

13.3 The Workforce Race Equality Standard (WRES) action plan and equality, diversity and inclusion (ED&I) communications strategy were presented and it was noted that a nurse recruited via the international recruitment programme would be invited to present their experience to a future meeting.

The Board noted the Strategic Black, Asian and Minority Ethnic Advisory Committee Key Issues Report.

14 Quality Committee Key Issues Report

14.1 AC provided an update from the meeting held on 18th November 2021 and reported that CN had held a number of drop-in sessions for staff to discuss the implications of the Care

Quality Commission (CQC) report for Liverpool University Hospitals NHS Foundation Trust (LUFT), the lessons learned and the effect on the Walton Centre and this would also be presented to Governors. Discussion regarding this would also be included in the Board Development session to be held in January 2022.

The Board noted the Quality Committee Key Issues Report.

15 Business Performance Committee (BPC) Key Issues Report

15.1 NED-DT provided an update from the meeting held on 23rd November 2021 and noted that there had been a focus on transformation and the quality improvement programme (QIP); it was recognised that QIP would be a challenge through H2. Work was underway to ensure funding from the digital aspirant programme was spent and it was highlighted that this had been impacted by the global shortage of semiconductors which had resulted in delays in obtaining equipment.

15.2 BPC had endorsed the menopause policy which formed part of the People Plan. The Trust was one of the first to produce a menopause policy which was a tool to increase understanding and training regarding his would be rolled out to line managers.

15.3 The Committee had also endorsed the business plan for procurement of a Neuro VR Simulator and recommended it for approval.

The Board noted the Business Performance Committee Key Issues Report.

16 Neuroscience Programme Board Key Issues Report

16.1 MD provided an update from the meeting held on 9th September 2021 and noted that this meeting was part of the formal Health and Care Partnership for Cheshire & Merseyside (HCP) process with internal and external representation in attendance including two GPs. The membership would be increased and revised going forward.

16.2 An update regarding the Everton Minds programme was presented and it was noted that the Deputy Director of Strategy and Head of Commercial Engagement and Marketing were working to link in with this programme.

The Board noted the Neuroscience Programme Board Key Issues Report.

17 Consent Agenda

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

17.2
- **Medicines Management Annual Report** – the report was considered and noted.

18 Any Other Business

18.1 There was no other business to be discussed.

18.2 The meeting was reviewed and it was felt that there had been the right level of discussion and scrutiny.

There being no further business the meeting closed at 12.05pm

Date and time of next meeting

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

TRUST BOARD
Matters arising Action Log
January 2022

	Complete & for removal
	In progress
	Overdue

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

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
		There were no outstanding actions to be completed.				

REPORT TO TRUST BOARD

Date 03/02/2022

Title	Integrated Performance Report
Sponsoring Director	Name: Lindsey Vlasman Title: Interim Chief Operating Officer
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Acting Deputy Chief Operating Officer
Previously considered by:	• Committee Quality Committee Business & Performance Committee

Executive Summary

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

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Activity Restoration
Referral to Treatment Stops

Opportunity for improvement
Theatres
Referral to Treatment Waits

Underperforming
N/A

Workforce Indicators

High Performing
N/A

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

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

Opportunity for improvement
N/A

Underperforming
Infection Control

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

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Board KPI Report
February 2022

Data for December 2021 unless indicated

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Explanation of SPC Charts and Assurance Icons

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

All SPC charts will follow the below Key unless indicated

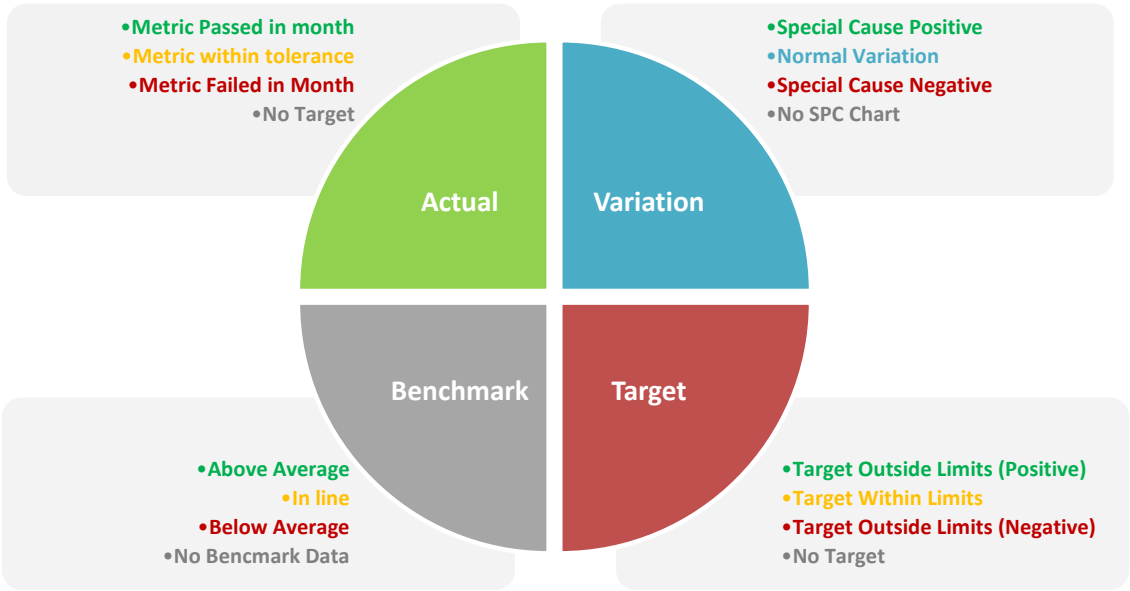
Actual | UCL | Average | LCL | National Average | Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

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



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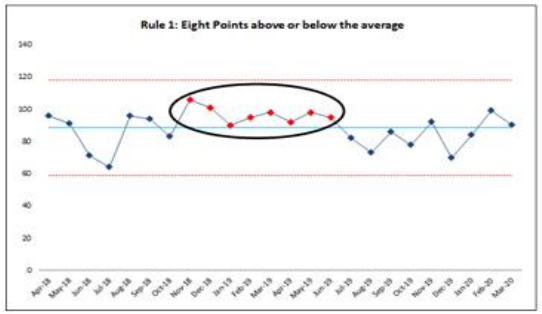
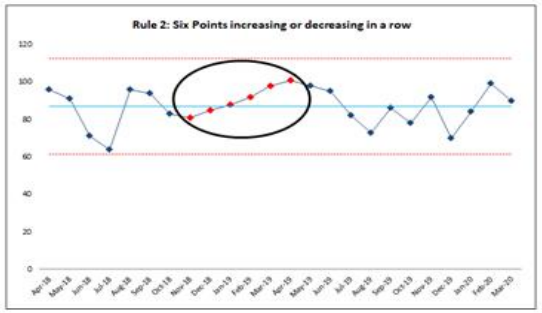
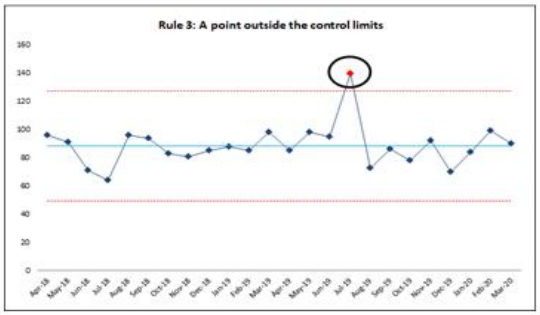
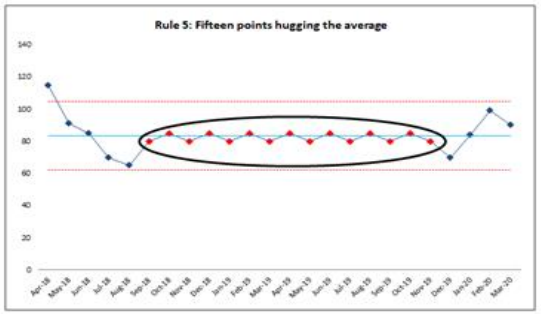
SPC Chart Rules

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









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Operations & Performance Indicators

Operational

Responsive - Cancer Standards

The Walton Centre NHS Foundation Trust

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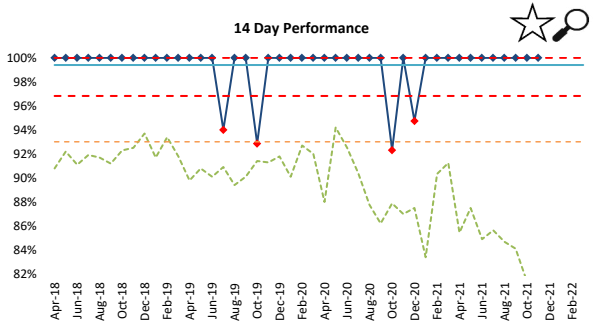
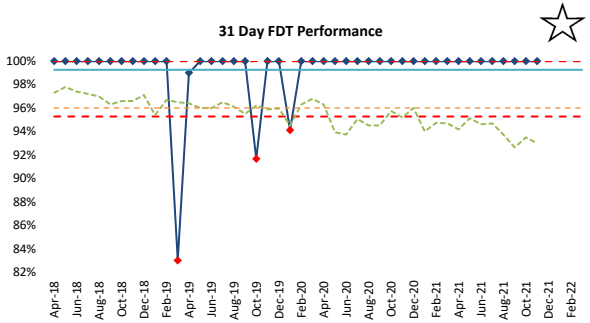
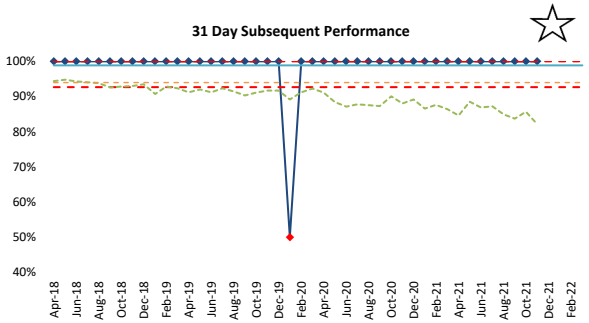
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

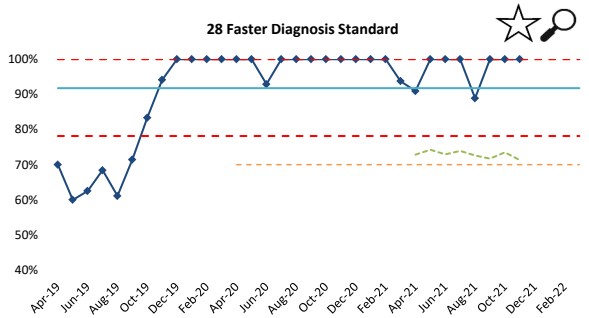
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

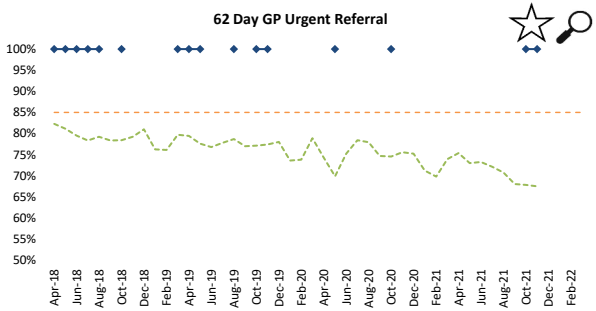
Associated Risks
001 - Covid-19
003 - Performance Standards

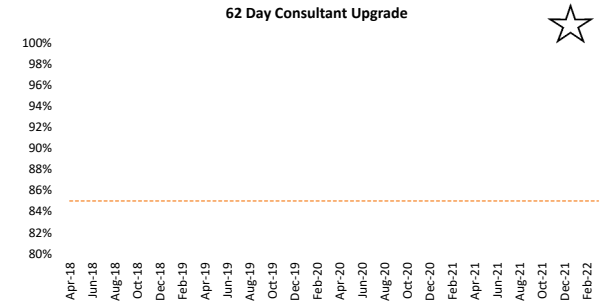












Operational

Responsive - Diagnostics

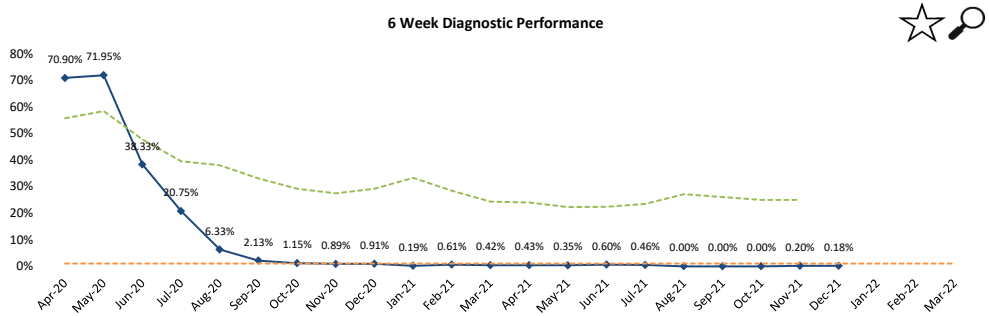
The Walton Centre NHS Foundation Trust

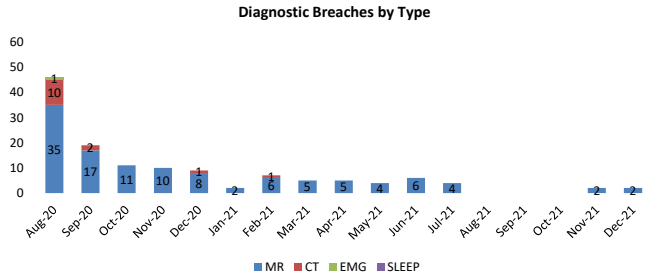
Excellence in Neuroscience

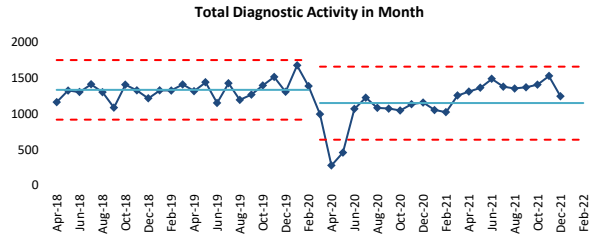
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.18%	

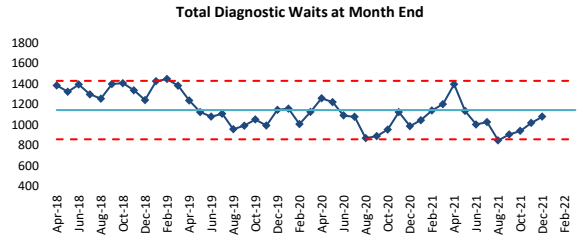
Associated Risks
001 - Covid-19
003 - Performance Standards

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









Operational

Effective - Theatres

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

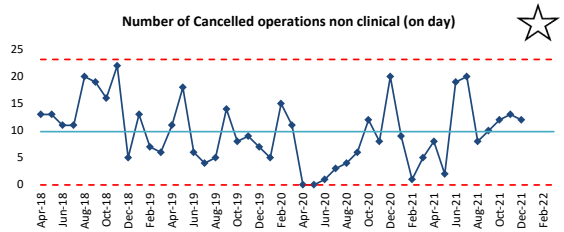
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	12	
% Cancelled operations non clinical on day	0.80%	1.11%	
28 Day Breaches in month	0	3	
Theatre utilisation of Elective Sessions	90%	90.16%	
Theatre utilisation of in Session Time	90%	73.16%	

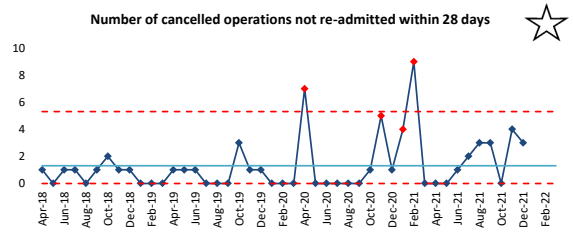
Non Clinical Cancellations

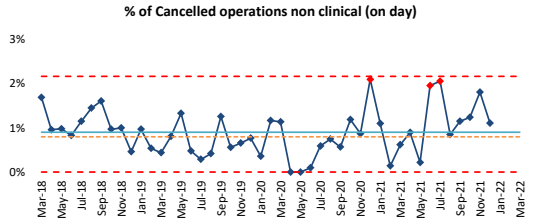
There were 12 patients cancelled at last minute for non-clinical reasons in December 2021, the predominant reason for the cancellations were list overrun (5), replaced by more urgent case(3), staff unavailable (2) and ITU bed unavailable (2).

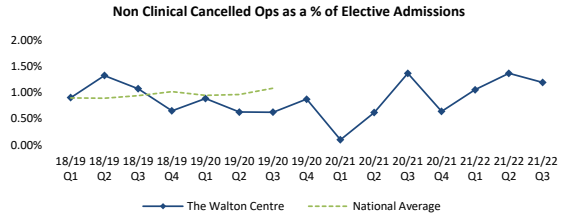
Theatres – Theatre Utilisation

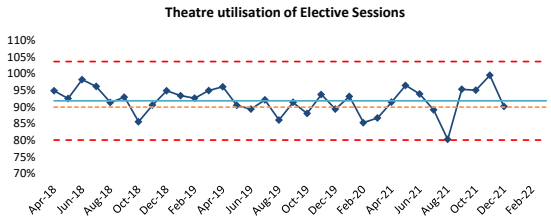
Elective session utilisation was 90.16% during December 2021. The Elective in session utilisation is 73.16%, the Trust, particularly during the Christmas period, is continuing to focus on urgent cases in addition to reducing the number of 52 week waiters, therefore it is more difficult than normal to effectively utilise in session theat re time.

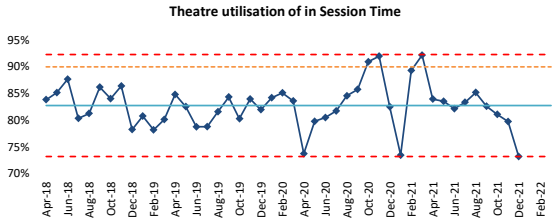












Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

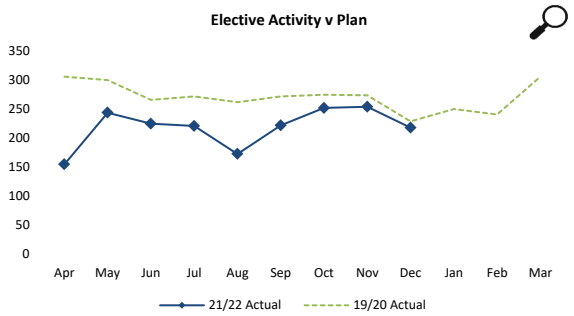
December 21 Activity Performance

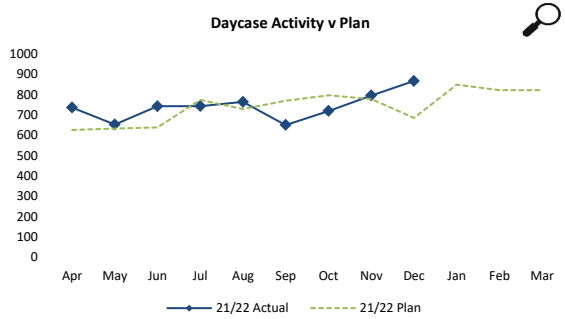
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	126.57%	89%
Elective	95.20%	89%
Elective & Daycase Total	**118.71%**	**89%**
Non Elective	103.09%	-
New Outpatients	82.00%	100%
Follow Up Outpatients	113.21%	100%
Outpatient Total	**101.15%**	**100%**

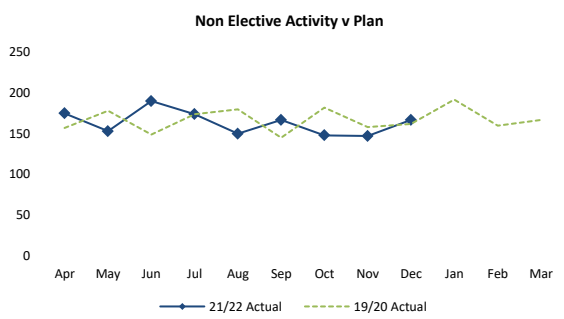
Continuing on from H1, each Trust was required to submit activity trajectories for the remainder of 2021/22 (referred to as H2) by month against the pre-COVID activity levels (comparing with the baseline of actual 19/20 SUS activity levels). The Trust has refreshed the activity plans and is forecasting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

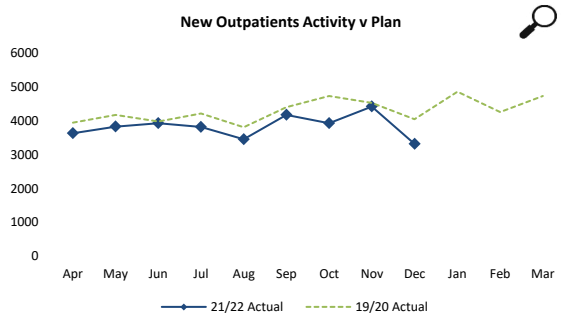
Daily operational huddles continue to review the activity performance against plan, taking into account the new methodology for Elective Recovery Fund (ERF).

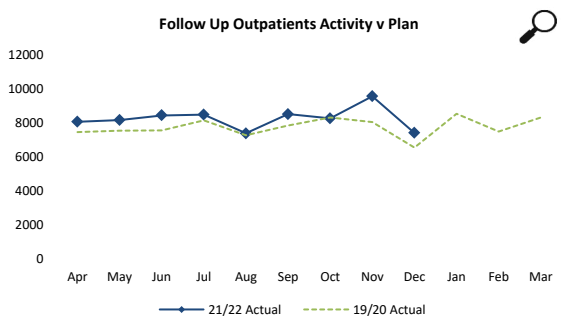
During December 2021 the Trust achieved the elective and daycase target of 89% at 118.71%. Total Outpatient activity was 101.15% against a target of 100%.











Operational

Effective - Elective Recovery Fund

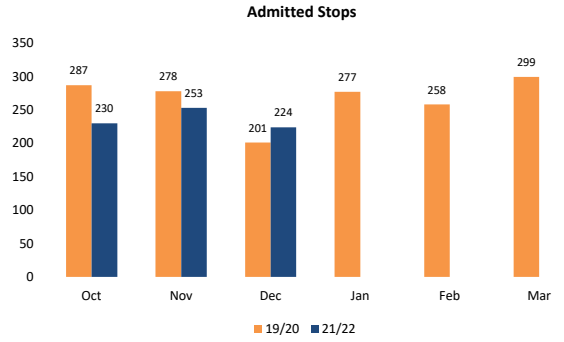
The Walton Centre NHS Foundation Trust

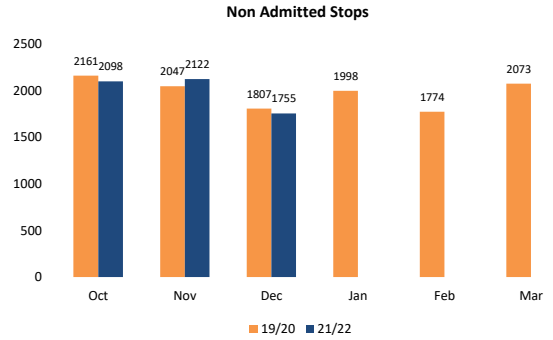
Excellence in Neuroscience

Month	Admitted			Non Admitted		
	19/20	21/22	%	19/20	21/22	%
Oct	287	230	80.14%	2161	2098	97.08%
Nov	278	253	91.01%	2047	2122	103.66%
Dec	201	224	111.44%	1807	1755	97.12%
Jan	277			1998		
Feb	258			1774		
Mar	299			2073		

During H2 Trusts are required to deliver 89% of RTT stops compared to 19/20. ERF funding is based on a working days adjusted tariff model. The following information is raw activity for the Trust.

In December the Trust stopped 111.44% of admitted pathways and 97.112% of Non Admitted pathways compared to 19/20.





The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Workforce Indicators

Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Staff FFT - Recommend Care (Q4 20/21)	-	95.00%	
Staff FFT - Recommend Work (Q4 20/21)	-	79.44%	
Appraisal Compliance	85%	73.76%	
Mandatory Training Compliance	85%	84.58%	

Mandatory Training Compliance

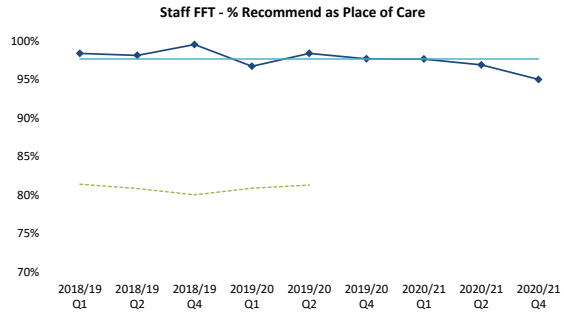
Overall mandatory training compliance in December 2021 dropped below the target of 85%.

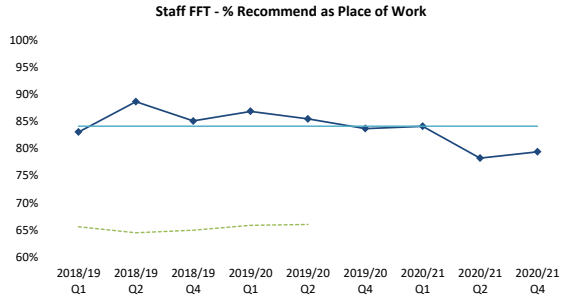
Appraisal Compliance

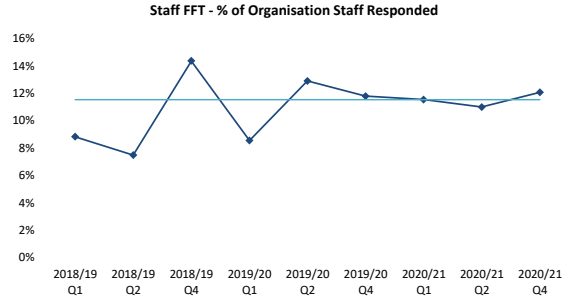
Appraisal compliance in December 2021 is 73.76% . The training team are continuing to work with individual departments to improve compliance.

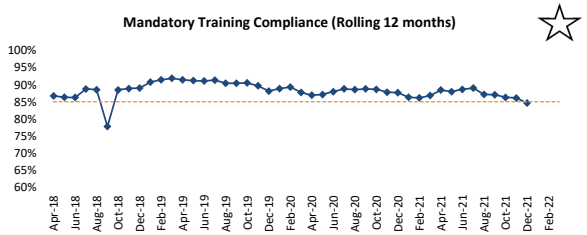
Staff Feedback

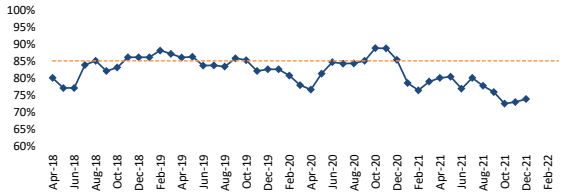
The Staff FFT survey has been retired and has been replaced by the Pulse survey which is currently out of responses in Q4 2021/22.











Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

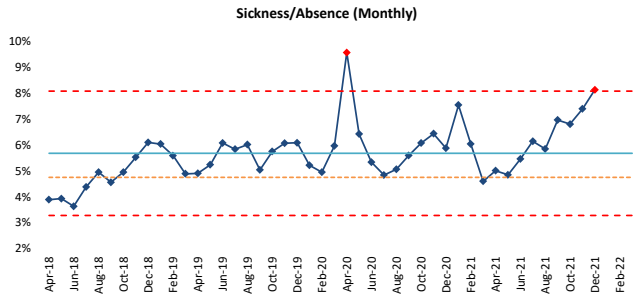
Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	8.14%	
Vacancy Levels	-	4.05%	
Nursing Turnover	10%	14.23%	
Other Staff Turnover	-	14.92%	

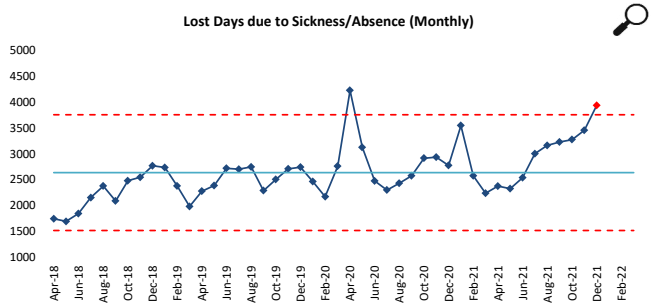
Sickness/Absence

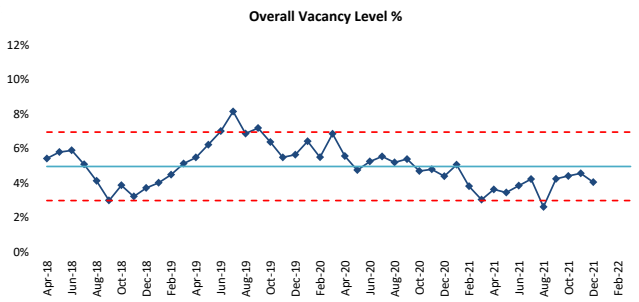
Sickness/Absence levels in December 2021 were above the target of 4.75% at 8.14% and have been increasing over recent months.

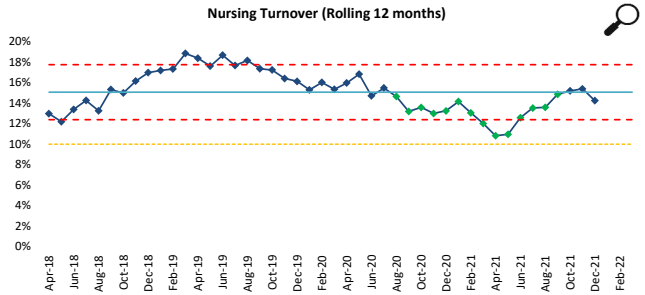
Nursing Turnover

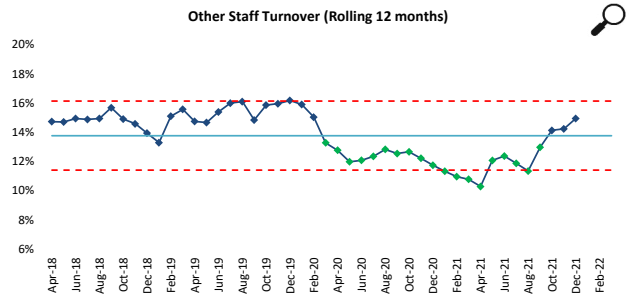
Nursing turnover now stands at 14.23% for December 2021. The position has detoriated after a period of sustained improvement.

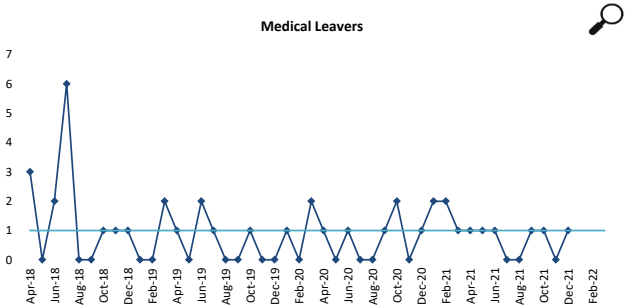












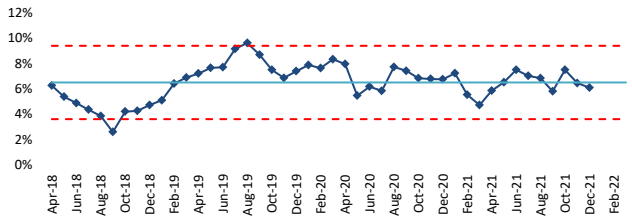
Quality of Care

Well Led - Workforce KPIs

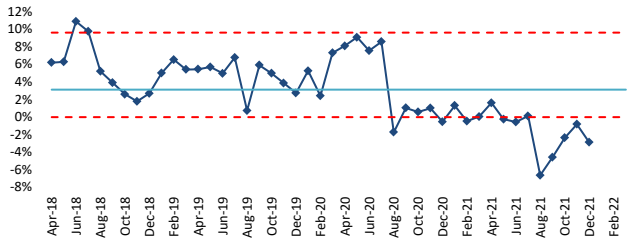
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

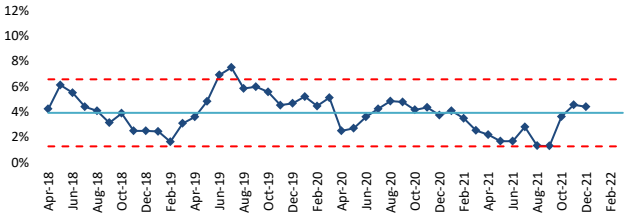
Nursing Vacancy Level %



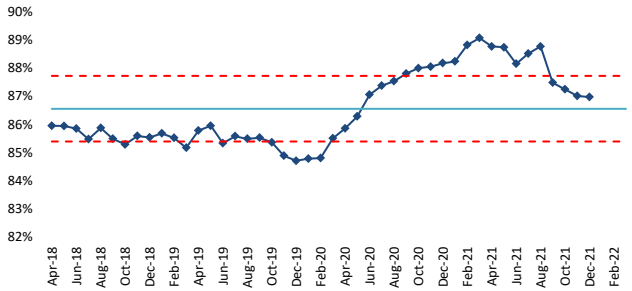
Medical Vacancy Level %



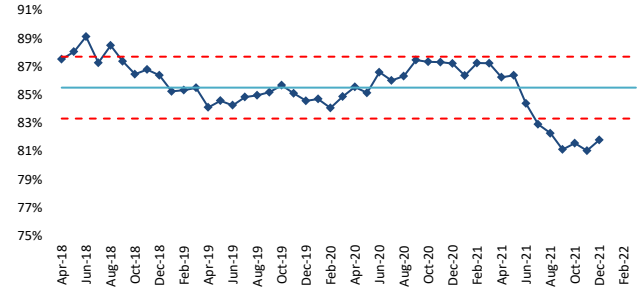
Other Staff Vacancy Level %



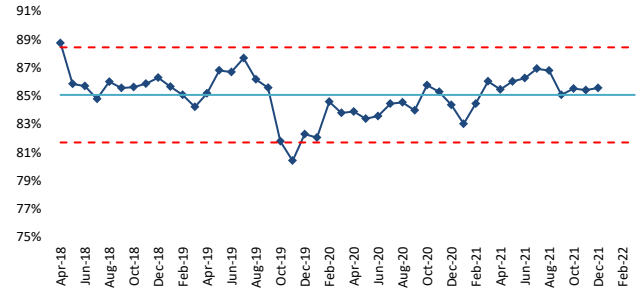
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

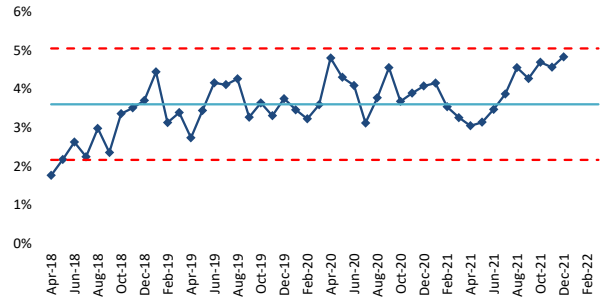


Quality of Care

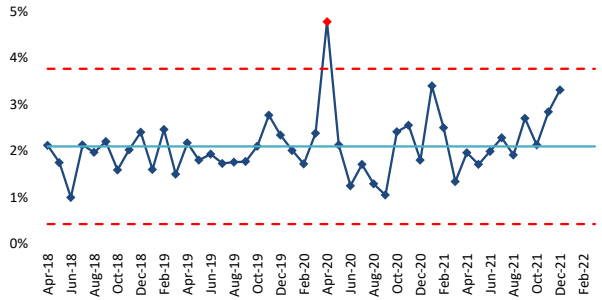
Well Led - Workforce KPIs

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

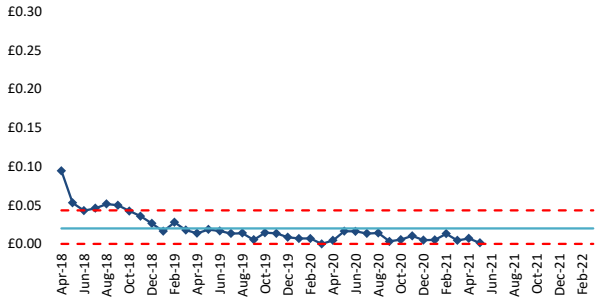
Long Term Sickness/Absence (Monthly)



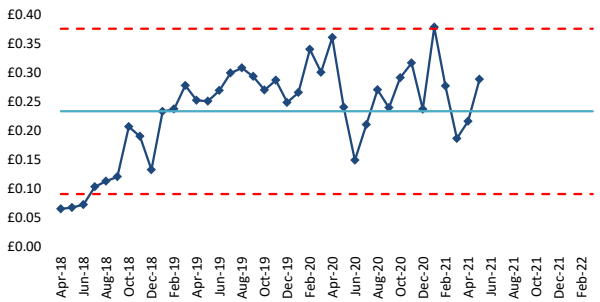
Short Term Sickness/Absence (Monthly)



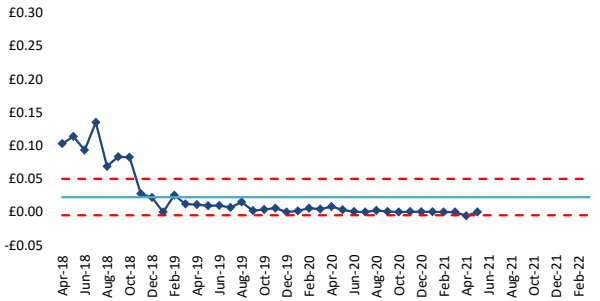
Nursing & HCA Overtime Spend (£m)



Nursing & HCA Bank Spend (£m)



Nursing & HCA Agency Spend (£m)



The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Quality Indicators

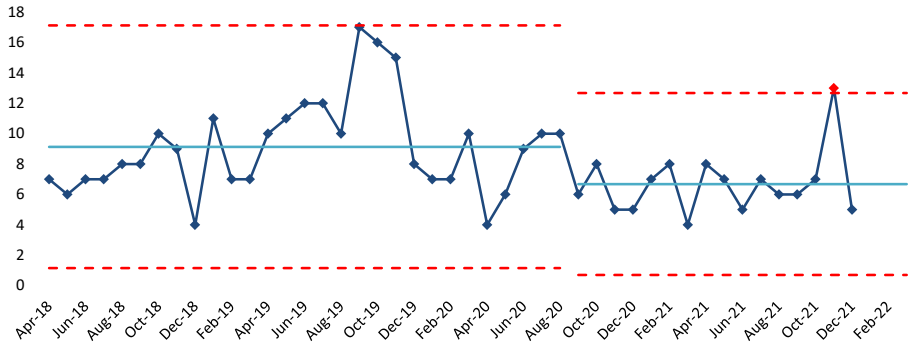
Quality of Care

Caring - Complaints

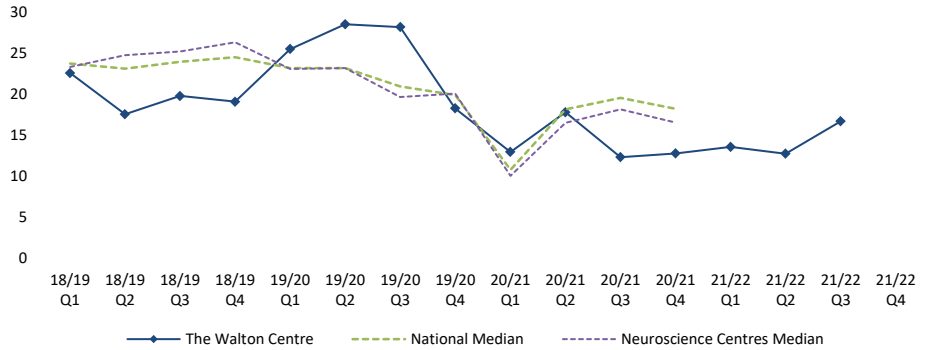
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

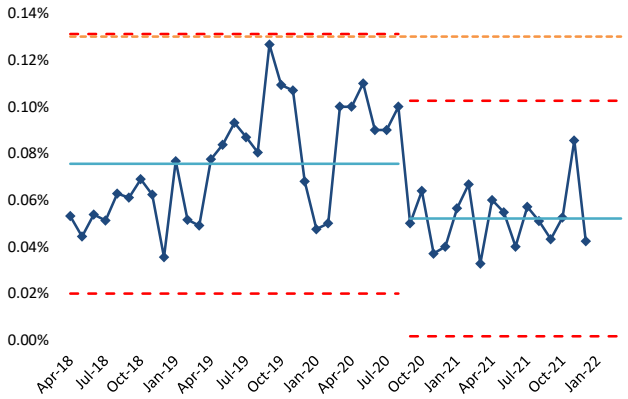
Total Complaints Received in month



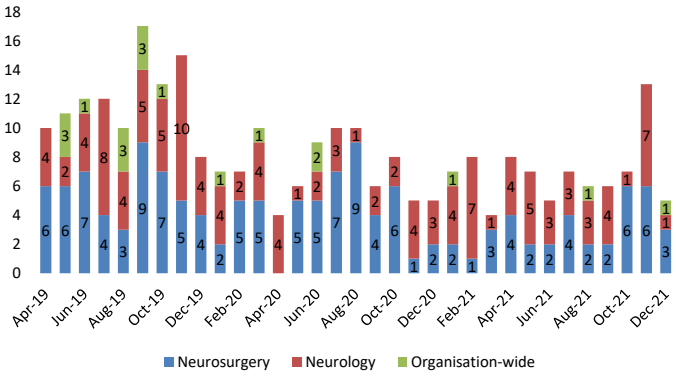
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



In December 2021 the Trust received 5 complaints; 1 Neurology, 1 Corporate and 3 Surgery.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 0 to 12 at an average of 6 per month. The number of complaints received has significantly dropped during recent months.

November 2021 saw an unexepcted increase in complaints, of the 13 received there were 6 related to Arrangement of Discharge/ Admission/Appointment; 5 related to Treatment, Care or Diagnosis, and 2 related to Communication or Approach/Manner

Due to the reduction seen the Trust is now below the national average and neuroscience centres average up the latest published period of Q4 2020/21.

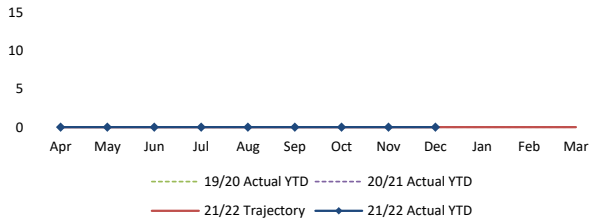
Quality of Care

Safe - Infection Control

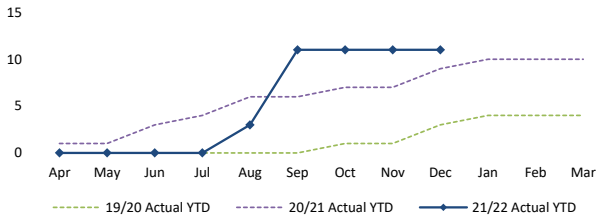
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

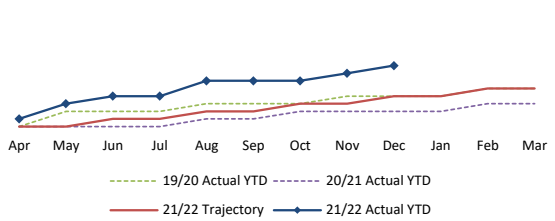
MRSA Bacteraemia



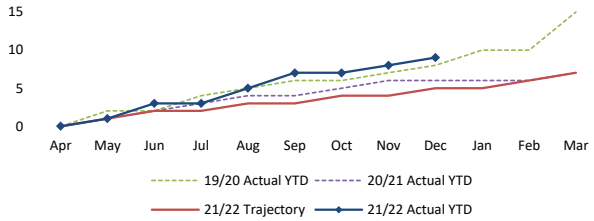
CPE



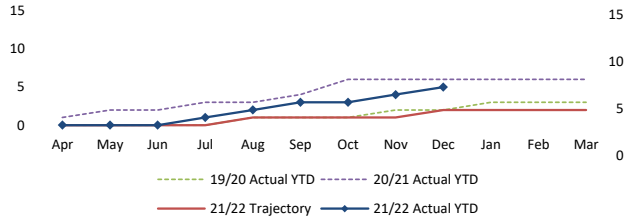
C.Diff



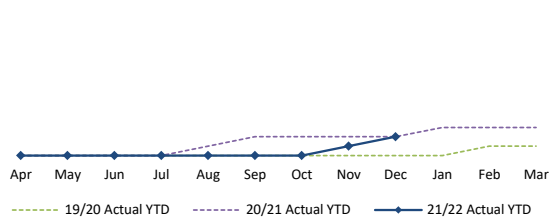
E.Coli



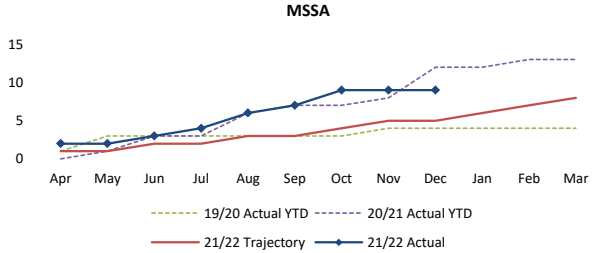
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2021/22

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		4	1	2				**7**
Caton				1				**1**
Chavasse				1	1	1	2	**5**
CRU			1					**1**
Dott				1			1	**2**
Horsley			5	3	4		6	**18**
Lipton								**0**
Sherrington		7	1	1		1		**10**
Total	**0**	**11**	**8**	**9**	**5**	**2**	**9**	**44**

December Breakdown by Ward

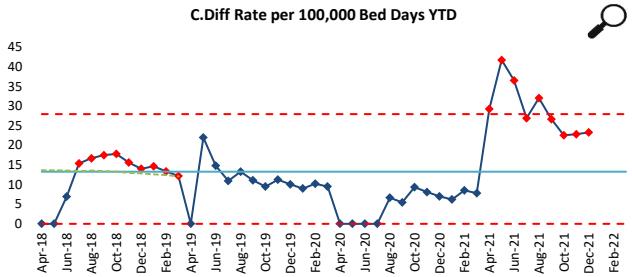
1x C.Diff - CRU
1x E.Coli - Caton
1x PB - Chavasse
1x KB - Horsley

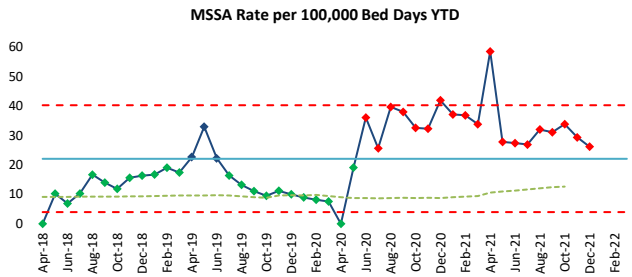
Quality of Care

Safe - Infection Control

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

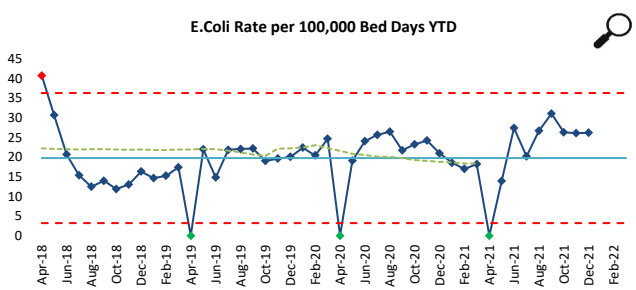


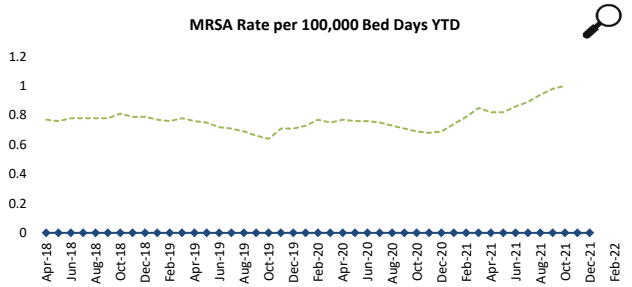


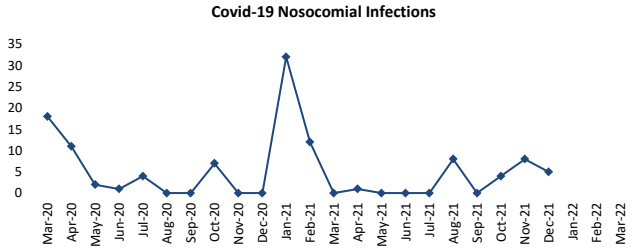
There are currently nine MSSA instances reported year to date against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 26.22 which is significantly above the latest national average (12.61).

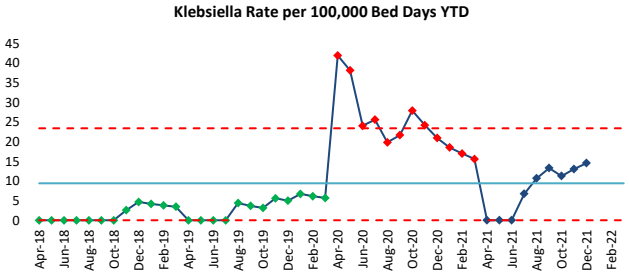
There have been eight C.Diff instances year to date against a year end trajectory of five. The rate per 100,000 bed days is currently at 23.31

Year to date there have been nine instances of E.Coli against a year end trajectory of seven. The current rate per 100,000 bed days is 26.22. Due to a counting and coding change nationally there is a delay in publishing the national E.Coli rate.









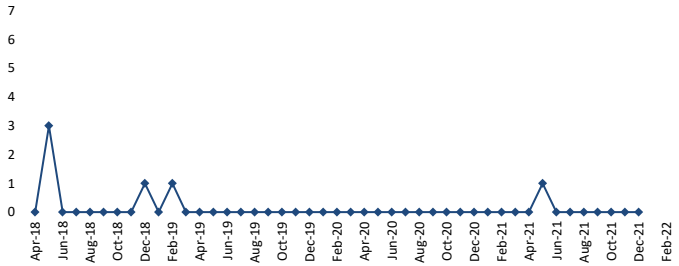
Quality of Care

Safe - Harm Free Care

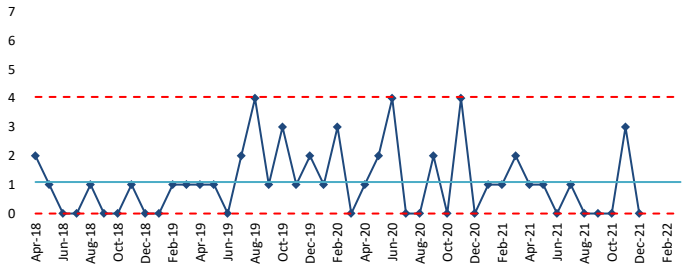
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

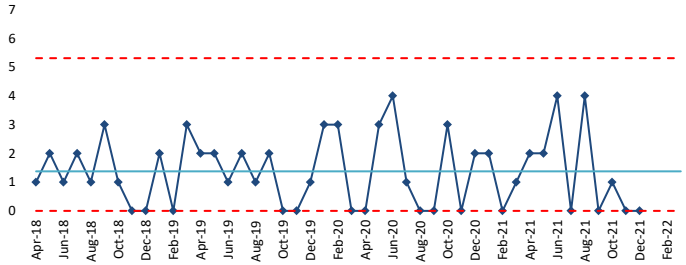
Total Moderate or Above Harm Inpatient Falls



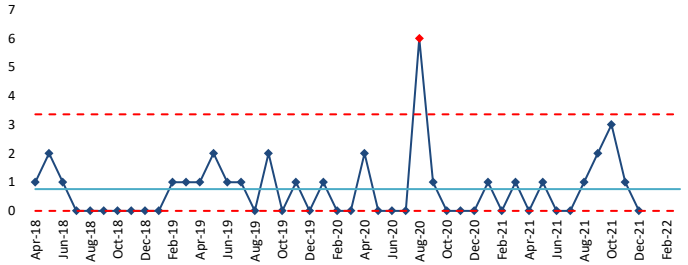
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

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

There was zero Hospital Acquired Pressure Ulcers in month

There was zero CAUTI incidence in month

There were no VTE incidences in month

All harm measures are within normal variation.

Ward Scorecard

December 2021

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

	Safe Staffing (November 21)				Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	88.8%	91.1%	160.0%	166.7%	0	0	0	0	0	0	0	0
Caton	100.0%	100.0%	95.0%	103.2%	0	0	0	0	0	0	1	0
Chavasse	92.7%	100.0%	152.7%	188.3%	0	0	0	0	0	0	0	0
CRU	121.7%	102.2%	149.4%	208.3%	0	0	0	0	0	0	0	1
Dott	97.3%	100.0%	112.4%	116.7%	0	0	0	0	0	0	0	0
Horsley ITU	100.0%	100.0%	102.2%	100.0%	0	0	0	0	0	0	0	0
Lipton	108.8%	100.0%	180.6%	176.7%	0	0	0	0	0	0	0	0
Sherrington	98.6%	100.0%	129.6%	163.3%	0	0	0	0	0	0	0	0

WELL LED

Finance

Trust I&E	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Patient Care Income	10,015	9,793	(222)	85,340	86,565	1,225	115,386	117,473	2,087
Exclusions	2,124	2,103	(21)	18,750	20,339	1,589	25,122	27,036	1,914
Private Patients	2	1	(1)	58	23	(35)	63	31	(32)
Other Operating Income	693	627	(66)	4,898	5,219	321	6,942	7,053	111
Total Operating Income	**12,834**	**12,524**	**(310)**	**109,046**	**112,146**	**3,100**	**147,513**	**151,593**	**4,080**
Pay	(6,627)	(6,845)	(218)	(56,927)	(59,077)	(2,150)	(77,026)	(80,071)	(3,045)
Non-Pay	(3,125)	(2,409)	716	(25,812)	(25,071)	741	(35,638)	(34,641)	997
Exclusions	(2,199)	(2,554)	(355)	(18,976)	(21,435)	(2,459)	(25,573)	(28,580)	(3,007)
COVID	(77)	(98)	(21)	(1,197)	(757)	440	(1,428)	(973)	455
Total Operating Expenditure	**(12,028)**	**(11,906)**	**122**	**(102,912)**	**(106,340)**	**(3,428)**	**(139,665)**	**(144,265)**	**(4,600)**
EBITDA	**806**	**618**	**(188)**	**6,134**	**5,806**	**(328)**	**7,848**	**7,328**	**(520)**
Depreciation	(505)	(508)	(3)	(4,437)	(4,440)	(3)	(5,952)	(5,964)	(12)
Profit / Loss On Disp Of Asset	0	1	1	0	(49)	(49)	0	(49)	(49)
Interest Receivable	0	0	0	0	0	0	0	0	0
Financing Costs	(49)	(52)	(3)	(465)	(439)	26	(612)	(586)	26
Dividends on PDC	(127)	(22)	105	(1,143)	(1,038)	105	(1,524)	(1,384)	140
I & E Surplus / (Deficit)	**125**	**37**	**(88)**	**89**	**(160)**	**(249)**	**(240)**	**(655)**	**(415)**
I&E impact capital donations and profit/(loss) on asset disposals	**20**	**20**	**0**	**180**	**210**	**30**	**240**	**281**	**41**
I & E Surplus / (Deficit)	**145**	**57**	**(88)**	**269**	**50**	**(219)**	**0**	**(374)**	**(374)**

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

The current plan includes:

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

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

In month 9, the Trust reported a £57k surplus position. This is a £88k adverse variance against the planned in month position of £145k surplus. The deterioration in month is in the main due to an under-performance in elective recovery funding against national trajectories (and against planned levels of elective recovery income).

The year to date position includes £2,086k elective recovery funding (all achieved in H1) against a planned position of £2,715k, £629k below plan. The Trust has not assumed any ERF income for Q3 given that the system did not deliver national activity trajectories in month 7 or 8.

The in-month position includes £98k spend incurred as a result of COVID-19.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	December-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	755	(114)
Tangible Assets	86,164	83,735	(2,429)
TOTAL NON CURRENT ASSETS	**87,033**	**84,490**	**(2,543)**
Inventories	1,157	1,731	574
Receivables	7,523	7,012	(511)
Cash at bank and in hand	35,689	36,045	356
TOTAL CURRENT ASSETS	**44,369**	**44,788**	**419**
Payables	(25,914)	(25,502)	412
Provisions	(245)	(245)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,425)	144
TOTAL CURRENT LIABILITIES	**(27,780)**	**(27,224)**	**556**
NET CURRENT ASSETS/(LIABILITIES)	**16,589**	**17,564**	**975**
Provisions	(701)	(679)	22
Finance Lease	(63)	(73)	(10)
Loans	(23,635)	(22,239)	1,396
TOTAL ASSETS EMPLOYED	**79,223**	**79,063**	**(160)**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,603	(160)
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,063**	**(160)**

STATEMENT OF CASH FLOW - 2021/22	November-21 Actual	December-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(197)**	**(160)**	**37**
Non-Cash Flows In Operating Surplus/(Deficit)	5,473	6,054	581
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**5,276**	**5,894**	**618**
Increase/(Decrease) In Working Capital	(466)	1,238	1,704
Increase/(Decrease) In Non-Current Provisions	(22)	(22)	0
Net Cash Inflow/(Outflow) From Investing Activities	(3,548)	(3,986)	(438)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**1,240**	**3,124**	**1,884**
Net Cash Inflow/(Outflow) From Financing Activities	(1,934)	(2,768)	(834)
NET INCREASE/(DECREASE) IN CASH	**(694)**	**356**	**1,050**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**34,995**	**36,045**	**1,050**

COVID-19 expenditure:

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

In month Actual: £97k.

Year to date Actual: £764k.

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

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Jun-21 Actual £'000	Jul-21 Actual £'000	Aug-21 Actual £'000	Sep-21 Actual £'000	Oct-21 Actual £'000	Nov-21 Actual £'000	Dec-21 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	54	47	36	25	61	472
Decontamination	0	7	3	0	0	0	2	0	1	13
Agile working	0	12	1	0	0	0	0	0	0	13
Infection Control	0	0	0	0	22	4	14	3	0	43
Other	20	1	43	19	21	37	27	20	35	223
TOTAL	**113**	**70**	**104**	**68**	**97**	**88**	**79**	**48**	**97**	**764**

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

Capital

In month variance - £1,194k below plan.

Year to date variance - £3,055k below plan.

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

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

The Trust has received an allocation of external funding in relation to Digital Aspirant and Cyber Security for IM&T innovation of £3.8m (to be spent in year) . The Trust also received £616K elective plus funding relating to the RANA project.

CAPITAL

	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	92	67	25	825	655	170	1,100	922	178
Estates	213	0	213	213	(4)	217	850	470	380
IM&T	81	29	52	727	342	385	969	986	(17)
Neurology	587	(2)	589	587	150	437	2,349	1,555	794
Neurosurgery	649	(15)	664	649	83	566	2,594	2,202	392
Corporate	123	0	123	123	0	123	491	68	423
Capital Slippage	(462)	0	(462)	(784)	0	(784)	(2,150)	0	(2,150)
TOTAL (excl. external funding)	**1,283**	**79**	**1,204**	**2,340**	**1,226**	**1,114**	**6,203**	**6,203**	**0**
Donated Assets	0	0	0	32	32	0	32	32	0
RANA	0	0	0	0	0	0	616	616	0
Digital Aspirant	302	312	(10)	2,717	776	1,941	3,623	3,746	(123)
Cyber Security	0	0	0	0	0	0	16	16	0
TOTAL (incl. external funding)	**302**	**312**	**(10)**	**2,749**	**808**	**1,941**	**4,287**	**4,410**	**(123)**
TOTAL	**1,585**	**391**	**1,194**	**5,089**	**2,034**	**3,055**	**10,490**	**10,613**	**(123)**

Capital spend in month is £391k.

- **Heating & Pipework**: £67k – Phase 4 works;
- **IM&T:** £29k - Staffing in relation to specific projects;
- **Digital Aspirant (PDC funded):** £312k – Software development, Case note scanning, Neurophys development and laptops and monitors refresh.

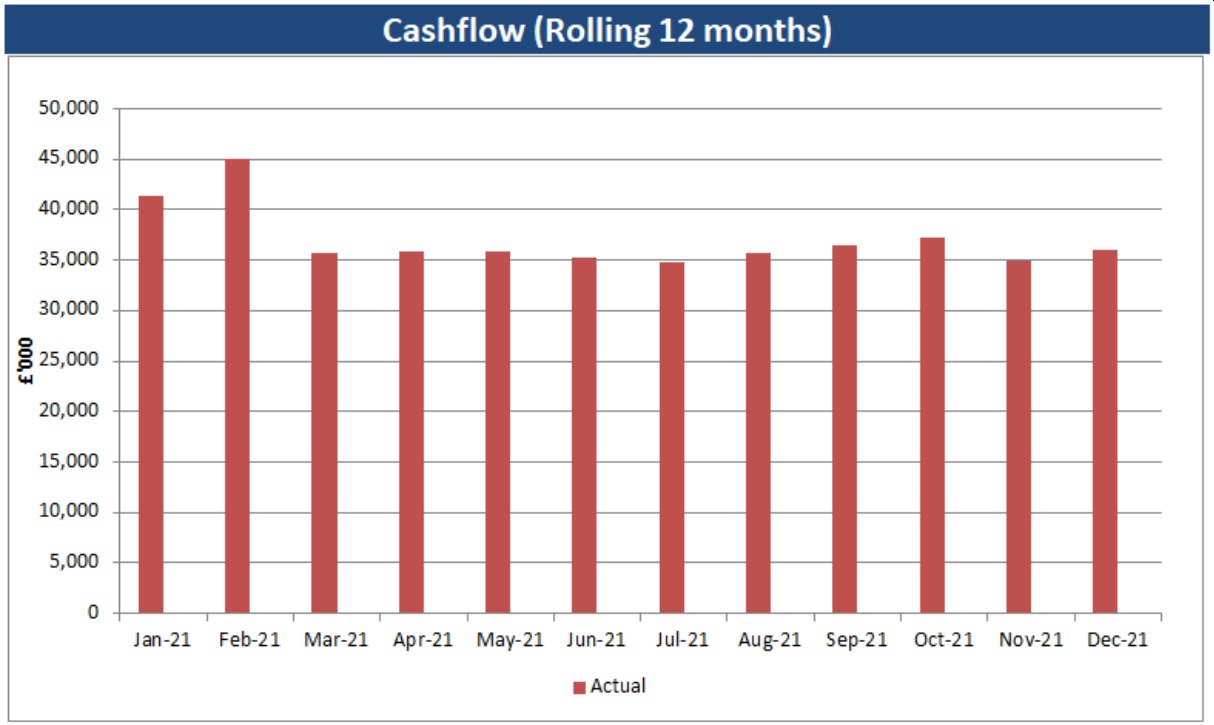
The year-end capital forecast is £10.6m (including external funding) which is in-line with the agreed funding allocations. It should be noted that a large amount of spend is due at the end of the financial year due to the replacement CT scanner and transcranial MR guided ultrasound, both of which will be completed by the end of the financial year.

The year end capital forecast is constantly being monitored to ensure that it meets the agreed capital funding

As of the end of November:

Actual Cash Balance: £36.0m.

Number of days operating expenses = 92 days.



The Trust cash balance at the end of December was £36.0m. This is an increase of £1.0m compared with the end of November due to

- A decrease in payables and NHS receivables; offset by
- An increase in non-cash flows within the operating position and cash outflows from loan and interest repayments.

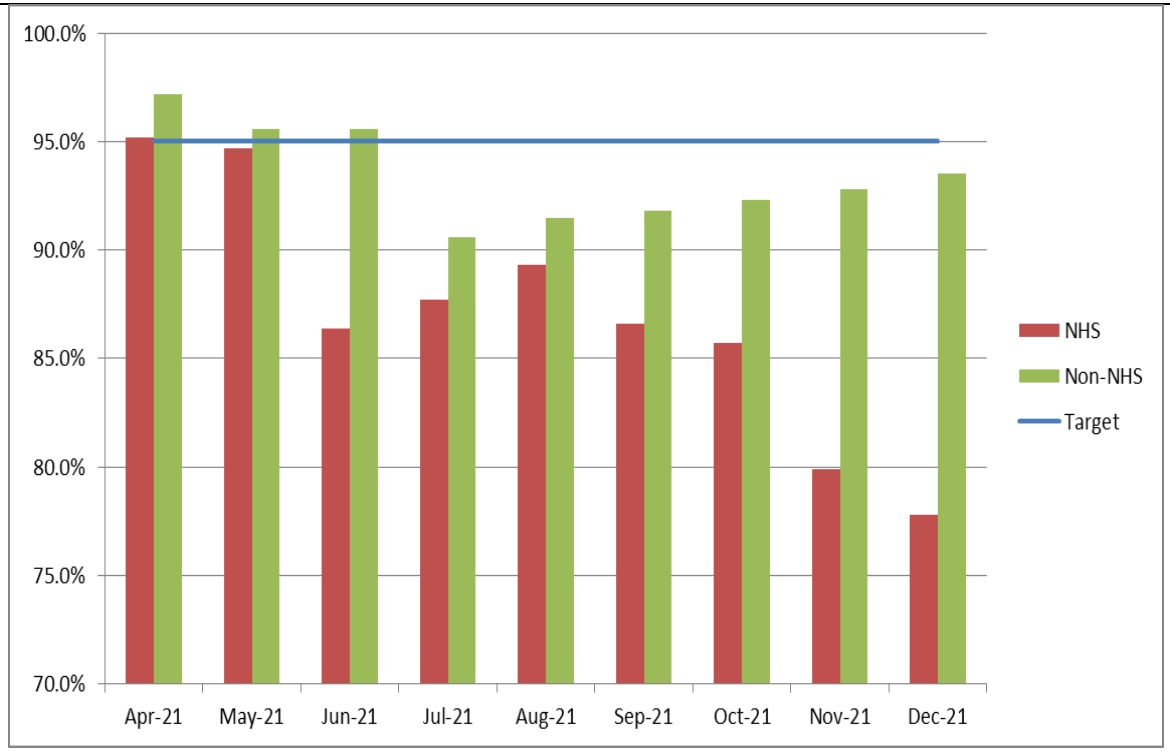
The reduction of cash in March 21 was due to the reversal of the advanced block payments that had been received from commissioners during 20/21 by the Trust each month for the financial arrangements to cover the COVID-19 pandemic.

Better Payments Practice Code (BPPC):

There is a renewed focus by NHSE/I on those Trusts that underperform against the better payments practice code standard of settling at least 95% of invoices within 30 days.

Letters will be sent to provider chief executives, directors of finance and audit committee chairs to seek action plans where there is significant under-performance.

In terms of contacting NHS organisations NHSE/I are looking specifically at non-NHS payments based on value.



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

- Non NHS 93.5%;
- NHS 77.8%;
- Total 87.7%.

This has seen an increase in non-NHS payments of 0.7% and decrease in NHS payments of 2.1% since the end of November. The decrease in % of NHS invoices paid is due to work being carried out to clear some of the aged LUHFT invoices.

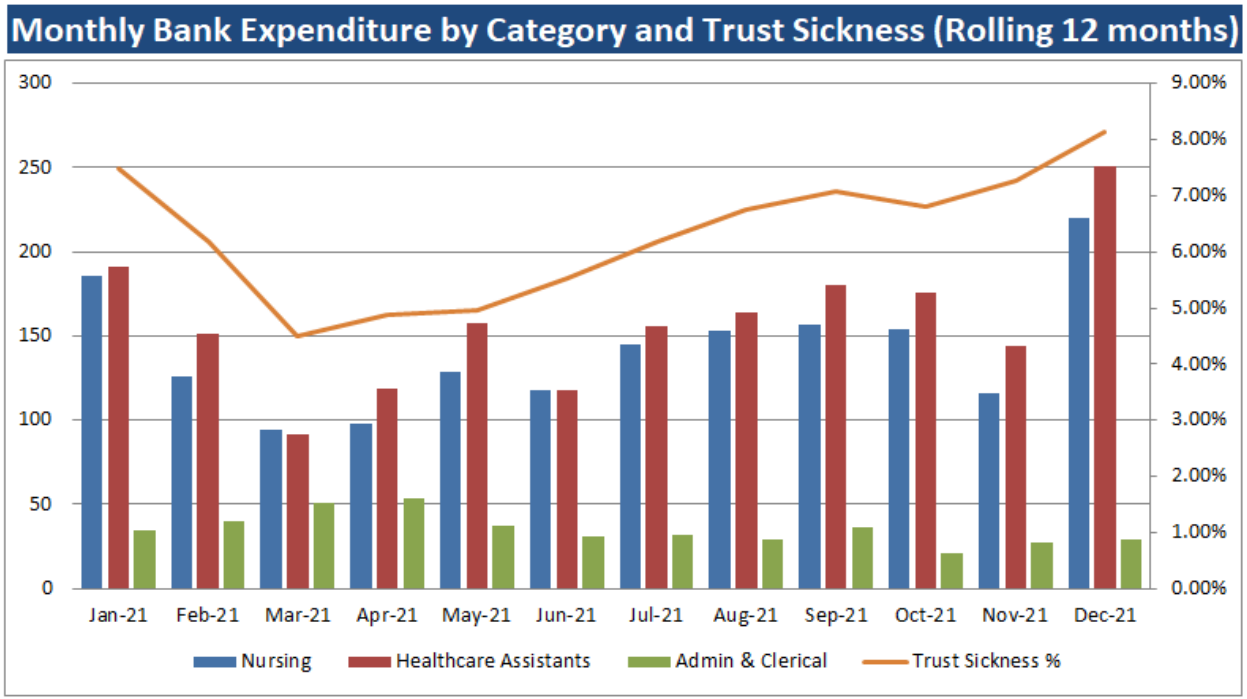
The Trust BPPC percentage (by number of invoices paid) at the end of December is 88%.

The finance team have put in place a weekly meeting and developed a monitoring system to review and implement payment processes to bring payment to within 30 days.

Bank Expenditure:

In month Actual: £503k.

Year to date Actual: £3,111k.



Bank expenditure incurred in November was £503k, an increase of £209k when compared to November. The in month increase was due to late receipt of a November invoice (not received until December). The number of shifts booked in December decreased following work undertaken by the Deputy Chief Nurse.

At the end of December, £387k bank expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

The trusts overall sickness rate increased from 7.27% to 8.14% in December.

Key Risks and Actions in 2021/22

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

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

- 2021/22 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this includes an allocation of additional PDC (Digital Aspirant Funding) allocated for IM&T innovation;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

Draft financial planning guidance for 2022/23 was issued late December with an update on key issues being provided to BPC in January 2022 but it should be noted that planning for 12 months will return (rather than 6 month financial planning which has been in place for the last 2 financial years).

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

RISK	COMMENT/ ACTIONS
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification was received that 2021/22 financial planning has been deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for all of 2021/22. Current national guidance states that providers will be required to achieve a breakeven position for H2. The financial framework has recently been published for 2022/23 and the Trust is now considering how the changes in regime will affects its future financial position (and what financial risks it may create), as well as what, if any, impact of the current variant of COVID will have on the future planning regime.
Efficiency requirements going forwards	The efficiency requirement of the Trust in H2 of this financial year has been set at 2.5% (in line with C&M Healthcare Partnership) and as such recurrent efficiencies will be required to be delivered in 2021/22 with work currently being undertaken to identify these. The Trust has delivered the majority of CIP non-recurrently up to M9. Work is on going between finance and Chief Operating Officer on future CIP regime and governance
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account the changes to IPC guidance. The Trust will be carrying out risk assessments to determine the risk of reducing IPC requirements as it continues to review processes for the delivery of safe

	services. There is also a risk to delivery of activity as a result of staff sickness / burnout due to and following the COVID-19 pandemic and also the potential impact on services if the Trust is required to support other Trusts in the region during the anticipated winter pressures that the NHS will face in H2 e.g. critical care surge capacity.
The impact of excluded drugs and devices	The impact of excluded drugs and devices in previous financial years had a nil impact on the trusts surplus/(deficit) position as income and expenditure would be equally matched. For 21/22 high cost drugs and devices are funded through a combination of block and cost and volume basis meaning that increased costs will not always be matched by income therefore potentially creating an overall cost pressure to the Trust if usage increases. Guidance for 2022/23 is being reviewed to assess whether this financial risk is likely to continue moving forward
Access to Elective Recovery Fund	There is a risk that if the Trust is able to achieve the new ERF requirements of delivering 89% of admitted and non-admitted clock stops, whilst the wider C&M system fails to deliver, then there will be an increased cost of delivery without a corresponding increase in income, as has been seen in months 7, 8 and 9. Whilst it is recognised that the achievement of these targets is imperative to reducing waiting lists and ensuring patients are treated, it must be recognised that delivery at organisational level could result in increased costs to the organisation, without associated income due to overall system under performance. Discussions are currently underway with NHSE/I to understand the activity performance targets they are reporting for months 8 and 9 as they appear to differ from internal calculations.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date – 3rd February 2022

The Walton Centre NHS Foundation Trust

Title	Mortality Report (Combined) Quarter 2 & Quarter 3 - 2021/22
Sponsoring Director	Name: Dr A Nicolson Title: Medical Director
Author (s)	Name: Patricia Crofton Title: Governance Lead for Mortality
Previously considered by:	• Quality Committee

Executive Summary This report is a combined report from quarter 2 and quarter 3 2021/22. The quarter 2 report was deferred at the October 2021 Trust Board due to IT issues.

There were 21 deaths in Q2, 14 in Q3. The RAMI remains below expected compared to peers. There were no deaths which were considered to be avoidable following review. All deaths have had an initial review, with 5 more detailed reviews outstanding from Q3. There was one unexpected death in Q3. This has had a full investigation and reviewed in the serious incident group, and was considered unavoidable.

The Medical Examiner process is due to be introduced in February at the Trust by the team from LUFT.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do.
Risks associated with this paper	None
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	
Any associated legal implications / regulatory requirements?	Compliance with National guidance on Learning, candour and accountability (A review of the way NHS trusts review and investigate the deaths of patients in England).
Action required by the Trust Board	The Board is requested to: • Discuss and note the position.

Mortality Report Quarter 2 & Quarter 3 2021-2022

Executive Summary.

This report is a review of Mortality from Quarter 2 (July–September) and Quarter 3 (November–December) 2021 within The Walton Centre NHS Foundation Trust. The Q2 report was deferred at the September Quality Committee as the September Neurosurgical meeting was cancelled due to IT issues. Unless stated, figures relate to both Neurosurgery & Neurology.
Morbidity has been removed from the report as the data related to admissions and readmissions and surgical site infection is presented monthly as part of the Integrated Performance Report (IPR).
CHKS data has been included (also reported in the IPR).

A summary of deaths for Q2/Q3 is included in the report, this includes information related to number of deaths, subspecialty the patients were admitted under together with the number of initial mortality reviews completed and presented. Following the initial review the case may be investigated further to determine if the death was associated with problems in the care provided and the degree of avoidability (using the Royal College of Physicians guidance) determined.

All deaths require an initial mortality review. Within the neurosurgical division, there has been an issue during Q2/3 in relation to the ability to complete initial mortality reviews within the specified time periods. This has led to a backlog of presenting reviews at the relevant mortality meetings, which has now been eliminated following the January mortality meeting.
All deaths are reported through Datix and are scrutinised by clinical leads and the governance department who liaise directly with the Medical Director, Chief Nurse and Divisional Clinical Leads, any concerns are escalated to the serious incident group. Of those deaths that have been reviewed by the mortality review groups no patient deaths have been considered avoidable.
Please note, Neurosurgery mortality meetings are monthly and Neurology mortality meetings are Quarterly. Going forward the Mortality review leads are considering the possibility of a combined monthly meeting.

The report also provides an update on a number of actions being taking to improve our learning from deaths processes. These actions include strengthening and formalising the triangulation of our mortality reviews, incident and complaints processes and the implementation of the medical examiner services.

Inpatient deaths Quarter 2 (July - September 2021.

There were 21 deaths in Q2, 18 in Neurosurgery and 3 in Neurology. Although an increase from Q1 (12), this figure represents a reduction of inpatient deaths in relation to the previous year as the Trust follows its plans to increase activity.

There was an increase in deaths related to trauma during Q2 (14) which may reflect the ending of restrictions in place during the pandemic.
19 patients were emergency admissions and 12 of those patients died within critical care. 9 patients died in the acute ward areas, one of whom was an inpatient in the acute rehabilitation unit (Lipton).

All patients had DNACPR with support from the palliative care and specialist organ donation teams (SNOD).
Several patients who died in critical care were referred to the SNOD for organ donation, 2 patients fulfilled the criteria for donation, 1 patient's family requested post-mortem tissue donation, and again this was facilitated by the SNOD.

There were 0 deaths of patients with learning disabilities.
There were 0 deaths where patients who tested positive for COVID 19.

Total number of deaths Q2.

Subspecialty

Total	Trauma	Vascular	Oncology	Spinal	Hydrocephalus	Neurology
21	14	3	1	0	0	3

Of the trauma patients the age range varies from 23-89 years.

Mechanism of injury for trauma patients includes:-
Falls,
Falls, with patients on simultaneous anticoagulation
Assault
Road traffic injuries with polytrauma.

Location of patient care

ITU	Acute wards	Emergency	Elective	(DNACPR)	Palliative care
12	9	19	2	21	20

Initial Mortality reviews completed

Total	Number of initial Mortality reviews	Presented at Neurosurgery Mortality meeting	Presented at Neurology Mortality meeting	Outstanding reviews	Deaths reviewed not requiring further discussion
21	21	7	3	0	11 (Neurosurgery).

Inpatient deaths Quarter 3 (November – December 2021.

There were 14 deaths in Q3, 11 Neurosurgery, 3 in Neurology. There was a reduction in inpatient deaths from trauma (4).
All patients were emergency admissions and 9 of those patients died within critical care. 5 patients died in the acute ward areas.
There were 0 deaths of patients with learning disabilities.
There was 1 patient who tested positive for Nosocomial COVID 19, prior to death; however this was not thought to be a contributory factor to the patient's death.

There was 1 patient death in Q2 of 20/21, where there was a learning point to be communicated to the referring hospital.

Summary of deaths Q3

Total	Trauma	Vascular	Oncology	Spinal	Hydrocephalus	Neurology
14	4	3	2	1	0	3

ITU	Acute wards	Emergency	Elective	(DNACPR)	Palliative care
9	5	13	1	8	7

Initial Mortality reviews completed

Total	Number of initial Mortality reviews	Presented at Neurosurgery Mortality meeting	Presented at Neurology Mortality meeting	Outstanding reviews	Deaths reviewed not requiring further discussion
14	14	1	0	3 Neurology 2 Neurosurgery.	8

There were 0 deaths of patients with learning disabilities.
There was no significance identified in relation to day of the week of admission
There was no significance identified in relation to day of the week of the patient's death.
There was 1 death where a patient tested positive for Nosocomial COVID 19 prior to transfer to a hospice, however this was not thought to be a contributory factor in the patient's death. EOL care was provided at the WCFT with specialist palliative care support.

There was 1 unexpected death in Q3; a patient suffered a cardiac arrest on the planned day of discharge. This patient death has been referred to HM coroner in line with guidance. The incident has been reported externally via StEIS and the Trust's Specialist Commissioners and is also subject to an internal Serious Investigation review. Duty of Candour has been followed and the Governance team have been in contact with the patient's family to explain the investigation process and how they can be involved (if they wish).

Update on the implementation of the Medical Examiner service

The implementation of the medical examiner (ME) service at the Trust continues with support from the ME team at Liverpool University Foundation Trust (LUFT). The referral forms have been incorporated into EP2 and it is expected the system will be in place for a pilot by early February. The referral process becomes statutory from 1/4/2022 and we will work to ensure that this mandated development is used to its greatest potential when it comes to scrutinising and learning from deaths that occur in our hospital.

A Governance lead for Mortality role has been established within the clinical governance team and together with the lead for patient experience, and we are considering how to improve how we engage and proactively support families through the mortality process. Bereavement literature is being re-designed to include details of the ME process with the aim of ensuring us that all families are informed of the changes in process and how they can be involved in feedback.

3) Coroner inquest update.

There were 8 Coroners inquests in Q3 where clinical staff from WCFT were required to give evidence regarding treatment or advice given by medical teams at the WCFT (4 Neurology, 4 Neurosurgery). None of the patients were inpatients at WCFT at the time of their death.
One inquest has been adjourned with a view to reschedule; to date we have not received a further date for the inquest. There were no concerns raised regarding care or advice in regards to the remaining cases. Staff were supported by the Claims and Legal Enquiries Manager.

CHKS Data

Quality of Care

Safe - Mortality

NHS
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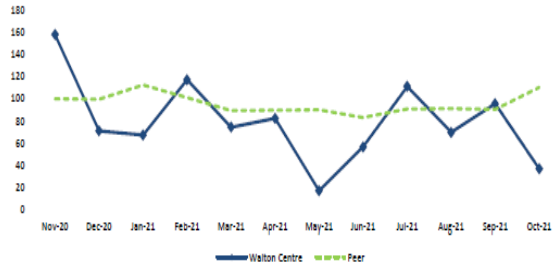
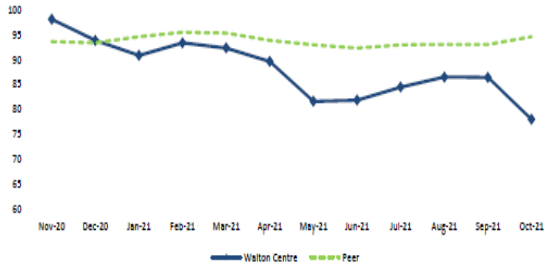
NHS Foundation Trust
Excellence in Neuroscience

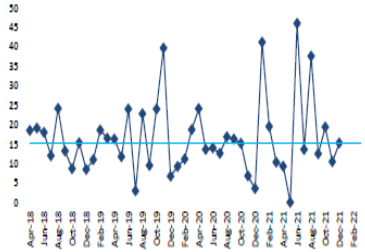
RAMI 2019 by Month



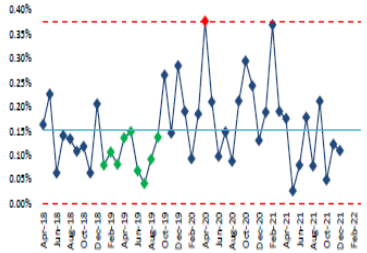
RAMI 2019 Rolling 12 Month



Mortality Average Length of Stay (Days)



Mortality per Bed Days Rate



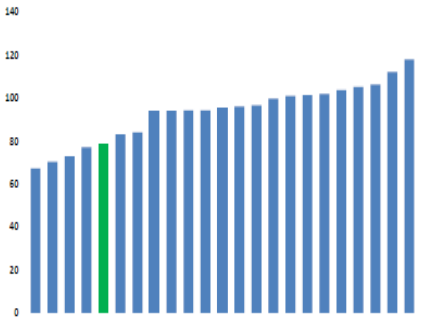
RAMI 2019 for all condition groups November 2020 to October 2021

CCS Group (Top 5)	Observed	Expected	Risk	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2019	64	82	78.03	82.97	94.54	101.68
109 - Acute cerebrovascular disease	29	36.00	79.83	85.33	94.75	108.76
233 - Intracranial injury	20	19.60	101.95	101.95	112.82	133.72
81 - Other hereditary and degenerative nervous system conditions	3	2.59	116.01	54.05	68.78	93.76
35 - Cancer of brain and nervous system	2	3.70	53.51	40.40	57.93	78.98
42 - Secondary malignancies	1	4.50	22.02	57.09	80.02	95.88

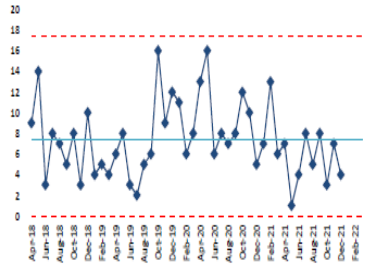
RAMI 2019 for HSMR condition groups November 2020 to October 2021

CCS Group	Observed	Expected	Risk	25th Percentile	Peer Value	75th Percentile
RAMI (Risk adjusted mortality index) 2019	52	64	81.24	81.57	93.83	101.80
109 - Acute cerebrovascular disease	29	36.00	79.83	85.33	94.75	108.76
233 - Intracranial injury	20	19.60	101.95	101.95	112.82	133.72
42 - Secondary malignancies	1	4.50	22.02	57.09	80.02	95.88
127 - Chronic obstructive pulmonary disease and bronchiectasis	1	0.05	2107.40	64.53	88.97	117.58
237 - Complication of device; implant or graft	1	0.51	197.24	66.21	96.70	139.69

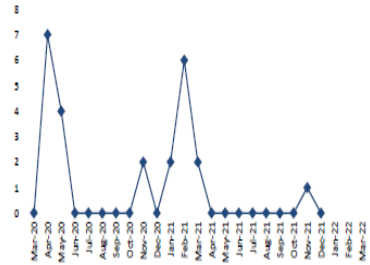
RAMI 2019 Rolling 12 Month Peer Distribution



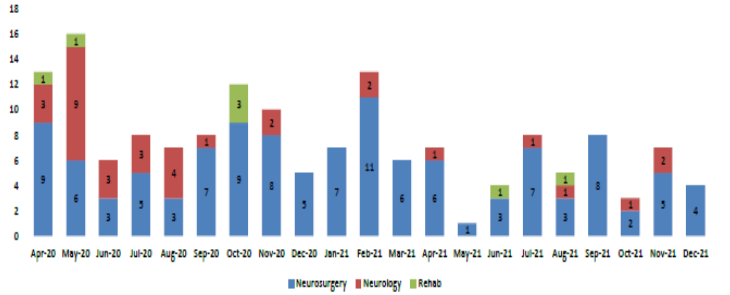
Crude Mortality



Deaths following a Positive Covid-19 Result



Crude Mortality by Specialty



As at October 2021 the rolling 12 month RAMI19 figure is 78.03. During the period there were a total of 64 observed deaths against 82 expected deaths. Compared to peers The Walton Centre has performed significantly better during the period.

When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 81.29.

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

Analysis of the supporting measures (to the right of the page) show that all indicators are within normal variationso they should not negatively impact the RAMI19 Risk greatly over the coming months.

The Walton Centre
NHS Foundation Trust

Report to the Board of Directors
Date: 3 February 2022

Title	**Board Assurance Framework Q3 2021-22**
Sponsoring Director	Lisa Salter Chief Nurse
Author (s)	Katharine Dowson Corporate Secretary
Previously considered by:	Executive Team – 12 January 2022 Quality Committee – 22 January 2022 Business and Performance Committee – 25 January 2022

Executive Summary

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review. The BAF was last reviewed by the Board of Directors on 7 October 2021 and BAF entries have been reviewed by Lead Executives, the Executive Team and relevant Committees during January 2022.

There are currently a total of 16 principal risks identified in the BAF and the current BAF entries are included for reference at Appendix 1 to this report. This includes a new risk BAF016 Infection Prevention and Control as agreed by the Board in October at the last review. All risks have been reviewed by Executive leads and associated risks by Quality and Business Performance Committees and proposed changes can be identified by the use of red font and strikethrough.

It is recommended that five of the risk scores are amended this quarter which are detailed in s.3. The Risk Appetite for all risks has been reviewed and it is recommended that BAF012 Capital and BAF011 are changed from Cautious to Moderate. There are also changes to the risk scoring where the current risk would otherwise by lower than the risk target. No new risks were identified by the Executive Team.

A glossary of acronyms used is included at the end of this paper.

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

1.0 Introduction

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

2.0 Background

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

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

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

An effective BAF:

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

Relevant BAF entries were last reviewed by the Board of Directors on 7 October 2021. The BAF is next scheduled for review by the Board of Directors on 7 April 2022 when the 2021/22 BAF will be closed and the 2022/23 BAF agreed.

3.0 Updated Position

There are currently a total of sixteen principal risks identified in the BAF, including the new risk, BAF016 Infection Prevention and Control. *If further HCAI trajectories are breached then there is a risk to patient safety and experience as the Trust has exceeded its health care associated infection trajectories for hospital acquired infections i.e. MSSA, C. difficile, Klebsiella, E.coli.*

Table 1 Proposed BAF016 Scoring

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

Each of the full BAF risks are included in this paper in Appendix 1 with proposed updates highlighted in red/strikethrough following review at the Executive Team, Quality Committee and Business Performance Committee (BPC) through January 2022. Due to meeting timings the Research, Innovation and Medical Education Committee (RIME) will review the risks, where it is identified as the assurance committee, in March 2022.

The Committees agreed with the proposals made by Executives with the exception of the reduction in scoring to the Cyber Security risk scoring. This had been recommended for reduction given the controls and external assurance in place. BPC proposed, following a further update from the Head of IM&T that the Cyber Security risk should in fact stay as it is due to an increase in threats during December which will take some time to mitigate against.

Two risks are aligned to the Board of Directors directly. These are BAF001 Covid-19 and BAF010 Partnerships. Changes have been proposed for each BAF risk to reflect activity that has taken place. No additional BAF entries were identified through this review process. Table 1 below details the movement in risk scores from Quarter 4 2020/21 to Quarter 3 2021/22 with changes highlighted in blue.

Table 1 Risk Scores and Risk Appetite

Risk ID	Risk Appetite	Title	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
001	**Cautious**	**Covid-19** Impact of COVID-9 on delivery of strategic objectives	**20**	**16**	**12**	**12**
002	**Cautious**	**Operational Performance** Inability to meet operational performance standards	**20**	**16**	**9**	**9**
003	**Cautious**	**Harm to Staff** Inability to prevention harm to staff	**12**	**12**	**12**	**9**
004	**Cautious**	**Quality** Inability to deliver the benefits within the Quality Strategy,	**16**	**12**	**12**	**12**
005	**Cautious**	**Our staff** Inability to attract, retain and develop sufficient numbers of qualified staff	**16**	**16**	**16**	**16**
006	**Cautious**	**Estates** Inability to maintain the estate to support patient needs	**12**	**12**	**12**	**9**
007	**Moderate**	**Digital** Inability to deliver the benefits of the Digital Strategy	**12**	**8**	**8**	**8**
008	**Cautious**	**Cyber Security** Inability to prevent Cyber Crime	**16**	**16**	**16**	**16**
009	**Cautious**	**Innovation** Inability to identify innovative methods of delivery	**12**	**12**	**12**	**12**
010	**Cautious**	**Partnerships** Inability to influence following establishment of the ICS may impact Trust negatively	**12**	**12**	**12**	**9**
011	**Moderate**	**Research and Development** Inability to maintain and grow the Trust's research and development agenda.	**12**	**12**	**12**	**12**
012	**Moderate**	**Capital** Allocation of capital set by the STP to the Trust will not support the full capital plan	**9**	**9**	**9**	**9**

013	**Cautious**	**Financial Plan** Inability to deliver the financial plan for 2021-22	**8**	**12**	**12**	**16**
014	**Cautious**	**Medical Education** Ensuring quality, capacity and capability of Medical Education	**15**	**9**	**9**	**6**
015	**Cautious**	**HCP Financial System** Trust income destabilised as result of transition to HCP financial system		**16**	**16**	**16**
016	**Cautious**	**Infection Prevention and Control** Risk to patients safety and experience if hospital acquired infections increase				**9**

3.1 Risk Scoring

There are a number of changes to risk scoring which are outlined in table 2 below.

Table 2 Changes to Risk Scoring

BAF Risk	Title	Current Score	Proposed Score	Change	Comments
003	**Harm to Staff**	**12**	**9**	↓	Likelihood remains the same but the consequence has been reduced to 3 (Moderate) from 4. This does not reduce the importance of this risk and the potential impact on staff, but brings it into line with the agreed risk descriptors* (Appendix 2)
006	**Estates**	**12**	**9**	↓	Levels of controls in place reduce the consequence e.g following fire protection remedial works the linked operation risk has reduced from a 16 to an 8
010	**Partnerships & ICS**	**12**	**9**	↓	Reduction of consequence as more is known about a potential negative impact from the establishment of the ICS. The risk target has also been reduced in anticipation of minimal negative impact in the long-term
013	**Financial Plan**	**12**	**16**	↑	As discussed at Board in October, likelihood of not meeting the end of year position has increased following agreed H2 plan, as ERF is dependent on system achievement of targets
014	**Medical Education**	**9**	**6**	↓	Work remains ongoing but the risk of deterioration in the quality of programme and related impact on reputation has been reduced in likelihood, given the controls in place and work underway.

3.2 Risk Targets

Changes are also proposed to the risk targets for two risks where current risks would otherwise be lower than the target.

Table 3 Changes to Risk Targets

BAF Risk	Title	Current Target	Proposed Target	Change	Comments
002	**Operational Performance**	**8**	**6**	↓	Consequence reduced from 4 (Major) to 3 (Moderate) to ensure target is aligned, as current scoring is 3 (Moderate)
006	**Estates**	**8**	**6**	↓	Target adjusted so the consequence would be the same as the updated current consequence scoring

012	**Capital Plan**	**9**	**6**	↓	Likelihood to move from 3 (Possible) to 2 (Unlikely) as capital budget likely to be underspent rather than overspent
015	**HCP Financial System**	**12**	**9**	↓	The consequences of the move to system-based financial monitoring are now perceived to have a lower potential negative impact on the Trust, together with the controls in place.

3.3 Risk Appetite

There are two proposed changes to risk appetite from 'Cautious' to 'Moderate' following review of the risk appetite descriptors (Appendix 2):

- BAF 011 Research and Development – this is an area that could be more open to more risk (moderate levels only) in order to achieve strategic ambitions
- BAF012 Capital – some risk may need to be taken to be ready for opportunities to access capital and to be flexible in the annual plan to ensure that funds are maximised

4.0 Next Steps

The 2021/22 BAF will be closed at the April Board of Directors meeting and a new set of risks agreed.

5.0 Recommendations

The Committee is recommended to:

a) review and approve the updated BAF for quarter 3 as detailed at Appendix 1
b) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board

Board Assurance Framework Glossary

ANTT	Aeseptic Non Touch Technique
BPC	Business and Performance Committee
C&M	Cheshire and Merseyside
CFO	Chief Finance Officer
COO	Chief Operations Officer
CQC	Care Quality Commission
DCN	Deputy Chief Nurse
DHSC	Department of Health and Social Care
EPR	Electronic Patient Record
ERIC	Estates Returns Information Collection
FoSH	Federation of Specialist Hospitals
FFT	Friends and Family Test
GMC	General Medical Council
HCP	Health & Care Partnership (Cheshire& Merseyside) in place to 30 June 2022
HEE(NW)	Health Education England (North West)
HFAI	Health Facility Acquired Infection
ICB	Integrated Care Board
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
ICO	Information Commissioners Office
ICS	Integrated Care System (Cheshire & Merseyside) in place from 1 July 2022*
IG	Information Governance
IOM	Isle of Man
ITU	Intensive Therapy Unit
KPI	Key Performance Indicator
LoA	Letter of Authority
LHP	Liverpool Health Procurement
MHRA	Medicines and Healthcare products Regulatory Agency
MIAA	Mersey Internal Audit Agency (Internal Auditors)
MoU	Memorandum of Understanding
MSSA	Methicillin-susceptible Staphylococcus Aureus
NHSD	NHS Digital (information, data, IT systems)
NHSE	NHS England
NHSEI	NHS England and NHS Improvement
NHSI	NHS Improvement
NHSP	NHS Providers
NHSX	NHS X (IT transformation)
NRC	Neuroscience Research Centre
RAG	Red-Amber-Green (scoring)
RCA	Root Cause Analysis (Investigatory Technique)
RN	Registered Nurse
PMO	Project Management Office
RIME	Research, Innovation and Medical Information (Committee)
SOP	Standard Operating Procedure
SORD	Scheme of Reservation and Delegation
SPA	Supporting Professional Activities
SPARK	Single Point of Access to Research and Knowledge
SRO	Senior Responsible Officer
UoL	University of Liverpool
WCFT	The Walton Centre NHS Foundation Trust

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

Risk ID: 001	Date risk identified: February 2020	Date of last review:	December 2021
Risk Title: **If the Covid-19 pandemic continues for an extended period then the Trust may be unable to deliver its strategic objectives leading to regulatory scrutiny and reputational damage.**		Date of next review:	February 2022
		CQC Regulation:	Regulation 16 Assessing and Monitoring service provision
		Ambition:	1. Deliver best practice in care and treatments
		Assurance Committee:	Board of Directors
		Lead Executive:	Acting Chief Operating Officer

Linked Operational Risks		
806	Reduced staffing	16
793	Poor patient experience and outcomes	16
807	Failure to adhere to social distancing measures	16
813	Mutual aid and training and development requirements	16
796	If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19	16
Further linked operational risks with ratings between 8-12 are ~~included on the Covid-19 Risk Register at Appendix 2~~ included on the Trust Risk Register		
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Catastrophic 5	Likely 4	20
	Moderate 3	Likely 4	12
Target	Major ~~4~~ ~~5~~	Unlikely 2	~~8~~ ~~10~~

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
~~1. Loss of life, Patients / Staff~~ 2. Disruption to business as usual 3. High levels of sickness absence leading to delays in treatment of patients due to decreased workforce 4. Infection Prevention and Control pathways will have to remain in place.	1, Continued uncertainty regarding new variants and lockdown relaxation 2. >90% of staff double vaccinated 3. Booster vaccination campaign ~~to commence September 2021~~ has now commenced and staff have been encouraged /supported to have their vaccinations 4. Staff testing encouraged as twice weekly 5. Visiting remains restricted

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Major Incident Plan – Jan 2018 2. Business Continuity Policy Oct 2019 - Command and control 3. Business Continuity Plans and escalation plans for all departments 2018 4. Infection Prevention and Control Policy and Programme 2020 5. Visitor Policy – March 2020 6. Flu Policy – April 2019 7. Health & Wellbeing Programme – Aug 2018 8. Shiny Minds App – Approved Aug 2018 9. Daily Staff Bulletin based on PHE advice 10. COVID WCFT Standard Operating Procedure– approved by Exec March 2020 11. Psychological support for staff available via internal helpline 12. FIT Testing and Training of key staff 13. Modification of estate to provide additional capacity in ITU ~~14. SLA with Aintree for Pharmacy/Pharmaceutical supplies~~ 15. Regional Operations Meeting – Weekly ~~16. Cheshire & Merseyside EPRR Network Meeting – twice per week~~ 17. Critical Care Network Operational Meeting 18. Corona Bill – passed March 2020 19. Staff vaccination programme via LUHFT Covid Vaccination Hub 20. Weekly LAMP testing available for front-line staff 21. Command & Control Inbox for National communications 22. Booster programme from September 2021 23. Internal patient vaccination plan ~~24. Regular staff reminders regarding IPC procedures, through Trust communications and daily safety huddle~~ 25. New BAF risk focused on IPC proposed for Q3 2021-2 26. Promotion and guidance of all available testing options for staff	1. Staff compliance with LAMP testing and IPC procedures post-lockdown easing ~~, the guidance has now been introduced for twice weekly mandatory staff testing~~ 2. Mutual aid requests being managed through hospital cell 3. Risk of further Covid waves as a result of mutations and new variants 4. Compliance with Booster campaign and flu campaign

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily Safety Huddle Divisional Daily Huddle Infection Prevention and Control Committee – monthly IPC Audits and Root Cause Analysis for cases Senior staff walk-abouts recommenced Regular staff reminders regarding IPC procedures, through Trust communications and daily safety huddles.	1. Staff compliance with IPC guidelines including testing 2. Risk of further Covid waves as a result of mutations and new variants.

Level 2 Infection Prevention & Control Quarterly Report – Quality Committee Quarterly Governance Report –Quality Committee, Trust Board Covid-19 Update – Trust Board Covid-19 Board Assurance Framework Trust Elective Recovery Plan **Level 3** Daily Sit Rep Reports submitted to NHS Digital NHSE DON's National call – bi-weekly NHSE/I Visit – February 2021 – action plan completed	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Terms of Reference, membership and reporting arrangements re Ethics Committee to be finalised	~~AN~~ MD	End of April 2021	Completed
2	Ongoing participation in regional and national plans (Recovery Plans)	~~JR~~ COO	~~March 2021~~ ~~July 2021~~ ~~September 2021~~ September 2022	On track
3	Promotion and support for staff who have not had the Covid-19 vaccination with a communications plan	~~LS~~ CN	July 2021	~~On track~~ Completed
4	Promotion and encouragement for staff to follow Trust IPC guidance (LAMP / Lateral Flow / General IPC guidelines)	~~LS~~ CN	October 2021	~~On track~~ Ongoing
5	Encourage all staff to be fully vaccinated and in particular support those staff who will be required by law to be double vaccinated by 1 April 2022 to be aware of the requirements	CN	April 2022	Commenced

Risk 002	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: If the Trust does not see and treat patients in a timely manner then it will not meet the NHS constitutional standards leading to poor patient outcomes and experience, regulatory scrutiny and reputational damage.		Date of next review:	February 2022
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	1 Deliver Best Practice in care and treatments
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Acting Chief Operating Officer

Linked Operational Risks				Consequence	Likelihood	Rating
43	Failure to meet mandatory waiting time standards for patients causing a poor patient experience and reduction in patient safety	16	Initial	Major 4	Almost Certain 5	20
815	RTT / Average Wait performance and volume of 52-week waiters	16	Current	Moderate 3	Possible 3	9
323	Capacity pressures associated with workforce, theatres and ward beds	16	Target	Moderate 3 ~~4~~	Unlikely 2	6 ~~8~~
Risk Appetite	**Cautious**					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Patients will wait longer for 1st and follow up appointments – which could result in harm or poor patient experience. • Referral to treatment standard (RTT) / average wait pilot standard will not be met. • Cancer standards will not be met. • Diagnostic standards will not be met. • 52 &36 week wait standard not met	Average Wait Performance Overdue Follow up waiting list in Neurology remains a concern Reduction in overall activity due to the impact of COVID-19 IPC pathway control for electives Increasing waiting list size Volume of 52-week waiters

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Draft Operational Plan 2020-21 - discussed at Exec Feb 20 2. COVID-19 Recovery Plan Phase 3 3. Performance Dashboard in Real-time 4. From October 2020, no longer accept GP referrals for pain as per NHSE published guidance in relation to Adult Pain Service Specification for Tier 3 services. 5. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 6. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 7. Submission of Recovery and Restoration plans for 2021/22 8. Use of Halton Hospital to deliver Pain daycase activity from May 2021 9. Stretch recovery target set for 100% of 2019/20 activity 10. Daily COO-led performance catch up 11. Divisional recovery plans 12. 52 week recovery plan 13. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners.	1. Activity plans do not take into account impact of sickness, shielding requirements due to COVID-19 2. COVID-19 Recovery Plan based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviors / compliance. 3. Planned transfer of Spinal services from LUHFT ~~September/ October~~ December 2021 – impact in relation to overall Trust RTT performance is currently unknown, neurosurgery are currently validating the data. This will be completed in January 2022.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**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 Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly PA Consulting have been contracted to work through C&M data and plan based on assumptions and winter plans. Divisional plan presented to support recruitment of key staff Daily monitoring of critical staff absences at Huddle. **Level 2** Integrated Performance Report – Reported monthly at Trust Board ~~COVID Update – Reported at Board meetings from April 2020~~ Recovery and Restoration Update provided at Trust Board **Level 3** Meetings with Commissioners – monthly	1. Transformation Board delayed due to COVID response 2. C&M approach to access and planning 3. Non-elective activity / ICU capacity 4. Thrombectomy demands 5. Sickness and self-isolation of critical staff 6. Recruitment and retention of key staff

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Transformation Board to be formally established and re-focused to address outpatient productivity	DoSO	~~April 2021~~	~~Commenced~~

	flow and theatres in the context of COVID-19 Recovery			Completed
2	Implementation of COVID Recovery Plan to increase activity	~~DoSO~~ COO	~~End of July~~ Sept 2022	~~Phase 1 complete~~ On track
3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	Superseded
4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	May 2021	~~Commenced~~ Completed
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue. NHSI pilot ongoing.	~~DoSO~~ COO	~~May 2021~~ March 2022	Delayed
6	Continued Job Planning for consultants for 2021/22	~~DoSO~~ COO	~~Mar 2021~~ Mar 2022	On track
7	Data requested from LUHFT to inform RTT position.	DoSO	June 2021	Complete
8	Closer monitoring of position and forecasted position	COO	September 2021	Complete
9	Divisions to provide workforce recovery plan in key areas (Theatres)	COO	September 2021	~~On track~~ Complete
10	Bed repurposing project to increase efficiency and respond to changing demand	COO	March 2022	Commenced December 2021
11	Overdue follow up waiting list is to be monitored by the division by undertaking a validation exercise and a review of the patients to determine what patients can be moved over to PIFU	COO	March 2022	On track

Risk ID: 003	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: Due to the specialist nature of patients with a higher incidence of violence and aggression, **if** the Trust does not establish effective processes to prevent harm, then staff and/or patients may experience physical harm which could lead to high turnover, sickness absence, litigation and regulatory scrutiny.		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks				Consequence	Likelihood	Rating
455	If controls are not put in place to manage violent and aggressive patients, who are violent and aggressive then there is a risk to staff safety. (Neurology Division / Neuro Surgery Division)	12	Initial	Major	Possible	
				4	3	12
			Current	~~Moderate~~ ~~Major~~	Possible	
				3	3	~~9~~~~12~~
			Target	Minor ~~Moderate~~	Possible	
				~~2~~3	3	6~~9~~
Risk Appetite	Cautious					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Physical Injury /- Emotional/psychological impact on staff and other patients - Low morale - Increased sickness levels - Litigation - Involvement with Regulators e.g. HSE, CQC, NHSE/I due to increased level of RIDDOR reports, staff harm due to violence and aggression (V&A), 4 fractures reported to HSE in past 12 months (2020/21) - Increase in staff turnover	**Physical Assaults on staff** **2019/20** **2020/21** **2021/22** **Q1 = 27 Q2 = 45** **Q1 = 22 Q2 = 56** **Q1 = 41** **Q3 = 40 Q4 = 29** **Q3= 78 Q4 = 40** **Q2 =27** **Related Claims** 1 claim received in 2019/20 **Staff Survey (relating to staff reporting physical harm)** **2020 - 20.3% (**against the national average of 4.1%) **2019 - 22.3%** (15.25% higher than acute specialist sector average of 5. 7%) **2018 – 21.9%** (National average 2018 over 6.7%, compared to best performing Trust at 1.8%)

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Violence and Aggression Policy - approved Feb 2018 2. Lone Worker Policy - approved Feb 2018 3. Mental Capacity Act Policy - approved Jul 2019 4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach) 5. Security Function (ISS) 6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required 7. Personal Safety Trainer Programme of work Apr-2019 8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 9. Additional Consultant reviews RVs where V&A has increased 10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot) 11. 11.Restraint Training rolled out in CRU and other ward areas – 287 staff have completed Restraint Training 12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are aggressive 13. National Violence Reduction Standards issued: 14. V&A Strategy in development in line with national standards – update on action plan was provided to Quality Committee October 2021 15. Baseline audit completed – reported to Health, Safety & Security Group May 2021 16. Special Observation of Patients Policy in place Post-incident staff debriefing in place (MDT approach) 17. Violence and Aggression Prevention operational group established July 2021	1. Lack of agreed KPIs within the Security Contract 2. Compliance with statutory and mandatory training ~~3. Restraint Training to be rolled out across all wards~~ ~~4. Psychologist sessions to be rolled out to all wards~~ 5. Potential for HSE visit due to increase in RIDDOR incidents related to fractures

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – daily Monday~~- Sunday~~ Friday Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – bi monthly Violence and Aggression Group **–** bi-monthly Transformation Board - monthly **Level 2** Annual Governance Report – Quality Committee Quality Dashboard – Quality Committee – monthly	~~1. Outcome of Shiny Minds App to be evaluated~~ 2. Lack of benchmarking data across similar Trusts – to commence with Queen's Square in Q1 2021/22 awaiting information as delayed due to Covid

Level 3 Staff Survey 2020 Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance Oct 2018 – actions completed Dec 2019 Quarterly review meetings with commissioners CQC Inspection Report 2019 Investors in People Health & Wellbeing Gold – re-accredited May 2019 Investors in People re-evaluation retained as Gold in 2020	

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

Risk ID: 004	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: If the Trust does not deliver the benefits identified within the Quality Strategy, then excellent patient and family centred care will not be sustained leading to potential harm, poor patient experience and reputational damage		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks			Consequence	Likelihood	Rating
543	If delays in completion of IT projects continue, then there is a risk to patient safety, specifically the risk of a loss, duplication and inaccurate key data on reports generated by Epatient (EPN) system, resulting in a lack of clinical confidence in the accuracy of the reports.	15			
			Major	Likely	
			Initial	4	4	16
753	If demand for acute in-patient assessment continues to exceed capacity, there is a risk to patient care.	12			
			Major	Possible	
			Current	4	3	12
621	If Neurophysiology reports are delayed (Exceeds Trust Target of 14 days), then there is a risk of negative clinical impact on patient care.	12			
			Major	Unlikely	
			Target	4	2	8
Risk Appetite	Cautious				

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Key objectives not met - Poor patient and family experience - Reputational damage - Standards of care	1. Increase in reported deaths from 92 in 2019/20 to 112 in 2020/21 which was due to Covid-related deaths and from the acute stroke service which was temporarily transferred from LUFT. (45 deaths in year to December 2021 and rolling 12 month Risk Adjusted Mortality Index (RAMI) better than expected through 2021/22 2. Reduction in the number of formal complaints received with 67 in 2020/21 compared to 129 in 2019/20 3. Zero Never Events in 2020/21. (One to date in the 2021/22). 4. 13 cases of MSSA against a threshold of 8 in 2020/21 5. Increase in Nosocomial Infections 6. Covid-19 pandemic and visiting suspended 7. C-Diff and Kiebsiella trajectory not currently being met in 2021/22 and MSSA infections increasing. There has been an increased incidence of HCAI this financial year which it is proposed to monitor via a new BAF risk 016
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Quality Strategy 2020 – 23 – approved Sept 2019 2. KPIs for Year 2 of the Quality Strategy approved March 2021and reviewed and approved in August 2021 by Quality Committee. 3. CARES Review Programme 2021/22 4. HCAI Reduction Plan 2021/22 5. FOCUS Programme 2021/22 6. Theatre Utilisation Programme 7. Patient Family Centred Care Group – on hold due to Covid, Patient Experience Group still running 8. COVID-19 Recovery Plan – May 2020 9. Clinical Audit Plan – CESG June 2021 10. IPC – strategic COVID 19 Plan January 2021. IPC BAF reviewed at Trust Board November 2021 11. Trust Recovery Roadmap 12. Virtual visiting with 'Facetime' etc. and regular phone calls to family / next of kin by nursing and medical staff 13. Monthly meetings with staff to manage quality accounts within timescales 14. Additional new BAF risk proposed for Infection Prevention and Control February 2022	1. Alignment of year 1 priorities across all strategies not tested 2. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 3. ~~Lack of resource within IPC to support Covid-19 response~~ – all vacancies now filled 4. Covid-19 pandemic – reduction in staffing due to sickness and shielding, different ways of working implemented
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – Daily Ward / Departmental Huddle Theatre User Group Divisional Governance Meetings – monthly Mortality Review Group – monthly Serious Incident Group - monthly Transformation Board Balance Score Cards – monthly Operational Management Board - monthly **Level 2** Quality Dashboard – Quality Committee – monthly Quarterly Governance Report	

IPC Annual Report – May 2021 Safeguarding Annual Report – June 2021 Annual Governance Report 2020/21 Medicines Management Annual Report – ~~June~~ December 2021 Quality Strategy Progress Report – March 2021 COVID- Update to Trust Board – monthly – now part of business as usual in CEO report Mortality Report to Quality Committee **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meeting with Commissioners – Quarterly National Inpatient Survey Results – ~~September 2020~~ moved from national score of 9th to 8th in 2020/21 - published October 2021 CQC Mental Health Inspection – December 2020 CQC Interventional Radiology Inspection – published December 2021	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Review of all Trust Strategies to ensure alignment of priorities in year 1/2	J Ross	~~April 2020~~ Aug 2020	~~Not started~~ Complete
2	Recruit to Tissue Viability Team or test alternative options to fulfill the role	L Vlasman	~~May 2020~~ Sept 2020	Completed
3	Transformation Board and reporting arrangements to be introduced	J Ross	~~February 2020~~ June 2020	Completed
4	On-going participation in discussions to ensure influence in future system wide plans	~~H Citrine~~ J Ross	~~March 2020~~ ~~March 2021~~ March 2022	On track
5	Recruit to additional post within the IPC Team to lead on the response to Covid	L Vlasman	~~March 2021~~ May 2021	~~On track~~ Complete
6	Address reduction in staffing due to Covid-19. Ongoing work required to address staffing due to increased variants and efficacy of vaccinations.	L Vlasman	~~June 2021~~ March 2022	On track

Risk ID: 005	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: **If the Trust does not attract, retain and develop sufficient numbers of qualified staff, both medical and nursing, in shortage specialties, then it may be unable to maintain service standards leading to service disruption and increased costs**		**Date of next review:**	February 2022
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	~~3 – Financially Strong~~ Excellence in patient care and staff wellbeing
		Assurance Committee:	Business Performance Committee
		Lead Executive:	~~Director of Workforce and Innovation~~ Chief People Officer

Linked operational risks		
	~~None identified~~	
140	If the Trust fails to achieve the agreed internal compliance target rate for all statutory and mandatory training topics, there is a risk to the achievement of CQC standards and regulatory requirements.	12
141	If Clinical and Medical Staff are unable attend mandatory training sessions, as a result of increased workload, there is a risk to the Trust achieving CQC standards and other external regulatory requirements.	12
3232	If capacity pressures, associated with workforce, theatres and ward beds continue then there is a risk the Trust will fail to deliver activity associated targets and financial plan.	16
Risk Appetite	**Cautious**	

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Reduced patient safety and poor patient experience • Business continuity • Reputational damage • Reduced staff morale • Sickness increases • Staff Turnover increases • Staff capacity to attend training and development and complete annual appraisals	Nursing Turnover Overarching Staff Turnover Sickness Absence Statutory and Mandatory Training Quarterly Pulse Survey Feedback from staff support sessions Vacancy rates Appraisal Rates

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning - 2019 3. Five year education plan to ensure supply - 2017 4. Quality Strategy 2020-2023 - Sept 2019 5. People Strategy revised in line with the national People Plan- Sept 20 6. Staff Survey / People Action Plan - June 21 7. Partnership working with universities to recruit newly qualified staff 8. Extension of apprentice roles - July 2019 9. Involvement with Regional Talent Management Board 10. WCFT Health and Wellbeing Programme 11. NHSP Bank 12. Collaborative Bank within North West 13. COVID-19 Recovery Plan 14. MoU across C&M in relation to staffing during COVID-19 15. National Nursing Bursary – 2020/21 16. Staff Survey regarding working during COVID-19 17. Agile Working Project 18. Debriefs following first wave of COVID 19. Mental Health First Aid Training 20. Collaborative International Recruitment – 38 arrived, 50 forecast for 2022/23 21. Virtual recruitment days for Qualified Nursing staff 22. Quarterly Staff Pulse Survey – commenced April 2021 23. Alternative methods of training devised and a blended approach is in place 24. Regular updates received re pensions and visa arrangements 25. Freedom to Speak up Guardian 26. Board Wellbeing Guardian 27. Exit Interview and Flexi Working Audit Planned 28. Hybrid training models developed to enable ongoing delivery of training with social distancing.	1. Implications of Brexit i.e. Visas on recruitment not yet known 2. Changes to pension arrangements 2020/21 complete though implications for recruitment and retention still not understood ~~3. Traditional training no longer appropriate due to social distancing and therefore alternative delivery methods to be developed~~ 4. Continued national shortage in supply of nursing staff

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

Level 1 Vacancy monitoring – weekly Daily escalation undertaken and all outcomes are reported to Senior Nursing Team. Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events – quarterly Staff Support sessions provided by NOSS Participation in Quarterly People Pulse Survey **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC – Mar 2021 (linked to People Plan) Communication and Engagement Strategy – Trust Board Sept 2020 **Level 3** Outcomes of 2020 Staff Survey. 2021 Staff Survey to commence September 2021 Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance Investors in People Accreditation 2020 – Gold Status, 2021 interim report received December 2021 Investors in People Wellbeing Award 2021 – Gold Status Final evaluation of Shiny Minds app	1. Delivery of National People Plan

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Outcome of Brexit and implications for recruitment and retention not fully understood. Ongoing involvement and discussion with NHS Employers, NW Staff Partnership Forums and Brexit Council for Liverpool.	~~DoW~~ CPO	Ongoing ~~Mar 2020~~ ~~Dec 2020~~	Complete
2	Outcome of national review of the 2015 NHS Pension Scheme and its implications awaited	~~DOW~~ CPO	~~Dec 2020~~ ~~March 2021~~ March 2022	On track
3	Alternative solutions for statutory and mandatory training in development whilst socially distanced training continues	~~DOW~~ CPO	March 2021	~~On track~~ Complete
4	Continued progress to develop a C&M Collaboration at Scale for Nursing Workforce and progress recommendations	~~DoW~~ CPO	~~End of March 2020~~ June 2022	Delayed
5	Outcome of Shiny Minds app to be evaluated	~~DOW~~ CPO	~~End of March 2020~~ ~~September 2020~~ Dec 2020	Complete
6	On-going participation in national/ regional meetings to inform local policy and realign strategy where necessary	~~DOW~~ CPO	March ~~2021~~ 2022	On track
7	Await outcome of Investors in People Assessment process for 2020 not received	~~DOW~~ CPO	November	Complete
8	Commit to international recruitment as part of a regional collaborative campaign Update June 2021 – Arrival of recruits delayed due to Covid-19 situation. Update January 2022 – Delayed recruits arrived. Further 50 committed for 2022/23	~~DoW & DoN~~ CPO & CNO	~~May 2021~~ Dec 2021	~~On track~~ ~~Delayed~~ Completed

Risk ID: 006	Date risk identified April 2020	Date of last review:	December 2021
If the Trust does not deliver the priorities within the Estates Strategy then the existing estate may not meet the needs of patients or support operational performance leading to poor patient experience and reputational damage and a building/ estate not fit for purpose.		Date of next review:	February 2022
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Acting Chief Operating Officer

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

	Consequence	Likelihood	Rating
	Major	Possible	
Initial	4	3	12
	Moderate	Possible	
Current	3 ~~4~~	3	9 ~~12~~
	Moderate	Unlikely	Rating
Target	3 ~~4~~	2	6 ~~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?*
- Unsafe environment for staff - Patient safety - Compromised quality of care - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance	The Trust currently has a costed backlog maintenance schedule which is updated annually for the purpose of the ERIC return submission. This schedule highlights high, significant, medium and low level backlog maintenance requirements.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Estates Strategy – approved 2015 2. Operational Plan 2019-20 3. Revenue and Capital budgets - Ongoing 4. Backlog Maintenance Register - updated June 2021 **5.** Maintenance Programme **6. Estates related policies** • Electrical Safety Policy - 2020 • Water Management Policy – 2021 • Fire Safety Policy 2019 • Control and management of Contractors 2018 • Health & Safety Policy 2019 - 2022 7. Specialist contracts - Ongoing 8. Site based partnership/SLA with Aintree Hospital - 2016 9. Contractual agreement with specialist contractors - ongoing 10. Recovery Plan following COVID-19 11. Water Management Action Plan including remaining Legionella actions 12. Premises Assurance Model – completed 2021 13. Completed Phase 3 of the heating replacement scheme 14. Remedial works through site to increase hot water circulation temperatures 15. Continued flushing of water outlets 16. Replacement of thermostatic mixing valves 17. Sink and pipework replacement programme, as possible 18. Use of 'point of use' filters to clinical outlets 19. Completion of the fire compartmentation reinstatement works 20. Sustainability plan update in progress – draft approved by BPC and Board in December 2021 and to be submitted to NHSIE in January 2022	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post COVID-19 2. ~~Under resourced Estates function~~ 3. Limited access to certain areas prevents visual inspection 4. ~~Lack of a finalised Sustainability Plan~~ 5. Policies require review to ensure that they are reflective of current legislation 6. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 7. Capital programme now being managed at an ~~STP~~ ICS level. 8. Programme for Pipework replacement incomplete 9. The national Premises Assurance Model (PAM) outcomes

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily Safety Huddle Water Safety Group – reporting into IPC Committee Health & Safety Group Contract review meetings with AUH – monthly Heating and Pipework Project Board – monthly **Level 2** Capital Programme approved by Trust Board	1. Limited Aintree University Hospital planned maintenance/KPI reporting in place 2. Lack of reporting of sustainability data

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

Corrective Actions: **To address gaps in control and gaps in assurance**		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Work with NW specialist trusts North West QIP for specialist trusts to consider wider solutions for hard and soft FM. This work continues to progress with Soft FM services being tackled in 1st wave	~~J Ross~~ Vlasman	~~March 2020~~ March 2023	Delayed
2	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of Aintree University Hospital via monthly meetings. Estates are currently reviewing resource and cost impacts in advance of recommendation	~~J Ross~~ L Vlasman	~~March 2020~~ March 2022	Delayed
3	Integrate Trust Sustainability Plan into Estates Strategy review and establish reporting to BPC. Walton Centre “wider” Estates Strategy to be incorporated into forthcoming ICS Estates Strategy. Sustainability Plan now Board approved and submitted to ICS. Local action plan to be developed. WC Estates Strategy to be incorporated into wider “sytem” strategy currently being led by LUFT	L Vlasman	~~Jan 2020~~ ~~September~~ ~~March 2021~~ September 2022	Delayed
4	Ongoing monitoring of Phase 4 Heating and Pipework Programme	~~J Ross~~ L Vlasman	~~March 2021~~ March 2022	Ongoing
5	Roll out of Premises Assurance Model and reporting	J Ross	March 2021	~~Not started~~ Complete
6	Design process initiated for upgrade works to Theatres 1-5 due to non-compliant Air Handling Units	L Vlasman	April 2022	Commenced

Risk ID: 007	Date risk identified April 2020	Date of last review:	December 2021
Risk Title: **If the Trust does not maintain and improve its digital systems through implementation of the Trust's Digital Strategy, it may fail to secure digital transformation leading to reputational damage or missed opportunity**		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:5	Adapt advanced technology and treatments enabling our teams to deliver excellent patient and family centered care.
		Assurance Committee:	Business Performance Committee
		Lead Executive:	~~Director of Finance and IT~~ Chief People Officer

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Organisation misses opportunity to modernise systems and processes for delivery of effective patient care • Missed objective • Reputational damage • Poor patient experience	EPR Programme paused during initial phase of Covid-19 but has now restarted Trust bid successfully for Digital Aspirant funding approved by NHS Digital. This funding will help to deliver the EPR and wider Digital Strategy over the next two years.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Outpatient Transformation Project 2. Inpatient Transformation Project 3. Theatres Project 4. Paper Light Project 5. Digital Transformation Board aligned to governance groups across the organisation (structure sign-off by Executive Team Q1 21/22) 6. IT Technical Programme of work 7. Cyber Security Programme 8. PMO Function underpinning the Digital Strategy 9. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 10. Post covid EPR rollout plan for 20/21 11. Digital Transformation Programme (LoA/MoU NHSD/X) 12. Digital Aspirant status to allow Digital Transformation 13. HiMSS Level 5 achieved, planning for Level 6 14. New Digital strategy with stakeholder involvement facilitated by MIAA 15. Representation on HCP Programme Boards 16. Head of IM&T SRO for upcoming NHSX 'What Good Looks Like' HCP Programme Board.	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy post COVID-19 across Hospital Cell may be different to Trust's internal digital strategy 3. Change in national priorities around Digital post Covid response may not be aligned to Trust digital priorities

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Outpatient Digital Group monthly Inpatient Digital Group – monthly – digital champions within the Divisions Clinical Systems Safety Group – monthly Digital Programme Board – bi-monthly Information Governance & Security Forum –monthly Digital Prioritisation Group - quarterly Clinical Risk Group Executive Team review of C&M Hospital Cell Digital Objectives Information Security Management Systems Certification IS27001 accreditation September 2020 **Level 2** Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group C&M Chief Information Officers Digital Collaboration Group National Chief Information Officer Weekly Meetings **Level 3** Critical Applications Audit – Jan 2020 Healthcare Information and Management System Level 5 Q1 2021/22	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. Workshops facilitated by MIAA Q2-3 2021/22.

Information Security Management Systems Certification IS27001 accreditation ~~Aug 2019~~ December 2021 Cyber security CertCare progress monitored by NHS Digital Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to HCP ~~STP~~ by C&M Digit@LL NHSX monitoring Digital Aspirant via CORA against LoA.	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Approval of the milestone plan by Digital Programme Board	~~AN~~ MD	~~April 20~~	Complete
2	Regular updates regarding the Trust's Digital objectives and alignment to the C&M Hospital Cell objectives around digital to Exec Team Update 1 Apr 21 – Slide deck containing HCP project dependencies and full Digital projects is shown at Operational Management Board and Digital Programme Board along with HCP updates	~~MB~~ CFO	March 2021	Complete
3	New Digital Strategy with MIAA / C&M HCP	~~MB~~ CPO	~~May 2021~~ ~~December 2021~~ April 2022	Commenced
4	Digital Aspirant MoU signed by all parties	~~MB~~ CFO	March 2021	Complete

Risk ID: 008	Date risk identified: April 2020	Date of last review:	December 2021
Risk Title: If methods of Cyber Crime continue to evolve then the Trust may receive a cyber-attack leading to service disruption, loss of data and financial penalties.		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	~~Director of Finance and IT~~ Chief People Officer

Linked operational Risks			Consequence	Likelihood	Rating
			Major	Likely	
			Initial 4	4	16
			Major	Likely	
			Current 4	4	16
			Moderate	Possible	
			Target 3	3	9
Risk Appetite	Cautious				

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of operational and clinical disruption or a ransom; - Potential financial loss due to loss of activity - Likely to lead to financial, business and operational impacts as well as reputational damage; - potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover - Non-compliance with Data Protection Laws/Network and Information Systems Directive - Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.	Q1 20/21 - 72 Carecerts (3 High, 3 Medium,66 Low Level) Q2 20/21 - 67 Carecerts (6 High Level, 61 Low Level) Q3 20/21 - 66 Carecerts (2 High Level, 64 Low Level) Q1 21/22 - 64 Carecerts (1 High Level, 63 Low Level) Q2 21/22 – 72 Carecerts (2 High Level, 20 Low Level) Cyber security attacks are increasing and ongoing work is required to keep up to date Log4j High Vulnerability identified at global level

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Firewall in place and kept up to date Ongoing 2. Security Information and Event Management(SIEM) monitors all live systems 3. Antivirus Installed on All Computers 4. Vulnerability Protection 5. Hard drive encryption (Laptops) 6. Endpoint Encryption on all computers to prevent local distribution of malware 7. 2 factor Authentication on Server Rooms 8. Swipe Access for staff areas 9. Smart water protection on all devices 10. Asset register and inventory 11. ISO27001 Accreditation process - Annual 12. Member of the Cheshire and Mersey Cyber Security Group - Ongoing 13. Pilot for NHS Digital Programmes relating to Cyber security - Ongoing 14. CareCERT Processing on a regular basis - Ad Hoc 15. Cyber Security Dashboard - ~~Jul 2019~~ 16. Network groups - IG - Radiology etc - Ongoing 17. Proactive monitoring of national cyber alert status 18. Daily National update logging of log4j remedial work	1. Limited funding and investment nationally regarding Cyber Security 2. Lack of skilled resources working in the area of cyber security and private sector competition pushing costs up.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 TIAG review of CareCERTs - Weekly Cyber Security Awareness Presentation to Executive Team - July 19 **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board July 2020 **Level 3** ISO27001 – accreditation August 2019 for 3 years MIAA audits of Data Security and Protection Toolkit –Jan 2020 - Substantial Assurance (draft outcome Jan 2021 – Substantial Assurance) External Penetration Testing – May 2021 Regional Desktop Exercise – March 2021 Internal Desktop Cyber Exercise – May 2021 Trust Board Cyber Security Training – April 2021 Full Cyber Library completed by C& M HCP – August 2021	1. Third party assurances required regarding satellite sites 2. Ongoing work with NHS Digital to inform funding requirements 3. Local skillsets limited resourcing(001) 4. Log4J National systems status still unknown

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Close working with MIAA to inform C&M system wide disaster recovery exercise Update 1 Apr 21 – First HCP Cyber Incident Management exercise scheduled for 30 Mar 21	~~MB~~ CFO	~~Aug 2020~~ ~~March 2021~~ Nov 2021	On track Completed
2	C&M Digital Cyber Group supporting work to establish 3rd party assurances of satellite sites. assurances of cyber security. Delayed due to change of working practice post Covid Update 1 Apr 21 – Delayed. Desktop Exercise outputs will help assurances. C&M working close as partnership with organisations including the Walton Centre.	~~MB~~ CFO	~~Aug 2020~~ ~~March 2021~~ ~~May 2021~~ August 2021	~~On track~~ ~~Delayed~~ Completed
3	On-going work with NHS Digital to inform funding requirements for Cyber Security post-Covid Update 1 Apr 21 – Work will continue on funding requirements in 2021/22 Update Jan 2022 - Working on regional solution 2022/23 with Digital Lead	~~MB~~ CFO	~~Aug 2020~~ ~~March 2021~~ June 2022	~~On track~~ Complete for 20/21 Delayed
4	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid Update 1 Apr 21 – Workshops with Specialist Trusts held Feb/Mar 21 to agree way forward. MIAA to run Cyber tools training in Q1 2021/22 under Digital Aspirant funding to ensure compliance. Revisiting with HCP with new digital lead and Cyber skillsets	~~MB~~ CFO	~~Aug 2020~~ ~~March 2021~~ ~~May 2021~~ ~~September 2021~~ June 2022	~~On track~~ ~~Delayed~~ Partially Complete
5	Recruit Cyber lead fixed term 24 months / service to underpin current processes with MIAA / C&M HCP.	~~MB~~ CFO	~~Aug 2021~~ April 2022	On track

Risk ID: 009	Date risk identified: April 2020	Date of last review:	February 2022
Risk Title: The Trust needs to embed a culture of innovation to underpin its status as a Centre of Excellence, develop/implement ground breaking patient treatments and attract/retain a world class consultant body.		Date of next review:	June 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Impact on Trust reputation 2. Inability to improve patient care and deliver efficiencies 3. External scrutiny e.g. CQC well led 4. Inability to retain clinical staff if unable to fulfil their innovation/research ambitions 5. Sufficient workplace capacity and resourcing must be maintained to ensure innovative practices, treatments and boundary scanning 6. Risk aversion, complacency and the status quo if staff demotivated 7. Too many innovations will not be fully implemented, acknowledged and celebrated 8. The Trust's innovation agenda becomes weakened in an environment of meeting/emerging system change	Achievement of Innovation Strategy Objectives: • Short term (2019/20) – Largely completed (some Covid-19 delays) • Medium term (2020/22) – Largely completed (some Covid-19 delays) • Long term (2022/24) – To be progressed • Individual projects being successfully delivered • Local and national political developments • Financial and Covid 19 pressures may distract from commitment to innovation

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Innovation Strategy 2019/24 developed 2. Strategy review to be undertaken in the context of Covid-19-related capacity issues 3. Strategy development required to clarify alignments/distinction between "innovation" and "commercial innovation" activities 4. Innovation Pipeline 5. Stakeholder Analysis 6. Innovation Strategy Communication Plan 7. Development of internal processes / information resources to support innovation 8. Developing additional funding streams 9. Investors in People accreditation (2020)	1. Covid-19 delays and impact on resourcing is delaying progress / reducing capacity 2. Lack of clarity around "innovation" and "commercial innovation" activities led by different directorates 3. Competitor Analysis to be completed (to be finalised by Communications & Marketing Manager, subject to prioritisation 4. Wider consultation with Trust stakeholders still emerging and managed through the communications plan (some Covid-19 delays. Consideration required on how best to involve patients in innovation decision making) 5. Complex alignment between Innovation and other teams has progressed significantly but more work is needed (Covid and resourcing limitations has delayed) 6. Multi-team working to improve consideration of innovations developed outside the Trust and address risk aversion ~~7. Innovation processes. guidance and methodology not yet fully developed~~ 8. Income generation model (for the Spinal Improvement Partnership) approved by Board but contracts still being negotiated - some Trust resourcing issues 9. The Trust may not be incentivised to develop new income streams if system level accountability and block finances remain post-pandemic.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Innovation Team Meeting – monthly (currently meeting less frequently due to resourcing issues) • Medical Innovation Group – bi-monthly (Meeting membership to be revised in 2022 to widen clinical representation to reflect the full range of services offered by the Trust) • Regular commercial/ innovation meetings with procurement, IT, IG, service improvement, clinical and other teams • Executive Team approval of innovation business cases and initiatives • RIME Committee approval of Charity Committee innovation funding applications	1. Benefit realisation for innovative business cases not yet feasible due to resourcing limitations and lack of defined metrics ~~limited time that Trust has had Innovation posts in place~~ 2. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency and potentially commercial innovators to identify appropriate process

Level 2 • Innovation bi-monthly update to RIME Committee • RIME Committee Chair's Report to Trust Board and Council of Governors • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • CQC Inspection report 2019 • CQC well-led criteria now includes innovation	

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

Risk ID: 010	Date risk identified: April 2020	Date of last review:	December 2021
Risk Title: **Establishment of a Cheshire & Mersey ICS will change the external landscape and how the Trust operates and influences within Cheshire and Merseyside with a potential risk that this could have a negative effect on the Trust.**		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Strategic Priority:	All Strategic Priorities
		Assurance Committee:	Trust Board
		Lead Executive:	Chief Executive

Linked Operational Risks		Consequence	Likelihood	Rating
Potential impact on ~~link to~~ all high level operational delivery risks	Initial	Major	Possible	
		4	3	12
	Current	~~Major~~ Moderate	Possible	
		~~4~~ 3	3	~~12~~ 9
	Target	~~Major~~ Minor	Unlikely	
		~~4~~ 2	2	~~8~~ 4
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Potential reduction of Trust autonomy with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance.	• Hospital Cell and Governance arrangements determined at regional level with limited consultation • Changes in national policy due to COVID-19 • ~~White Paper~~ Health and Care Bill in process of going through Parliament indicates decreased autonomy for individual Trusts with increased control by ICS / central Government, but ongoing accountability for Trusts for individual organisational performance • Establishment of Provider Collaboratives • Guidance published on ICS and ICBs including model Constitution

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Trust Strategy 2018-2023 – ~~plans in place to refresh~~ review and consultation underway for an approval by April 2022 2. Communication and Engagement Strategy 2020 - 2025 3. Active membership of Cheshire and Merseyside Health Partnership (C&M HCP) and Collaboration at Scale Programme 4. Member of Liverpool Health Partnership 5. Member of Liverpool PLACE 6. Member of Trauma Partnership 7. Membership of Specialist Trust Alliance 8. Medical Directors Group HCP level 9. Chief Operating Officer Group HCP level 10. Membership of Directors of Finance Group HCP level 11. Management Side Chair of NW Staff Partnership Forum 12. Membership of Director of Nursing Group HCP level 13. Membership of Director of Workforce Group HCP level 14. Neuroscience Programme Board – Quarterly 15. Revised MoU provides for Specialist Trusts to have 1 x Chair and 1 x CEO representative on the HCP Board which will aid influence 16. Member of the newly-established Provider Collaborative ~~17.~~ ICS CEO and interim Chair appointed, other senior roles being recruited to ~~Interim HCP leadership team in place~~	1. Hospital Cell and governance arrangements potentially result in greater influence for larger providers 2. Financial arrangements now determined across HCP level – BAF 15 3. Clarity on the ability of Provider trusts to influence future ICS arrangements 4. Completion of review of Stakeholder Analysis 5. ~~Lack of certainty on future ICS financial arrangements – clarification anticipated Q2 2021/22~~ 6. Potential for Health and Care Bill to not pass through parliament in time and 1 April 2022 date may not be met 7. Leadership appointments not yet all in place and interim Chair in place

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Executive Team meetings – weekly Weekly C&M CEO meeting **Level 2** Chair and Chief Executive Reports - Trust Board Part of C&M Provider Collaborative Meeting **Level 3** ~~Board to Board meeting of Specialist Trusts - February 2020~~ Part of Specialist Trust Alliance Updates from HCP on progress and plans with opportunity to comment on drafts to influence direction of travel e.g. HCP MoU One to One meetings between CEO of HCP and CEO of Walton Centre Part of ICS Transformation Programme Board (Neurosciences Programme)	• Long term role and purpose of in hospital cell not determined • Outcomes of NHS England 'Changing Landscapes' • Lack of clarity on future of specialist commissioning • Potential impact on services outside future ICS arrangements • Postponement of arrangements due to Covid-19

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Ongoing engagement with regional partners	CEO	March 2022	Ongoing
2	Meeting with Jackie Bene (CMHCP)	CEO	January 2021	Complete
3	Meeting with Sheena Cumiskey arranged	CEO	Sep 2021	Complete
4	Ensure Trust engaged in developing system and taking on system roles – CEO appointed to Lead Nurse in Hospital Cell from October 2021	CEO	March 2022	Ongoing
5	Involvement in Provider Collaborative – attendance at CEO development session and CEO and Chair's briefings, Audit Committee briefings from MIAA regarding ICS arrangements.	CEO	March 2022	Ongoing

Risk ID: 011	Date risk identified: April 2020	Date of last review:	December 2021
Risk Title: If the Trust does not maintain and grow the Trust's research and development agenda it may negatively impact upon its centre of excellence status leading to loss of income, reduced profile and inability to recruit/retain the most ambitious clinical staff.		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research, Innovation & Medical Education (RIME) Committee
		Lead Executive:	~~Director of Workforce and Innovation~~ Chief People Officer

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

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

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

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

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	NRC organisational service change process supported by Human Resources.	CPO ~~DW&I~~ &CDRD	April 2022 (due to COVID 19)	~~On hold~~ On track
2	Senior Neuroscience Research Group with agreed action	CPO ~~DW&I~~ & CDRD	September 2020	On track
3	~~Internal NRC redesign work~~ *(action merged with action 1)*	~~Internal R&D Team~~	~~Ongoing~~	~~On track~~
4	Investors in People Assessment	DW&I	October 2020	~~On track~~ Complete

5	External review undertaken by Caroline Murphy, Kings College London. Report and findings to be presented at RIME committee in March 2021.	DW&I	November 2020	~~On track~~ Complete
6	Clinical Director of Research and Head of LHP SPARK have begun to meet on a regular basis, it is envisaged this relationship will enable growth of closer working between WCFT and LHP to enable reciprocal engagement. Workshops are planned between NRC function and LHP.	Clinical Director of Research & Development	April 2022	On track

Risk ID: 012	Date risk identified October 2020	Date of last review: December 2021
Risk Title: There is a risk that the allocation of capital set by the HCP to the Trust will not support the full capital plan for 2021-22 **There is therefore a risk that the Trust will overspend the capital allocation or defer schemes which may result in maintenance and revenue costs or deterioration of the Estate.**		**Date of next review:** February 2022 **CQC Regulation: 17 Good Governance** **Ambition: Be financially strong and invest in services** **Assurance Committee: Business Performance Committee** **Lead Executive:** ~~Director of Finance~~ Chief Finance Officer

Linked Operational Risks		Consequence	Likelihood	Rating
~~None Identified~~ • Specific capital risks reviewed as part of CMG agenda • Some on-going long term schemes are subject to funding allocations through ICS (given capital allocations are based on 1 year only) which means difficulty in identifying resources for multiple year projects.				
	Initial	Moderate 3	Possible 3	9
	Current	Moderate 3	Possible 3	9
Risk Appetite	Target	Moderate 3	Unlikely 2 ~~3~~	6 ~~9~~
	~~Cautious~~ Moderate			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on ICS footprints with the Trust's capital resource limit (CRL) allocated from the HCP total. The Trust's allocation was 50% higher than if based on historical capital allocation calculations but was nonetheless oversubscribed. - On-going replacement equipment will not be able to be paid through capital given the Trust's Capital Resource Limit (CRL) has been set at £6.2m - Any overspend on capital against out CRL will need to be covered by the other Trusts in the HCP (reducing their ability to spend capital); - Impact on revenue budgets should there be a risk to patient safety;	Between the draft plan and the intended final plan submission, some additional material capital requests have been raised. The Trust received additional capital funding in 2020/21 through Public Dividend Capital as well as additional CRL agreed with the HCP. It is unlikely that this will be repeated in 2021/22 which gives minimal flexibility in management of the capital programme. The Trust currently has one of the lowest capital spends year to date (Sep 21) of its overall allocated plan in the North West.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Capital Management Group reviews all capital business cases and sanctions expenditure based on budget allocations – Chaired by COO 2. SFI's/SORD have appropriate approval levels for capital expenditure so CFO / COO are sighted on expenditure 3. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc. 4. Monthly reporting of capital expenditure in board report so cumulative spend is transparent to senior management and board members 5. Capital prioritisation being undertaken by Ops, Clinical and Finance staff utilising a range of criteria to enable RAG rating of all schemes and prioritisation of the capital plan 6. Regular capital updates provided to BPC (in addition to updates provided in the Finance IPR).	1. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend 2. Some items are not specified in detail and therefore there is an ability to substitute items in year which means capital slippage is difficult to manage 3. Limitations of regional approach to capital allocations 4. Reliance on specific items which cause delays if not available 5. Priorities may change in year which may lead to pressures against the plan 6. Market prices may differ from estimates once equipment is purchased 7. Clarity of how future revenue costs associated with capital and digital investment will be funded in the long term.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular forecasting of the capital position between Finance and the key stakeholders to understand the latest projected year end spend. Capital Management Group – discusses any capital expenditure up to £50k and includes work around prioritising schemes when there are pressures on the budget /forecast. Business case and approval process at this forum to manage value for money. **Level 2** Executive Team - Expenditure up to £100k is approved through this group with regular updates on the capital programme presented. Business case and approval process at this forum to manage value for money. Business Performance Committee / Board – capital plan approved and all cases >£100k < £500k are approved by BPC and above £500k are approved by Board. Regular updates on Capital expenditure and forecasts to BPC. **Level 3** Participation in the C&M Directors of Finance meeting where capital allocations / funding and forecasts are discussed to enable decisions to be made regarding moving funds within the system. External audit annually on capital expenditure	1. Level of capital resources limit (CRL) are based on allocations from HCP and not the former basis which enabled Foundation Trusts the freedom to generate their own cash resources to spend on capital requirements; 2. The timeliness of national decisions on when additional capital is available / can be spent which could lead to a reduction in the ability to spend capital given funds cannot be carried forward into future financial years; 3. Capital allocations are currently based on 1 year limiting decision-making / resource allocations on longer term projects.

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

Risk ID: 013	Date risk identified: October 2020	Date of last review:	December 2021
Risk Title: If the Trust does not deliver the financial plan for 2021/22 **due** to the changes in the financial framework and the impact of Covid-19 then it will fail to meet its financial duties and may be unable to deliver its strategic objectives leading to regulatory scrutiny and level of financial efficiencies will not be deliverable		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive	Chief Finance Officer

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

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Financial plan submitted for H1 2021/22 in May 2021 and for H2 2021/22 in November 2021 2. Capital Programme – allocation by HCP in April 2021 and regularly monitored by Capital Management Group. See BAF Risk ID 012 3. Finance and Procurement Strategy – approved July 2019 and progress report to BPC May 2021 and October 2021 4. Budgetary Control Process including run rate information - monthly 5. Standing Financial Instructions (SFI's) & Scheme of Reservation and Delegation – approved November 2020 6. Divisional Finance meetings to highlight on-going financial issues - monthly 7. Block Contract in place for H1 2021/22 due to COVID-19 8. Monthly financial forecasts based on current run rates to assess anticipated H1 position compared to plan. 9. Monthly reporting to Board of financial performance through the Integrated Performance Report	1. Financial plan approved by BPC (with delegated authority from the Board) in November ~~May~~ 2021. Extremely short system and national deadlines meant that there was insufficient time to gain full assurance that a breakeven position was achievable 2. ~~Expenditure budgets based on average run rates for Q3 2020/21~~ Expenditure budgets based on H1 run rates (excluding planned ERF margin) updated for anticipated changes in H~~1~~2 2021/22. This caused a particular issue for trusts who planned for ERF as these allocations were stripped out in H2 leaving a gap. Budgets do not take account of agreed establishments or long term historical allocations for non-pay for departments 3. Block contract based on ~~Q3~~ H1 values in ~~2020/21~~ 2021/22 amended for planned ERF margin, specific H2 agreed pressures and allocation of central HCP funding. It is currently not clear whether the H2 block contract values will cover expenditure run rates given the need to deliver restoration at risk should the system not deliver and the higher proportion of CIP to be delivered coupled with unknown ongoing Covid requirements ~~be representative of 2021/22 given the intermittent stop/start of elective activity and potential ongoing Covid requirements~~ 4. QIP plan will be required in ~~2021/22~~ H2 to close the gap to deliver a break even plan. Value of QIP to be delivered 2.5% which is above the national average given the financial position of the HCP. Recurrent savings for ~~H1~~ 2021/22 impaired by methodology for allocations, lateness in plan submissions and difficulty in identifying schemes whilst trying to deliver elective restoration. Aim to cover QIP non-recurrently in H2~~1~~ allowing time to identify and deliver recurrent savings in 2022/23 when it is hoped to move back to 'business as usual' 5. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance and remain on a payment by results basis 6. Currently no guidance on financial regime beyond March 22 ~~30 Sep 21~~ as national guidance has yet to be issued. Consequently, financial planning for the ~~full~~ next financial year is not possible.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monitoring expenditure and income against budgets via Finance Calculation of forecast position for the H2~~1~~ financial period for comparison against budgets - monthly Covid allocation to recover directly related costs Bed Management Meetings – daily Performance Management Review meetings – monthly Executive review of financial position – monthly NHSI/E review of financial position on a ~~regular~~ monthly basis HCP review of system-wide financial position – monthly **Level 2** Integrated Performance Report – monthly review by Business Performance Committee Integrated Performance Report – review by Trust Board each meeting Financial Plan – regular measurement of actual performance against plan including monthly reforecasting to provide assurance around year-end financial plan. Five year financial planning exercise being undertaken, in collaboration with Operational teams, despite lack of national guidance beyond March 2022. ~~September 2021~~ **Level 3** Internal Audit review of Accounts Payable – Substantial Assurance Jan 2021 Internal Audit review of Accounts Receivable – High Assurance – Jan 2021 Treasury Management Review – High Assurance –Jan 2021 Internal Audit review of General Ledger – High Assurance Jan 2021 Internal Audit review of Budgetary control (including CIP) – high assurance - Jan 2021 Internal Audit review of financial reporting – High Assurance – April 2020 ESR Payroll – Substantial Assurance – April 2019 GIRFT Review – Spinal Contract Review Meetings with Commissioners – ~~bi-~~monthly Internal Audit review of coding systems – Substantial assurance – Dec 19 Unqualified opinion on 2020/21 Annual Accounts by external auditors	1. ~~Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21 and plan for H1 2021/22 based on average run rates in Q3 2020/21 meaning comparison of budgets is not accurate.~~ H2 2021/22 plan is based on H1 run rates which makes meaningful comparison of budgets is not accurate 2. Financial Framework suspension means Trust not being managed via regulator directly but through system / regional approach which is reviewing overall balance 3. Covid expenditure audit by external party yet to be carried out so unsure if any expenditure will need to be repaid. This now seems unlikely. ~~4. Covid cost allocation insufficient to cover actual costs incurred.~~

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

Risk ID: 014	Date risk identified: December 2020	Date of last review:	December 2021
Risk Title: ~~Ensuring the ongoing quality, capacity and capability of Medical Education for the Trust that is sustainable over the longer term.~~ If the Trust does not develop and grow its capacity in line with increasing delivery requirements, there will be an adverse impact on the quality of its medical education and therefore its reputation over the long term.		Date of next review:	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	~~Director of Workforce and Innovation~~ Chief People Officer

Linked Operational Risks		Consequence	Likelihood	Rating
	Initial	Catastrophic 5	Possible 3	15
	Current	Moderate 3	Unlikely ~~Possible~~ 2 ~~3~~	6 ~~9~~
Risk Appetite	Target	Minor 2	Unlikely ~~Possible~~ 2 ~~3~~	4 ~~6~~
	Cautious			

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

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

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

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

Risk ID: 015	**Date risk identified** December 2020	**Date of last review:**	December 2021
Risk Title: The move to an Integrated Health Care Partnership financial system along with changes to tariffs and population based specialised commissioning could destabilise the Trust's income base.		**Date of next review:**	February 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Finance Officer

Underlying Operational Risks				**Consequence**	**Likelihood**	**Rating**
135	If the move to the blended payment approach and population based commissioning allocations continue then this may lead to a risk of reduced allocations for the Trust.	16	**Initial**	**Major** 4	**Likely** 4	16
Understanding of impact on capacity / staffing of any changes in flows etc.			**Current**	**Major** 4	**Likely** 4	16
			Target	~~**Major**~~ **Moderate** 3	**Possible** 3	9 ~~12~~
Risk Appetite	**Cautious**					

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Potential deterioration of the Trust's financial position through commissioning / tariff changes - Loss of decision making responsibilities as move to system based financial targets - Working with different tariff systems (Wales and Isle of Man) - Loss of key relationships in commissioning to Trust. - Impact on specialist Trusts of new arrangements	Recent NHSI/E consultation shows that there will be a move to system working Tariff consultation also requested feedback on changes to both tariff and the move to population based funding. Lack of clarity around financial regime beyond September 2021 (block funding has remained in place for Apr-Sep 2021)

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Trust engagement on C&M HCP meetings 2. Existing relationships with Specialised Commissioning through the transitional period (2022/23) 3. Trust has fed back on consultation to changes on tariffs / population based commissioning 4. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) on this agenda 5. ~~DoF~~ CFO currently a member of the FoSH Finance Group which is reviewing impact of the new financial framework on the system for specialist providers and engaging with the wider system on potential changes 6. Progression of commercial strategy to explore new / alternative sources of income to mitigate any potential reduction of income in relation to core NHS contracts. 7. Critical Care and rehabilitation tariffs have been discussed with Specialised Commissioning to see if there is any flexibility for change given latest intelligence.	1. ~~Move to system allocations via HCP puts trust at risk as no longer dealing with commissioners who have detailed knowledge of trust services~~. Lack of detailed understanding on how commissioning will occur given the changes from NHSE to HCP 2. Larger acute trusts with underlying structural deficits may have a bigger influence within the HCP in terms of funding allocations 3. Some of Walton Centre patient population lies outside C&M HCP and therefore does not align with population basis for commissioning / funding allocations 4. Trust basis for funding based on historical local tariffs recognising disproportionate costs of delivery may not be taken into account for services leaving trust with financial gap 5. Affordability given the C&M system already has a large deficit historically meaning that the Trust may have to take a proportion of this deficit. 6. Governance around the provider model and how this fits in with the wider HCP financial system delivery, especially around some timescales required for delivery of financial returns (and incompatibility with Board / Committee meetings) 7. Lack of clarity on future financial framework beyond ~~30 September 2021~~ 31 March 2022. Lack of longer term financial planning creates further uncertainty for the Trust.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular review of risks at Board level and on-going review of mitigations Review of financial position at every Board and ongoing monitoring through financial controls and processes. **Level 2** Risk being reviewed across several organisations and also by FoSH so potential to influence the agenda. Transitional period in 2021/22 will ensure that financials will be broadly in line with current regime for a year until full implementation of population based commissioning. c75% of current referrals within the current HCP boundary with 12% outside so not as fragmented population base for referrals given the size of C&M HCP (the rest are Wales / IOM) which limits though does not eliminate financial risk. Trust engaging on the collation of a 5 year plan with specialist trusts in C&M to understand what the longer term finances look like for each of the trusts. **Level 3** External Audit of Annual Accounts and going concern considerations	1. Move from existing regulatory relationship with NHSI/E and commissioning relationships with NHSE, Specialised Commissioning to single relationship with HCP and how this will work. 2. Post transitional period finances i.e. population based commissioning will still leave a potential c12%+ income at risk if they no longer are commissioned from Trust. 3. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR.

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with HCP on system development. Previously responded on consultation, fed back on Memorandum of Understanding. Separately also fed back to NHSI/E on tariff consultation.	ALL	~~On going~~ 30 April 22	On track
2	Meeting planned with HCP DoF and Specialist Trust DoFs to show how specialist trusts can support the system in terms of finance and activity restoration etc.	~~DoF~~ CFO	Ongoing	On track
3	Review of out of HCP referrals / activity to understand the largest CCGs and formulate what can be done to continue activity into 2022/23 with the Trust.	~~DoF~~ CFO	~~Mar 21~~ ~~Sep 21~~ 30 June 2022	On track
4	Continue to work with FoSH around a national response on how specialised trusts will benefit the new way of system working.	CEO/CFO ~~DoF~~	Ongoing	On track
5	Continue to provide mutual aid during the pandemic response to enhance reputation as a system player.	DCOO/ CEO/ MD	Ongoing	On track
6	Prepare internal 5-year financial plan based on anticipated changes to tariff to understand longer term financial risks for the Trust and support strategic planning.	CFO ~~DoF~~ / COO ~~DoSO~~	~~Sep 21~~ 30 June 22	On track

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

Linked Operational Risks				Consequence	Likelihood	Rating
96	If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19.	12	Initial	Moderate 3	Likely 4	12
47	If high numbers of hospital acquired infections (MSSA, Ecoli, CDIF) continue, then there is a risk the Trust may exceed it set trajectories.	16	Current	Moderate 3	Possible 3	9
			Target	Moderate 3	Unlikely 2	6
Risk Appetite	Cautious					

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

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

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

DRAFT

The Walton Centre
NHS Foundation Trust

2022/23 Draft Revenue finance and contracting Guidance

High level summary

Mike Burns – Chief Finance Officer

Helen Wells – Deputy Chief Finance Officer

Excellence in Neuroscience

22/23 Key Points

The Walton Centre NHS Foundation Trust

- Systems continue to be key unit for planning and have a breakeven requirement
- ICB's not statutory until 1st July 2022
- Plans for full 12 months of 22/23
- Baseline is 21/22 H2 allocations (x2)
- Signed contracts with commissioners required for 22/23
- Currently no detailed timetable but key HCP dates 14th March and 28th April

Operational planning guidance

The Walton Centre NHS Foundation Trust

- 22/23 goal to deliver over 10% more elective activity than before pandemic (30% more by 2024/25)
- Eliminate waits of over 104 weeks and reduce waits of over 78 weeks
- Develop plans to support overall reduction in 52-week waits where possible
- Reduce OP follow ups by minimum of 25% against 19/20 activity levels by March 2023
- Expand uptake of patient initiated follow-up (PIFU), moving or discharging 5% of OP attendances to PIFU by March 2023
- Delivering 16 specialist advice requests, including advice and guidance, per 100 OP 1st attendances by March 2023
- People waiting longer than 62 days for cancer pathway to return to Feb 2020 levels
- Increase diagnostic activity to minimum of 120% of pre-pandemic levels in 22/23

ICB Programme allocations

The Walton Centre NHS Foundation Trust

- Move back to fair share system resource distribution
- ICB allocations based on H2 of 21/22 annualised (H2 x 2) with adjustments:
  - Baseline normalising adjustments (removing NR funding etc.)
  - 22/23 growth (including general efficiency requirement of 1.1%)
  - Convergence adjustment towards fair share allocations
- Convergence adjustment replaces Trusts Financial Improvement Trajectories (FIT)
- Distance from target allocation will be single measure of resource utilisation relative to fair share distribution

ICB provisional revenue allocation

The Walton Centre NHS Foundation Trust

	21/22	22/23	Notes
Recurrent allocations	£4,671,404	£4,801,960	Includes growth & convergence adjustment
HI Funding		£11,537	
Maternity		£3,371	
COVID	£253,102	£108,915	
TOTAL	**£4,924,506**	**£4,926,143**	

Notes:
COVID reduction & convergence reduction total £195m
Elective recovery funding held nationally £2.3bn

System business rules

The Walton Centre NHS Foundation Trust

- Local capital and revenue resource should not exceed limits set by NHSE/I
- If ICB's deliver an in year under or over spend, it will be carried forward and maintained as a cumulative position
- If ICB overspend an additional interim efficiency will be required for a minimum of 1 year, or until ICB spend reduced to allocation limit
- Net historical CCG overspend balances will be frozen and written off if system and ICB breakeven for each of the 2 following years (obligation will be reinstated after this period if breakeven not achieved)

ICB Elective Services recovery

The Walton Centre NHS Foundation Trust

- Nationally £2.3bn elective recovery funding available
- Elective recovery funding apply to:
  - Elective ordinary
  - Day case
  - Outpatient procedures
  - Outpatient 1st attendances
- Additional funding available (systems):
  - Activity over target – 75% of tariff will be earned
  - Activity below target – 75% of tariff will not be earned
- Additional funding available (providers):
  - Activity over target – 75% of tariff will be earned
  - Activity below target – 50% of tariff will not be earned
- Provider activity payments will be linked to actual levels of activity delivered

Specialised commissioning

The Walton Centre NHS Foundation Trust

- NHSE regional commissioners to re-establish local responsibility for payment arrangements for specialised commissioning
- Needs based allocations formula for specialised services being developed for future implementation (will be implemented using aligned convergence approach)
- NHSE/I will maintain central budgets for investment in service and clinical priorities (allocated in-year as investment decisions made)

High cost drugs and devices

The Walton Centre NHS Foundation Trust

- Tariff-excluded high cost drugs:
  - ‘block’ drugs (not volatile in terms of uptake) will be added to fixed element of contracts
  - ‘cost and volume’ drugs will have notional baseline (based on M6 21/22) in fixed element of contract with under/ over performance subject to variable payment
- New NICE approved drugs will continue to be reimbursed on 100% cost and volume basis based on actual reported data
- All national tariff excluded high cost device funding to be managed outside contract baselines
- Trusts will be reimbursed directly by national team

Clinical networks

The Walton Centre NHS Foundation Trust

- Specialised commissioners invest in trust-hosted specialised services clinical networks
- From 22/23 will be funded from baseline allocation funding (previously linked to achievement of CQUIN)
- Funding for specialised services clinical networks will be reconfirmed annually

COVID-19 system allocation

The Walton Centre NHS Foundation Trust

- Systems will continue to receive fixed system allocation for COVID 19 services
- Allocation will reduce from H2 2021/22 annualised levels
- Reduction in line with spending review 2021 (SR21) settlement – equivalent to 57% reduction (£144m)
- Reduction covers transfer of resource from Covid allocation to elective recovery funding
- No 22/23 support for non-NHS income loss – systems will need to take action to recover their positions

Guidance - additional points

The Walton Centre NHS Foundation Trust

- Expectation to reduce reliance on agency workers and move towards compliance with agency controls
- Procurement target operating model should be implemented
- Corporate services target operating model:
  - Systems should develop plans for corporate services transformation where appropriate and should include:
    - Legal
    - Finance back office
    - Payroll
    - Staff bank
- Better care fund will continue in 22/23
- Inflation: Government committed to fund direct cost of impact relating to employer costs of Health and Social Care Levy
- Car parking:
  - Free for disabled, frequent OP attenders and staff working night shifts – funding within ICB allocations
  - Funding removed for providing free car parking to all other staff

Guidance – additional points (contd)

The Walton Centre NHS Foundation Trust

- Revenue support for capital investments:
  - National capital programmes will be allocated a specific revenue support fund to assist with some of short term costs of capital
- Health Education England – continue to be funded on activity basis
- Devolved administrations – contract terms revert back to locally determined arrangements comprising either PBR or establishing block contracts
- Commercial and overseas visitors income – trusts should continue to develop opportunities to grow non-NHS income
- Arrangements for risk sharing of chargeable overseas visitors remains suspended in 22/23
- PPE will continue to be procured centrally until the end of March 2023
- Continued focus on prompt payment targets are achieved

Contracts and payments

The Walton Centre NHS Foundation Trust

- Transition back towards local agreement of contracts (from emergency payment arrangements)
- 22/23 – simplified payments system will remain in place to support agreement of contract values
- 22/23 contract values should be assumed to fund 19/20 activity levels plus relevant activity growth funded through core commissioner allocations for intervening years
- National tariff payment system – proposals for 22/23 have been published
- Expectation for signed contracts for 22/23

Contracts and payments (contd)

The Walton Centre NHS Foundation Trust

- Contracts will comprise:
  - Fixed element:
    - Based on agreed level of activity (it is not encouraged to re-price activity using new tariff prices)
    - Includes CQUIN funding of 1.25% of contract value
  - Variable element for volume related payment for actual activity delivered
  - Funding for agreed level of activity to be in fixed element
  - Variable element for:
    - Where actual elective activity differs from this agreed level
    - Actual achievement of BPT and CQUIN criteria and advice and guidance services delivered
- CQUIN to operate from 1st April 2022

Contract baselines

The Walton Centre NHS Foundation Trust

- Baseline – annualised H2 2021/22 contract value (except specialised services which have been adjusted on net neutral basis)
- Adjust contract value baseline for:
  - Service changes from 1 April 2022
  - 22/23 Growth funding
  - Inflation (2.8%) and general efficiency (efficiency factor of 1.1%)
  - Additional efficiency – to reduce resource towards affordable, fair share levels
  - 22/23 ERF should be applied on top of baseline contract value in line with agreed system activity plan
  - Service development funding
  - Specialised excluded drugs and devices
  - COVID 19 funding

2022/23 national tariff consultation

The Walton Centre NHS Foundation Trust

- Consultation on proposed changes ends 28th January
- High cost drugs and devices:
  - Introduce parity of funding so any drug commissioned by NHSE on cost & volume funded in the same way regardless of commissioner
  - Any NICE guideline approved items should be on cost and volume basis
  - Add 17 items but remove 70 items from high cost drugs list (including removing Botulinum Toxin)
  - Trust 19/20 botox spend £1.45m
  - Add 4 items and 1 category (thrombectomy devices) to high cost devices list
  - Add 7 items to innovative products list
- Currency:
  - Proposed to use HRG4+ currency based on 18/19 reference costs to set national prices
  - A number of changes to HRG design (remove 60 but add 122 others at more granular level)

2022/23 national tariff consultation (contd)

The Walton Centre NHS Foundation Trust

- Best Practice Tariff (BPT)
  - Same approach introduced in 21/22 national tariff
  - Providers and commissioners agree level of BPT attainment – funded in fixed element of contract
  - Adjustments for actual attainment levels would be within variable element of contract
- No changes proposed for top up payment rates from 21/22 tariffs
- No proposed changes to specialised service top up identification rules and provider eligibility lists

CQUINS

The Walton Centre NHS Foundation Trust

- CQUIN being re-introduced from 2022/23
- CQUIN 1.25% of fixed contract element
- Only earnable on 5 most important indicators as agreed with commissioners
- Performance against all indicators still required regardless of whether included in CQUIN scheme
- To be paid in advance and in full to provider as part of monthly contract payments) with deductions as part of variations to fixed payment for any under performance
- Financial value of each indicator to be equally weighted
- Where fewer than 3 appropriate national indicators commissioners may offer additional local ones
- Funding under the scheme is non-recurrent

CQUINS – quality indicators (acute only)

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- Staff flu vaccinations (goal 70% - 90%)
- Appropriate antibiotic prescribing for UTI in adults aged 16+ (goal 40% - 60%)
- Recording of NEWS2 score, escalation and response time for unplanned critical care admissions (goal 20% - 60%)
- Compliance with timed diagnostic pathways for cancer services (goal 55% - 65%)
- Treatment of community acquired pneumonia in line with BTS care bundle (goal 45% - 70%)
- Anaemia screening and treatment for all patients undergoing major elective surgery (goal 45% - 60%)
- Timely communication of changes to medicines to community pharmacists (goal 0.5% - 1.5%)
- Supporting patients to drink, eat and mobilise after surgery (goal 60% - 70%)
- Cirrhosis and fibrosis tests for alcohol dependent patients (goal 20% - 35%)

CQUINS – quality indicators (specialised)

The Walton Centre NHS Foundation Trust

- Achievement of revascularisation standards for lower limb ischaemia (goal 40% - 60%)
- Achieving high quality shared decision making conversations in specific specialised pathways to support recovery (goal 65% - 75%)
- Achieving progress toward Hep C elimination within lead Hep C centres (goal 60% - 75%)
- Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines (goal 74% - 98%)

Timetable/ Next Steps

The Walton Centre NHS Foundation Trust

- Currently no detailed timetable issued – key dates mentioned by HCP 14th March and 28th April
- Internally weekly planning meetings between finance, operational and information staff have started to consider activity and financial plans for 22/23
- Understanding of run rates critical
- Identification and delivery of recurrent cost efficiencies critical

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Thank you and questions

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REPORT TO BOARD OF DIRECTORS
3 February 2022

Title	**Reducing the burden of reporting and releasing capacity to manage the COVID-19 Pandemic**
Sponsoring Director	Jan Ross - Chief Executive
Author (s)	Katharine Dowson - Corporate Secretary
Previously considered by:	Trust Board – 4 March 2021

Executive Summary

Over the past year the Trust Board has considered three letters, sent in March and July 2020 and January 2021, which set out the revised regulatory requirements for NHS Trusts in response to the COVID-19 pandemic.

The purpose of this report is to set out the Trust's ongoing approach in response to updated correspondence from NHS England & NHS Improvement dated 24 December 2021. A copy of this correspondence is included for reference at Appendix A to this report. In addition Mersey Internal Audit Agency (MIAA) sent out a governance checklist in early January which expands on some of these areas and the Trust response to this is detailed in Appendix B.

The Trust's approach to the areas set out in the NHSE/I correspondence is detailed at s3.1 of the report at Table 1 and details of delegated levels of authority and emergency powers arrangements have been included at s3.2 and s3.3 respectively. These emergency powers were last reviewed on 4 March 2021.

Action required by the Board:	The Board of Directors is recommended to: • Receive the report and note the Trust's position on areas set out in correspondence from NHSEI dated 24 December 2021 (included at Appendix A) • Endorse the delegated authority and emergency powers arrangements set out at s3.2 and s3.3 of the report • Note the response to the MIAA governance checklist
Related Trust Ambitions	• Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Related Assurance Framework entries	Risk ID 001 – COVID-19
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	No

1.0 Introduction

1.1 The response to the coronavirus (COVID-19) emergency situation required NHS organisations to operate differently to normal business as usual practice. The purpose of this report is to update the Board on the Trust's approach in response to new correspondence received from NHS England & NHS Improvement dated 24 December 2021. (Appendix A)

2.0 Background

2.1 The Board of Directors initially approved revised governance arrangements for management of the pandemic situation on 30 April 2020. These arrangements, which aimed to facilitate both agile decision-making and streamlined business agendas to ensure appropriate operational focus, were gradually eased as the impact of the pandemic situation began to reduce during the summer and autumn of 2020. During the winter period of 2020/21 when significant pressures on the NHS returned, the Trust was advised to review its arrangements again in order to reduce the burden on staff and allow focus on operational pressures. This was reviewed at the Board meeting of 4 March 2021.

2.2 Following a recovery period through the summer and autumn of 2021 governance arrangements were again gradually in the process of being restored with, for example, the Trust Board returning to face to face meetings. The arrival of the Omicron variant in December 2021 has resulted in renewed pressure, both regionally and nationally, in recent weeks in managing capacity and supporting staff during periods of high levels of staff absence.

2.3 Once again the NHS is under pressure and a further review of arrangements to reduce the burden and release capacity on Trusts has been issued and has been reviewed again by the Trust. The Board is asked to note the update and approve the continued arrangements of emergency powers set out in s3.2 and s3.3 of this report.

3.0 Approach

3.1 The Trust's approach to the areas set out in the NHSE/I correspondence of 24 December 2021 is detailed in Table 1 below with changes in both the areas to consider and the Trust's response highlighted in blue/strikethrough:

Table 1

Areas for NHS organisations to consider	Trust's Response
1. Board and Sub-Board Meetings • Trusts should continue to hold Board meetings but streamline papers, focus agendas and hold virtual, not face-to-face meetings. No sanctions for technical quorum breaches (e.g. because of self-isolation). • For Board Committee meetings, Trusts should continue Quality Committee meetings, but consider streamlining other Committees. • While under normal circumstances the public can attend at least part of Board meetings, Government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation.	• The Trust reviewed its approach to Board agendas and reintroduced streamlined agendas with effect from the Board meeting held on 4 February 2021. Substantive agenda items will be focused on key operational matters. • A Consent Agenda approach has been introduced to assist with the streamlining of meeting and mitigate the risk of business backlog. • ~~The Quality Committee continues to meet in accordance with its normal business cycle~~. All ~~other~~ Board Committees ~~also~~ continue to meet utilising streamlined agendas and the Consent Agenda approach where appropriate. • All Board and Committee meetings were held virtually using MS Teams until October 2021. Some meetings through to December 2021 were held face to face. The Trust will continue to risk assess each meeting with the February 2022 Board Meeting returning to Teams • The Chair has returned to holding weekly briefings for Non-Executive Directors (NED).

2. FT Governor Meetings • Face-to-face meetings should be stopped at the current time. Virtual meetings can be held for essential matters e.g. transaction decisions. • FTs must ensure that Governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 e.g. via webinars/emails.	• Council of Governors and associated meetings are currently being held on a virtual basis approach, utilising streamline agendas where necessary. • Governors have expressed a preference to remain using virtual meetings for the time being. The Chair maintains regular contact with the Lead Governor and holds ~~fortnightly~~ monthly virtual briefings for members of the Council of Governors. Governors also have access to the Trust's weekly news bulletin 'Walton Weekly'.
3. FT Governor and Membership Processes • FTs are free to stop/delay Governor elections where necessary. • Annual Members' Meetings should be deferred. • Membership engagement should be limited to COVID-19 purposes.	• The Trust deferred elections to the Council of Governors in 2020 as a result of the pandemic situation. 2021 elections took place as normal ~~It is currently planned to hold elections during the period June-August 2021~~ in order to mitigate the risk that level of vacancies will affect meeting quoracy. • The Trust held virtual Annual Members' Meetings in September 2020 and ~~currently plans to hold the next meeting in~~ September 2021. These plans will be reviewed and may be adjusted dependent on the prevailing circumstances. • Normal membership engagement activities continue to be suspended although virtual options are now being offered in conjunction with other Liverpool Trusts.
4. Annual Accounts and Audit NHSE/I wrote to the sector on 15 January 2021 to make the following adjustments to reporting requirements: • Extending the 2020/21 accounts and audit year end timetable • Allowing Providers to apply for a further extended timetable for submitting 2020/21 financial accounts • Deferring introduction of IFRS 16 to 2022 • Simplifying the 'agreement of balances' exercise Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	• The Audit Committee was briefed on the revised timetable at its meeting held on 19 January 2021. • The Trust applied for the further extended timetable (submission date of 29 June 2021 as opposed to 15 June 2021) on the advice of External Audit. The request for extension was subsequently approved by NHSE/I. • The Trust is anticipating that the Annual Accounts and Audit will be prepared on the same basis as 2021/22 but is awaiting updated guidance
5. Quality Accounts – Preparation • The deadline for Quality Accounts preparation of 30 June is specified in Regulations. ~~DHSC is currently reviewing whether Regulations should be amended to extend the 30 June deadline for 2020/21.~~ • As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	• ~~The current deadline of 30 June 2021, and the likelihood that this may change, has been noted.~~ Quality Accounts are likely to be prepared on the same basis as 2020/21.
6. **Quality Accounts and Quality Reports – Assurance** We are removing requirements for FTs to include quality reports within their 2021/22 annual report and removing the need for assurance of quality reports and quality accounts from all trusts.	Noted and confirmed that External Audit are aware that there is no requirement to undertake assurance review of the 2021/22 Quality Report. Consideration is being given as to whether Internal Audit will review the Quality Account as part of the plan for 2022/23

7. Annual Report We wrote to the sector on 15 January 2021 confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 and kept for 2020/21 are available for 2021/22.	Noted. ~~The work plan for the 2020/21 Annual Report was circulated for action on 19 February 2021.~~ Planning for 2021/22 annual report will be made on the same basis as 2020/21.
8. Decision-making Processes While having regard to their Constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	The emergency powers arrangements initially approved by the Board on 30 April 2020 remain in place. See section 3.2 and 3.3 of the report.
Reporting and Assurance	
1. Constitutional Standards Relevant standards and arrangements detailed at Annex A of NHSE/I letter dated 24 December 2021.	• The Trust continues to analyse and report on performance against constitutional standards via the divisional management structure. • The Trust continues to submit data returns as required. • The Integrated Performance Report contains the relevant standards and continues to be reported to Trust Board. NEDs have the opportunity to submit questions in advance of the meeting where they are seeking greater assurance.
2. Friends and Family Test Reporting requirement to NHS England and NHS Improvement has been paused. However, Trusts have flexibility to change their arrangements under the new guidance and published case studies show how Trusts can continue to hear from patients whilst adapting to pressures and needs.	• The Trust resumed completion of the Friends & Family Test (FFT) in January 2021 utilising electronic means of data capture where appropriate. The Trust has no plans at present to suspend FFT.
~~**3. Operational Planning**~~ ~~• The 2021/22 planning and contracting round will be delayed; it will not be initiated before the end of March 2021 and we will roll over the current financial arrangements into Q1 2021/22.~~	~~• Noted. The Trust has commenced 2021/22 planning for internal purposes.~~
~~**4. Long Term Plan: System by Default**~~ ~~• System by Default development work (including work on CCG mergers) has been restarted. NHSE/I actively encourages system working where it can help manage the response to COVID-19. We will keep this work under review to ensure it continues to enable collaborative working and does not create undue capacity constraints on systems.~~	~~• Noted. The Trust continues to participate in collaborative system working in both local and regional systems.~~
3. Long Term Plan: Mental Health NHSE/I will maintain Mental Health Investment guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.	Noted.
4. Long Term Plan: Learning Disability and Autism ~~NHSE/I will maintain the investment guarantee.~~ Systems should continue learning disability and autism investment and transformation to support the LTP.	Noted.

5. Long Term Plan: Cancer NHSE/I will maintain its commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response, and restoration and maintenance of cancer screening and symptomatic pathways.	Noted.
6. Long Term Plan: Maternity and Neonatal Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report. We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.	Noted.
7. GIRFT (Getting it Right First Time) and transformation programmes Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.	Noted.
8. NHSE/I Oversight Meetings ~~Virtual meetings will be held. Streamline agendas and focus on COVID-19 issues and support needs.~~ Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.	Noted.
9. Integrated Care System (ICS) Development Activity System working is essential in managing the response to COVID-19 and delivering the NHS priorities in 2022/23. Work to establish ICSs – and Integrated Care Bodies (ICB)s as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.	Noted.

10. Corporate Data Collections (e.g. licence self-certs, Annual Governance Statement, mandatory NHS Digital submissions • Look to streamline and/or waive certain elements • Delay the Forward Plan documents that FTs are required to submit • We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.	Noted. The Trust will ensure compliance as and when further guidance is promulgated.
11. CQC routine assessments and Use of Resources assessments ~~CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHSE/I continues to suspend the Use of Resources assessments in line with this approach~~. • With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. • CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced. .	Noted.
12. Provider transaction appraisals / CCG mergers / Service reconfigurations • ~~Complete April 2021 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors.~~ • ~~Complete April 2021 CCG Mergers.~~ • ~~Where possible and appropriate we will streamline the process to review any reconfiguration proposals, particularly those designed in response to COVID-19.~~ • Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors • Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.	The Trust does not have any pending transaction appraisals or service reconfigurations although the transfer of spinal services to the Trust is continuing.
13. 7-day Services Assurance • ~~Suspend the~~ Self-cert statements to continue.	Noted.
14. Clinical Audit • ~~Given their importance in overseeing non-Covid care, clinical audits will remain open. This will be of particular importance where there are concerns from patients and clinicians about non-Covid care such as stroke, cardiac etc.~~ • ~~However, local clinical audit teams will be permitted to prioritise clinical care where necessary – audit data collections will temporarily not be mandatory.~~ Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain	Noted.

open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.	
15. Pathology Services • ~~We need support from Providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent and consumables.~~ We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.	Noted.
Other Areas including HR and staff-related activities	
1. Mandatory Training New training activities – refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.	Mandatory training being undertaken where possible within prevailing restrictions.
2. Appraisals and Revalidation • ~~Indications are that the Appraisal 2020 model is helping to support doctors during the pandemic, however we recognise with rising pressures in the system appraisals may need to be reprioritised, so appraisals can be declined. If appraisals are going ahead, please use the revised shortened Appraisal 2020 model.~~ • ~~The GMC has now deferred revalidation for all doctors who are due to be revalidated between 17 March 2020 and 16 March 2021.~~ • Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred • The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate ~~between March and December 2020.~~ December 2021 and March 2022.	Noted
3. Primary Care We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy.	Not applicable, primary care only.
4. CCG Clinical Staff Deployment • Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. • CCG Governing Body GP to focus on primary care provision and booster programme.	Not applicable, CCGs only.

5. Repurposing non-clinical staff from CCGs Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.	Not applicable, CCGs only.
6. Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

3.2 **Delegated Authority for Expenditure** – At its meeting on 30 April 2020 and again on 4 March 2021, the Board of Directors approved a temporary departure from the delegated limits set out in Standing Financial Instructions to facilitate efficient decision-making for COVID-19 related expenditure only. These arrangements continue in place and are as follows:

Financial Limit	Authority
Up to £5,000	Bronze Command
£5,001 to £20,000	Silver Command
£20,001 to £25,000	Deputy Director of Finance
£25,001 to £40,000	Gold on Call
£40,001 to £50,000	Executive Directors
£50,001 to £100,000	Director of Finance
£100,001 to £250,000	Chief Executive

The Board of Directors is recommended to endorse continuation of these arrangements.

3.3 **Emergency Powers** - Also at the meeting held on 30 April 2020, the Board of Directors agreed Emergency Powers for general commitment of expenditure. The relevant entry in the Trust's Scheme of Reservation & Delegation (SoRD) relates to items of pay and non-pay expenditure including software, IT equipment, maintenance contracts, goods and services contracts and management consultants. Delegated levels of authority and associated emergency powers are based on the financial levels set out in the SoRD which was approved at Board on 4 November 2021.

Consequently, the current delegated levels and associated emergency powers are as follows:

Value	Standard Delegation	Emergency Powers
Up to £25,000	Divisional Directors/ Deputy DON/	Director of Operations & Strategy or Director of Nursing & Governance
£25,001 to £35,000	Deputy Director of Finance	Director of Finance
£35,001 to £60,000	Other Executive Directors	Chief Executive **or** two Executive Directors jointly
£60,001 to £100,000	Director of Finance	Chief Executive or 2 x voting Executive Directors
£100,001 to £150,000	Chief Executive (Executive Team)	Chief Executive or 2 x voting Executive Directors
£150,001 to £500,000	Business Performance Committee	As per Standing Order 5.2 Emergency Powers - Chief Exec or 2 Executive Directors and Chair acting jointly and after having consulted with at least 2 Non-Executive Directors. The exercise of such powers shall be reported to the next formal meeting of the Board for ratification.
£500,001 and above	Board of Directors	

The Board of Directors is asked to consider continuation of these arrangements.

3.3 In January 2022 MIAA circulated a governance checklist which was based on the Reducing Burden, Releasing Capacity paper but asked some further questions as well. The Executive team have reviewed this document as well and this has been provided as Appendix B.

4.0 Recommendations

4.1 The Board of Directors is recommended to:

- Receive the report and note the Trust's position on areas set out in correspondence from NHSE/I dated 24 December 2021 (included at Appendix A)
- Note the Trust's position set out in response to the MIAA Governance Checklist
- Endorse the delegated authority and emergency powers arrangements set out at s3.2 and s3.3 of the report
- Set a date at which the emergency powers should be reviewed again.

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS 111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

24 December 2021

Dear Colleague

Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

Once again, the NHS is facing a significant challenge from COVID-19. As we continue to manage infections from the Delta variant, the Omicron variant is growing substantially and once again there is a risk of significant levels of COVID-19 hospitalisations with the challenges these place across the whole NHS. At the same time, the NHS is delivering a national COVID booster vaccination programme and continuing to provide essential non-COVID care.

This letter should be read in conjunction with 'Preparing the NHS for the potential impact of the Omicron variant and other winter pressures', which declared a Level 4 National Incident.

Following our letters in March and July last year and January, this letter updates our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- streamlining oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focusing our improvement resources on COVID-19, vaccination, discharge, UEC and elective recovery priorities
- only maintaining development workstreams that support recovery and safety.

Our intention is that the measures here will collectively help you free up resource to address the priorities we have set out.

We will keep this under close review, making further changes where necessary to support you and remaining mindful of the balance between timely information and not flooding the service with requests. We will review and update the measures set out in this letter in Q1 2022/23.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenge of COVID-19 since March 2020.

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

A) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas. No sanctions for technical quorum breaches (eg because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation. All system meetings to be virtual unless there is a specific business reason to meet face to face.	Organisations to inform audit firms where necessary
2.	FT governor meetings	Face-to-face meetings should be stopped wherever possible at the current time[1] – virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19, eg via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor
4.	Annual accounts and audit	Wherever possible the NHS England and NHS Improvement accounts team will reduce the administrative burden of year-end accounts as far as is possible, but the current intention is to stick with the published timetable. We will, as ever, remain responsive to challenges as they emerge.	Organisations to continue with year-end planning in light of updated guidance
5.	Quality accounts – preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. As in previous years, we intend to write to all providers concerning the requirements for 2021/22 Quality Accounts.	No action for organisations at the current time

[1] This may be a technical breach of foundation trusts' constitution but acceptable given government guidance on social isolation.

No.	Areas of activity	Detail	Actions
6.	Quality accounts and quality reports – assurance	We are removing requirements for FTs to include quality reports within their 2021/22 annual report and removing the need for assurance of quality reports and quality accounts from all trusts.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January 2021 confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 and kept for 2020/21 are available for 2021/22.	Organisations to continue with year-end planning in light of updated guidance
8.	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

B) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, cancer, ambulance waits, mental health and learning disability measures)	See Annex A
2.	Friends and Family Test	Reporting requirement to NHS England and NHS Improvement has been resumed. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. We emphasise local discretion.
3.	Long Term Plan: mental health	NHS England and NHS Improvement will maintain the Mental Health Investment Guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
4.	Long Term Plan: learning disability and autism	Systems should continue learning disability and autism investment and transformation to support the LTP.
5.	Long Term Plan: cancer	NHS England and NHS improvement will maintain their commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. We will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response

No.	Areas of activity	Detail
		and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6.	Long Term Plan: maternity and neonatal	Systems should ensure that maternity services can operate safely in the pandemic context and continue to implement initiatives which support this, such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report. We will work with local maternity systems to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will help them to maintain safe services. This will include reviewing planning milestones, such as submission of plans to roll out continuity of carer and improve equity.
7.	GIRFT and transformation programmes	Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation, personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc.
8.	NHS England and NHS Improvement oversight meetings	Oversight meetings will continue to be held by phone or video conference unless it is agreed that there is a compelling business reason to hold them face-to-face, and they will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure it is appropriate, streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9.	ICS development activity	System working is essential in managing the response to COVID-19 and delivering the NHS's priorities in 2022/23. Work to establish ICSs – and ICBs as statutory NHS bodies – continues, with a revised target date of July 2022. This will allow sufficient time for the remaining parliamentary stages of the Health and Care Bill and provide some extra flexibility for systems in preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response.
10.	Corporate data collections (eg licence self-certs, annual governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the forward plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.

No.	Areas of activity	Detail
11.	CQC routine assessments, Use of Resources assessments, HSIB investigations	With CQC, we continue to prioritise our Recovery Support Programme work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures. CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHS England and NHS improvement continue to suspend the Use of Resources assessments in line with this approach. Visits and inspections in connection with HSIB investigations will also be reduced.
12.	Provider transaction appraisals – mergers and subsidiaries	Potential for NHS England and NHS Improvement to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors.
	Service reconfigurations	Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13.	7-day services assurance	No changes – self-cert statements to continue.
14.	Clinical audit	Given the importance of clinical audit in COVID and non-COVID care, clinical audit platforms will remain open for data collection. It should be noted clinical teams should always prioritise clinical care over data collection and submission.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables. Trusts must also continue to support the prioritisation of covid testing and genotyping services within their own laboratories.

C) Other areas including primary care, HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.
2.	Appraisals and revalidation	Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.

		The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022.
3.	Primary care	We have already announced a series of changes to GP contract arrangements and some changes for community pharmacy.
4.	CCG clinical staff deployment	Review internal needs to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. CCG governing body GPs to focus on primary care provision and booster campaign.
5.	Repurposing non-clinical staff from CCGs	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services and the vaccine booster programme.
6.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc.

Annex A – constitutional standards and reporting requirements

While existing performance standards remain in place, we continue to acknowledge and appreciate the challenges in maintaining them during the continuing COVID-19 response. Our approach to tracking those standards most directly impacted by the COVID-19 situation is set out below.

A&E and ambulance performance – Monitoring and management against the four-hour standard and ambulance performance continues nationally and locally, to support system resilience.

RTT – Monitoring and management of RTT and waiting lists will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. Application of financial sanctions for breaches of 52+ week waiting patients occurring during 2020/21 continue to be suspended. Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital.

Discharge – Monitoring and management of delayed discharge for patients who no longer meet the reasons to reside will continue, and from Tuesday 21 December daily calls will take place in every region with every ICS discharge SRO to discuss performance and actions to decrease the number of people with a delayed discharge.

Cancer: referrals and treatments – Cancer treatment remains a priority and should be protected. We will continue to track cancer referral and treatment volumes to provide oversight of the delivery of timely identification, diagnosis and treatment for cancer patients. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Screening: cancer (breast, bowel and cervical) and non-cancer (abdominal aortic aneurysm, diabetic eye and antenatal, newborn screening and targeted lung checks) – Screening remains a priority and should be protected.

Immunisations – All routine invitations should continue to be monitored via the NHS England and NHS Improvement regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and through the urgent and emergency care daily SitRep return we now capture data on the clinical priority ('P code') of elective cancellations and patients who have not yet been booked for treatment. This is vital management information to support our operational response to the pandemic, and we require 100% completion of this data with immediate effect. Guidance can be found here.

Note: it has been necessary to institute a number of additional central data collections to support management of COVID – for example, the daily Covid SitRep and the Critical Care Directory of Service (DoS) collections. These collections continue to be essential during the pandemic response, but to offset some of the additional reporting burden that this has created, the following collections will be suspended:

Title	Designation	Frequency
Critical care bed capacity and urgent operations cancelled	Official Statistics	Monthly
Delayed transfers of care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex accommodation	Official Statistics	Monthly
Venous thromboembolism (VTE)	Official Statistics	Quarterly
Mental health community teams activity	Official Statistics	Quarterly
Dementia assessment and referral return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week patient choice offer	n.a. - trial	weekly

(This has already been communicated to data submission leads via NHS Digital.)

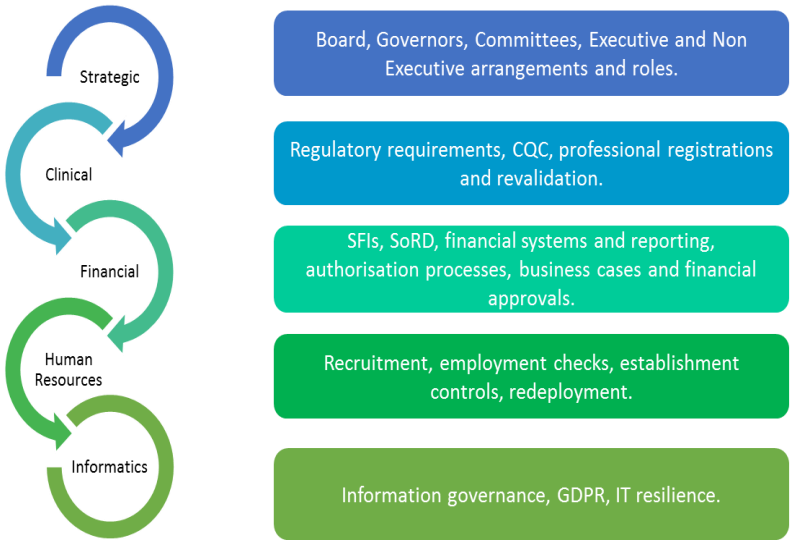
MIAA 2021/22 Checklist Series - Governance (Trusts and FTs)

The response to the coronavirus (COVID-19) emergency situation required NHS organisations to operate differently to normal business as usual practice.

Last year MIAA produced a Governance Considerations in the Context of COVID-19 Checklist to support our clients in reviewing their governance arrangements in the unprecedented situation. MIAA reviewed and updated the governance considerations as our clients continue to respond to the pandemic as well as restore and recover their services.

On 24th December NHS England and NHS Improvement (NHSEI) issued a letter covering arrangements for *Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic* (Publication approval reference: C1518). We have reviewed and updated the contents of this checklist to reflect NHSEI's current 'position on regulatory and reporting requirements for NHS trusts and foundation trusts' outlined in the letter issued.

This tool is structured around the aspects of governance outlined in the adjacent diagram.



Strategic Governance

In the context of COVID-19 the strategic governance of the organisation had to be agile. There needed to be clarity on 'changed' roles and responsibilities, decision making, communication and record keeping. In essence, who needed to be involved in what, how this can be done efficiently and effectively and how best to communicate and maintain records.

Areas for NHS organisations to consider	Organisation's response
1. Board meetings	
Have agendas been reviewed to ensure meetings are focussed and papers streamlined?	Yes. Consent agenda introduced to mitigate business backlog
Are meetings (including system meetings) being held virtually where possible and has the impact on public attendance been considered (i.e. are the public able to attend virtually or are they to be excluded from meetings)?	Meetings moved to Teams, Governors and members of public are able to attend virtually on request.
Have quoracy requirements been reviewed/documented to reflect the current position of no sanctions for technical quorum breaches (e.g. because of self-isolation)?	Yes through 'Reducing the Burden' papers to Board
2. Committee meetings (see Board meetings)	
Have committees been reviewed and streamlined where appropriate?	Yes balanced with requirements of business as usual for agendas.
Have emergency response structures been aligned with business as usual structures?	Yes, Board is updated through CEO report of Covid issues and concerns.
3. Governors (FTs only)	
Have face to face meetings been stopped and this communicated to governors?	All meetings on Teams and Governors have been kept informed. Governors have been surveyed to understand preferences for keeping some meetings on Teams permanently
Are processes in place to include governors in regular	

Areas for NHS organisations to consider	Organisation's response
communications on the response to COVID-19 and is engagement limited to this? Are governors' elections in progress, if so, have these been delayed or stopped? Have annual meetings been deferred?	Monthly Chair's briefings instigated on key topics including but not limited to Covid, recent examples include the Sustainability Plan and Patient Experience 2020 elections were deferred. 2021 elections went ahead as normal No, meetings in 2020 and 2021 were moved to Teams.
4. Executive roles and responsibilities Does the Scheme of Reservation and Delegation (SoRD) need to be updated to reflect any changes made in the response to the pandemic that are no longer required?	SoRD was updated in November 2021. Changes made due to the pandemic are exercised as emergency powers in parallel to SoRD and Standing Financial Instructions (SFI). Board informed in April 2020 and March 2021 of ongoing authorisation limits due to Covid. The attached paper serves as ongoing authorisation for 2022/23.
5. Emergency powers and decision making Does the SoRD capture any revised decision-making processes including emergency powers that can be reinstated if needed following a further wave of COVID-19?	Captures standard emergency powers in line with paragraph 5.2 of the Standing Orders of the Board of Directors as described in the Trust Constitution. Decision to be made by Chair and Chief Executive with two Non-Executive Directors.
6. Changes to Governance arrangements Are arrangements in place to keep structures under review as the situation changes? Have key controls been identified in the event of reduced staff numbers? (i.e. segregation of duties**)**	Review of arrangements to be added to 2022/23 cycle of business for Board. The response to reduce staff numbers will principally be through the use of bank, agency and overtime. In the event of a very challenging reduction, key element of patient services would be prioritised though Command and Control arrangements co-ordinated by the COO and the Chief Nurse.

Areas for NHS organisations to consider	Organisation's response
7. Risk management Have risk management processes continued to be reviewed and amended if appropriate? Has the organisation assessed the impact of the pandemic on the effectiveness of risk management?	Management of risk remains an important part of managing the Trust response to the pandemic. New BAF risk identified regarding impact of the pandemic in April 2020 and remains on BAF.
8. COVID-19 Inquiry Are processes being established to support the organisation's future response to the COVID-19 Inquiry, if and when required, including allocation of a lead, consideration of document retention requirements etc…?	Chief Nurse identified as lead. Communications have taken place regarding Stop notice issued and likely timeframe of enquiry.

Clinical Governance

The aspects below are those that need to be considered in respect of regulatory requirements.

Areas for NHS organisations to consider	Organisation's response
1. Quality accounts Are processes in place to collate, produce and review the Quality Account and to submit by the deadline date? NHSEI to write to all providers concerning the requirements for 2021/22 Quality Accounts.	2020/21 process approach currently planned for 2021/22 report pending guidance from NHSEI.
FTs are not required to include quality reports within their 2021/22 annual report and assurance work on 2021/22 Quality Accounts is not required.	Governors have been made aware of audit requirements.

Areas for NHS organisations to consider	Organisation's response
2. Regulatory requirements (including CQC) Are arrangements being maintained to ensure ongoing regulatory compliance and assurance reporting?	The Trust maintains regular monthly / quarterly meetings with the CQC relationship manager to discuss all elements of care at The Walton centre and this is reported to Quality Committee / Audit Committee / Trust Board as appropriate.
3. Constitutional Standards and Performance Reporting Are arrangements being maintained to continue to monitor and report on key standards as required by NHSE/I? Have performance reporting arrangements been reviewed to streamline where possible?	The Integrated Performance Report has now been streamlined with key information only (less narrative) to provide information on all of the key standards. The operational team continue to attend the NHS England/ NHS Improvement (NHSEI) regional meetings and the hospital cell meetings to ensure we are updated on any key further requirements for the Trust.
4. Clinical Audit Have all national clinical audits, confidential enquiries and national joint registry data collection been reinstated? Has the impact on clinical care of data collection and submission been assessed and clinical care prioritised? Are systems in place to continue data collection for the child death database and MBRRACE-UK-perinatal surveillance data?	Yes all reinstated. Clinical care has been prioritised over audit and therefore no impact has been identified. Not applicable to the Trust.

Financial Governance

There are requirements that need to be considered when reviewing financial governance arrangements. The key principles of good financial governance remain, but within this the organisation needs to ensure speed of decision making and transactions, cover arrangements and clarity of changed systems/ processes.

Areas for NHS organisations to consider	Organisation's response
1. Annual Accounts and Annual Reports	
Has the accounts timetable been updated to reflect this year's deadlines?	Initial timetable received, awaiting further guidance and release of Annual Reporting Manual by NHSEI.
Has it been agreed which forum will approve and sign off the accounts?	Board of Directors
Have the options available to simplify parts of the annual report introduced in 2019/20 and available for 2021/22 been considered and built into plans where appropriate?	Yes, as per 2019/20 approach.
2. Authorised Signatories	
Are additional authorised signatories required to ensure 'contingency'/ cover arrangements for when staff are absent or operating remotely?	The Trust has a process in place to amend these as part of normal business arrangements to cover Annual (or unexpected) Leave and this has continued during the pandemic with people identified in a chain to cover as necessary. Trust systems are set up so that they can be accessed remotely (whilst working on the trust secure remote server) by staff meaning that they are still able to approve when working remotely.
Are electronic signatures (for bank account signatories) held securely and are processes in place to maintain an audit trail of usage?	These are held in place securely and an audit trail is in place for use of signatories. Copies of emails approving the usage of electronic signatures are maintained for audit purposes.
Where appropriate has the SoRD been updated?	The Trust updated its arrangements under 'Emergency Powers' at the onset of the pandemic which included changes to SoRD and SFI's and this remains in place.

Areas for NHS organisations to consider	Organisation's response
3. Systems and processes Are processes in place to update/develop procedures to support system changes/new systems?	Yes, Command and Control structure was utilised during Covid peaks to facilitate quick actions. Outside of peaks business as usual processes used to support transformation/ change.
4. 2021/22 budget and month end processes Is a 2021/22 budget in place to support financial reporting? Has this budget been aligned with current financial regimes?	The Trust has a budget in place that aligns with the current Financial Framework (in that it based on run rates rather than funded establishments)
Are there any proposed changes to month end processes?	There have been no changes to month end processes though guidance has been introduced to help budget holders to understand their statements and finance are looking to streamline processes to speed up the process. The finance department will also be undertaking a series of financial training sessions over the coming months for new/ existing budget holders with the training be provided to nurse ward managers in the first instance.
Have cashflow forecasting and reporting processes been reviewed and aligned to NHSE/I requirements as appropriate?	The reporting and forecasting processes align with both NHSE/I and HCP requirements. Financial Board reports/ IPR reconcile back to monthly submissions made to NHSE/I.
5. Cost Improvement Programmes (CIP) Have you reinstated arrangements to identify and monitor CIPs?	Arrangements have been reinstated with regular meetings with the appropriate people to identify and deliver CIPs and divisional / departmental targets set. A trust wide CIP tracker has been updated and re-implemented to help with the monitoring of CIP delivery and performance

There was rightly a significant focus on the capacity, capability and resilience of the workforce needed to meet the challenges of COVID-19, now organisations need to ensure that practices are reviewed and amended as appropriate.

Areas for NHS organisations to consider	Organisation's response
1. Revalidation Have revalidation processes for doctors been reinstated? Have revalidation processes for nurses been reviewed to reflect the Nursing and Midwifery Council (NMC) extending the revalidation period for registered nurses and midwives by an additional three months for those due to revalidate between December 2021 and March 2022?	We paused appraisals as advised by the General Medical Council (GMC) in March 2020 and resumed in autumn 2020. We have carried on since. The GMC paused revalidation decisions for that period also but everyone is back to the normal process now There are processes in place to ensure that all registered nurses are compliant and have revalidated during the pandemic.
2. Appraisals and Mandatory Training Have arrangements been put in place to postpone or cancel appraisals if required? If appraisals are continuing is the Appraisal 2020 model being used? Have mandatory training requirements been reviewed and reprioritised as appropriate?	There has been no postponement of the appraisal process and we are continuing with the existing process which is being updated in partnership with Staff Side. Mandatory training has continued to be a priority throughout the pandemic and remains so.
3. Sickness Absence Have sickness absence policies and processes been reviewed and amended as a result of the pandemic to include for example, reporting of sickness, shielding, self-isolation, Return to Work interviews, trigger points?	Both the process for managing sickness absence and its reporting have been modified to reflect the requirements of the pandemic

Areas for NHS organisations to consider	Organisation's response
4. Approval/ Authorisation Are appropriate processes in place for the approval and recording of: Establishment changes Redeployment Bank and Agency Overtime Expenses/Subsistence allowance (where staff are staying away from home to continue to work) Pre-employment checks?	There are appropriate policies and processes for the approval and recording of all the six processes identified and have been developed in partnership with Staff Side colleagues.
5. Policy review and approval Are processes in place for the development and approval of new policies if required?	Yes polices have continued to be written, ratified and approved during the pandemic. Some policies were given an extension due to Covid pressures however processes are in place to ensure that they continue to be ratified.

Information Governance

In the context of COVID-19 the key information governance requirements remained, and the organisation should continue to operate within these.

Areas for NHS organisations to consider	Organisation's response
1. Data Security and Protection Toolkit Has the internal audit of the toolkit been agreed?	In draft Internal Audit Plan for 2022/23

Areas for NHS organisations to consider	Organisation's response
2. Cyber risks Are operational systems and assurance processes being maintained for the management of cyber risks?	The Trust holds regular ISMS meetings to review cyber risks and updates requirements in line with CARECERT requests regularly.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 03/02/22		**Report of: Quality Committee**
Date of last meeting: 20/01/22		**Membership Numbers:**
1.	**Agenda**	The Committee considered an agenda which included the following: • Medical Director's Update • Integrated Performance Report (IPR) and KPI report • Quarter 3 Governance & Risk Management Report • Mortality & Morbidity Q2 & Q3 Report • Infection Prevention Control (IPC) Q3 Report • Tissue Viability Report • Board Assurance Framework • Quality Accounts • NICE Exception Report • Pathology Quality Assurance Dashboard • Clinical Audit Progress Report • Patient Experience Terms of Reference • Clinical Effectiveness Terms of Reference • Chairs' Report from Sub-committees • Quality Committee Work plan
2.	**Alert**	• The Medical Director (MD) reported a never event relating to wrong site injection of Botox. Full duty of candour was followed and the RCA is underway. Minor side effects were experienced by the patient but otherwise there was no harm. • IPC Q3 report - Regarding hospital acquired infections, the trajectories for 2021-22 have been exceeded. However on-going work and actions are in place and as such there was a reduction in the occurrence of MSSA, E-Coli and CPE in the last quarter. Two Covid outbreaks in Q3 were reported and all is being done to keep patients safe. • TVN - It was noted that the number of incidents of pressure ulcers may increase as training on the wards improves identification processes. Assurances were provided for the management of cases by the Tissue Viability Nurse (TVN). The extensive work completed by the TVN since starting at the Trust in November was acknowledged and feedback on ward based training is positive.
	Assurance	• IPR – updates were provided with regards to staffing, NEWS scores, Risk assessments and work undertaken with the informatics team. The management of incidents is improving as has the management of policies. A written report encompassing both divisions was included providing further detail of nursing and Trust IPR outcomes. The Divisions will provide individual reports at future

		Quality Committee Meetings. • Mortality & Morbidity Reports for Q2 & Q3 were presented. It was noted that the RAMI data indicates that the Trust is below average for mortality rates in comparison to peers, which is positive. There was one unexpected death for which an RCA is near completion. Full Duty of Candour was followed. • BAF – a new risk for IPC016 has been added to the BAF for Quality Committee. Risk 003 to include an SPC chart to indicate number of harms to staff arising from violence and aggression incidents to provide further assurances. • The Governance & Risk Management Q3 report was presented detailing significant work achieved by the team despite current vacancies. Assurances were provided in that data around health inequalities and protected characteristics is regularly added to dashboards to support KPI metrics. Data can be accessed daily and can be monitored. • The Quality Accounts were presented and agreed. A further detailed document to be sent to the Quality Committee members.		
	Advise	• The MD advised that feedback for the Critical Care Network Peer Review which took place in the summer had been received. The positive feedback reflected the excellent work which takes place on ITU and noted the excellent MDT approach and work undertaken for staff well-being. Areas of improvement included a focus on Level 4 competencies for senior nurses and the lack of weekend cover of respiratory physiotherapists. • NICE Exception Report – the MD advised that further work is required to update the report. Delays are due to deficits within the team responsible for the report. Requests have been made for increased reviews at Clinical Effectiveness & Services Group (CESG) until the report is up to date • Clinical Audit Progress Report – again it was noted that further work needs to be undertaken to ensure that the report is up to date and that Trust priorities for audits are included. Responsibility for this report lies within the same team as the NICE exception report which is why the report is not at the required standard. Increased reviews at CESG are planned.		
2.	Risks Identified			
3.	Report Compiled by	Seth Crofts	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 25/01/22		**Report of:** Business Performance Committee
Date of last meeting: 23/11/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report December 2021 • Review of 28 day emergency readmissions • Transformation and Quality Improvement Programme Quarterly Update • Operational and Financial Planning Guidance 2022/23 • Staff Wellbeing Survey Results • Response to People Plan and Trust Annual Staff Survey • Digital Aspirant NHSX Monthly Update • Digital Business Change Management Report • Digital Aspirant Matched Spending Report • Trustwide Risk Register • Board Assurance Framework • Terms of Reference – Capital Management Group and Information and Data Quality Group • Chair Reports from 9 subcommittees • Business Sustainability
2.	**Alert**	• Vaccination as a Condition of Deployment (VCoD) presents a risk of enforcing a material reduction of patient-facing staff. Considerable; concerted efforts ongoing to encourage further Covid vaccine uptake amongst relevant staff. • Emerging risk identified regarding ongoing Botox treatments and exclusion from the tariff. Potential unfunded cost of £1.5m. Work underway by clinicians to endorse the ongoing clinical need for a specialist group of patients
	Assurance	• Operational performance in cancer, diagnostics and against the recovery plan were all strong in December, despite the disruption caused by the Omicron wave. Our own targets towards Elective Recovery Fund (ERF) were met/exceeded (although payment is not expected since the whole system targets are not expected to have been met). Theatre activity remains difficult, driven partly by staffing issues. • A very large capital spend is required in Q4 to meet the planned spend for the year. Assurance was given that there was line of sight of schemes in progress to achieve this.

		• A health and well-being survey provided valuable input to be incorporated into an update of the wellbeing strategy. Progress against the overall people plan reviewed. • Assurance was provided on active and involved change management relating to the Digital Aspirant project, together with assurance of securing all the funding (£1m agreed to be rolled over to next year). • A global cybersecurity alert in December has required significant effort to maintain/assure the robustness of our systems; an external review of ISO27001 returned a full bill of health. • Following challenge from the NEDS the Trustwide Risk Register to be reviewed to ensure all risk actions and assurances have been captured and updated.		
	Advise	• Waiting list metrics deteriorated during December, breaking the prior improvement trajectory, partly because the transfer of spinal service from LUHFT has brought additional long waiters. • Patient Initiated Follow Up (PIFU) first target was not quite met, despite Walton being in top quartile. The service is now being expanded to additional areas, which is expected to increase take-up and work is underway to meet the next target. • Sickness absence increased above 8% in line with the new Covid Omicron variant wave. Mandatory training dipped below threshold as a knock-on from sickness. • Appraisal completion remains low although a 1% improvement had been made. The People Group will deliver an improvement plan next month and work on a renewed plan for staff retention as part of the people strategy. • Process and data quality improvements were made in response to the trend in emergency readmissions noted in the last meeting. A new sub-group has been formed to oversee data quality more widely. • The opportunity to utilise external funding to devise and implement a bed repurposing project has necessarily demanded the majority of the transformation team's focus to be able to fast-track this. The flip-side is that other programmes, including this year's short-term QIP schemes, have made less progress. • December's revenue surplus of £57k was £88k behind plan mainly because ERF income didn't materialise. Costs were better than plan despite additional staffing bank costs to cover sickness absence. Year to date position is £219k deficit and end of year forecast is £340k deficit against a planned break even position. • An update to the projected financial impact of taking on the spinal service is planned to be presented to Board in coming months. • The relevant Board Assurance Framework (BAF) risks were updated with a few changes recommended to Board. • Two Terms of Reference (TOR) were approved and 9 sub-group reports were reviewed.		
2.	Risks Identified	• Threat to achieving break-even in 21/22. • Financial planning principles for 22/23 indicate big challenges ahead • Increased threat of Cyber Security risks with new threats identified and patches will take some time to complete.		
3.	Report Compiled	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 03/02/22		**Report of:** Audit Committee
Date of last meeting: 18/01/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Recommendation Report • Counter Fraud Progress Report • Anti-Fraud, Bribery and Corruption Policy • External Audit Progress Report • External Audit Annual Report • Bad Debt Write Off Report • Losses and Compensation Report • Tender Waivers • Preparation of the 2021/22 Financial Statements • CQC Assurance Report • External Recommendations Report • Annual Cycle of Business • Annual Review of Effectiveness of Internal and External Audit Functions • Data Quality Performance Assurance and Escalation Presentation
2.	**Alert**	• The Committee noted that no audit reports had been finalised for the second quarter in succession. Assurance was provided that there were no concerns relating to an audit opinion being provided and work was underway for each of the audits at this stage. • The Committee noted that there had been eight fraud prevention notices published since the previous report and a number of actions taken in response to these. One attempt at ESR payroll fraud targeting a member of staff had been identified by the staff member targeted and this fraud attempt had been unsuccessful. • The audit of 2020/21 Complex Discharge Process had provided limited assurance. Improvement actions were in the process of being undertaken and these processes would then be reaudited.
	Assurance	• The Committee considered the Internal Audit Progress Report and noted that no Audit Reports had been finalised since the last meeting on 19th October 2021.

		The following audits were noted to be in progress: o Review of SMART (this audit was in the reporting stage) o Exit Interviews (fieldwork was in progress for this audit) o Procurement (fieldwork was in progress for this audit) o Key Financial Controls (fieldwork was in progress for this audit) o Assurance Framework (fieldwork was in progress for this audit) o IT Infrastructure (scoping work was in progress for this audit) o Flexible Working (scoping work was in progress for this audit) o Data Protection and Security Toolkit (scoping work was in progress for this audit) • The Committee reviewed the outstanding internal audit recommendations report and noted that considerable work had been undertaken to review and close outstanding recommendations. Additional evidence had been submitted following production of the report to close further recommendations which was under review and an updated position would be circulated following review. • The Committee received the External Audit Annual Review focussing on value for money and no significant weaknesses had been identified however there were to recommendation notices recorded. Overall this was recognised to be a positive report. • The Committee reviewed the CQC Assurance Report and were assured that no essential works were required following the last CQC inspection and work was progressing against the action plan which would be closed at Quality Committee in March 2022 prior to submission to Trust Board.		
	Advise	• The Anti-Fraud, Bribery and Corruption policy and response plan had been updated to align with the national strategy and policy template. A summary of amendments was reviewed. • The Committee approved two changes to the Internal audit plan relating to The Informatics Improvement Plan and Waiting Lists. • The Committee's private session with the Internal and External Auditors identified no matters of concern.		
2.	Risks Identified	• None		
3.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 21/1/22		**Report of:** The Walton Centre Charity Committee Meeting
Date of last meeting: 21/1/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Presentation by Investment Manager CCLA • Finance Report – including investment reports • Fundraising Activity update • Charity Risk Register • T&D Funding Applications and Annual Report and 4 applications from The Walton Centre Charity • Update on Reserves Options Policy • Home from Home Annual Report • Report on the Preparation of the Financial Statements for The Walton Centre Charity 2021/22 • Approval of 2 Fundraising Policies • Cycle of Business
2.	**Alert**	•
3.	**Assurance**	• The Committee were given an annual presentation from CCLA one of the Investment Managers for the Charity. It was a detailed and informative update that provided assurance that the funds held were being managed well with consistent and competitive returns whilst maintaining the ethical investment restrictions agreed by the Committee. Since the initial investment of £500k was made in July 2018 the portfolio now stood at £639,442 with an annual income forecast of £18,133. CCLA would be carrying out an investment review over the next six months and members of the Committee would be invited to partake. The results would be shared at the annual presentation in January 2023. • The Head of Fundraising provided an update on fundraising activity highlighting the Jan Fairclough Ball which took place on 12 November 2021. The event attended by 260 people raised £72k towards the Neuro VR Simulator Appeal. The total cost for the Simulator is £122,860 which includes 5 years warranty and maintenance, delivery, installation and training. The equipment will be delivered in February and funds were available for the first payment of £86,951. Further annual events previously cancelled due to Covid 19 that would also be taking place in 2022 included the Hope Mountain Hike in April; Walton Centre Charity Golf Day in May and a Ladies Lunch in June.

		• The Committee noted that work on the Charity Risk Register was progressing well however more work was required on the scoring of the risks and this would take place between the Head of Fundraising and Corporate Secretary prior to the next meeting in April when a final version of the Risk Register would be ready for approval. • The Committee approved the Ethical Donation Acceptance or Refusal Policy and Fundraising Policy. • The Committee approved the Report on the Preparation of the Financial Statements for The Walton Centre Charity 2021/22. This was to allow the Charity Committee to approve the accounting policies and confirm that they are satisfied that the accounts should be prepared on a going concern basis. It was confirmed the accounts had now been published on The Charity Commission website.
4.	**Advise**	• The Committee received the Finance Report which showed that fund balances had reduced by £100k during Q1-Q3. The closing balance of the funds as at 31 December 2021 was £1,593,093. Covid 19 had continued to impact fundraising although the Committee were pleased to note that funding was being disbursed. The Committee were pleased with the additional and updated charts and graphs incorporated into the Q3 report. The Investment Reports (presented by CCLA) and provided by Ruffer were noted and no concerns were raised. • The Committee approved the following funding applications: ○ 9 applications from the Training & Development Department for part funding towards staff professional development. The Department's Annual Report was also received by the Committee ○ PhD fees for Christopher Millward (£2,431) in addition to £9k previously approved (from Neurosurgical / Neuro-oncology Fund) ○ Study Leave for Research by Mr Nish Srikandarajah totalling £5,209 (fund to be agreed) ○ Long Service Awards – recognition gifts for staff (£6,000) from General Fund. An application for investment to implement a Violence & Aggression App to enable staff to conduct standardised risk assessments, create personalised intervention plans and share patient data across teams in a more streamlined and effective way was presented at length to the Committee and discussed. It was well received, however required further discussion by the Executive Team before a decision was made on whether to approve the application estimated to be in the region of £40k + VAT (if not exempt) from the Sid Watkins Fund. • The Committee received the annual report on the Home from Home Accommodation for 2021 from the Head of Patient Experience providing an overview of the use of the accommodation and a summary of the feedback received. Challenges experienced included the conflicting demands on the services of the Housekeeper with other ISS duties and as this service was paid for with charitable funds the Committee felt it should be discussed further outside the meeting to find a solution. • Feedback from a meeting with the Independent Examiner about the level of

		reserves appropriate for the Charity was provided to the Committee and it was noted that the current unrestricted cash level of £1.6 million included £875K of designated funds which were earmarked as per donors wishes. This left approximately £800K in 'free reserves', from which a level needed to be set to enable the Charity to take advantage of opportunities as they presented themselves and to have sufficient working capital to allow for fundraising, support and governance costs to enable operations for a suggested time frame of 12 months. It was also noted that although there is a spending/approval process, there is currently no formal impact/outcome reporting structure as part of that process. This would help the Committee to continuously review the efficiency of the expenditure, and make appropriate changes as necessary (i.e merging funds, transferring the General Purpose etc) and help determine the levels of reserves necessary year on year. Head of Fundraising to draft a comprehensive Grant Making Policy for review at the next meeting. • The Committee received the first draft of the 2022-23 budget which will be updated to reflect comments provided at the meeting with a view to presenting the budget again at the next meeting. • The fund balances at 31 December 2021, after taking account of future commitments, stood at £1,024,754 and there continued to be on-going efforts to utilise funds and consolidate them where appropriate.		
5.	Risks Identified	• None.		
6.	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date: 3rd February 2022

Title	**Governance, Risk and Patient Experience Quarter 3 (2021/22) Report**
Sponsoring Director	Lisa Salter, Chief Nurse
Author (s)	Kate Bailey , Clinical Governance Lead Lisa Judge, Head of Patient & Family Experience
Previously considered by:	• Quality Committee

Executive Summary
The purpose of the report is to:

- Provide a Quarterly summary of Governance activity across the Trust for Quarter 3 2021/22, comparing results of data with the previous financial Quarter (Quarter 2 2021/22).

- Provide assurance to the Trust Board that issues are being managed affectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

The report has been compiled using a collaborative approach with key services across the Trust, including Nursing, HR, Quality and Divisional Management to ensure those themes and trends identified are actioned appropriately.

Themes and Trends have been identified and agreed via a multidisciplinary approach, with input from the following colleagues: Matrons of Neurology and Neurosurgery, Deputy Director of Workforce, Neurosurgery Operational Services Manager, Neurology Operational Services Manager, Quality Manager and Freedom to speak guardian, Neuroscience Laboratories Quality and Governance Manager, Radiology Manager, Radiology Clinical Governance Lead, Estates Manager & Digital Health Records & IG Manager.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with CQC/HSE regulations
Action required by the Board	• To consider and note

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Governance, Risk and Patient Experience

Quarter 3 Report

(October – December 2021)

"Governance is a framework to receive, assess and act upon information we know about the services that we provide. Good governance provides assurance about the key issues and themes relating to the safety and experience of patients and staff. Governance is the backbone of the organisation."

1. Introduction

The Quarter 3 report (October – December 2021) provides an overview of activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health & safety.

The report has been compiled using a number of inputs across the Trust, to ensure that any themes and trends are identified, escalated, actioned and lessons learnt as appropriate. These themes and trends also inform the Governance Assurance Framework (GAF).

1.1. The purpose of this report is to provide:

- a summary of governance activity in Q3 (2021/22) compared to Q2 (2021/22)
- assurances that actions are in place to mitigate identified risks, in order to reduce harm and ensure that learning is embedded
- assurance to the Trust Board that issues are being identified, escalated and managed effectively

2. Executive Summary

2.1. Throughout Q3, the Risk Team has:

- continued to deliver additional mandatory training sessions (including evening sessions)
- continued to deliver Datix risk and incident training (including refresher training)
- significantly reduced the number of policies, procedures and guidelines past the identified review dates on the Trust intranet
- worked closely with the Informatics team to develop a governance dashboard on Minerva, which provides incident leads with an overview of overdue incidents within Datix. This has supported the substantial reduction in incidents outstanding Trust wide, also improving the process for incident management across the Trust going forward
- supported with the reduction of outstanding incident investigation recommendations
- continued to support with the management of violence and aggressive patients
- supported the Head of commercial engagement and marketing to explore how co-creation & development of a digital risk assessment app could help improve the safety of staff and patients, assist with interventions and gain insights that can lead to reduction of violent & aggressive incidents across the Trust.
- completed the Emergency Planning Resilience Response (EPRR) national return
- produced a new template for business continuity plans and updated existing plans for the wards
- created a Trust Cold Weather Plan establishing a new process for Met Office weather warnings
- re-established the Resilience Planning Group
- completed a new training programme for new starters in line with the statutory training schedule
- supported with the completion of display screen equipment assessments across the Trust
- completed an EBME competencies refresh

2.2. Throughout Q3, the Patient Experience Team has:

- continued to listen to, proactively act on and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided support to families unable to visit their loved-ones as visiting remains restricted and support for the families of the bereaved
- induct, support and safely reintroduce volunteers on site
- continually strive to improve the complaints management process in line with Trust targets
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge
- delivered be-spoke training sessions to teams including therapies and Council of Governors
- developed a project which includes the introduction of a Patient Support Assistant role to work on the wards 7 days a week, to bridge the gap between the ward and Patient Experience Team to provide support to patients and families during visiting restrictions
- developed business plan to improve the delivery of Friends & Family Test (FFT)
- review the mortality and learning from deaths process in line with the introduction of the Medical Examiner
- developed a Task & Finish Group to improve communication processes to patients & families with the aim to reduce concerns relating to the same

3. Governance Assurance Framework (GAF)

Two new themes have been added to the GAF following review of Q3 statistics, at the Quarterly Thematic Review Group:

- Ref 312 - Outstanding recommendations identified from the Root Cause Analysis (RCA) Process. (20th December 2021)
- Ref 313 – Covid-19 (20th December 2021)

No themes were closed during Q3.

4. Incident Management

4.1. Total numbers:

- 860 incidents were reported in Q3 compared with 773 in Q2

4.2. Serious Incidents (SI):

- 2 serious incidents were reported in Q3 compared with 1 in Q2

4.3. Moderate (& above) incidents:

- 35 moderate harm (& above) incidents reported in Q3 compared 35 in Q2

4.4. Duty of Candour:

- 33 of the moderate harms incidents required a verbal and written notification, which was adhered to within the appropriate timescales

4.5. Incidents by category:

4.5.1 Infection control Incidents:

- 41 incidents were reported in Q3 compared with 63 in Q2

4.5.2 Communication incidents (GAF entry 304):

- 101 incidents were reported in Q3 compared with 91 in Q2

4.5.3 Information Governance incidents:

- 23 incidents were reported in Q3 compared with 29 in Q2

4.5.4 Medication incidents:

- 79 incidents were reported in Q3 compared with 58 in Q2

4.5.5 Safeguarding incidents and concerns:

- 72 incidents were reported in Q3 compared with 64 in Q2

4.5.6 RIDDOR:

- 3 Incidents were reported during Q3 to the HSE via RIDDOR compared with 0 in Q2.

4.5.7 Violence & Aggression:

- 73 incidents were reported in Q3 compared with 58 in Q2

5. Risks

- During Q3 the Trust wide risk register received scrutiny at Quality Committee
- A review of the Covid-19 risk register was completed by the Executive Team in Q3; with a request for Covid-19 risks to be managed via the appropriate Divisional risk register. This work is now completed
- A review of the corporate risk register was completed by the Executive Team
- The rotational review of risk registers divisionally continued via the divisional risk register work plan and via Quality & Patient Safety Group

6. Complaints & Concerns

- 100% of formal complaints received in Q3 were acknowledged within 3 working days and responded to within the negotiated timeframe meeting the Trust's key performance indicators (KPI)
- 22 new complaints were received in Q3 (a further 1 was received but later rejected and is therefore not included in the figures) this is an increase of 37.5% when compared to 16 in Q2
- 25 complaints closed in Q3; 6 upheld, 5 partially upheld and 14 not upheld
- In Q3, the overall average response time was 25 working days for formal complaint responses. This is an improvement as is lower than the average response time for Q2 which was 27 working days. This is despite there being 3 complaints escalated to level 2 in Q3 (the same amount as Q2). We aim to respond within 25 working days for level 1 complaints and 45 working days for level 2 complaints in line with our Trust KPIs (our average for level 1 complaint responses was 22 working days and for Level 2 complaint responses was 44 working days)
- By Division, the average response time for Neurology was 21 working days for Q3 (including 1 level 2 complaint) in comparison to 26 working days in Q2. Neurosurgery average response time was 32 working days for Q3 (including 1 level 2 complaint) in comparison to 28 working days in Q2. There were 4 cross-divisional complaints received within Q3, the average response time for these was 27 working days (including 1 level 2 complaint). This has been highlighted to the Divisional Operational Team during the weekly meetings in an aim to improve upon these response times

- There was a 39% increase in the number of concerns received with 224 received in Q3 compared to 161 received in Q2
- 67 enquiries/request for support were received in Q3, in comparison to 81 received in Q2; themes relate to the referral process and general hospital enquiries

6.1. Compliments:

- 51 compliments were reported in Q3 compared with 47 in Q2

6.2. Patient Experience:

- Outpatients - **87.5 %** of patients were extremely likely/likely to recommend based on a total of **547 responses (2.8% response rate)**
- Inpatients – **97.6%** of patients are extremely likely/likely to recommend based on a **42.1%**response rate compared to the number of discharges (1,996) in Q3

7. Claims

7 new claims were reported in Q3 compared with 1 in Q2. No claims were reopened. 6 claims were closed in Q3 compared to 7 in Q2.

8. Recommendation

Quality Committee is asked to receive and note this report.

9. Governance Assurance Framework (GAF) Log – Q3 2021/22

9.1. Items for continued monitoring:

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression (Opened 9th October 2017)	The Trust is part of the Mersey Major Trauma & Critical Care and Cheshire and Merseyside Rehabilitation Network. The Trust now treats more complex and challenging patients. Feedback from incidents, staff and staff surveys highlight a higher risk of injury to staff whilst caring for challenging patients who lack capacity. There are often difficulties and delays experienced whilst trying to discharge or transfer complex patients. **Lead:** LSMS (Health Safety & Security Group).	• There were 73 incidents in Q3 compared with 58 in Q2. • 36 physical assaults on staff in Q3. All patients lacked capacity • 6 patients responsible for 6 physical assaults (patient on staff). • On-going issue – incidents patient was deemed medically fit for discharge. These delays in discharge usually result in further incidence of violence or aggression.	• Develop a strategy to implement the National Violence & Reduction standards (Q4). • Continue to provide support for staff. • Violence & Aggression working group (group to meet bi-monthly). • Recommendations and actions from MIAA audit of complex discharges to be implemented.	It is recommended that this remains on the GAF for further monitoring. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 286 – Appointment cancellations /delays (closed 21s September 2021)	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in Do Not Attends (DNAs), complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Patient Access and Performance Director.	• There has been an increase in concerns received in 2020/21, regarding appointment arrangements. • Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments • 28/06/2021. • Review of call recordings since being provided access has enabled managers to provide timely feedback to staff. It has also allowed us to distinguish between genuinely abusive calls and patients who express frustration due to ineffective communication of the process from staff.	• The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. However, Covid-19 recovery and restoration plans are being devised and been submitted. • Continuous review of patient concerns and complaints. 24 concerns were due to patients unable to get through to PAC 01/03/20 - 16/03/2021 compared to 51 from 01/03/19 - 28/02/20, this will continue to be monitored. • 28/6/21 the introduction of Synertec became live since end of May. Some teething problems with some letters not being processed. Currently working with Synertec and IT • LJ, ES and LA setup task and finish group to identify ways to improve communication concerns. Considering actions including developing letters to patients currently on waiting lists. • Noticed an increase in patient initiated cancellations due to Covid-19. Will continue to monitor as it may impact waiting times moving forward.	It is recommended that this entry is re-opened following an increase in concerns received during Q3. **Recommendation**: Re-open

Theme	Context	Analysis	Action	Recommendation
Ref 300 Rejection Of Pathology samples by LCL 2nd October 2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. **Lead:** Labs Quality & Governance Manager (Neurosurgery).	• Rejection data reports now received monthly from LCL. Approximately 60 samples a month rejected across the Trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. • OPD and HITU are the highest affected locations. • Rejections may increase in the near future when samples will be rejected if time of collection is not included following a Serious Untoward Incident in LCL.	• An integrated care IT system is being developed in the Pathology Cheshire and Merseyside network – expected completion date summer 2022. From then it will be decided in what order Trusts in the region will be connected to the order communication system.. Next update July 2022. **Lead:** Head of IMT. Timescale: July 2022	Incidents to be monitored through Datix**.** **Recommendation:** Continue to monitor.
Ref 304 – Communication 19th December 2019	Communication issues have been identified via a number of sources, including the staff survey (2020/21), incidents, concerns and complaints. Lead: Head of Patient Experience/Divisional Director for Neurology/Neurosurgery.	• A slight increase in Quarterly incident statistics can be seen on review of communication incidents, increasing from 91 Q2 to 101 in Q3. • Concerns relating to communication including visiting restrictions continue to be monitored (no specific trend) also continue to be identified and monitored with regards to formal complaints.	• Complaints continue to be monitored via the Board KPI Report and presented bi-monthly to Executive Team. • Divisions continue to closely monitor concerns and complaints via weekly meetings with Patient Experience Team (PET). • Actions/learning from concerns/complaints are monitored at weekly PET/Divisional meetings and recorded on Datix.	Continue to monitor this theme via incidents, complaints and concerns. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 310 - Pressure Ulcers 24th March 2021	There have been a number of incidents reported via Datix of patients developing hospital acquired pressure ulcers (PU). This could potentially lead to moderate/severe patient harm and a poor patient experience. **Lead:** Tissue Viability Specialist Nurse.	• During Q1- Q3 2021/22 there has been 5 category 2 pressure ulcers (PU), 1 DTI PU, 0 category 3/4/unstageable PU's. This equates to 8 verified hospital acquired PU. • There has also been 1 category 1 and 1 DTI unverified hospital acquired PU's. • In the financial year 2020/21 there was 18 verified hospital acquired PU's and 4 unverified in total. In relation to the trajectory of hospital acquired pressure ulcers for this financial, using the data provide, it would appear that we have had a reduction in our HAPU's to date. • New TVN started in November 2021 • HAPU data analysed from 2018 to current date by new TVN. All incidents reviewed and review/outcome details scrutinised on EP2 and Datix system to assure accuracy. This will be circulated shortly.	• 12 months TV training program has been implemented. Consisting of ward based training, one to one training and study days. • Ward/unit Tissue Viability Link Nurses requested for each area; all areas notified and named nurses requested. • 72 hour investigation being requested and compliance with time frame improving. • Completed investigations to be uploaded to Datix system reviewed and agreed at senior level • Wound assessment charts (Ep2) updated and awaiting sign off by nursing documentation group 11/1/22. • Introduction of SSKIN bundles for all wards; document also reviewed and awaiting sign off as above bullet point. • Update Pressure Ulcer Policy to reflect changes. (ongoing) • Register to be compiled of PU training to aid compliance • Audit dissemination of PU education at ward level, following training sessions. (ongoing) • Themes and trends monitored and highlighted in TV bi-monthly bulletin.	Continue to work through all actions and monitor. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 311 Theatre Ventilation System – 05th May 2021	Theatres 1 – 5 do not meet the required level of air changes per minute as required by Health Technical Memorandum (HTM) 2025 guidance. **Lead:** Estates Manager (BPC).	• During the annual validations of Theatre ventilation system (1 - 5) it has been identified there are not sufficient air change rates. • Recent intervention work has taken place which has provided improvements, but fails to meet HTM standards. • The National Infection Rate for Theatres does not indicate a high prevalence of infection which is an indicator of a clean environment. Additionally, it is known that the air cascade, as prescribed in HTM 2025 is correct.	• A options appraisal paper was presented to divisions for discussion and direction. It was agreed that full replacement of the AHUs is required. • Engagement has taken place with design consultant to evaluate preferred options and quoations given to develop the design to tender stage. • A further paper was taken to Capital Monitoring Group for approval to proceed with Design Development. This was approved to proceed for furtehr approval at Operational Management Group. • A further paper is being developed for Board approval, including further refurbishments to Operating Theatres. • Design development business case approved. Purchase order raised for design to be develop upto, and including tender packages	**Recommendation:** Continue to monitor and work through all actions.

Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	• There has been an improvement over recent months of the circulation of hot water temperatures which are now in line with HSE Guidance.	• Undertake meeting with Estates Manager, Head of Risk, Consultant Microbiologist, Infection Prevention & Control Team (IPCC), Director of Nursing and Trust's external water treatment chemist to establish options for future chlorination and treatment of the water pipework. • Establish a process for re-balancing, treatment and testing that will lead towards the future removal of all point of use filters. • Continue programme of temperature testing to ensure stability of circulation. • Maintain flushing and regime via Compass water management system. • Water Safety Group / IPCC to monitor results of above. • Prepare a paper with options and potential capital implications for a system wide chemical treatment of the water system. • Trust has liaised with PHE regarding dosing levels. Awaiting response.	**Recommendation:** Continue to monitor and work through all actions.

Theme	Context	Analysis	Action	Recommendation
Ref 311 – Carbapenemase-Producing Enterobacteriaceae (22nd September 2021)	Significant increase in CPE (Carbapenemase-Producing Enterobacteriaceae) incidents reported throughout Quarter 2. **Lead:** Infection Control Team.	Incidents of CPE have decreased from 11 in Q2 to 0 in Q3.	• Enhanced screening for MDRO across high risk areas in place. • Expert internal/external group review as needed. • Robust action plan and risk reduction actions in place. All action plans now monitored monthly via IPCC. CPE action plan almost complete • Revisit the option of routinely screening patient all patients on admission and those who are re admitted to the Trust within 12 months. • Review use of digital system to monitor screening compliance. There has been feedback that this may occur at national level and be implemented late summer 2022. • Review process to ensure that changes to policies' are communicated effectively • Cleaning sign off sheet for ISS and ward managers introduced • Continue with staff education and raising awareness • Review process for rapid review to ensure learning is embedded effectively. Rapid reviews are now completed within 72hr (working day) deadline.	**Recommendation:** Continue to monitor and work through actions. Review at end of Q4 2021/22.

9.2. New GAF Themes identified during Q3

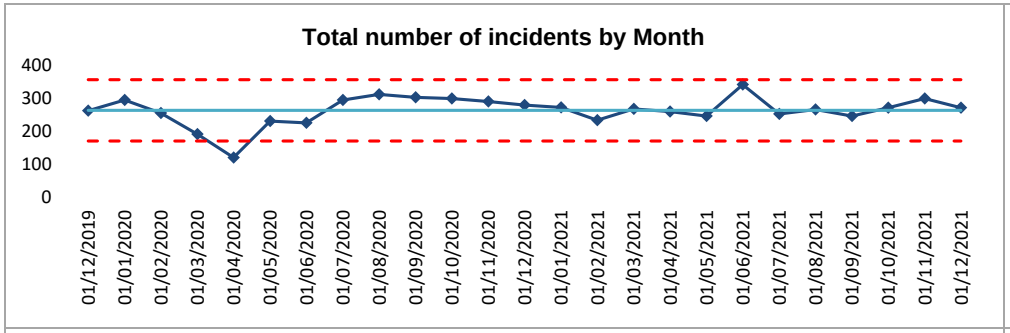
Theme	Context	Analysis	Action	Recommendation
Ref 312 - Outstanding recommendations identified from the Root Cause Analysis (RCA) Process. (20th December 2021)	If outstanding recommendations, identified from Incident investigation process, are not completed (i.e. evidence provided) within the timescales set, then there is risk to Patient Safety as a result of potential re-occurrence of incidents. **Lead:** Divisional Management Teams.	• Outstanding recommendations by division: ○ Surgery division – 92 ○ Neurology division - 84	• Risk recently added to the Trust risk register Risk ID 885 – rating 12. • Weekly - outstanding recommendations are reviewed and monitored at Trusts Weekly safety meeting. • Monthly – numbers of outstanding recommendations monitored by divisional governance meetings.	**Recommendation:** Continue to monitor.

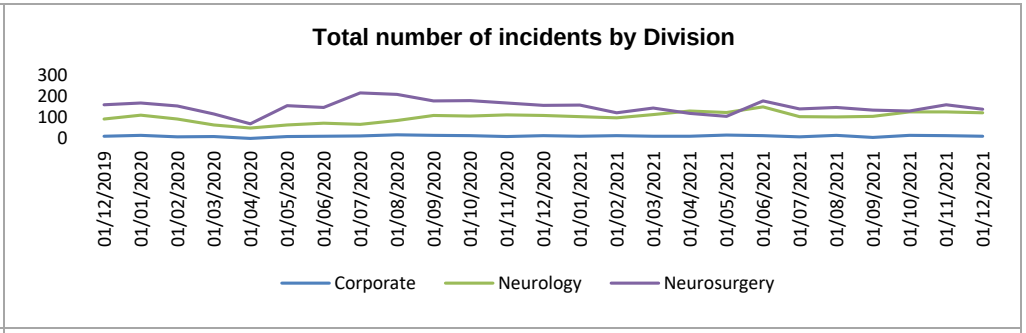
Theme	Context	Analysis	Action	Recommendation
Ref 313 – Covid-19 (20th December 2021)	Following the recognised increase in regional and national Covid-19 infection rates and the introduction of mandatory vaccinations for all NHS staff by April 2022, it is identified that there will be a significant impact to all Trust services. **Lead:** Thematic Review Group.	It is anticipated that there will be: • An increase in Covid-19 infections • An increase in appointment cancellations /delays • Longer waiting times for appointments • Longer waiting times for procedures • Patients being on waiting lists and not being informed of progress • No visiting • Patients families not receiving regular communications or updates in relation to inpatients • Patients often raise they do not wish us to say • Patient behaviour towards staff is not always kind as they are running out of patience • If staff are not double vaccinated by April 2022 then they will be dismissed from the Trust. This will have an impact on the Trusts ability to maintain service standards leading to service disruption.	• Monitor any increased infections via the daily safety huddle. • Incident reporting and investigation. • Addition of 2 new risks to the Trust wide risk register to control and mitigate the risks associated with increased infection rates and mandatory vaccinations. • Divisions will continue to closely monitor any identified concerns and complaints associated with Covid-19 via weekly meetings with Patient Experience Team (PET). • Continue to log actions/learning from concerns/complaints associated with Covid-19 which are monitored at weekly PET/Divisional meetings.	**Recommendation:** Continue to monitor.

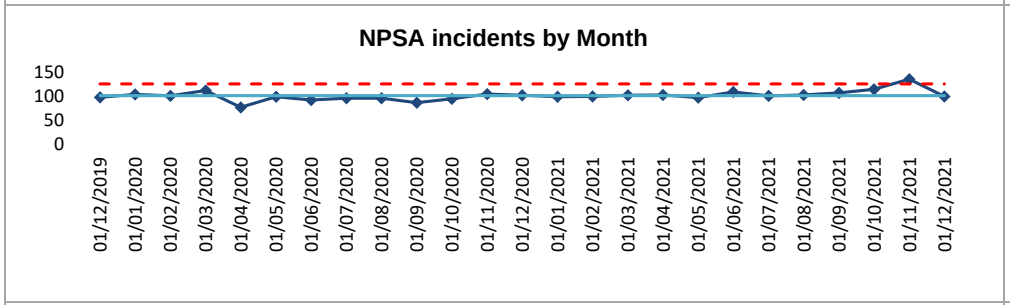
10. Safety and Risk

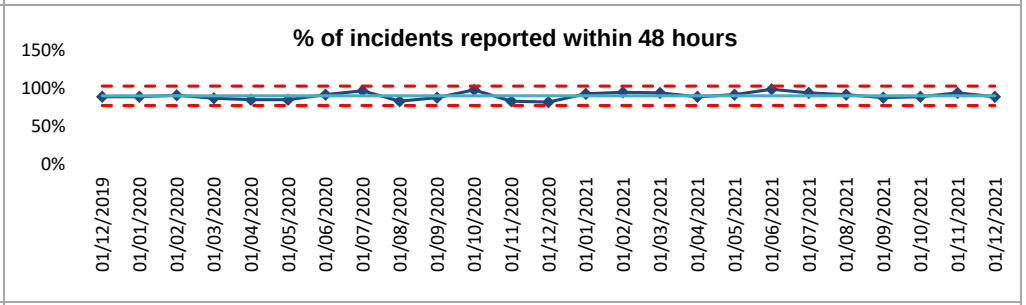
This section provides an analysis of the number and type of incidents reported during Q3 2021/22, the SPC charts below reflect reporting trends from the previous 3 years. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

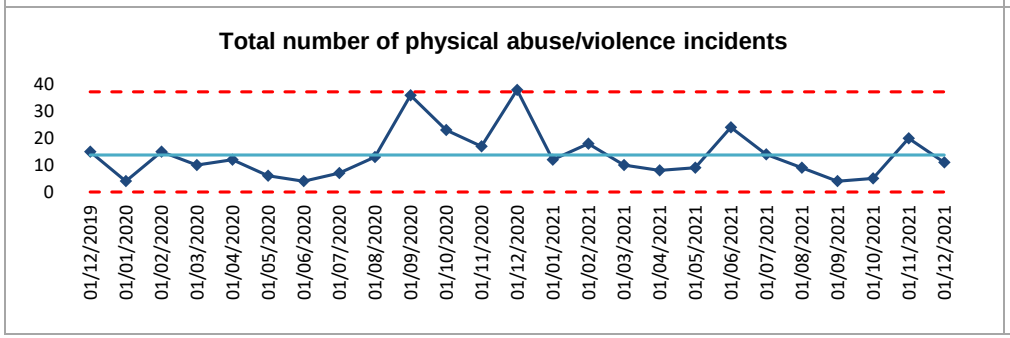
10.1. Incident Management Overview:

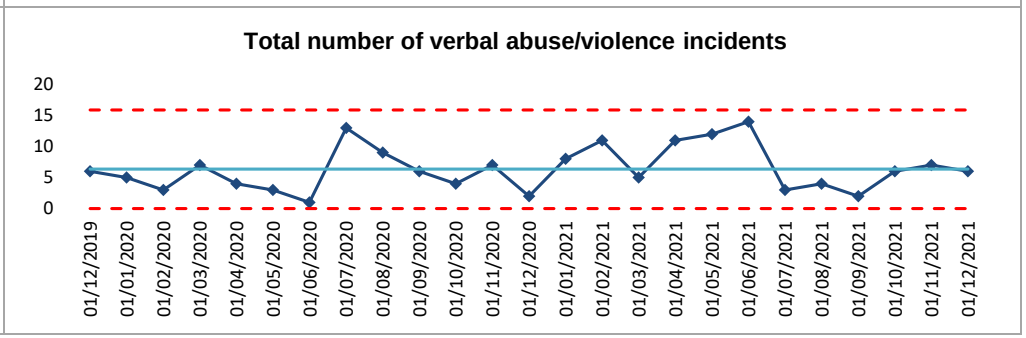


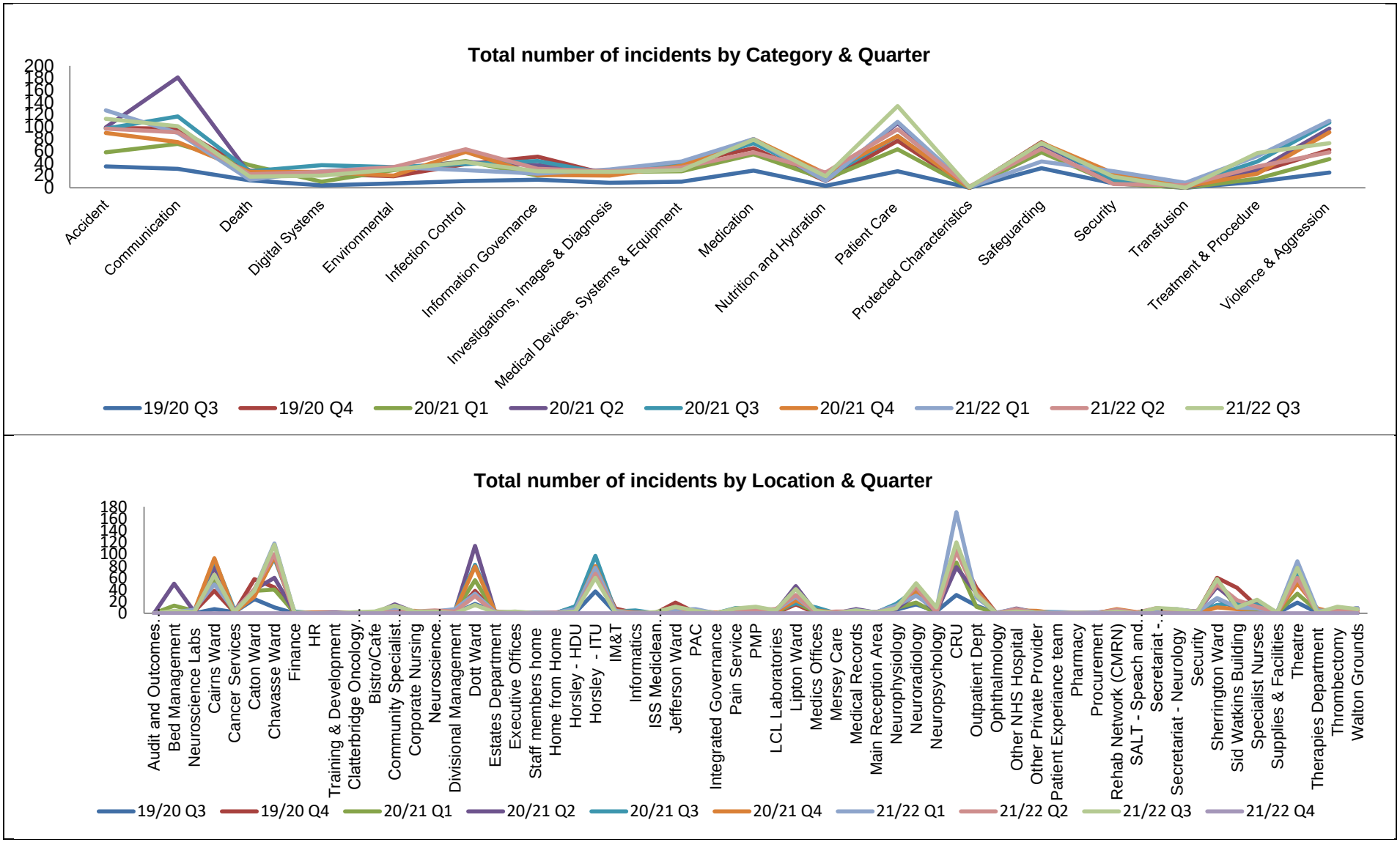











Total number of incidents by Category & Quarter
200
180
160
140
120
100
80
60
40
20
0
Accident
Communication
Death
Digital Systems
Environmental
Infection Control
Information Governance
Investigations, Images & Diagnosis
Medical Devices, Systems & Equipment
Medication
Nutrition and Hydration
Patient Care
Protected Characteristics
Safeguarding
Security
Transfusion
Treatment & Procedure
Violence & Aggression
19/20 Q3
19/20 Q4
20/21 Q1
20/21 Q2
20/21 Q3
20/21 Q4
21/22 Q1
21/22 Q2
21/22 Q3
Total number of incidents by Location & Quarter
180
160
140
120
100
80
60
40
20
0
Audit and Outcomes
Bed Management
Neuroscience Labs
Cairns Ward
Cancer Services
Caton Ward
Chavasse Ward
Finance
HR
Training & Development
Clatterbridge Oncology
Bistro/Cafe
Community Specialist
Corporate Nursing
Neuroscience
Divisional Management
Dott Ward
Estates Department
Executive Offices
Staff members home
Home from Home
Horsley - HDU
Horsley - ITU
IM&T
Informatics
ISS Mediclean
Jefferson Ward
PAC
Integrated Governance
Pain Service
PMP
LCL Laboratories
Lipton Ward
Medics Offices
Mersey Care
Medical Records
Main Reception Area
Neurophysiology
Neuroradiology
Neuropsychology
CRU
Outpatient Dept
Ophthalmology
Other NHS Hospital
Other Private Provider
Patient Experiance team
Pharmacy
Procurement
Rehab Network (CMRN)
SALT - Speach and
Secretariat -
Secretariat - Neurology
Security
Sherrington Ward
Sid Watkins Building
Specialist Nurses
Supplies & Facilities
Theatre
Therapies Department
Thrombectomy
Walton Grounds
19/20 Q3
19/20 Q4
20/21 Q1
20/21 Q2
20/21 Q3
20/21 Q4
21/22 Q1
21/22 Q2
21/22 Q3
21/22 Q4

10.2. Incidents Management statistics:

10.2.1 Total numbers:

- 860 incidents were reported in Q3 compared with 773 in Q2

10.2.2 Moderate & above incidents:

- 2 serious incidents were reported in Q3 compared with 1 in Q2
- 35 moderate incidents were reported in Q3 compared with 35 in Q2
- all incidents complied with the Duty of Candour Regulations

10.2.3 Communication incidents (GAF Entry 304):

- 101 incidents were reported in Q3 compared with 91 in Q2

10.2.4 Infection control incidents:

- 41 incidents were reported in Q3 compared with 63 in Q2

10.2.5 Safeguarding incidents and concerns:

- 72 incidents were reported in Q3 compared with 64 in Q2

10.2.6 Information Governance incidents:

- 23 incidents were reported in Q3 compared with 29 in Q2
- No incidents were externally reported to the Information Commissioners Office (ICO) in Q3 compared with 1 in Q2
- 0 Breaches of Subject Access Request were reported in Q3
- No Breaches of Freedom of Information requests noted in Q3

10.2.7 Medication incidents:

- 79 incidents were reported in Q3 compared with 58 in Q2

10.2.8 RIDDOR (staff more than 7 day absence):

- 3 incidents reported via RIDDOR for Q3 compared with 0 in Q2.

10.3. Violence & Aggression:

- Increase in violence and aggressive incidents from 58 Q2 to 73 in Q3
- increase in physical assault incidents against staff, from 27 in Q2 to 36 in Q3 (all 36 incidents in Q3 relate to patients that lacked capacity)
- 6 patients were responsible for 27 of the physical assaults (patient on staff).
- violence reduction strategy is currently under development, to be completed in Q4 21-22
- violence and aggression working group continues to meet bi-monthly
- the Personal Safety Trainer/LSMS continue to support ward staff with challenging patients
- the Neuropsychiatry Team can:
  - review patients who present with agitation and violent and aggressive behaviour
  - provide advice regarding the management of patients who pose a risk towards themselves or others
  - consider environmental and pharmacological changes to patient's treatment to reduce agitation

10.4. Fire Safety:

- Unfortunately the Trust experienced 9 unwanted fire signals during Q3, of which 5 were attended by Merseyside Fire and Rescue Service (MFRS). 4 of the unwanted fire signals attended by the MFRS occurred out of hours and 1 during normal

working hours. This was due to inaccurate information being passed to Aintree (LUHFT) switchboard. 3 of these calls occurred during the Christmas period, 2 of which have been identified as avoidable.

- Mandatory training compliance currently stands at 79%.
- Fire risk assessments continue to be reviewed with any findings discussed with all relevant parties.
- The Fire Safety Advisor has been working alongside the Estates Manager with regards to new work plans and upgrade works, to ensure continued compliance.

10.5. Datix:

- Datix training continued to be delivered during Q3 via both MS teams and face to face sessions for incident and risk management

10.6. Health and Safety:

The Governance team are currently recruiting for permanent members of Health and Safety support function, during Q3 the interim Head of Risk has focussed on the following items:

- supporting the policy review process with scheduled amendments to the policies for medical devices, external recommendations and display screen equipment
- review and amendments to approved documentation for cold weather planning and coping with trauma
- completion of a Trust Christmas and bank holiday plan highlighting department working patterns and contact details
- developing and updating medical device competencies and guidance
- supporting to develop an apprentice risk assessment process
- completion of DSE assessments throughout the Trust
- reporting of 3 RIDDOR reports to the Health and Safety Executive the categories of these incidents are below:
    - Lifting and handling – moving a patient
    - Lifting and handling – moving equipment
    - Violence and aggression –collision with fixed infrastructure

10.7. Emergency Preparedness, Resilience and Response (EPRR):

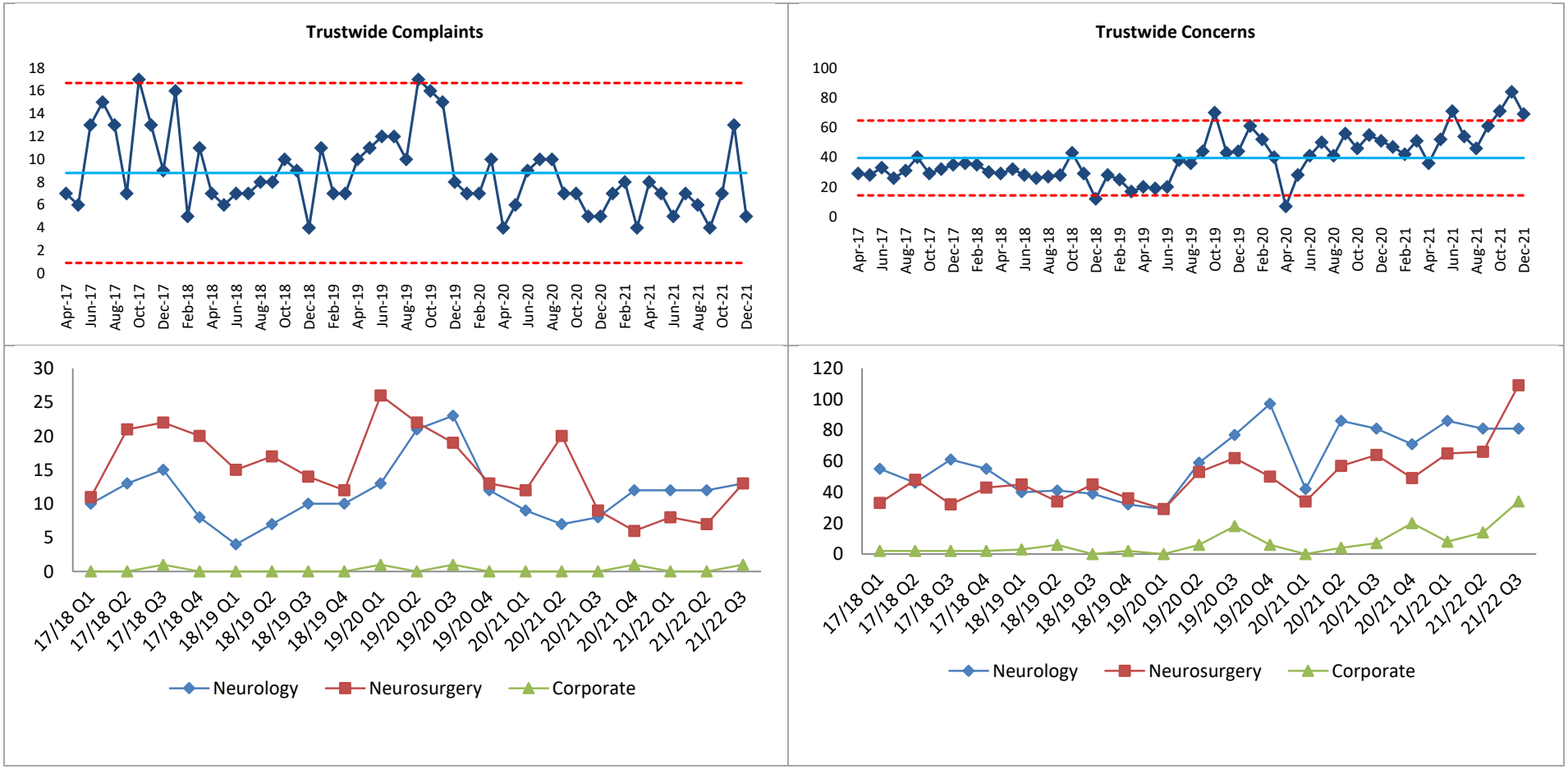
Fit testing continues as a priority and the team have worked to get more support around the Trust including providing a single point of contact for external queries and information returns.

The EPRR function is also supported by the Governance team and as such interim cover is being provided by the Interim Head of Risk during the recruitment process whilst the Team recruits. The following activities have been completed during Q3:

- amendments to the regional EPRR assurance self-assessment return detailing information about the Trusts O2 procedures
- continuation of business continuity planning work with completed Business Continuity Plans for Neuropsychiatry, Lipton Ward, Horsley Unit, Caton and Dott wards
- completion of a hot and cold debrief process around the Liverpool Women's Hospital vehicle explosion incident including supporting the regional EPRR team with their debrief process and feedback
- receiving and communicating the Met Office weather alerts throughout the Trust

11. Complaints & Concerns

The Patient Experience Team (PET) receives a wealth of information surrounding the experience of patients and their families. The Trust use the positive feedback to share and promote good practice and this information can be found in the table below. This section focuses on the areas of concern raised by patients and their families. This information helps us to improve services and learn lessons to improve the care and service we provide to our patients. This section analyses the complaints and concerns raised with the Patient Experience Team.



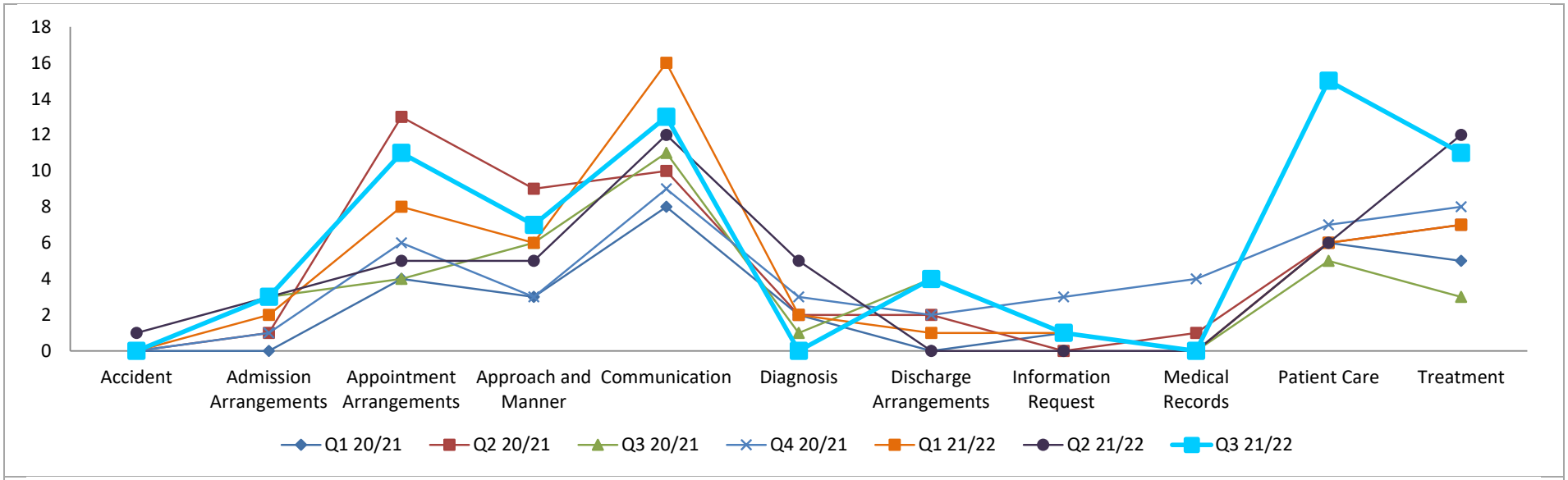
11.1. Quarter 3:

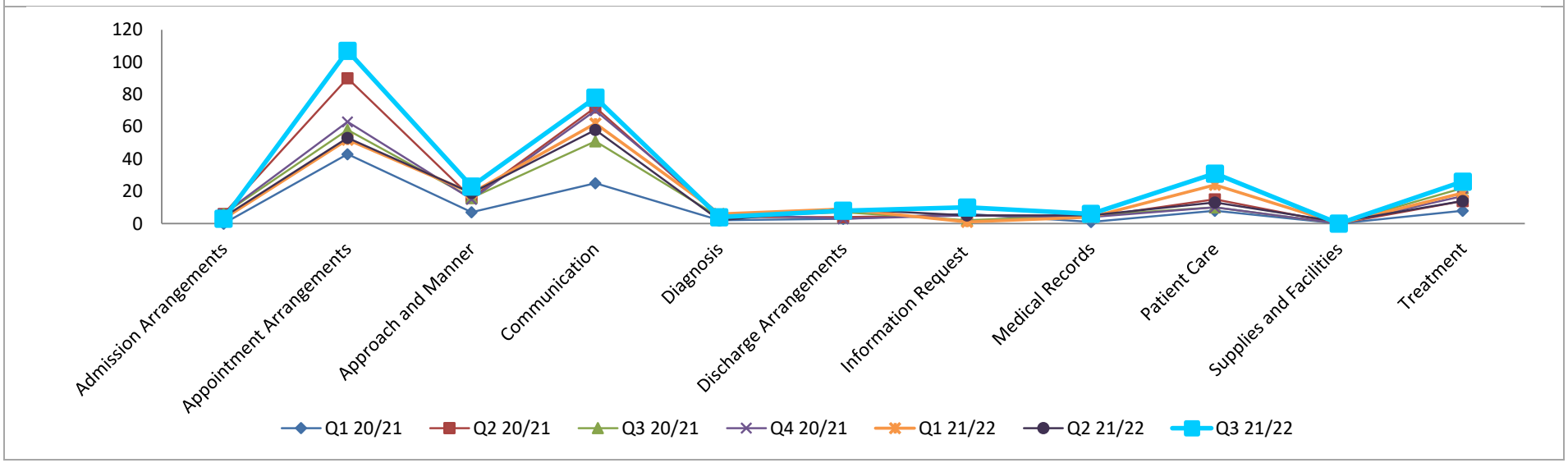
- 100% of complaints received in Q3 were acknowledged within 3 working days and responded to within the negotiated timeframe in line with Trust KPI targets
- 22 new complaints were received in Q3 (a further 1 was received but later rejected and is therefore not included in the figures) an increase of 37.5% when compared to 16 in Q2 of 2021/22
- 3 complaints were re-opened in Q3 as further clarity was sought in comparison to 1 in Q2
- 25 complaints closed in Q3; 6 upheld, 5 partially upheld and 14 not upheld
- In Q3, the overall average response time was 25 working days for formal complaint responses. This is lower than the average response time for Q2 which was 27 working days. This is despite there being 3 complaints escalated to level 2 in Q3 (the same amount as Q2). We aim to respond within 25 working days for level 1 complaints and 45 working days for level 2 complaints in line with our Trust KPIs (our average for level 1 complaint responses was 22 working days and for level 2 complaint responses was 44 working days).
- By Division, the average response time for Neurology was 21 working days for Q3 (including 1 level 2 complaint) in comparison to 26 working days in Q2. Neurosurgery average response time was 32 working days for Q3 (including 1 level 2 complaint) in comparison to 28 working days in Q2. There were 4 cross-divisional complaints received within Q3, the average response time for these was 27 working days (including 1 level 2 complaint). This has been highlighted to the Divisional Operational Team during the weekly meetings in an aim to improve upon these response times
- the Divisional split of complaints remains fairly static with Neurology receiving 12 (including 2 re-opened) in Q3, compared to 10 (including 1 re-opened) in Q2, Neurosurgery 11 in Q3 compared to 5 in Q2. There were also 2 cross-divisional complaints (including 1 re-opened) and 1 corporate complaint received in Q3.
- There was a 39% increase in the number of concerns received with 224 received in Q3 compared to 161 received in Q2. The team have began tracking concerns by level of involvement – level 1 being resolved within a couple of days and level 2 taking longer with multiple communications/interactions with both the patient/relative and staff. For Q3, there were 149 level 1 concerns and 78 level 2 concerns.
- in addition to concerns, 67 enquiries/request for support were received in Q3, in comparison to 81 received in Q2; themes relate to the referral process and general hospital enquiries

11.2. Key themes for formal complaints:

- **Patient care** is the highest theme in Q3, largely in relation to patients' perception of overall poor medical care and medication issues; however, there were no particular themes, areas or particular staff to note. The 16 patient care issues related to 14 separate complaints of which - 4 were upheld, 2 were partially upheld, 6 were not upheld and 2 remain under investigation.
- **Communication** is the second highest theme and a task/finish group has been set up with the Dept Director of Operations to put measures in place to address this issue.

11.3. Key themes for concerns:





10.1. Protected Characteristics:

- There was 1 concern raised in Q3 in relation to the nine protected characteristics which include *race, disability, sex, gender reassignment, religion or belief, sexual orientation, marriage/civil partnership and pregnancy and maternity*. This concern related to disability. We were aware the patient had both hearing and vision impairments; however, the patient had always independently attended appointments. On this occasion patient was unaware of the change of location for a specific appointment and the patient confirms they did not check the detail of this. An apology was given to the patient and her correspondence has been indicated for large print font in future to provide additional support and prevent a reoccurrence. The patient was happy with the outcome.

10.2. Compliments:

- 51 compliments were reported in Q3 compared with 47 in Q2

10.3. Police/Coronial Requests:

- 15 police requests for statements/copies of health records received in Q3 compared to 12 in Q2
- 3 Coroner's requests were received in Q3 compared to 6 in Q2

10.4. Volunteers:

- 45% (25) of the 56 Trust volunteers are currently on site in roles and have undertaken 591 hours of volunteer work in Q3. Two inductions were undertaken in Q3 for both new and existing volunteers. Individual Covid-19 risk assessments have been reviewed and updated.
- active roles include:
    - meet & greet
    - infection control
    - patient experience (FFT support)
    - TONIC
    - gardener
    - pain management programme
    - LAMP testing – ad hoc

10.5. Friends & Family:

- Outpatients - 87.5 % of patients were extremely likely/likely to recommend based on a total of 547 responses (2.8% response rate)
- Inpatients – 97.6% of patients are extremely likely/likely to recommend based on a 42.1%response rate compared to the number of discharges (1,996) in Q3
- Full details contained within Trusts Integrated Performance Report
- Wards receive a monthly report/poster from PET highlighting both positive and any negative comments

10.6. Summary:

In Q3 there were 25 formal complaints investigated and closed, 228 concerns resolved and 67 enquiries successfully responded to in a timely manner.

It is very encouraging to note that the average response times for formal complaints remain in line with the tiered timescales outlined within our policy despite the increase in complaint activity. The PET and Divisional teams strive to ensure we are rapidly responding and resolving enquiries and concerns to prevent them escalating to formal complaints which is reflected in the number of each received.

12. Claims / Legal

Trust Wide	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
Total new claims received	9	9	4	4	1	7
Neurosurgery claims	6	5	1	1	1	4
Neurology claims	1	2	3	1	0	2
Corporate claims	2	2	1	2	0	1
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	7	7	7	16	4	10
Number of closed claims in quarter	5	3	3	10	7	6
Value of closed claims - Public liability	£0.00	£0.00	£5,000	£3,920.	£1,250.	£0.00
Value of closed claims - Employer liability	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£3,203,388.	£209,929.	£128,261.	£374,658.	£337,153.	£29,824

- All staff involved in claims/coronial reviews or inquests receive full support throughout the process
- 7 new claims and 0 re-opened claims in Q3

12.1. Lessons Learnt:

Details for lessons learnt from on-going claims/coroner inquests included in section 13. Please note that lessons have been learned following an RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.
Three claims are currently under review where there may be an opportunity for lessons learned and an update will be provided in Q4.

12.2. Thematic Review:

Poor documentation and allegations relating to informed consent remains an ongoing theme in many of the claims received. This continues to be highlighted to medical staff during induction and to junior doctors at mandatory training sessions to raise awareness. Work continues with regards to informed consent with the support of Trust's solicitors.

12.3. Clinical Negligence Trials:

3 Trials are listed for 2022, although one may now be settled before the September 2022 Trial date.

13. HM Coroners Inquests updates:

Current status: There are 9 inquests investigations open and of these 2 have inquest dates confirmed for 2022. We are awaiting confirmation from the Coroner as to whether WCFT staff will be directed to attend the remaining 7 Inquests.

The Trust also attended 7 Inquests in Q3. Two of these were as properly interested persons (PIP). Five were as factual witnesses.

The Coroners investigating the deaths did not raise any concerns regarding treatment provided by the Trust.

There has been an increase in Coroner requests over the last 12 months which is due to a backlog of cases from 2017 onwards. Listed below are updated cases for Q3.

13.1. Neurosurgery

The family raised concerns regarding the care/treatment provided to the deceased at Southport Hospital (they had no concerns regarding WCFT). The family queried a stitched laceration to the right side of the deceased's head which they presume was there on admission to WCFT, as this was commented on by an ICU nurse. During our investigation we spoke to the treating clinician and ICU staff that had cared for the deceased. None of which could recall such a laceration or neither was this recorded on the body map document following surgery in May 2018.

Outcome: No concerns were raised regarding care provided at the WCFT.

13.2. Neurosurgery

Patient fell on 28/08/2020 outside their home and banged their head and the patient was admitted to WCFT ICU on 28/08/2020. The patient transferred to the ward on 05/09/2020. The patient was referred for rehabilitation but the units referred to would not accept the patient as they could not meet the patient's rehab needs. The patient was finally accepted at Church Walk Nursing Home in Rochdale until a bed became available in Liverpool (6-8 weeks) and was transferred to Church Walk on 05/02/2021.. The patient had a fall in Church Walk (the patient's head was protected by staff during the fall and some point later the patient was taken to Oldham Hospital A&E. The patient was admitted and antibiotics were prescribed for 5 days. Sadly the patient deteriorated and died on 31/03/2021. The family raised concerns with the Coroner regarding the care that the patient received at Church Walk. A complaint was also made to NHSE about the Neuro Rehabilitation Case Manager regarding misleading information. The consultant in charge of care and discharge planner provided statements to the Coroner.

Outcome: Coroner's Inquest was held on 29/10/2021 in Rochdale and 2 staff members attended from WCFT. No concerns were raised regarding WCFT involvement re transfer.

13.3. Neurology

The deceased was a pedestrian and involved in a RTC 28/10/2016 which proved fatal. WCFT was required to give evidence in relation to the driver of the vehicle involved in the RTC who was a patient of the WCFT. It appeared that the driver may have had a medical episode and lost consciousness at the wheel.

Outcome: Inquest was heard on 04/11/2021 via Teams. No concerns were raised regarding treatment received at WCFT.

13.4. Neurosurgery

It appears that this case was a Covid-19 vaccine related complication which resulted in a likely thrombus. The patient was transferred from Warrington to LUFT (Royal site) and advice was provided from WCFT from 02/04/2021 to 04/04/2021. Sadly the patient deteriorated and surgery was deemed not an option.

Outcome: Inquest was heard on 09/11/2021 via Teams. No concerns were raised regarding advice provided from WCFT.

13.5. Neurology

The deceased was arrested for committing a criminal offence on 18/07/2017 following an incident outside a neighbour's house. Following arrest the deceased was transferred to an ambulance and taken to hospital due to injuries sustained during the arrest. The deceased was discharged on 27/07/2017. On 28/07/2017 the deceased became ill and the deceased's sister started CPR. Paramedics arrived and confirmed the death. PM documented cause of death as pulmonary thromboembolism due to DVT.

Outcome: Inquest was heard on 19/11/2021. No concerns were raised regarding treatment received at WCFT.

13.6 Neurology

The deceased lived in residential care following a RTC in 2009. The deceased developed post-traumatic epilepsy secondary to severe brain injury. The deceased was found unresponsive in their room on 29/03/2017 at 14:45 hours and was pronounced dead at 15:05 hours. A PM report was completed in April 2017. A forensic PM report was completed in November 2019. The WCFT was asked to provide a report of the treatment provided to the deceased and to also comment on both of the PM reports. WCFT Neurologist gave factual evidence regarding treatment provided. The Neurologist also gave expert evidence regarding different types of epilepsy, epilepsy medication, what impact missing medication doses would have on seizure control and epilepsy and death. The Neurologist was also asked to comment on the PM report. The Neurologist confirmed that some of the questioning was outside of their area of expertise.

Outcome: Inquest was heard on 22/11/2021 via Teams. No concerns were raised regarding treatment received at WCFT.

13.7 Neurosurgery

The deceased was found at the bottom of an empty swimming pool in Tenerife on 01/02/2014. The deceased received treatment in ICU in Tenerife. The deceased was transferred to WCFT on 20/02/2014 and managed on ICU. The deceased was discharged to rehab setting on 08/07/2014 but sadly died on 15/07/2017. Two members of staff provided statements for the Coroner's investigation in 2014 and 2019 respectively. They were directed to give factual evidence on 08/12/2021 at the Inquest.

Outcome: Inquest was heard on 08/12/2021 via teams. No concerns were raised regarding treatment received at WCFT.

The Walton Centre NHS Foundation Trust

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REPORT TO TRUST BOARD
Date: 3rd February 2022

Title	**Quality Account Priorities 2022/23**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	• Quality Committee
Executive Summary The report provides an update on the quality priorities the trust is focusing on during 2022/23 and the monitoring which takes places throughout the year to ensure they are achieved.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments Be recognised as excellent in all we do
Risks associated with this paper	The report provides assurance on patient safety, clinical effectiveness and patient and staff experience and how the priorities are monitored. Failure to achieving the agreed indicators throughout the year may have an effect on patient, family and staff members. This may also impact on the reputation of the trust.
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Quality Account is a requirement as per the NHS Act 2009 in the terms set out in the NHS (Quality Accounts) Regulations 2010
Action required by the Board	• To consider and note

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Quality Account Priorities 2022/23

Quality Account Priorities - Overview

Quality initiatives are discussed and debated through various committees which include the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These committees report to Trust Board to ensure that patient safety is a priority and is progressed.

Towards the end of the financial year the trust liaised with stakeholders and presented priorities as areas of focus for improvement during 2022/23.

The delivery of the quality improvement priorities are monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with sub groups focussing on the 3 domains of quality which include patient safety, clinical effectiveness and patient experience. The Chief Nurse is the Executive Lead responsible for delivering the plan and designates duties to operational leads for each of the priorities.

All of the priorities were identified following a review by the Trust Board on each of the domains. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing and agreeing the priorities for 2022/23.

How progress to achieve these priorities are monitored and measured

Each of the priorities has identified lead/s who agree milestones throughout the year. Meetings take place to review progress against the priorities and support is given as required.

How progress to achieve these priorities are reported

Updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Mersey Internal Audit Agency (MIAA) did not audit the quality account priorities or provide assurance on the previous years Quality Account due to COVID-19. It is envisaged that MIAA will be fully involved during the year and will provide regular reviews and assurance via the Audit Committee.

Quarterly quality meetings are held with the commissioners to review quality assurance and provide external scrutiny and performance management.

The trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care.

The information below provides details of the improvement priorities the trust are focusing on during 2022/23.

Patient Safety:

- **Priority: 95% completion of MUST within 12hrs of admission**

Aim for 95% compliance of MUST risk assessment on admission.

This will improve patient outcomes by ensuring timely referrals to Dietitians and initiation of appropriate dietetic treatment plan.

- **Priority: Pilot the Whiston Project (initially Whiston Hospital patients)**

Improve the pathway for patients with a brain tumour deemed unsuitable for surgery and require best supportive care.

Significant unmet need identified for patient cohort resulting in patient not receiving right support/care.

Aim to provide enhanced responses and information for patients and reduce AED attendances.

- **Priority: Introduce Same Day Admission/ Discharge (surgery)**

Aim to ensure patients are not spending longer than is absolutely necessary in hospital.

Creating safer pathways and processes for patients to be admitted and discharged on the same day as their operation.

This will improve not only patient overall experience, but will also reduce length of stay and mitigate against hospital acquired infections.

Clinical Effectiveness:

- **Priority: Introduce Nutrition Champion Training Programme**

Increase staff training to support nursing teams.

This will improve patient outcomes through improvements to their nutritional care.

- **Priority: Implement Virtual Reality (VR) Simulator**

Purchase a neuro VR simulator for teaching junior neurosurgeons.

Training occurs under the watchful eye of consultant neurosurgeons. The VR allows junior neurosurgeons to practice major procedures such as craniotomies in a virtual, but realistic environment mitigating against any potential patient safety risks that could arise in a live environment.
In addition we would offer training as an educational tool to the region and beyond.

- **Priority: Introduce Patient Initiated Follow Up (PIFU) – Surgery**

Rolling this project out in neurosurgery will see patients taking more control of how/when they are followed up.

Aim to reach 2% (trust wide) of our patient follow up cohort to be initiating their own follow up appointments.

Patient Experience:

- **Priority: Develop Training Programme**

Enable staff to develop knowledge and skills in undertaking and evaluating quality improvement projects.

This will improve the experience of patients and service delivery.

- **Priority: Introduce Staff Training to Support People with Communication Difficulties**

This will improve experience by increasing understanding and the ability to support patients, carers, family and staff with communication difficulties.

Ensure the trust is accredited to use the Communications Access Symbol.

- **Priority: Reduce the Number of Complaints**

Year on year reduction of complaints received by the divisional teams.

Embed learning and actions to prevent re-occurrences.

Audit of the 2021/22 Improvement Priority

As part of the Quality Account review Governors were asked to vote for a 2021/22 priority they wanted to be audited. The improvement priority they chose was improving patient flow across the trust.

REPORT TO Trust Board
3 February 2022

The Walton Centre
NHS Foundation Trust

Title	**Board Development**
Sponsoring Director	Jan Ross, Chief Executive and Seth Crofts, Acting Chair
Author (s)	Katharine Dowson, Corporate Secretary
Previously considered by:	N/A
Executive Summary Summary of the draft plan for Board development for the first half of 2022.	
Related Trust Ambitions	Delete as appropriate: • Be recognised as excellent in all we do
Risks associated with this paper	N/A
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	No
Action required by the Board	To consider and note

Board Development

Proposed Sessions 2022

Date	Provider	Content
January 26	Director of Strategy	Trust Strategy Development
February 2	Deloitte	Final Session of 2021 Programme – Culture
March 27 or 29 (tbc)	NHS Providers	Back to Basics: the Unitary Board and the role of Board Members
April 7 (following Board)	Corporate Secretary	Strategic Risks 2022/23 and the BAF
Late April (tbc)	HR	Understanding your colleagues: Psychometrics and Skills Audit

A new programme of Board development for the remainder of 2022/23 will evolve as areas are identified to support the implementation of the new Trust Strategy and Well Led assessment work.

Mandatory training sessions that had to be cancelled at the end of 2021 will also be factored in.