The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 1st July 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
1st July 2021
Virtual Meeting
WCFT
09:30 – 12:15

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.35	Minutes and actions of meeting held on 10th June 2021	J Rosser	Decision (d)
4	09.40	Patient Story	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executives Update	J Rosser/ J Ross	Information (v)
6	10.10	Progress against Trust Strategy 2018-23	J Ross	Discussion (d)
7	10.30	Board Assurance Framework	P Buckingham	Assurance (d)
PERFORMANCE & GOVERNANCE				
8	10.40	Recovery & Restoration Update	J Ross/ Execs	Information (v)
9	10.50	Integrated Performance Report	CEO/Execs	Assurance (d)
10	11.10	Medical Revalidation Report	A Nicolson	Assurance (d)
11	11.20	Safeguarding Annual Report	L Salter	Assurance (d)
12	11.30	Major Incident Plan	M Woods	Assurance (d)
13	11.40	Research, Development & Innovation Annual Report	M Gibney	Assurance (d)
14	11.50	Equality, Diversity & Inclusion Annual Report	M Gibney	Assurance (d)
15	12.00	Key Issues Report – Quality Committee	S Crofts	Assurance (d)
16	12.05	Key Issues Report – Business Performance Committee	D Topliffe	Assurance (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: •				
CONCLUDING BUSINESS				
17	12.10	Any Other Business	J Rosser	Information

Date and Time of Next Meeting:
2nd September 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

10th June 2021

Present:

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

In attendance:

Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary
Dr C Burness	Consultant Neurologist / Guardian of Safe Working (item TB39-21/22 only)
Ms L Gurrell	Head of Patient & Family Experience (item TB34-21/22 only)

Observing:

Ms A Chesterton	Staff Governor
Mr M Winstanley	Public Governor – North Wales

Trust Board Attendance 2021-22

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

TB31-21/22 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams and noted that Ms A Chesterton was observing in her capacity as Staff Governor and that Mr M Winstanley was observing in his capacity as Public Governor for North Wales.

TB32-21/22 Declarations of interest

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

TB33-21/22 Minutes of the meeting held on 6th May 2021

The minutes of the meeting held on 6th May 2021 were agreed as a true and accurate record.

TB34-21/22 Patient Story

Ms Gurrell joined the meeting.

Ms Gurrell presented the patient story and provided an overview of the patient experience and journey from arrival, though to surgery and a stay as an inpatient prior to discharge home. The patient was very complimentary about their experience with The Walton Centre and noted that although there was no visiting allowed from family or friends during their stay they had been offered virtual visiting but had declined this as they wished to utilise the time to heal and rest. Daily parcels had been received from loved ones and the patient highlighted that staff had taken the time to help and support the patient in packing their belongings ready for their discharge home. The patient felt well informed throughout their stay and always felt safe in the care of the Trust. The patient had noted that they were anticipating a second admission for an additional procedure and felt that their experience from the initial admission had helped to allay any anxieties. The patient noted that the only thing that could have improved their stay would have been larger badges for staff as it was difficult to read staff names under PPE and hear the staff names while they were wearing masks. Ms Gurrell noted that a follow up story would be presented following the patients second admission to compare both experiences.

Ms Rai noted that the caring element of the patient story came out throughout their journey and the patient had highlighted that although the pandemic was ongoing it felt very much business as usual within the Trust.

Ms Salter informed that although the patient had a positive experience regarding the lack of visiting this was not the same for all and some patients had found the impact of no visitors very difficult.

The Chair thanked Ms Gurrell for presenting the patient story and recognised that the patient had a very positive experience during their admission.

Ms Gurrell left the meeting.

TB35-21/22 Chair & Chief Executive's Report

Ms Ross provided an update noting that the numbers of COVID positive patients across the region remained low while the number of vaccinations was increasing. It was highlighted that some boroughs had experienced an increase in COVID numbers and surge testing was in place however this did not seem to be leading to an increase in hospital admissions.

The Government would be launching a statutory enquiry into the pandemic response in Spring 2022 and a legal stop notice would be issued to all NHS organisations to prevent any data or records relating to the pandemic or decision making from being destroyed. It was recognised that a large amount of information would be requested during this enquiry.

It was noted that the management of urgent care was causing concern with changes on GP practices having an impact on urgent care. Attendance at emergency departments had increased and patients were reporting that they had not previously tried to attend their GP before attending the urgent care setting. Discussions and engagement around this issue were ongoing.

It had been agreed at regional level that there would be two Provider Collaboratives recommended to the ICS. The first would encompass mental health and community Trusts and the CEO Lead for this collaborative would be Joe Rafferty. The second would encompass acute and specialist Trusts and the CEO Lead for this collaborative would be Anne Maher.

The Chair reported that recruitment for the Chair of the Cheshire and Merseyside ICS was underway and there were ongoing discussions around the CEO position.

The Governor election process was underway with 16 eligible seats for public governors. 11 of these were new positions with a further 5 re-elections and the process was open until September 2021.

The second reading of the Government white paper regarding a reform of the NHS was currently scheduled for July 2021 and it was noted that this included a recognition that Trusts would continue to maintain a Council of Governors.

Ms Rai requested an update on the staff vaccination programme and it was confirmed that just under 90% of staff had received the vaccine and a review of the reasons why some staff had declined to be vaccinated was ongoing. Initial feedback had identified no common theme and it was highlighted that black, Asian and minority ethnic staff had a higher uptake than overall staffing. Staff continued to be encouraged to receive the vaccine via regular staff communications and at the daily safety huddle. Work to encourage staff to participate in the LAMP testing programme was also ongoing and it was recognised that there were peaks and troughs with the uptake of this.

The Board:

- **noted the report.**

TB36-21/22 Recovery and Restoration Update

Ms Ross noted that the Trust was performing well against plans and exceeded all targets during May 2021. The number of patients waiting 52 weeks or more had decreased and stood at 182 at the end of May 2021 against a target of 221. Patients at higher risk had been identified and diagnostic waiting lists had been prioritised.

The Board:

- **noted the update.**

TB37-21/22 Integrated Performance Report

Ms Ross provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Business Performance Committee and Quality

Committee as noted within the Chair's reports. It was highlighted that the number of open complaints had improved and significant action had been taken in this area. Good compliance had been noted in mandatory training figures however there were some concerns highlighted around nurse turnover, vacancy and sickness rates. All cancer targets continued to be met and an expected under performance in RTT figures was identified. It was recognised that the biggest challenge group in relation to mandatory training was Junior Doctors as they move across different Trusts during their training and work was underway to implement a 'training passport' that could be transferred from Trust to Trust.

Ms Rai queried why staffing was so high on some wards and it was clarified that this was predominantly due to high numbers of specialling with some patients requiring level 4 specialling.

Ms Bentley queried if the Welsh RTT figures being below target was due to the recovery and it was clarified that the target had not been amended during COVID and the Trust continued to be measured against the pre-COVID target. It was noted however that the Trust achieved 93.02% at the end of May which was much improved.

Quality

Mr Crofts provided an overview of all HCAI targets noting that issues regarding MSSA remained with a further 2 infections recorded in Q1 and a project group had been formed to reduce the number of MSSA infections as this was a high priority area to address. There had been no hospital acquired pressure ulcers reported, a tissue viability nurse had been successfully recruited and was working dynamically with the team to implement a mandatory training programme around pressure ulcers. It was also noted that 2 catheter associated urinary tract infections (CAUTI) had been reported. Ms Salter highlighted that the number of HCAI was slightly lower than other specialist organisations in the region however work was ongoing to improve these figures.

Workforce

Mr Gibney advised that workforce metrics continued to improve including PDR and staff appraisal rates. Staff sickness figures had improved and there was currently 5.45% of staff absent from work and 0.61% of staff were absent due to having to isolate. It was recognised that nurse turnover rates had decreased however it was expected that this figure would increase again during the summer.

Finance

Mr Topliffe noted that there had not been much movement on the 2021/22 capital programme however there were no concerns around this reported.

The Board:

- **noted the integrated performance report.**

TB38-21/22 Nurse Staffing – Biannual Acuity Review

Ms Salter presented the biannual nurse staffing acuity review and noted that this report provided an overview of the first 6 months and full year report would be presented to the November 2021 meeting. It was highlighted that staffing data was captured on a daily basis at the safety huddle and there was also an additional daily staffing meeting in place. The international recruitment programme was ongoing and a number of potential areas for

recruitment were being explored. There had been some ward closures within the Trust during the pandemic and also due to the ongoing heating and pipework replacement programme and staff from these areas had been redeployed to other wards which had reduced the utilisation of bank staffing.

Benchmarking work was underway with Queens Square Hospital and this would be reported upon completion.

The CQC had informed the Trust that they had closed down the query made following a whistleblowing concern being made and confirmed that they had been satisfied with the Trust's response.

Mr Crofts queried the increased numbers of patients requiring specialling and Ms Salter clarified that this was due to the recovery plan focussing on P1 and P2 patients which had increased specialling activity. It was recognised that the daily safety huddle provided an opportunity for any staffing issues to be raised with a response provided in real time.

The Board:

- **noted the biannual nurse staffing acuity review report.**

TB39-21/22 Guardian of Safe Working Report – Q1 2021/22

Dr Burness joined the meeting.

Dr Burness presented an update on Q1 of the Guardian of Safe Working report and provided an overview of issues escalated during the period February 2021 to May 2021. It was noted that the number of exception reports received had reduced following a discussion with one member of the team. The importance of monitoring the number of hours for Neurology Registrars was recognised and this would be updated as part of the next report.

Work around the Doctors' mess was nearing completion and feedback received had been very positive. Dr Nicolson noted that the BMA had also reported that they had been very pleased with the progress on the Doctors' mess and along with the input that had been provided from the Trust and the Trust charity.

The Board:

- **noted the guardian of safe working report for Q1.**

Dr Burness left the meeting.

TB40-21/22 Mortality & Morbidity Report

Dr Nicolson presented the mortality and morbidity report for Q4 and noted that an increase in the number of deaths had been recorded during 2020/21 due to COVID and the mutual aid provision of a stroke ward. The rate of readmission within 28 days of discharge remained low at 3.3% and it was also highlighted that the surgical site infection rate was low at 1.62% It was noted that there had been 26 inpatient deaths during Q4 with 24 of these within Neurosurgery and Critical Care and 2 within Neurology.

The NHSEI guidance framework for reviewing COVID related deaths was presented within the report and it was recognised that this was a useful document for identifying any themes.

An increase in the number of referrals to the coroner had been recorded however it was noted that no themes had been identified regarding this. It was reported that a patient who had an unexpected cardiac arrest had been referred to the coroner and an RCA had been completed which highlighted that all processes had been followed with no critical comments identified however there had been some lessons to be learned noted.

The Board:

- **noted the mortality and morbidity report for Q4.**

TB41-21/22 Staff Survey Action Plan

Mr Gibney presented the action plan that had been developed in partnership with Staff Side following receipt of the outcomes from the staff survey and noted that the action plan was aligned with the key requirements of the annual people plan. The action plan was reviewed and it was highlighted that Ms Bentley had been appointed as the Trust Health and Wellbeing Guardian. A quarterly staff survey would be undertaken in conjunction with the annual survey and staffing networks would be introduced with a number already in place with agendas under development. It was noted that a joint ED&I Lead role had been appointed in partnership with Alder Hey and Clatterbridge and the successful candidate would be taking up the post in January 2022. Timescales for progress updates and completion would be added to the action plan for clarity and assurance.

Ms Bentley informed that she had met with the Deputy Director of Workforce and Innovation regarding the Health and Wellbeing Guardian role and noted that the action plan reflected that national survey however national guidance around team working was due to be published and the action plan would then be revised to reflect this guidance. Mr Gibney highlighted that feedback from the recent Investors In People re-accreditation had recognised that there was excellent team working across the corporate function of the Trust however this approach would be expanded for implementation across all areas.

Professor Thakkar queried how the Trust would reconcile staffing pressures while encouraging staff to take annual leave. Mr Gibney clarified that there were not many staff members who had built up an excess leave allocation and this would be reviewed on a case by case basis. This had been proactively managed and staff had taken annual leave throughout the pandemic and a reduction in staff sickness figures had been recorded due to this approach. It was also noted that agile working was a challenge, this was working well although it was recognised that this was easier to implement for back office staff. It was highlighted that some clinical staff were able to review patients in clinic and then update patient notes from home however the need to ensure security and good governance for this approach was recognised. It was also noted that the Trust was working with trade unions regarding domestic abuse as it was recognised that agile working enhanced opportunities for abusers and the Trust was working to provide training and raise awareness.

Mr Gibney informed that Building Rapport training had been undertaken by managers across the Trust during the previous year and this training programme would be improved and available to other staff groups. Training was also available on wards regarding patient

on staff violence and the trainer visited wards to train staff and observe practice to understand if anything was a trigger for the patient. The LASTLAP initiative was also in place for staff at the end of every shift.

Mr Gibney noted that the action plan would be updated to include timescales for progress updates and completion and would then be submitted to Business Performance Committee.

The Board:

- **noted the staff survey action plan.**

TB42-21/22 Strategic Black, Asian and Minority Ethnic Advisory Committee Chairs Report

Ms Ross provided an update from the meeting of the Strategic Black, Asian and Minority Ethnic Advisory Committee held on 26th April 2021 and highlighted the importance of undertaking and reviewing risk assessments, particularly among black, Asian and minority ethnic staff. There had been some discussion around terminology and communications had been received from the @Race Forum advising that the term 'Black, Asian and minority ethnic' should be used in full in documentation.

Two presentations had been provided at the meeting, the first of which focussed on the disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities. The second presentation focussed on the history of Liverpool and how the city was shaped by events relating to slavery, the slave trade and its connections to health and medicine.

A key focus for the committee going forward would be how improvements could be measured.

The Board:

- **noted the Strategic Black, Asian and Minority Ethnic Advisory Committee Chair's report.**

TB43-21/22 Quality Committee Chair's Report

Mr Crofts provided an update from the meeting of the Quality Committee held on 20th May 2021 and highlighted that an application would be made to the Tessa Jowell Brain Cancer Mission for the Trust to be designated a Centre of Excellence.

A peer review of the Critical Care unit had been undertaken which had reported that the unit was compliant in 151 of the 155 areas reviewed, initial feedback had been received which was reported to be very positive.

A category 4 pressure ulcer had been recorded on ITU, a rapid review had been undertaken which indicated that there had been no lapses in care. It was also noted that a patient on Caton ward had suffered a fractured humerus following a fall and full RCAs were underway regarding both incidents.

The Governance and Risk Management report for Q4 was presented and it was noted that there had been a significant increase in the number of concerns received however

there had been a reduction in the number of complaints and complaint response times were much improved.

The Board:

- **noted the Quality Committee Chair's report.**

TB44-21/22 RIME Committee Chair's Report

Mr Crofts provided an update from the meeting of the RIME Committee held on 5th May 2021 and highlighted that there had been an independent review of the research department and an action plan was currently being compiled.

There had been two new appointments within Medical Education with Dr Rhys Davies taking over as Director of Medical Education and Elaine Anderson appointed to the position of Royal College Tutor for Anaesthetics.

An update on the innovation pipeline was presented and it was highlighted that a number of collaborative partnerships were being supported which would develop income, equity or royalties.

It was noted that the Medical Education department had developed a number of online resources including the Neuro Podcast project which was originally designed for medical students. Consent was sought to affiliate the project with the Trust and promote the Trust from a Medical Education perspective and encourage other Consultants to participate in the project.

The Board:

- **noted the RIME Committee Chair's report.**

TB45-21/22 Business Performance Committee Key Issues Report

Mr Topliffe provided an update from the meeting of the Business Performance Committee held on 25th May 2021 and noted that the Committee was trialling new formats for reports submitted to the Committee and also reporting out from the Committee. An overview of the report format was provided and it was noted that the report was broken down into four areas which provided an overview of the meeting agenda, items to be highlighted for Board attention, assurances provided around each item and any advisory issues to be noted for attention.

The Trust financial plan for H1 was presented for approval and it was noted that there was an expectation from the HCP that the Trust would report a break even position. The challenges involved in delivering the plan were reviewed and it was noted that there was only limited assurance that the plan would be met. The Committee approved submission of the financial plan to the HCP and it was recognised that there was currently no guidance regarding the financial framework for H2.

Feedback had been received from finance and procurement staffing groups regarding a return to on-site working. It was noted that this was currently being managed and it was suggested that general organisational advice and guidance would be beneficial for departments who may experience these issues going forward.

Mr Topliffe welcomed comments on the format of the key issues report.

The Board:

- **noted the Business Performance Committee key issues report.**

TB46-21/22 Consent Agenda

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

- **Infection Prevention and Control Annual Report (including Infection Prevention and Control Board Assurance Framework** – received and noted the infection prevention and control annual report and associated board assurance framework.
- **Quarterly Governance Report – Q4 2020/21** – received and noted the quarterly governance report.

TB47-21/22 Any Other Business

There was no other business to discuss.

There being no further business the meeting closed at 11.30am

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

TRUST BOARD
Matters arising Action Log
June 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **May 2020** Work on hold until after COVID-19 **June 2021** MG noted that the current approach to DBS checks was a paper solution and there was a regional plan for an electronic solution that staff could transfer from Trust to Trust if they were to move. There was an ongoing debate with trade unions regarding whether the staff member or organisation would pay for the annual DBS check. A survey would be undertaken in September and a report published in October. Remove from tracker.	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ ~~March 2021~~ ~~June 2021~~	

Actions not yet due

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

The Walton Centre
NHS Foundation Trust

REPORT TO TRUST BOARD
1st July 2021

Title	**Progress Against Trust Strategy**
Sponsoring Director	Name: Jan Ross Title: Chief Executive
Author (s)	Name: Jan Ross Title: Chief Executive
Previously considered by:	Executive Team Meeting

Executive Summary

The update reviews the successes against last years (year 3 of strategy) priorities and additional achievements in year that further our strategic ambitions.

Once approved by the Trust Board a publication will be shared with staff and via communication channels to patients and stakeholders over the summer.

Related Trust Ambitions	• All
Risks associated with this paper	• Risk of not having updated strategy would mean lack of clarity for staff and patients on next steps
Related Assurance Framework entries	• Several BAF risks are associated with the strategic ambitions and in particular new ways of working during pandemic – the strategy update provides direction in this year's approach to help mitigate some of those risks further.
Equality Impact Assessment completed	• N/A
Any associated legal implications / regulatory requirements?	• Well led CQC criteria expects live Trust strategy that is regularly updated and communicated to staff
Action required by the Board	The Board is requested to: • To discuss Strategic update • Note progress on year 3

Trust Strategy Executive Operational Plan 2020/21. Updated end of Q1 2021/22

The Walton Centre NHS Foundation Trust

Our Approach – Recap.

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

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

Our Vision

Excellence in Neuroscience

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

Our Purpose

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

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

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

Our Ambitions

We will:

Our Values

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

Our successful strategy will mean that we are:

- **Leading standards** and consistently delivering **excellent evidence based care** in neurosciences.
- Providing patients with an **experience** that is **beyond their expectations**.
- Improving quality and services using a **consistent quality improvement methodology** across the organisation.
- Delivering the **best patient clinical outcomes** in our field.
- Continually investing in our **patient environments**.
- Ensuring our **staff** have access to training, education and events that **increase their knowledge and empower them in their roles**.
- Working together recognising our **strength in diversity and embracing our inclusivity**.

In 2020/21 our commitments are;

1. Deliver best practice care that supports approach to COVID19.
   - A) Supporting wider C&M system by caring for stroke patients and extending our skills.
   - B) Supporting the wider system and providing theatres and staff for Aintree's patients requiring head and neck cancer surgery.
   - C) Caring for patients with COVID 19 critical care transferred from Aintree and other hospitals during COVID surges.

No	Exec	Lead/s	Qtr	Actions	RAG
1. A	AN LS JR MB	MW/Jri l/HW	Q2 Q3 Q4 Q1 (21/ 22)	Stroke patients cared for on Sherrington until September 2020. **Completed**. Review of stroke services and develop a feasibility options paper to determine if Walton to include stroke services in the future . Completed and deemed not feasible Now working with North Mersey Stroke Board on partnership plan Case to be taken to Stroke Board after internal review and board agreement. Thrombectomy – 24/7 pilot continues and Trust works as part of C&M Stroke Board. On target to deliver thrombectomy service up to 23:00hrs by July 21. North Merseyside Stroke centralisation plan continues with the Walton centre providing the 24/7 Thrombectomy service from October 2021	
1. B	JR AN	EB/SL	Q1 Q2 Q4 Q1 (21/ 22)	Theatres and staff were provided for head and neck cancer patients from Aintree in Q1. The service moved back to Aintree after the initial COVID-19 surge – all patients were treated safely and this prevented further delays in treatment. **Completed** Plan for further mutual aid requests to support C&M cancer recovery plan in wave 2 COVID-19 outbreak As part of recovery and restoration programme Trust will continue to work with Aintree Hospital re head and neck cancer./support. Offer remains, however no support requested in this quarter. Spinal services also part of offer / further centralisation	
1. C	AN LS JR	Mwils JRil/ Eb/SL	Q1 &2 Q4 Q1 (21/ 22)	Patients transferred from Aintree site and others cared for with COVID and specialities outside of Neurosciences. Staff training undertaken where possible eg critical care. Critical care in particular were busy with these patients Q1 and early Q2. Current number of in patients with COVID are low and so service stood down. Rehab services reviewed admission criteria in line with COVID patients requirements. **Completed** Review critical care ODN action plan for Trusts in readiness for future COVID surges in critical care Work with Critical ODN on equipment loans and critical care capability to surge. Trust will include in its restoration and recovery plan opportunity for critical care surge. Working on recovery plan and continue to work with critical care network on C&M capacity and WCFT role in any future surge. Capacity to support surge if required, no request this quarter	

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- Ensuring our **staff** have access to training, education and events that **increase their knowledge and empower them in their roles**.
- Working together recognising our **strength in diversity and embracing our inclusivity**.

In 2020/21 our commitments are;

1. Deliver best practice care that supports approach to COVID19.
   - D) Prioritising our neuroscience patients care and services adapting and changing in line with COVID new ways of working.
   - E) Redesigning policies and practices in line with national guidelines

No	Exec	Lead/s	Qtr	Actions	RAG
1. D	JR AN LS	EB /Jri/SL/ MW	Q1 /2	Followed national and regional guidelines as well as speciality specific. Reviewed all services when to stop and start. Prioritising patients as COVID restrictions changed or patient conditions changed. Continued timely care of all patients with cancer for example. **Completed** Adapting and changing as COVID restrictions and guidance change eg self isolation/colour coded wards and patient pathways/prioritisation of patients. Review of all long waiters to identify any changes in condition/requirements to ensure patient safety. Work across the region collaboratively as required. Develop SOP to support pre-op screening of all elective patients- work with LCL on process. Q3 /4 Commence day case activity at Halton hospital for pain management patients to help restore patient activity. Recommenced May 2021 Work with regional teams in phase 3 planning and execution/ Develop monitoring at trust level. In process of developing the Restoration and Recovery plan prioritising patients by priority codes/clinical conditions. Q1 (21 /22) Working on recovery plan and ensuring OPD / virtual clinic sizes are safely managed in line with IPC guidelines. Good progress against restoration & recovery plan. Implementation of the new RANA service , ongoing review of IPC pathways to support patient flow	
1. E	**all**	all	Q1 -4	Ensure timely review and redesign of all policies and practices as required with COVID19 and national and regional changes. e.g EPRR plans going forward will reflect changes at a national level e.g (HR mobility work etc). Q1 (21 /22) Agile working policy agreed and approved at SPC and BPC. Ongoing review of policies & practices, IPC Flow, Outpatient – attend anywhere etc. in line with recovery plan	

DELIVER
best practice
care

Our successful strategy will mean that we are:

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- Ensuring our **staff** have access to training, education and events that **increase their knowledge and empower them in their roles**.
- Working together recognising our **strength in diversity and embracing our inclusivity**.

In 2020/21 our commitments are;

2. Review our current environments, services, workforce, IT and equipment using transformational quality improvement approaches as we adapt and change to new ways of working with and after COVID pandemic keeping patients, families and staff safe and well cared for.
3. Continue to support our staff's well being and embrace inclusivity using Anchor Institute and Walton Way values investing in our staff and communities health and wellbeing.

No	Exec	Lead/s	Qtr	Actions	RAG
2	**all**	MG	Q1 /2 Q4 Q1 (21 /22)	**staff,** Utilise the flexible working policy, to support staff to work in new ways. Use survey results and task and finish groups to understand what staff require to work more flexibly. **patients,** Utilise IT to support patient access through virtual appointments where appropriate. **Enablers** Invest in IT software, hardware and staff support. Develop an agile working policy and programme of work to deliver. • New Deputy Head of IT recruited and staffing review to take place in Q3/4 regarding fitness for purpose going forward for digital function • Direct Access/Mitel softphone/Virtual smartcards/MS Teams – all allowing teams to work remotely safely; • Implementation to N365 will update Trust IT infrastructure to cope with new demands; • Patients able to utilise bedside technology to 'meet' family during periods when visiting suspended. Working with LUFT on increasing IT infrastructure capacity given the increase in remote working / use of technology as demand increases. An exercise has been undertaken to understand flexible working arrangements across the trust both formal and informal. Changing culture so staff recognise agile working as business as usual. Working group has recently been introduced to look at sustainability and the carbon footprint across the Trust with a plan to have a strategy in place and signed off by board in March 2022.	
3.	**MG**	JM	 Q4 Q1 (21 /22)	All staff to have a risk assessment and risk assessments for all vulnerable staff to be kept under review to ensure all staff are safe and protected in the work environment Trial of online staff engagement "Civica Empower" tool which provides real time data in Radiology, SMART team and Finance Member of Liverpool City Council Strategic Wellbeing Group Deputy lead for NHSE/I North West People Experience & Health & Wellbeing work stream. H&WB conversations commenced with staff as part of appraisal process . Together with Liverpool City Council looking to develop more H&WB to include social care and part of C&M bid to develop more H&WB online resource and WCFT is helping to shape that. We are now publicising a growing offer from NHSE/I as appropriate including the NHS Digital Weight Management Programme. The trust has just been accredited with the Industry Standard IIP Health & Wellbeing award as Gold. Appointed a NED as well being guardian for the trust.	

Our successful strategy will mean that we are:

- **Leading standards** and consistently delivering **excellent evidence based care** in neurosciences.
- Providing patients with an **experience** that is **beyond their expectations**.
- Improving quality and services using a **consistent quality improvement methodology** across the organisation.
- Delivering the **best patient clinical outcomes** in our field.
- Continually investing in our **patient environments**.
- Ensuring our **staff** have access to training, education and events that **increase their knowledge and empower them in their roles**.
- Working together recognising our **strength in diversity and embracing our inclusivity**.

In 2020/21 our commitments are;

4. To support and develop pathways for patients with visual impairment
5. Implement FOCUS (Free of Criticism Universal Safety) in theatres and ITU department.

No	Exec	Lead/s	Qtr	Actions	RAG
4.	LS	SG	Q1 Q3 Q4 Q1 (21/22)	A PAS alert has been put in place to manage skull base patients with a visual impairment with a further pilot project to improve our current process for this patient group For patients identified as having visual impairment an alert of VISN is added to PAS. Trust now has the visually impaired magnetic signs to go above patient bed. Complete	
5	LS	OT/MR	Q3 Q4 Q1 (21/22)	FOCUS A3 QI methodology agreed and presented to executives. Pilot to shape roll out to both areas. On track FOCUS A3 re quality improvement has been relaunched specific to Theatres part of the new quality account.. No change to Q4	

PROVIDE
more services closer to patients' homes

Our successful strategy will mean that we:

- Establish **new partnerships**, delivering **collaborative benefits** with commissioners, local authorities, community services, business and commercial partners.
- Build on our Neuro Vanguard work by **positively influencing patient pathways** of best practice across Cheshire and Merseyside (C&M) and beyond. **(Neuroscience Programme)**
- **Build and increase** on the range of **services** we provide and the areas in which we provide them.
- **Involve patients and the public to shape our services** and developments at every stage.
- **Invest in new roles and technology** to enhance services and partnership working.

In 2020/21 our commitments are;

1. Review our range of services and approaches in relation to COVID 19 exploring new ways of working.
2. Utilise IT solutions to enable more out-patient services to take place closer to home, or reach areas currently with poor accessibility (e.g. Ashworth).
3. Work with C&M in-hospital and out of hospital cell for collaborative benefits of NHS services.

No	exec	Lead/s	Qtr.	Actions	RAG
1.	**all**	MG JR	Q1/ Q2 Q3 /Q4 Q1 (21/22)	**Key thoughts** **Agile working project** Non- face to face Outpatients Screening pre op Delivered phase 1 &2 recovery plan Phase 3 recovery plan Critical review CT Scanner Winter plan First phase complete and recovery plan in place. Development of a Policy approved across all committees. Agile working agreed and approved at SPC and BPC, a survey monkey will be undertaken in July 2021 to identify any further work that needs to be undertaken. Work ongoing across the divisions to model new ways of working	
2.	**MB** **AN**	JG	Q1/2 Q3/4 Q4 Q1 (21/22)	Attend Anywhere being utilised for OPD and functioning well now. Enhanced IT solutions for OPD are functioning well now. Attend Anywhere contract extension OPD improvement programme C&M specialist collaboration reviewing the opportunities to bring digital services together to support the wider community; Expansion of system linkage with NWAS Review opportunities for Ashworth patients and agree approach Review of alternative options for remote clinics / consultations e.g. MST through N365. (Include patient engagement feedback and impact of Attend Anywhere and triage going forward (biggest use of AA in NW). Not as yet commenced in Ashworth but is set up if required and in conversations with IoM. Capability for remote consultations set up for Ashworth on a case by case basis. Regular AA clinics take place for IoM. Complete	
3.	**HC**	JR	Q1 Q2 Q3/ Q4	HC in in-hospital cell. Good collaborative working clinically. Good collaboration across C&M re activity and finance plans. Recovery Plan aligning Restoration and Recovery Plan to wider system through collaboration with In -hospital cell.	

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- **Involve patients and the public to shape our services** and developments at every stage.
- **Invest in new roles and technology** to enhance services and partnership working.

In 2020/21 our commitments are;

4. Continue our increased services in COVIDs initial response, for example, caring for patients who have had a stroke and spinal patients from Liverpool University Hospitals.
5. Commence our community rehabilitation services for patients in St Helens & Knowsley
6. Invest in new IT and infrastructure to enable a more agile working for staff and to support more remote patient access and care closer to home.

No	exec	Lead/s	Qtr.	Actions	RAG
4.	**HC** **AN**	JR AN	Q1/2 Q3 Q4 Q1 (21/22)	COVID-19 has expedited spinal services consolidating on one site with spinal rota agreed. Complete Phase 3 recovery plan Commissioners confirmed only requires level1 consultation . Reviewing stroke services through stroke board of whether North Mersey stroke should be based at Walton or Aintree (LUFT) Develop mutual aid support plan to ensure C&M cancer recovery plan can be delivered. Recovery and Restoration Plan continued to work through restoration and recovery programme working with wider system to ensure equity of access. Continued support for spinal patients from LUFT with LUFT surgeons taking part on the regional complex spine rota and operating at WCFT. Recovery and restoration plan on track, mutual aid is supported as required across Cheshire and Merseyside	
5.	**JR** **MB**	JRi	Q1 Q2/3	Community services commenced as planned in Q1. Completed. Now undertaking review of need to inform future ways of working and investment **Complete.**	
6.	**MB**	JG	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Significant investment made in IT hardware and infrastructure to enable agile working. This includes configuration of the Attend Anywhere system and hardware to enable patient appointments to continue to take place. Continued review of requirements of agile working including a review of MST for appointments. Successful Digital aspirant bid will allow a focus on a range of areas and to re-visit and update the Trust Digital Strategy. Move to Hybrid working model with increased hot desk docking stations in the organisation . Digital aspirant funding has allowed further expansion to full hybrid model throughout the organisation. Virtual smartcard now adopted to replace all physical smartcards to allow agile access to NHS functions. Digital dictation device management to allow hybrid working for secretaries introduced.	

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- **Build and increase** on the range of **services** we provide and the areas in which we provide them.
- **Involve patients and the public to shape our services** and developments at every stage.
- **Invest in new roles and technology** to enhance services and partnership working.

In 2020/21 our commitments are;

7. Implement the Trust's new Spinal Improvement Partnerships and explore application in new service areas.
8. Operationalise the agreed single spinal partnerships approach across C&M for patients.
9. Introduce Road to Recovery Rehabilitation Programme for Welsh patients in a community setting in Wales.

No	exec	Lead/s	Qtr.	Actions	RAG
7.	MG	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Business model and legal compliance completed. Customer engagement on final product specification with 3 international suppliers. Engage with customers to agree final report format. First organisation due to sign agreement July 2021.	
8.	JR AN MB MG	EB SC	Q1/2 Q3/ Q4 Q1 (21/22)	Single spinal rota agreed and in place. Royal surgeons now operating during COVID on Walton site Finalise transition including transfer of income and establishment of staffing costs and HR requirements. Financially best option is to wait until move back to 'normal' contracting regime otherwise any benefit may accrue to the system. Ongoing Financial, clinical and operational agreements	
9.	LS AN	JRi	Q1 Q2 Q3 Q4 Q1 (21/22)	The trust want to roll out the Road to Recovery Rehabilitation programme to welsh patients based in Wales to make it more accessible for Welsh patients to attend, this has been put on hold due to COVID but we are currently looking at undertaking this on zoom Not progressed as not been able to get to Wales. This was put on hold due to COVID-19 but podcasts have now been implemented for Welsh patients working closely with Comms and the vascular team. There will be further progress in Q2.	

INVEST
be financially strong

Our successful strategy will mean that we:

- **Consistently meet** our financial targets by working closely with commissioners & patients to ensure **excellent outcomes, service delivery & good value for money.**
- Deliver a NHS Improvement **risk rating of one** (lowest risk) which enables the Trust to have maximum autonomy in terms of financial decision making.
- Explore **new opportunities** and markets to **diversify** our portfolio of **income**.
- **Consistently deliver** our cost improvement programme through our **Quality Improvement Programme** (QIP) methodology.
- **Increase our productivity and efficiency** through **streamlining** patient pathways and **utilizing technology**.
- Concentrate on **two main Trust wide service improvements** utilising our QIP approach each year.
- **Build partnerships** to deliver mutual benefits.
- **Invest in our services, staff, facilities and innovations** for patients.

In 2020/21 our commitments are to;

1. Deliver value for money and build on local partnerships developed during COVID as part of our Anchor Institute ambition.
2. Procure locally wherever possible and utilise weighting in contract specification to recognise firms investments in the local populations health and well being (Corporate responsibility).
3. Adapt to new challenges as NHS and regional finance approaches change e.g. block contracts.

N	Exec	Lead/s	Qtr.	Actions	RA
1.	MB JR	KT AR	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Ensured procurement processes weighted to reflect local priorities. Successfully appointed a joint procurement lead across Sp Trust alliance. PPE mutual aid and collaborate buying between providers in system. This continues as and when it is required. Working with trusts on innovation portal in response to PPE shortages and working more locally with suppliers etc. Further work on specialist procurement collaboration to take place now that Associate Director post has been recruited to. Specialist Trusts have agreed in principle of single procurement department to be hosted by WCFT. MoU and project timeline has been developed (sent to other trusts for feedback) with aim to move to 1st stage of single service from Oct 2021 (all HR departments are involved to begin staff consultation required to progress TUPE of staff to WCFT). **Staff consultation has been undertaken and ends on Friday 25th June with Phase 1 of the transfer taking place between July and September 2021 with phase 2 to begin between January and March 2022. Lead DOF for collaboration Board has been assigned with first Board meeting to take place July 2021 (bi-monthly) with steering group to take place the week before (lead DDoF has been assigned)**	
2.	MB	KT AR	Q1/ Q2 Q3/ Q4	Procurement tendering includes environmental factors such as evaluation criteria as well as considering social values and impact on local employment. Work to continue to review evaluation criteria. Not as much progress has been able to be made on this due to OVID demands on team.	
3.	MB	HW	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Ongoing. Trust is adapting to new rules and reviewing its approach to 2nd half of the financial year and 21/22 in terms of adherence and reporting. Ongoing as more guidance is published. Guidance in relation to 21/22 is still outstanding but work will continue to ensure that the Trust adapts in line with revised financial arrangements. Internal Trust draft financial plan to be presented to BPC in March 21. **Financial arrangements for H1 (1st 6 months) of 2021/222 have been released which means that income remains on block and expenditure based on average spend of Q3 of 20/21. Continuous updates have been provided to BPC and Trust Board on the changes. Currently no indication on the financial arrangements for H2 of 21/22**	

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In 2020/21 our commitments are to;

4. Meet financial targets and remain risk rating 1 or equivalent.
5. Utilise transformational quality improvement approaches in learning from COVID and new ways or working;
    - Align to Walton Way values
    - Align to Anchor Institute values
    - Informed by our new green ambitions
    - Improve our patient and staff well being
6. Diversify our income streams through spinal improvement partnership so we can invest in innovation.
7. Review the Finance 'offer' to the Trust as a result of the changes following COVID-19 and new ways of working including understanding and implementing the new Financial Framework.

N	Exec	Lead/s	Qtr.	Actions	RA
4.	MB	HW	Q1 Q2 Q3 Q4	Financial framework suspended. Trust working within new framework. As above will need to adhere with the ongoing guidance that is being published Awaiting final guidance.	
5.	JR MB MG	AR KT JM	Q1 Q2 Q3 Q4	Establish a team to consolidate organisational learning from wave 1 of COVID-19 including focus groups, questionnaires and team events. Feedback themes and reflect in future planning. Agile Working, de-brief sessions, refreshed H&WB group, support from NOSS, staff rest area, link to Charity Update around Review in here. Committed to Liverpool City Region fair employment charter. NOSS workshops to support recovery in place. Health and Well being conversations part of PDR paperwork, REACT conversations training to be rolled out via Building Rapport programme.	
6.	MG	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Developed and agreed business model. Final phases of product negotiations. No further progress has been made whilst uncertainty around future NHS financial regime exists. To be reviewed in 21/22 given current financial regime. **Still awaiting update given uncertainty around longer term financial regime**	
7.	MB	HW	Q3/ Q4 Q1 (21/22)	This will include a review of how the team adapts to the new framework and communicates to the Trust in terms of how it operates going forward from a financial viewpoint e.g. block contracts will mean no income growth to fund investments. This work continues in line with changes to NHS financial regime. Updated budget holder training packs are being developed and will be rolled out in Q4/Q1. HW in discussion with divisional directors around future finance support required by divisions – will include divisional accountants being based in divisional offices when on site (given the roll-out of agile working means that all finance team have laptops). Monthly meetings taking place with DO&S and Divisional Directors concerning requirements. **Guide to revised financial regime has been produced and will be rolled out to budget holders (June 2021) and DDoF working with communications team around longer term financial training (putting something on video on the intranet for managers to access).** **DDoF continues to work with divisions around the finance offer currently provided and changes that can be made to enhance this**	

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In 2020/21 our commitments are to;

8. Continue to ensure that finance are accredited by FSDIFFF showing staff are developed and to attracted the best talent to the organisation.
9. Develop and establish costing strategy to further embed SLR within the Trust.
10. Implement the Trust's new Spinal Improvement Partnership to generate a new stream of income.

N	Exec	Lead/s	Qtr.	Actions	RA
8.	MB	HW	Q3/ Q4 Q1 (21/22)	Work continues towards re-accreditation in Q4 though deadlines may change due to current COVID-19 situation. Re-accreditation visit (virtual) taking place in May 21 with accreditation panel sitting in June. All accountancy bodies have re-accredited WCFT as training partner from 2020 (required as part of the FSD accreditation process). **Finance re-accreditation took place June 2021 and the NW Towards Excellence Group recommends that L2 FSD/FFF accreditation is awarded (this needs to be confirmed by the national group).** Engage with customers to agree final report format. First organisation due to sign agreement July 2021.	
9.	MB	HW	Q3/ Q4 Q1 (21/22)	Work to be carried out to review services with service leads given the different approach required to investment that will need to be undertaken Team utilising PLICs information to develop proposals e.g spinal Network. Meetings have taken place with Queens Square regarding sharing of PLICs information. **HW meeting with costing team fortnightly to progress costing strategy. Meetings have taken place with interim Director of Ops to utilise the data as it currently exists to identify potential areas for review**	
10.	MG	AR	Q1/ Q2 Q3/ Q4	Developed and agreed business model. Final phases of product negotiations Work continued on negotiations with commercial partner. Discussion required as to the best period to enact any transaction given the current financial framework. Task and Finish Group to look at commercial. Engage with customers to agree final report format. First organisation due to sign agreement July 2021.	

LEAD
research, education and innovation

Our successful strategy will mean that we:

- Develop a **culture of learning and innovation** through a pipeline of Trust wide projects.
- **Collaborate with** universities, businesses & commercial **partnership**s to lead innovation, education, research & new ways of thinking.
- **Increase research,** publications and the number of patients in clinical and commercial trials in neurosciences.
- Demonstrate how our research, education and innovation **lead, shape and improve practice in our field**.
- Create & **embed a focus upon neuroscience** across the whole curriculum for both under and post graduate medical students.
- Increase the effectiveness of clinical and academic delivery for the whole workforce through a **more integrated and seamless education provision**

In 2020/21 our commitments are;

1. Collaborate with University of Liverpool John Moores University, Edge Hill University and Liverpool Health Partners to increase and progress our neuroscience research ambitions.
2. Use new ways of working to create opportunities to invest staff's time in research, education and innovation to inform our practice, benefit our patients and lead in our field.
3. Design research, education and training trajectories/career escalators for staff wishing to pursue these areas to help lead and shape our future.
4. Review our education, learning and development approaches in line with new agile ways of working and flexibility for staff.
5. Agree priority initiatives for research and ensure appropriate level of resource.

No	exe	Leads	Qtr	Actions	RAG
1.	MG		Q1 Q2 Q3/ Q4 Q1 (21/22)	Suspended BAU to focus upon COVID-19 related research. Reviewing current ways of system working to support the improvement of a system wide approach. Review completed and agreed map forward with the system. Trust been invited to apply to be University Teaching Hospital and currently working through the process. Completed external review of Research capability and co-producing action plan with LHP/SPARK – initial feedback to Board 1.7.21.	
2	MG AN	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Combined innovation medical education and research into a single committee structure. Review PA's associated with these key service areas. Review of research is going to be completed in conjunction with innovation and Med Ed and looking at combining the clinical leadership of those 3 areas. New clinical lead for research, Med Ed and Innovation appointed. Presentation to Consultant body at Clinical Senate on the future of clinical research and Med Ed. This is a key element of the plan being developed for Research and Med Ed approved by RIME committee.	
3.	MG		Q1 Q2 Q3 Q4 Q1 (21/22)	Surveyed key stake holders informally to shape action plan. Redesign/review underway Career pathways being co-produced with LHP on both a local and regional level.	
4.	MG	RS	Q1 Q2 Q3 Q4 Q1 (21/22)	Identify baseline of current approach. Development of online solutions including podcasts as a method of delivery. Everything moved online and where traditional training takes place face to face smaller numbers and socially distanced takes place. The question is it working and better quality etc. Online training now standard with additions being created such as podcasts.	
5.	MG	SM	Q1 Q2 Q3 Q4 Q1 (21/22)	Refocused research agenda to support COVID-19 response. Further analysis and commissioned external review of function. The initial scoping is completed with a comprehensive resource request due in July 21.	

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- Increase the effectiveness of clinical and academic delivery for the whole workforce through a **more integrated and seamless education provision**

In 2020/21 our commitments are;

6. Increase research opportunities for our patients and our staff.
7. Finalise our movement analysis business case and launch fundraising appeal
8. Deliver MSc module for spinal in conjunction with Liverpool John Moores University (LJMU).
9. Ensure the successful introduction of the new and expanded model of medical education.

No	exe	Leads	Qtr	Actions	RAG
6.	MG AN LS	RS	Q1 Q2 Q3 Q4 Q1 (21/22)	Suspended BAU to focus upon COVID-19 related research. Further analysis and commissioned external review of function The trust has participated in the COVID-19 vaccination trial, the lead nurse for research is also promoting research amongst the specialist nurses and ANPs to undertake research as part of their role. Business as usual helped system re Covid research and Liverpool City region rated 4 overall. Reviewing how a rotational placement of 6 months for Registered Nurses can support awareness and engagement of nursing staff in research. Reviewing research within the Trust in light of NRC review and relationships with LHP and UoL. Clinical senate presentation on enhancing opportunities for research for clinical staff. This is part of the on going action planning post external review.	
7.	MG	RD	Q1 Q2 Q3 Q4 Q1 (21/22)	Business case complete – needs Commissioner engagement which has been paused. This has been delayed due to the pandemic.	
8.	LS	YS/SN	Q1 Q2 Q3 Q4 Q1 (21/22)	Course content completed. Work with LJMU on start dates. The spinal module is due to commence March 2021, delayed from September due to COVID-19. Delayed and due to commence in September 21. Spinal course due to start September 21.	
9.	MG	CD	Q1 Q2 Q3 Q4 Q1 (21/22)	Developed appropriate infrastructure to meet new requirements. Successfully introduced new model. Complete – commenced in September and had positive feedback . Initial feedback has been positive, costing agreed and proposal for deployment in draft format.	

LEAD
research,
education
and innovation

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- Demonstrate how our research, education and innovation **lead, shape and improve practice in our field**.
- Create & **embed a focus upon neuroscience** across the whole curriculum for both under and post graduate medical students.
- Increase the effectiveness of clinical and academic delivery for the whole workforce through a **more integrated and seamless education provision**

In 2020/21 our commitments are;

10. Support the development of Liverpool health ventures to facilitate regional innovation.
11. Further phases of the TONIC study to be initiated with international companies and academic partners.
12. Support the further development of VERA, ERNST and other initiatives.
13. Secure spinal improvement partnership contracts to support further innovation.
14. Use links with local, national and international partners (in the public, business and third sectors) to innovated

No	exe	Leads	Qtr	Actions	RAG
10	MG	GH	Q1 Q2 Q3 Q4 Q1 (21/22)	Fully engaged in leading agenda. Pursuing a number of investment opportunities with LHV. Trust has supported this and attended events but been on pause. Fully participating in the regional agenda and hoping for opportunities post covid.	
11	MG AN	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Funds secured to review future of the programme. Commercial review on-going and additional external funding secured. Tonic - secured additional funding from NIHR and organisation of administrative support ongoing.	
12	MG	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Both initiatives continuing to be developed. Charitable funding secured for VERA / national engagement for ERNST. All three initiatives progressing with funding secured.	
13	MG	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Developed and agreed business model. Final phases of product negotiations. (go back to invest) Engage with customers to agree final report format. First organisation due to sign agreement July 2021.	
14	MG	AR	Q1 Q2 Q3 Q4 Q1 (21/22)	Strong local partnership working. Usual channels of engagement re commenced. Many examples of innovation during the pandemic (especially at a local level) and ERNST/VERA progressing. Supported national innovation conferences and engaged with local business community.	

ADOPT advanced technology and treatments

Our successful strategy will mean that we:

- **Maximise technology** at patients' bedsides and beyond to improve care and enhance patient experience.
- Utilise **data and analytics** to **reduce duplication** and **enhance decision** making for staff.
- Be **part of a 'one digital record' ambition** across Cheshire & Merseyside to connect patient records to improve/integrate safer care.
- **Develop digital intelligence**, utilising analytics and technology to drive service and pathway improvements for patients, whilst enabling staff to continuously inform service development.
- Have a **culture of innovation, curiosity and creativity** that progresses options for digital, IT, pharmaceutical, diagnostic and treatment **technology to advance patient care**.

In 2020/21 our commitments are:

1. Maximise IT/technology to support agile and flexible working to enhance patient services.
2. Utilise our improved data and business intelligence to guide our future thinking and services for patients.

No	Ex	Lead	Qtr	Actions	RAG
1	MB	JG MW	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Delivered agile environment via direct access; Hot desking / safe pods set up for agile working within Trust; AA / MST – enable remote clinics for patients and agile meetings for staff; Virtual Smartcard allows access to ESR and SCR remotely; Softphone access allows remote workers to be accessed via desk phone extension. Agile working developments will continue to be reviewed and updated. Additional funding secured to further develop and deploy agile working laptops to more staff groups in Q1 next year. Expansion of hybrid model throughout the organisation including virtual smartcards expansion. Technical architecture refresh for hybrid working model commenced with firewall upgrades. HiMMS EMRAM level 5 achieved for Digital Maturity (Max level 7. Developing strategy in line with achieving HiMMS level 6. HCP participant to ensure joined up approach across the region for future proofing.	
2.	MB	MF	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Combined Intelligence for Public Health Action (CIPHA) to support COVID response Share2Care linkage to other 'ologies' underway under WCFT pilot Weekly SUS reporting now underway. Work is continuing to make Minerva the portal for information provision in the Trust, with more dashboards and reports being added to meet the Trust's information needs. All Patient Tracking Lists are now available as dashboards and are accessible through Minerva. The team is providing training to show users how to access information through Minerva. The team has successfully launched a report that allows clinicians access to their clinic lists, detailing the appointment medium. The team is working closely with the Divisions to create Divisional dashboards. SUS is submitted weekly. We are looking to include additional clinical coding, moving from 12 to 30 procedure and 30 diagnosis code before the end of Quarter 4. The BI team expanded in January with the appointment of a new Business Intelligence Developer. Successful delivery of all 20/21 milestones of the Intelligence Strategy, Over 50 self serve reports available for Trust staff to use to access intelligence on demand. Internal processes have been automated where possible and are continuously reviewed for further opportunities to utilise resources better. The culture of the organisation in relation to the relationship people have with data has improved considerably over the last 12 months. The Information & Business Intelligence team are involved in supporting many Trust projects now which was the aim of the Intelligence strategy to ensure data is behind decisions.	

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- Utilise **data and analytics** to **reduce duplication** and **enhance decision** making for staff.
- Be **part of a 'one digital record' ambition** across Cheshire & Merseyside to connect patient records to improve/integrate safer care.
- **Develop digital intelligence**, utilising analytics and technology to drive service and pathway improvements for patients, whilst enabling staff to continuously inform service development.
- Have a **culture of innovation, curiosity and creativity** that progresses options for digital, IT, pharmaceutical, diagnostic and treatment **technology to advance patient care**.

In 2020/21 our commitments are:

3. Digitise our out patients offer with 'attend anywhere' and other options reducing the need for face to face consultations.
4. Review patient outcomes and quality gains following investment in the innovative multi-tom rax in radiology
5. Progress our digital strategy ambitions

No	Ex	Lead	Qtr	Actions	RAG
3.	MB	JG	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Attend Anywhere in place for all clinicians to utilise. Review of alternative options for remote clinics / consultations e.g. MST through N365 Central extension of AA supplied by NHSX to 2022. Continuing to investigate MS Teams Virtual Visits at NHS Digital release the functionality centrally. Trust currently number 1 highest user of virtual clinics in C&M at circa 57%+ Representation on the regional Digital inclusion group to ensure that no one is left behind digitally and access is available to all citizens or alternatives	
4.	JR AN	SN YS	Q1/ Q2 Q3 Q4 Q1 (21/22)	Equipment installed however training suspended due to COVID-19 pandemic. Multi-tom Rax now operational – initial feedback positive. Due to Covid there were some delays in utilisation of the full capabilities of the multi-tom rax. 3D imaging capability expected in Q2. Feedback remains positive and cost savings achieved.	
5.	MB	JG	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Updated digital priorities reviewed at Programme Board Medics module now live Continued work with C&M HCP (on-going) EPR expansion continues. EDMS expansion of digitised documents both from physical casenotes and increased scanning/digitisation. ITU work commenced, HCA module completed. Digital strategy being re-written for next 3 years and presented to Digital Transformation Board Q2. Digital Aspirant status achieved for next 2 years. Representation on the nation Blueprinting steering group. Expansion of Digital team with DA funding to ensure 70 identified projects are completed. Digital Change lead to ensure change management is a priority due to timescales. Expansion of server resilience both internally and cloud migration	

ADOPT advanced technology and treatments

Our successful strategy will mean that we:

- **Maximise technology** at patients' bedsides and beyond to improve care and enhance patient experience.
- Utilise **data and analytics** to **reduce duplication** and **enhance decision** making for staff.
- Be **part of a 'one digital record' ambition** across Cheshire & Merseyside to connect patient records to improve/integrate safer care.
- **Develop digital intelligence**, utilising analytics and technology to drive service and pathway improvements for patients, whilst enabling staff to continuously inform service development.
- Have a **culture of innovation, curiosity and creativity** that progresses options for digital, IT, pharmaceutical, diagnostic and treatment **technology to advance patient care**.

In 2020/21 our commitments are:

6. Expansion of agile working architecture to ensure connectivity to hospital systems.
7. VOIP expansion to reduce reliance of LUFT's system and expand unified communications within the Trust
8. Investment into load balancing architecture to ensure greater resilience of critical trust systems.
9. Introduce the Trust's new website to benefit both staff and patients enhancing the new ways of working.

No	Ex	Lead	Qtr	Actions	RAG
6.	JR MG	QI team PB JM	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Agile Working, de-brief sessions, refreshed H&WB group, support from NOSS, staff rest area, link to Charity Work through trust teams to deliver hospital wide agile working. Investment into IT hardware to enable expansion to agile working; Completed server upgrades for direct access NHS mail and N365 rollout. Procurement of new firewalls to provide increased security and performance for both on site and remote workers. Agile working policy agreed and approved at SPC and BPC Work ongoing across the divisions to model new ways of working. An exercise has been undertaken to understand flexible working arrangements across the trust both formal and informal.	
7.	MB	JG	Q1/ Q2 Q4	Mitel roll out near completion Micollab software adopted throughout trust utilising telephony software and expending unified comms. Additional licenses deployed to further expand services to more staff. A VOIP Contract Centre has been implemented into the PAC department to improve patient access and reduce waiting times to the appointments teams. Remaining faxes being migrated over from legacy LUFT system to the VOIP system before end of March 21.	
8.	MB		Q1/ Q2 Q3/ Q4 Q1 (21/22)	PAS load balanced. Server mirroring 90% completed. Work continues with EPR architecture and SQL. Procurement of SQL. Enterprise licenses for the EPR Web Farm to enable real time reporting for the Trust Information Team and also provide an Active/Active architecture of the system to provide increased performance and less disruption during maintenance works. Further cloud investigation to see what systems would benefit from cloud migration. As they become EOL Agile remote servers introduced to handle more applications and spread user load. Additional positions introduced with DA funding to support Technical team. Regional Cyber desktop exercise and local penetration exercise tested server and backup resilience	
9.	MG	AR comms	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Commissioned external website developer. Agreed final specification and project lead out to advert. New website in advanced stage of development building upon extensive internal stakeholder engagement.	

Our successful strategy will mean that we :

- **Compete with the best** in Europe in neuroscience **patient outcomes and treatment options**.
- Have a reputation for **delivering outstanding care by outstanding specialist staff**.
- Be at the **leading edge of innovation and research** shaping neurosciences treatment and care for the future.
- Have an **engaged workforce** that is increasingly flexible, adopting new ways of working, being recognised as a representative employer and valuing and **embracing diversity** in our workforce.
- Have **a health and wellbeing programme** for staff that is an **exemplar** in the NHS and supports our staff in their roles.
- Be a **system leader** working with partners to **share best practice** & improve patient pathways & experiences in the communities we serve & beyond.

In 2020/21 our commitments are;

1. To have undertaken fundamental review of our current services and approaches to further improve patient care and staff health and well being.
2. Have successful new ways of working that support our patients needs and care following COVID19 pandemic.
3. Have extended and changed our services and provided excellent care to our patients and new patient groups.
4. To have increased our research involvement and trials for patients, to influence our future care.

No	Exec	Lead/s	Qtr.	Actions	RAG
1.	**All**	JR	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Reviewed special leave policy. Repurpose charity to support health and wellbeing agenda. Developed phase 3 recovery plan to support restoring elective activity. Developed systems and processes to support patient access. Introduction of the Patient safety champions for the trust Debrief sessions One review had been carried out – need to go back to revisit the questions – will form part of work on agile working group. Briefs for staff have been commenced and supportive sessions from NOSS Annual leave carry over approved. An exercise has been undertaken to understand flexible working arrangements across the trust both formal and informal	
2.	**All**	LS/JR	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Theatre and inpatient pathways developed to support IPC principles. Attend anywhere utilised to support OPD attendance. Pre op screening process in place to ensure patient is managed on the correct pathway. New pathways for patient flow during COVID 19 and review of ward reconfiguration has been introduced New visiting guidance for patients and families, the use of iPad and social media working closely with brain charity Road to Recovery pod casts and zoom sessions for rehabilitation JR- back to patient engagement ie Ipads for increased communication – sharing of roadmap and then service reviews – agile working group. Life-size screens purchased to enable better communication between patients and families to support rehab activities.	
3.	**JR** **AN** **LS**		Q1/ Q2 Q3/ Q4 Q1 (21/22)	The patient experience and lead nurse walkabouts have now commenced, Introduction of electronic FFT Call for concern / FOCUS will also be rolled out this year to improve quality care for patients. Inpatient vaccination programme and international recruitment. Inpatient vaccination programme commenced Looking at alternative recruitment from other countries in order to boost nursing establishments Exec / non exec walkabouts to recommence June 2021	
4.	**MG** **AN**	RD GH	Q1 Q2 Q3 Q4	Clinical trial activity impacted significantly by Covid. Clinical staff involved in Covid clinical trials and some of our clinicians leading nationally on research into the neurological impacts of covid. Refocused research into Covid related trials and supported the wider system. The Walton Centre has been commended for its successful contribution. New clinical research lead in place and presented research ambitions to clinical staff. Enhanced relationship with LHP and UoL. Will now be able increase clinical research activity.	

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- Have **a health and wellbeing programme** for staff that is an **exemplar** in the NHS and supports our staff in their roles.
- Be a **system leader** working with partners to **share best practice** & improve patient pathways & experiences in the communities we serve & beyond.

In 2020/21 our commitments are;

5. To have utilised IT and technology to support staff agility and flexibility to support care and care for patients differently.
6. To aspire to Investors in People platinum award, including the new industry standard for Health and Well-being.
7. To deliver outstanding care and to be recognised as such by the Care Quality Commission.
8. To be an anchor institute and system leader supporting the communities we serve.

No	Exec	Lead/s	Qtr.	Actions	RAG
5.	**MB**	JG	Q1/ Q2 Q3/ Q4 Q1 (21/22)	Ongoing – priorities discussed at Digital Programme Board. Will be built around the requirements of the patients / organisation with appropriate measures to be put into place. Hybrid model expansion ensures everyone has access to the right equipment to do their work. Improvements in outpatient clinic hardware through DA has been identified as a project with NHSX. Representation on the regional Digital inclusion group to ensure that no one is left behind digitally and access is available to all citizens or alternatives are offered, The organisation achieved an excellent digital maturity rating of HiMSS stage 5 in its HiMSS external audit.	
6	**All**	MG	Q1 Q2 Q3 Q4 Q1 (21/22)	The process of reaccreditation commenced in Oct 2020 Staff interviews and presentations have taken place via teams, all data has been sent Gold award received – Trust ambition is Platinum. Reaccredited as Gold in IIP and IIP Health & Well being awards	
7.	**LS** **JR** **AN**	LV JK all	Q1 Q2 Q3 Q4 Q1 (21/22)	New CQC review process undertaking mock inspections and regulations and continue with CQC engagement meetings with new relationship manager. Further development work in mental health service following CQC (LS) Mental health work signed off by CQC. To align with new CQC process following release of their new strategy.	
8.	**HC**	AR, all	Q1 Q2 Q3 Q4	Leading on partnership working with the local authority on workforce opportunities and wellbeing. Proactively promoting the NHS to local business community via Professional Liverpool and shaping the One Liverpool strategy to include anchor institutions as a priority.	

RECOGNISE
be recognised as excellent in all we do

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- Have a reputation for **delivering outstanding care by outstanding specialist staff**.
- Be at the **leading edge of innovation and research** shaping neurosciences treatment and care for the future.
- Have an **engaged workforce** that is increasingly flexible, adopting new ways of working, being recognised as a representative employer and valuing and **embracing diversity** in our workforce.
- Have **a health and wellbeing programme** for staff that is an **exemplar** in the NHS and supports our staff in their roles.
- Be a **system leader** working with partners to **share best practice** & improve patient pathways & experiences in the communities we serve & beyond.

In 2020/21 our commitments are;

9. To achieve year on year improvements in our in-patient and staff national surveys.
10. Develop and implement the next stage of Building Rapport training programme to include action learning sets.
11. Embed the regional strategic Workforce Partnership with Liverpool City Council with particular emphasis on recruitment and retention.

No	Exec	Lead/s	Qtr.	Actions	RAG
9.	LS MG	LV JM	Q1 Q2 Q3/ Q4 Q1 (21/22)	Internal staff surveys re experiences during COVID carried out and followed up by focus groups This year has seen an improvement in the national inpatient survey and the staff survey with a robust action plan devised for all areas of improvement. NHS People Plan issued July 20 People Strategy mapped to People Plan, action plan for 20/21 agreed Readiness to return survey carried out National staff survey Work will continue with the patient and family centred care group to support improvements in patient experience. Walkabouts and listening events continue to support staff as required. COVID staff debriefs have now commenced CQC inpatient survey – year on year improvement achieved. Overall staff survey has improved this year and extensive work underway to implement subsequent action plan	
10	MG	JM	Q1 Q2 Q3 Q4 Q1 (21/22)	Paused due to COVID Additional half day added to programme Programme dates confirmed to end of the year All modules including additional half day to be completed Evaluation of programme and next steps Programme has been evaluated successfully and new ED&I (civility) module resourced and under development.	
11	MG	JM	Q1 Q2 Q4 Q1 (21/22)	Group engagement continued during phase 1. Four joint groups established- recruitment and retention, staff training, communications, health and wellbeing. The Walton Centre continues to co-chair the group and lead health and wellbeing shared agenda. Considerable progress related to recruitment, retention and health and wellbeing.	

The Walton Centre NHS Foundation Trust

Report to the Board of Directors
Date: 1 July 2021

The Walton Centre NHS Foundation Trust

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

Executive Summary

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review. The BAF was last reviewed by the Board of Directors on 1 April 2021 and relevant BAF entries were subsequently reviewed by the Quality Committee and Business Performance Committee on 17 June and 22 June 2021 respectively. There have been no changes to either the Trust's strategic objectives or the associated principal risks.

There are currently a total of 15 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, have been reviewed by Executive Directors in advance of the Board meeting on 1 July 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table at s3 of the report details the risk scores for BAF entries at Quarter 1 2021/22. A reduction in risk score is proposed for 5 of the 15 BAF entries.

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Board Assurance Framework supports the Annual Governance Statement which is a requirement of the annual report in line with the NHS Improvement Annual Reporting Manual.
Action required by the Board	The Board of Directors is recommended to: a) review and approve the BAF content for 2021/22 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;

3.0 Current Position

The BAF was last reviewed by the Board of Directors on 1 April 2021 and relevant BAF entries were subsequently reviewed by the Quality Committee and Business Performance Committee on 17 June and 22 June 2021 respectively. There have been no changes to either the Trust's strategic objectives or the associated principal risks during Quarter 1 2021/22.

There are currently a total of 15 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, have been reviewed by Executive Directors in advance of the Board meeting on 1 July 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been updated since the last review by the Board can be identified by the use of bold blue font and

strikethrough. The table below details the risk scores in Quarter 1 2021/22 together with the closing risk scores at Quarter 4 2020/21.

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

Movements in risk scores during Quarter 1, all of which reflect a reduced risk score are summarised as follows:

- Risk ID 001, Covid-19 - Risk score reduced from 20 to 16
- Risk ID 002, Operational Performance – Risk score reduced from 20 to 16
- Risk ID 004, Quality - Risk score reduced from 16 to 12
- Risk ID 007, Digital - Risk score reduced from 12 to 8
- Risk ID 014, Medical Education - Risk score reduced from 15 to 9

Board members should note that the reduction in risk score for Risk ID 002 and Risk ID 004, were recommended by the Business Performance Committee (BPC) and Quality Committee respectively. The BPC will consider whether a further reduction in score for Risk ID 002 is appropriate at the next quarterly review in the context of performance against the recovery trajectory.

No new principal risks have been identified for inclusion in the BAF during Quarter 1 2021/22.

4.0 Next Steps

BAF entries will continue to be reviewed by the relevant lead Committees in accordance with agreed business cycles. The next iteration of the BAF, reflecting the position for Quarter 2 2021/22, is scheduled for review by the Board of Directors on 7 October 2021.

5.0 Recommendations

The Board of Directors is recommended to:

a) review and approve the BAF content for 2021/22 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.

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

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

	Consequence	Likelihood	Rating
	Catastrophic	Likely	
Initial	5	4	20
	Major	Likely	
Current	~~5~~4	4	~~20~~16
	Catastrophic	Unlikely	
Target	5	2	10

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

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily COVID-19 Control Meetings Daily Safety Huddle Divisional Daily Huddle Infection Prevention and Control Committee – bi-monthly Pandemic Testing Reported to Resilience Planning Group Aug 2019 Daily Executive Meeting Ethics Committee **Level 2** Infection Prevention & Control Quarterly Report – Quality Committee Quarterly Governance Report –Quality Committee, Trust Board Covid-19 Update – Trust Board EPRR Self-Assessment – Nov 2019 Trust Board Assessment of Interim Governance arrangements to Trust Board – April 2020 Covid-19 Board Assurance Framework **Level 3** Daily Sit Rep Reports submitted to NHS Digital EPRR – Self Assessment submitted to NHSI – Nov 2019 NHSI National call – weekly NHSE/I Visit – February 2021	1. Asymptomatic screening provides inconsistent results 2. Managing potential consequences of enhanced regional testing regime 3. **88% of staff have had their Covid-19 vaccination**

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Terms of Reference, membership and reporting arrangements re Ethics Committee to be finalised	AN	End of April	Completed
2	Ongoing participation in regional and national plans	JR	~~March 2021~~ July 2021	On track
3	**Promotion and support for staff who have not had the Covid-19 vaccination with a communications plan**	**LS**	**July 2021**	**On track**

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Patients will wait longer for 1st and follow up appointments – which could result in harm or poor patient experience. • Referral to treatment standard (RTT) / average wait pilot standard will not be met. • Cancer standards will not be met. • Diagnostic standards will not be met. • 52 &36 week wait standard not met	Average Wait Performance Overdue Follow up waiting list in Neurology remains a concern Reduction in overall activity due to the impact of COVID-19 Self-isolation guidance impacting on patient choice Increasing waiting list size ~~52-week breaches increasing~~ **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. Workforce Plan 2018-2019 3. COVID-19 Recovery Plan Phase 3 4. Job Planning for consultants - Ongoing for 2020-21 **/ 2021/22** 5. National Call – NHSI – Weekly 6. Performance Dashboard in Real-time 7. 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. 8. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 9. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 10. ~~Development~~ **Submission** of Recovery and Restoration plans for 2021/22 11. **Use of Halton Hospital to deliver Pain daycase activity from May 2021**	1. Workforce 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 behaviours. 3. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 4. Lack of clarity re waiting time standard - RTT /Average wait going forward 5. Planned transfer of Spinal services from LUHFT ~~early 2021/22~~ **September / October 2021** – impact in relation to overall Trust RTT performance is currently unknown.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Weekly monitoring of performance of RTT Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly PA Consulting have been contracted to work through C&M data and plan based on assumptions and winter plans. **Level 2** Integrated Performance Report – Reported monthly at Trust Board COVID Update – Reported at Board meetings from April 2020 **Level 3** Meetings with Commissioners – ~~bi-~~monthly	1. Transformation Board delayed due to COVID response 2. C&M approach to access and planning

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Transformation Board to be formally established and re-focused to address outpatient productivity flow and theatres in the context of COVID-19 Recovery	DoSO	April 2021	Commenced
2	Implementation of COVID Recovery Plan to increase activity	DoSO	End of July	Phase 1 complete
3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	Superseded

4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	May 2021	Commenced
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue	DoSO	May 2021	Delayed
6	Continued Job Planning for consultants for 2020/21 **/ 2021/22**	DoSO	~~Mar 2021~~ **Mar 2022**	On track
7	Data requested from LUHFT to inform RTT position.	DoSO	June 2021	On track

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

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

Key Impact or Consequence

- 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**
- Increase in staff turnover

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

Physical Assaults on staff

2018/19	2019/20	2020/21
Q1 = 45 Q2 = 34	Q1 = 27 Q2 = 45	Q1 = 22 Q2 = 56
Q3 = 50 Q4 = 18	Q3= 40 Q4 = 29	Q3 = 78 Q4 = 40

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

1. Violence and Aggression Policy - approved Feb 2018
2. Lone Worker Policy - approved Feb 2018
3. Mental Capacity Act Policy - approved Jul 2019
4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach)
5. Security Function (ISS)
6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required
7. Personal Safety Trainer Programme of work Apr-2019
8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018
9. Additional Consultant reviews RVs where V&A has increased
10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot)
11. Restraint Training rolled out in CRU and other ward areas
12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are aggressive
13. **National Violence Reduction Standards issued:**
    - **V&A Strategy in development in line with national standards**
    - **Baseline audit completed – reported to Health, Safety & Security Group May 2021**
14. **Special Observation of Patients Policy in place**
15. **Post-incident staff debriefing in place (MDT approach)**

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

1. Lack of agreed KPI's within the Security Contract
2. Compliance with statutory and mandatory training
3. Restraint Training to be rolled out across all wards
4. Psychologist sessions to be rolled out to all wards
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?

Level 1
Trust Safety Huddle – daily Monday-Sunday
Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments
Safeguarding Group review of escalation concerns – bi monthly
Violence and Aggression Group – ~~quarterly~~ **bi-monthly**
Transformation Board - monthly

Level 2

Annual Governance Report – Quality Committee
Quality Dashboard – Quality Committee – monthly 2020

Level 3
Staff Survey 2020
Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance

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

1. Outcome of Shiny Minds App to be evaluated
2. Lack of benchmarking data across similar Trusts – to commence with Queen's Square in Q1 20201/22
3. ~~Evaluation of LAST LAP (Looking After Staff That Look After People) initiative - due in Q1 2021/22~~

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Violence and Aggression Policy - approved Feb 2018 2. Lone Worker Policy - approved Feb 2018 3. Mental Capacity Act Policy - approved Jul 2019 4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach) 5. Security Function (ISS) 6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required 7. Personal Safety Trainer Programme of work Apr-2019 8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 9. Additional Consultant reviews RVs where V&A has increased 10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot) 11.Restraint Training rolled out in CRU and other ward areas 12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are aggressive **13. National Violence Reduction Standards issued:** • **V&A Strategy in development in line with national standards** • **Baseline audit completed – reported to Health, Safety & Security Group May 2021** **14. Special Observation of Patients Policy in place** **15. Post-incident staff debriefing in place (MDT approach)**	1. Lack of agreed KPI's within the Security Contract 2. Compliance with statutory and mandatory training 3. Restraint Training to be rolled out across all wards 4. Psychologist sessions to be rolled out to all wards 5. **Potential for HSE visit due to increase in RIDDOR incidents related to fractures**
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	LS	~~End of Nov 19~~ ~~Oct 2020~~ June 2021	Delayed
2	Continued focus on statutory and mandatory training compliance Trust Wide – in line with new social distancing requirements	MG	~~End of March 2021~~ June 2021	On track
3	Pilot of Shiny Minds App to be evaluated	MG	~~End of March 2020~~ ~~September 2020~~ ~~December 2020~~ June 2021	Delayed
4	Benchmarking of nurse turnover of similar Trusts across Cheshire & Merseyside	LS	End of Sept 2020	Complete
5	Roll out of Looking After Staff to Look after Patients to all wards	LS	End of Aug 2020	Complete
6	Audit of LASTLAP to be completed **Update 17 Jun 21 – Audit completed in May 2021**	LS	~~Jan 2021~~ Quarter 1 2021/22	~~Not started~~ On track **Complete**
7	Outcome of Investors in People to be reported	MG	~~Jan 2021~~ June 2021	On track
8	Roll out of Restraint Training across all wards	LS	~~March 2021~~ June 2021	~~On track~~ ~~Delayed~~ On track
9	Roll out of psychology sessions across the wards for staff health and well being	LV	~~March 2021~~ June 2021	On track

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

Linked Operational Risks			Consequence	Likelihood	Rating
			Major	Likely	
			Initial	4	4	16
			Major	~~Likely~~ Possible	
			Current	4	43	~~16~~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 experience - Reputational damage - Standards of care	1. Increase in reported deaths from 92 in 2019/20 to **112 in 2020/21**. 2. A~~n increase~~ **reduction** in the number of formal complaints received with **67 in 2020/21** compared to 129 in 2019/20 ~~3. 1 Never Event – November 2019~~ **Zero Never Events in 2020/21** ~~4. 15 cases of E Coli against a threshold of 12 for 2019/20~~**13 cases of MSSA against a threshold of 8 in 2020/21** ~~5. Operation or procedure wrongly sited – December 2019~~ ~~6. 2 Category 3 Pressure Ulcers – December 2019 / Feb 2020~~ 7. Increase in Nosocomial Infections 8. Covid-19 pandemic

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Quality Strategy 2020 – 23 – approved Sept 2019 2. KPI's for Year ~~1~~ **2** of the Quality Strategy March 2021 3. CARES Review Programme ~~2019-20~~**2021/22** 4. HCAI Reduction Plan ~~2019-20~~ **2021/22** 5. FOCUS Programme ~~19-20~~ **2021/22** 6. Theatre Utilisation Programme 7. Patient Family Centred Care Group 8. COVID-19 Recovery Plan – May 2020 9. Clinical Audit Plan – ~~approved June 2020~~ **CESG June 2021** 10. IPC –strategic COVID 19 Plan January 2021 11. Trust Recovery Roadmap	1. Alignment of year 1 priorities across all strategies not tested 2. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 3. Lack of resource within IPC to support Covid-19 response 4. Covid-19 pandemic – reduction in staffing
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – Daily **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 ~~2020~~ **May 2021** Safeguarding Annual Report – ~~May 2020~~ **June 2021** Annual Governance Report ~~2019/20~~ **2020/21** Medicines Management Annual Report – ~~July 2020~~ **June 2021** Quality Strategy Progress Report – ~~July 2020~~ **March 2021** COVID- Update to Trust Board – monthly **Level 3** CQC Inspection Report 2019 ~~Weekly~~ **Monthly** reporting to CQC Relationship Manager Review meeting with Commissioners – Quarterly National Inpatient Survey Results – September 2020 CQC Mental Health Inspection – December 2020	

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

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

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning 2019 3. Five year education plan to ensure supply 2017 4. Quality Strategy Sept 2019 5. People Strategy revised in line with the national People Plan Sept 20 6. Staff 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. De-briefs following first wave of COVID 19. Mental Health First Aid Training 20. Collaborative International Recruitment 21. Virtual recruitment days for Qualified Nursing staff 22. **Quarterly Staff Pulse Survey – commenced April 2021**	1. Implications of Brexit i.e. Visas on recruitment not yet known 2. Changes to pension arrangements 2020/21 and implications for recruitment and retention still not understood 3. Traditional training no longer appropriate due to social distancing and therefore alternative delivery methods to be developed 4. Continued national shortage in supply of nursing staff ~~5. Lack of clarity regarding annual leave and TOIL nationally~~

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Vacancy monitoring – weekly Daily escalation undertaken and all outcomes are reported to Senior Nursing Team. Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events – quarterly **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC – ~~Sept 2020~~ **Mar 2021** Communication and Engagement Strategy – Trust Board Sept 2020 **Level 3** Staff Survey March ~~2020~~ **2021** Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance	1. Outcome of Shiny Minds App to be evaluated 2. Delivery of National People Plan

Investors in People Accreditation 2020 – Gold Status **Investors in People Wellbeing Award – Reassessment June 2021**	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Outcome of Brexit and implications for recruitment and retention not fully understood. Ongoing involvement and discussion with NHS Employers, NW Staff Partnership Forums and Brexit Council for Liverpool.	DoW	Ongoing ~~Mar 2020~~ ~~Dec 2020~~	Complete
2	Outcome of national review of the 2015 NHS Pension Scheme and its implications awaited	DOW	~~Dec 2020~~ March 2021	On track
3	Alternative solutions for statutory and mandatory training in development whilst socially distanced training continues	DOW	March 2021	On track
4	Continued progress to develop a C&M Collaboration at Scale for Nursing Workforce and progress recommendations	DoW	End of March 2020	Delayed
5	Outcome of Shiny Minds app to be evaluated	DOW	~~End of March 2020~~ ~~September 2020~~ ~~Dec 2020~~	Complete
6	On-going participation in National/Regional Meetings to inform local policy and realign strategy where necessary	DOW	March ~~2021~~ **2022**	On track
7	Await outcome of Investors in People Assessment process for 2020 not received	DOW	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.**	DoW & DoN	~~May 2021~~ **Dec 2021**	~~On track~~ **Delayed**

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

Linked Operational Risks				Consequence	Likelihood	Rating
305	Legionella positive samples found in water outlets in Walton Centre.	16	Initial	Major	Possible	
				4	3	12
301	Fire Safety Compliance	12	Current	Major	Possible	
				4	3	12
			Target	Major	Unlikely	
				4	2	8
Risk Appetite	Cautious					

Key Impact or Consequence *What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated*	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Unsafe environment for staff - Patient safety/ - Compromised quality of care" - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance	The Trust currently has a costed backlog maintenance schedule which is updated annually for the purpose of the ERIC return submission. This schedule highlights high, significant, medium and low level backlog maintenance requirements.

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily Safety Huddle Water Safety Group – reporting into IPC Committee Health & Safety Group Contract review meetings with AUH – monthly Heating and Pipework Project Board – monthly **Level 2** Capital Programme approved by Trust Board – March 2019 **Level 3** 6 Facet Survey – Jul 2019 CQC Inspection Report Aug 2019 NHS Digital acceptance of ERIC return 2018 Cladding Review – Sept 2016 Fire Brigade post-incident review of Fire Processes - 2019	1. Limited AUH planned maintenance/KPI reporting in place 2. Lack of reporting of sustainability data

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

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

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

Linked Operational Risks				Consequence	Likelihood	Rating
670	System failure of Electronic Referral Management System (ERMS)	12	Initial	Major 4	Possible 3	12
			Current	Major 4	Possible ~~3~~2	~~12~~8
			Target	Major 4	Unlikely 2	8
Risk Appetite	**Moderate**					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• 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 ~~has~~ bid for Digital Aspirant funding ~~from~~ **approved by** NHS Digital. ~~which has yet to be formally granted.~~ This funding will help to deliver the EPR and wider Digital Strategy over the next two years.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Digital Strategy – approved January 2020 2. Outpatient Transformation Project 3. Inpatient Transformation Project 4. Theatres Project 5. Paper Light Project 6. EPR Milestone group with clinical representation 7. IT Technical Programme of work 8. Cyber Security Programme 9. PMO Function underpinning the Digital Strategy 10. Member of North Mersey / C&M H&C Partnership – aligning strategies 11. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 12. Post covid EPR rollout plan for 20/21 13. Digital Transformation Programme 2021-23 to be completed Q1 2021/22 to lay out competition of digital roadmap for the organization ~~14.~~ Digital Aspirant status to allow Digital Transformation ~~to achieve HIMSS Level 5/6~~ 15. **HiMSS Level 5 achieved, planning for Level 6**	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy post COVID-19 across Hospital Cell may be different to Trust's internal digital strategy ~~3. Additional investment required for remote working due to Covid-19 Given the pressures on the capital programme, EPR may need to be re-phased to enable this investment.~~ 4. Change in national priorities around Digital post Covid response may not be aligned to Trust digital priorities

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Outpatient Digital Group monthly Inpatient Digital Group – monthly – digital champions within the Divisions Clinical Systems Safety Group – monthly Digital Programme Board – bi-monthly IGSF –monthly Digital Prioritisation Group - quarterly Clinical Risk Group Executive Team review of C&M Hospital Cell Digital Objectives ISMS Certification IS27001 accreditation September 2020 **Level 2** Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group C&M CIO Digital Collaboration Group **Level 3** Critical Applications Audit – Jan 2020 ePatient Neurophysiology system – Limited Assurance Jan 2020	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives (to be completed and agreed ~~Q1~~ **Q2** 2021/22).

Digital Matrix Index score 2018 ISMS Certification IS27001 accreditation Aug 2019 Cyber security CertCare progress monitored by NHS digital Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to STP by C&M Digit@LL **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	~~April 20~~	Complete
2	Regular updates regarding the Trust's Digital objectives and alignment to the C&M Hospital Cell objectives around digital to Exec Team Update 1 Apr 21 – Slide deck containing HCP project dependencies and full Digital projects is shown at Operational Management Board and Digital Programme Board along with HCP updates	MB	March 2021	Complete
3	New Digital Strategy	MB	May 2021	Commenced
4	Digital Aspirant MoU signed by all parties	MB	March 2021	Complete

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of operational and clinical disruption or a ransom; - Potential financial loss due to loss of activity - Likely to lead to financial, business and operational impacts as well as reputational damage; - potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover - Non-compliance with Data Protection Laws/NIS Directive - Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.	Q1 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)**

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 TIAG review of CareCERTs - Weekly Cyber Security Awareness Presentation to Executive 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**	~~1. Cheshire & Merseyside system wide recovery response not tested~~ 2. Third party assurances required regarding satellite sites 3. Ongoing work with NHS Digital to inform funding requirements

Corrective Actions: To address gaps in control and gaps in assurance	Action	Forecast	Action

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

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

Linked Operational Risks

- Inability to retain clinical staff if unable to fulfil their innovation/research ambitions
- Ensuring sufficient workplace capacity to maintain innovative practices, treatments and boundary scanning
- Ensuring that the inevitable financial and Covid-19 pressures do not distract from the Trust's commitment to innovation
- Challenging risk aversion, complacency and the status quo where employees become demotivated
- Too many innovations that are not fully implemented, acknowledged and celebrated
- The Trust's innovation agenda becoming weakened in an environment of meeting/emerging system change
- Local and national political developments

Risk Appetite — **Cautious**

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

Key Impact or Consequence

1. Trust reputational impact at a time of system change and Covid-19 impacts
2. Inability to improve patient care and deliver efficiencies
3. External scrutiny e.g. CQC well-led

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

Achievement of Innovation Strategy Objectives:

- Short term (2019/20) – Largely completed (some Covid-19 delays)
- Medium term (2020/22) – Largely completed (some Covid-19 delays)
- Long term (2022/24) – To be progressed
- **Individual projects being successfully delivered**

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

1. Innovation Strategy 2019/24
2. Innovation Pipeline
3. Stakeholder Analysis
4. Innovation Strategy Communication Plan
5. Development of internal processes / information resources to support innovation
6. Developing additional funding streams
7. Investors in People accreditation (2020)

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

1. **Covid-19 delays and impact on resourcing is delaying progress / reducing capacity**
2. Competitor Analysis to be completed (to be finalized when Communications & Marketing Manager starts in March 2021)
3. 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)
4. Complex alignment between Innovation and other teams has progressed significantly but more work is needed
5. Multi-team working to improve consideration of innovations developed outside the Trust and address risk aversion
6. Innovation processes. guidance and methodology not yet fully developed
7. Income generation model (for the Spinal Improvement Partnership) approved but contracts still being negotiated **with some Trust resourcing issues**

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

Level 1

- Innovation Team Meeting – monthly
- Medical Innovation Group – bi-monthly
- Regular innovation meetings with procurement, IT, IG, service improvement, clinical and other teams
- Executive Team approval of innovation business cases and initiatives

Level 2

- Innovation bi-monthly update to RIME Committee
- RIME Committee Chairs Report to Trust Board
- Trust Board endorsement of innovation business cases

Level 3

- Board level membership at Innovation Agency NWC
- CQC Inspection report 2019
- CQC well-led criteria now includes innovation

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

1. Benefit realization for innovative business cases not yet feasible due to limited time that Trust has had Innovation posts in place
2. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency and potentially commercial innovators to identify appropriate process

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

7	Investors in People Assessment	DW&I	October 2020	Completed
8	**Addressing resourcing issues in Innovation / Commercial team**	**DW&I**	**June 2021**	**On track**

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

Linked Operational Risks		Consequence	Likelihood	Rating
Potential link to all high level operational delivery risks				
		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?*
Potential reduction of Trust autonomy with a consequent impact on delivery of objectives.	• Hospital Cell and Governance arrangements determined at regional level without consultation • Changes in national policy due to COVID-19 • White Paper indicates decreased autonomy for individual Trusts with increased control by ICS / central Government

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Trust Strategy 2018-2023 2. Communication and Engagement Strategy 2020 3. Active membership of Cheshire and Merseyside Health Partnership (C&MHCP) and Collaboration at Scale Programme 4. Member of Liverpool Health Partnership 5. Member of Liverpool PLACE 6. Member of Trauma Partnership 7. Membership of Specialist Trust Alliance 8. Medical Directors Group STP level 9. Chief Operating Officer Group STP level 10. Membership of DOFs Group STP level 11. Management Side Chair of NW Staff Partnership Forum 12. Membership of Director of Nursing Group STP level 13. Membership of Director of Workforce Group STP 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	1. Hospital Cell and Governance arrangements potentially result in greater influence for larger providers 2. Financial arrangements now determined across STP level 3. Clarity on the ability of Provider trusts to influence future ICS arrangements 4. Completion of review of Stakeholder Analysis 5. Lack of clarity on planned legal challenges and full details of White Paper 6. Lack of certainty on future ICS financial arrangements – clarification anticipated Q1 2021/22

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

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

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

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

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

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Senior Neuroscience Research Group chaired by the Chief Executive • Sponsorship Oversight Group • Research Capability Funding Sub-committee • Roy Ferguson Compassionate Care Award Group **Level 2** • Research update to RD&I Committee • RD&I Committee Chairs Report to Trust Board **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019	1. Ongoing service redesign incomplete (review pending) 2. Organisational change process suspended due to COVID-19 3. Engagement/utilisation of LHP and SPARK inconsistent

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Organisational change process supported by Human Resources	DW&I &CDRD	TBC (due to COVID 19)	On hold
2	Senior Neuroscience Research Group with agreed action	DW&I & CDRD	September 2020	On track
3	Internal NRC redesign work	Internal R&D Team	Ongoing	On track
4	Investors in People Assessment	DW&I	October 2020	On track
5	External review undertaken by Caroline Murphy, Kings College London	DW&I	November 2020	On track

Risk ID: 012	Date risk identified October 2020	Date of last review: April 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:** July 2021
		CQC Regulation: 17 Good Governance
		Ambition: Be financially strong and invest in services
		Assurance Committee: Business Performance Committee
		Lead Executive: Director of Operations and Strategy

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on 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 ~~£4.0m~~;**£6.2m** - Any overspend on capital against out CRL will need to be covered by the other Trusts in the STP (reducing their ability to spend capital); - Impact on revenue budgets should there be a risk to patient safety;	Between the draft plan and the intended final plan submission, some additional material capital requests have been raised. **The Trust 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.**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Capital Management Group reviews all capital business cases and sanctions expenditure based on budget allocations – Chaired by DO&S; 2. SFI's/SORD have appropriate approval levels for capital expenditure so DoF&IT / DO&S are sighted on expenditure; 3. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc.; 4. Monthly reporting of capital expenditure in board report so cumulative spend is transparent to senior management and board members. ~~5. Regional underspend forecast in December 2020 providing additional flexibility in year.~~ 6. **Capital prioritization being undertaken by Ops, Clinical and Finance staff utilizing a range of criteria to enable RAG rating of all schemes and prioritization of the capital plan** 7. **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; 2. Some items are not specified in detail and therefore there is an ability to substitute items in year which means capital slippage is difficult to manage. 3. Limitations of regional approach to capital allocations ~~4. Any utilisation of regional underspend in 2020/21 may result in a corresponding reduction in the Trust's capital allocation for 2021/22.~~

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

Corrective Actions: 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	On track – continuous review
2	~~Operational Management Board to help manage priorities and help to manage demand~~ **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	On track
4	Regular capital forecasts to provide up to date position on the year end projections	DoF	Ongoing	On track
5	Continued discussions with HCP DoF to ensure aware of capital pressures and so allocations forthcoming as required from other provider underspends.	DOF	Ongoing	On track

Risk ID: 013	Date risk identified October 2020	Date of last review:	April 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:**	July 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Financial risk rating may decline and lead to increased regulatory scrutiny • Potential breach of statutory duties • Inability to deliver strategic objectives • Loss of decision making responsibilities • **Reduced ability to influence across the system**	~~Original plan submission of £1.5m deficit. Given overall C&M position, HCP were requested to improve the position. Currently (M10) forecasting a year end surplus of £0.5m for HCP submission. This position could change depending on performance in M11-12 (including uptake of further activity.~~ **Original plan submission £1.4m (for H1 2021/22). However, in accordance with system plans, there was a requirement for all provider organisations to report a breakeven position (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 has reduced the level of required financial savings in H1.**

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.~~ inancial plan submitted for **H1 2021/22 in May 2021** ~~2nd half of year 2020-21 – October 20~~ 2. Capital Programme – **allocation by HCP in April 2021** ~~approved by HCP August 20~~ 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** 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 ~~(to remain in place for Q1 2021/22 and may be extended to Q2)~~ 8. **Monthly financial forecasts based on current run rates to assess anticipated H1 position compared to plan.** ~~Current allocations in second half of year are improving the Trust's position against plan/forecast.~~	~~1.~~ **Financial plan approved by BPC (with delegated authority from the Board) in May 2021. Extremely short deadlines meant that there was insufficient time to gain full assurance that a breakeven position was achievable.** ~~Financial plan not approved – overall balance at HCP level so further submissions likely to be required; Overall HCP financial plan not approved. Ongoing forecast submissions have been required on a regular basis to assess closure of the financial gap.~~ ~~2.~~ **Expenditure budgets based on average run rates for Q3 2020/21 updated for anticipated changes in H1 2021/22. Budgets do not, however, take account of agreed establishments for departments.** ~~Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21 – run rates only a guide rather than a control;~~ 3. Block contract based on **Q3 values in 2020/21 uplifted for inflation.** ~~19/20 values and not fully representative of 20/21; Given that the block contract will remain in place for Q1 2021/22~~ It is currently not clear whether the block contract values will be ~~amended and whether they will be~~ representative of 2021/22 given the intermittent stop/start of elective activity and potential ongoing Covid requirements ~~4. Formal planning approval governance processes not in place due to rapid turnaround of submissions;~~ ~~5.~~ QIP plan will be required in 2021/22 to close the gap to individual plans. ~~(although value not yet clear). Planning delayed due to pandemic response (until at least Q2 2021/22);~~ **Value of QIP to be delivered is being finalized but ability to deliver recurrent savings for H1 impaired by lateness in plan submissions and methodology of using Q3 run rates as allocations. Aim to cover QIP non-recurrently in H1 allowing time to identify and deliver recurrent savings in H2 2021/22.** 6. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance ~~7.~~ **Currently no guidance on financial regime beyond 30 Sep 21 as national guidance has yet to be issued. Consequently, financial planning for the full financial year is not possible.** ~~NHSE/I negotiated a reducing contract value with Wales as activity reduces in tranches of 25%. This could reduce payments should lockdown mean that activity is cancelled.~~

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monitoring expenditure and income against budgets via Finance **Calculation of forecast position for the H1 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 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 **Five year financial planning exercise being undertaken, in collaboration with Operational teams, despite lack of national guidance beyond September 2021** ~~2021/22 internal business planning being undertaken despite national delay in business planning~~ **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	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** 2. Financial Framework suspension means Trust not being managed via regulator directly but through system / regional approach which is reviewing overall balance; 3. Covid expenditure audit by external party yet to be carried out so unsure if any expenditure will need to be repaid; 4. Covid cost allocation insufficient to cover actual costs incurred.

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	March ~~2021~~ **2022 - ongoing**	On track
2	DoF on HCP planning group weekly calls	DoF	March ~~2021~~	On track

			2022 - ongoing	
3	Raising issues with non-English commissioners to NHSI/E	DoF	March ~~2021~~ **2020 - ongoing**	On track

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

Linked Operational Risks		Consequence	Likelihood	Rating
		Catastrophic	Possible	
	Initial	5	3	15
	Current	~~Catastrophic~~Moderate	Possible	
		~~5~~3	3	~~15~~ 9
	Target	~~Catastrophic~~ Minor	~~Unlikely~~ Possible	
Risk Appetite	Cautious	~~5~~2	~~2~~ 6	~~10~~ 6

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Compliance with education contract and operational delivery of undergraduate and postgraduate clinical placement outcomes: • Supervision • Teaching • Site infrastructure Internal educational governance, succession planning and support for educators and learners	• Difficulties experienced **during the 2020/21 academic year** recruiting to undergraduate supervisor roles. Approx 24 consultants signed up as supervisors for 4th year programme but just 10 have committed thus far. Reasons for withdrawing include not having activity within current job plan as well as post-covid service pressures • Postgrad supervisors also drawn from same supervisor 'pool', exacerbating demand on a limited consultant resource • Challenges responding to rapid changes in teaching delivery / accessing external platforms and databases e.g. university Zoom teaching. Facilitating student access to clinical activity remotely. WiFi strength • A perception 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.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Established Medical Education Committee and clear reporting line to the Board of Directors 2. Lead educator roles established with DME engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and **meets at least bi-monthly, more frequently when planning for the new academic year. C**linical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed. SOPs have been created to standardize and assure processes.	1. Ensuring educator roles are fully understood along with commitment required, activity has transformed over past 5 years, SOP / definition of role expectations to provide transparency for trust and individual 2. Silo working - communication between postgrad and undergrad in regard to available resource, are expectations to be a joint supervisor realistic? 3. Will a template of an optimal week be adequate to help inform / support supervisors during job planning process or is more robust 'intervention' needed? No routine auditing cycle of SOPs.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 ~~Neurology registrar engagement in undergraduate education is encouraged and facilitated. They attend the UG operational working group and support the undergrad programme facilitating and developing aspects of the timetable. These measures engage junior doctors and ensure they are developing an appreciation for education delivery. They are encouraged to develop as educationalists by senior colleagues and for those that remain at the trust will be supported by CSD to hone experience as they progress. We have evidence this approach is successful by the appointment of a former trainee to the role of deputy CSD, other registrars due to be appointed who demonstrate interest in contributing to education which will be supported by the ed team~~ ~~Students and doctors in training have been able to remotely join teaching via MS teams and Zoom. Feedback has been good suggesting delivery has been successful.~~ • **Medical Education Committee** • **Medical Education overarching Action Plan** • **Medical Undergraduate Working Group** • **Junior Doctor Forum (held alongside Guardian of Safe Working)** • **End of Placement Feedback – Undergraduate** • **Placement Exit Survey – Postgraduate** **Level 2** • **Medical Education Quarterly Report to RIME Committee**	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.

• **Medical Education Annual Report to RIME Committee** • **HEENW Annual Education Return** **Level 3** • **GMC NTS – Postgraduate Trainee and Trainer** • **UoL Clinical Undergraduate placement RAG reports** • **Annual Education Self-Assessment Report - HEENW**	

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

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Potential deterioration of the Trust's financial position through commissioning / tariff changes; - Loss of decision making responsibilities as move to system based financial targets; - Working with ~~2~~ different tariff systems (Wales **and Isle of Man**); - Loss of key relationships in commissioning to Trust.	Recent NHSI/E consultation shows that there will be a move to system working Tariff consultation also requested feedback on changes to both tariff and the move to population based funding. **Lack of clarity around financial regime beyond September 2021 (block runding 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. 3. Trust has fed back on consultation to changes on tariffs / population based commissioning. 4. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) on this agenda. 5. DoF currently a member of the weekly HCP finance planning group so able to raise issues and get an understanding of direction of travel in relation to HCP position. 6. CEO is part of in hospital cell which is likely to be influential in the Provider Alliance which constitutes part of the HCP structure.	1. Move to system allocations via HCP puts trust at risk as no longer dealing with commissioners who have detailed knowledge of trust services. 2. Larger acute trusts with underlying structural deficits may have a bigger influence with HCP in terms of funding allocations. 3. Some of Walton Centre patient population lies outside C&M HCP and therefore does not align with population basis for commissioning / funding allocations. 4. Trust basis for funding based on historical local tariffs recognising 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** ~~with~~ the Trust may having to take a proportion of this deficit. 6. Governance around the provider model and how this fits in with the wider HCP financial system delivery, **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. 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. **Level 2** Risk being reviewed across several organisations and also by FoSH so potential to influence the agenda. Transitional period in 2021/22 will ensure that financials will be broadly in line with current regime for a year until full implementation of population based commissioning. c75% of current referrals within the current HCP boundary with 12% outside so not as fragmented population base for referrals given the size of C&M HCP (the rest are Wales / IOM) which limits though does not eliminate financial risk. **Level 3**	1. Move from existing regulatory relationship with NHSI/E and commissioning relationships with NHSE, Specialised Commissioning to single relationship with HCP and how this will work. 2. Post transitional period finances i.e. population based commissioning will still leave a potential c12%+ income at risk if they no longer are commissioned from Trust. 3. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR.

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

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

Covid-19 Risk Register - for review at Trust Board 1st July 2021
Date report produced - 24th June 2021

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood	Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Planned	Review date	Risk Lead
858	21/06/2021	Adverse Event /Incident	**If the current red, amber, green pathways and the way in which level of cohorting patients determines insufficient bed usage continues, then there is a risk that the elective recovery plan will not be achievable and P1, P2 and patients who have waited 52 weeks or more are cancelled/postponed.**	Major	Likely	High 16	1. Daily bed meeting to establish expected discharges and future admissions 2. Weekly theatre list planning, coordinating expected admissions with bed situation 3. Identified red, amber, green pathways and designated wards 4. WLI sessions offered weekly 5. Bed / patient moves to accommodate admissions and maintain RAG status 6. Use of Jefferson for same day admissions as and when this can be accommodated 7. Use of socially distanced beds where appropriate and with exec approval 8. Clinical re-triage and contact with patients awaiting treatment	1. Admissions / discharges often change due to clinical need 2. list planning often changes based on non-elective demand, and change to clinical priority of elective patients 3. Depending on non-elective & elective activity by day, the demand for amber or green beds often surpasses capacity 4. Uptake of WLI dependent on staffing and willingness 5. Increased risk of IPC issues with multiple bed/patient moves and poor patient experience 6. Inability to use Jefferson for all SDA patients as SAL currently not operational 7. Not in-line with national guidance	1. Discussed and monitored in R&G 2. Discussed and monitored in TUG 3. Discussed and monitored in weekly performance meeting 4. Discussed and monitored in SNT	1. Currently none	1. No action plan identified.	21/07/2021	Divisional Manager of Neurosurgery
798	20/07/2020	Business Continuity	**If staffing levels are unable to be maintained within the Pathology departments, as a result of Covid 19, there is a risk to service delivery.**	Minor	Unlikely	Low 4	1. Environmental risk assessments detailing social distancing and other measures to reduce risk of transmission of Covid-19 while working in the laboratory. 2. Neuroscience Labs Business Continuity Plan in place. 3. Majority of staff now vaccinated. 4. Positive cases in the community now lower. 5. Weekly LAMP testing available to staff.	1. Many measures in place however cannot guarantee elimination of transmission risk. 2. BCP does not take into account loss of ALL staff within the department.	1. Low number of covid positive cases in the department in the past 12 months. 2. Positive cases have not transmitted to other staff in the department demonstrating control measures are effective.	1. None currently identified.	1. Currently no actions	13/08/2021	Quality & Governance Manager The Neuroscience Laboratories
797	13/07/2020	Risk Assessment	**If controls are not put into place to prevent surgical face masks being used for self-harm attempts of suicide, there is a risk to patient safety.**	Catastrophic	Unlikely	Mod 10	1. Patients monitored and observed closely. 2. Any concerns escalated appropriately. 3. Neuropsychiatry and Neuropsychology input when required 4. Masks only used within clinical areas.	1. No gaps in controls, storage space to be provided for surgical masks to ensure they are placed in a safe storage area.	1. No incidents to date June 2021. 2. Neuropsychiatry service monitored and manages any risk identified.	1. Patients may not express suicidal tendencies.	1. None currently identified	25/07/2021	Advanced Neuropsychiatry Nurse Practitioner
806	01/10/2020	Business Continuity	**If school children are sent home due to displaying Covid 19 symptoms, parents will need to self-isolate for 14 days and children will need to be swabbed then there is a risk of reduced staffing in all areas of the trust during this period of time.**	Moderate	Likely	Mod 12	1.Systems in place for the swabbing of children including a SOP 2. No children under the age of 2 to be swabbed at the trust 119 to be used for this group of children. 3. Support provided to the management of swabbing arrangements and outpatients department 4. Daily staffing and bed meetings to manage safe staffing. 5. Daily safety huddle and daily command and control. 6. Daily communications 7. Close working with NHSP 8. Close working with the bed management team to ensure we are using bed capacity appropriately 9. Redeploying staff across all areas. 10. Children now have biweekly testing 11. 88% of staff now vaccinated	1. Reliance on bank and agency and redeployment of staff. 2. Dependant on LUHFT for swab results. 3. Shifts not covered low fill rates.	1. Team in place for managing and arranging the swabs and the governance around this 2. SOP in place. 3.Daily safety huddle / command and control.	1. Being able to manage the amount of children sent home from school and the reduction in staffing. 2. Reduced capacity in the lab to process the swabs and delays in results and further delays in getting staff back to work.	1. Continue with daily safety huddle, command and control and bed meetings 2. Working closely with NHSP to see if all staff can be registered on NHSP 3. Ensure SOP is used and staff are compliant 4. Work closely with LUHFT to ensure that the text messaging service is in place	01/07/2021	Deputy Director of Nursing & Governance
807	01/10/2020	Business Continuity	**If compliance with the 2 metre social distancing rule is not adhered too, then there is a risk of staff contracting Covid 19.**	Major	Possible	Mod 12	1.All staff are provided with appropriate PPE 2.Social distancing is enhanced in all staff rooms 3.Posters and floor markings are in place 4.Patient day rooms are now in use for staff to be able to manage breaks across 2 areas to support with social distancing 5.Staggered break times, 6. Additional staff areas i.e. marque sort to support social distancing during staff break time.	1.Non-compliance with IPC control measures	1.Continuous promotion of IPC guidelines 2.Managers working with the areas to ensure social distancing is maintained 3.Daily safety huddle 4.Daily walkabout to monitor the use of PPE 5. Observational audits by the IPC team. 6. 88% of staff have now been vaccinated.	1.Non-compliance with IPC guideline and social distancing	1.Continue with promotion via daily safety huddle 2.Regular communications reminding staff of PPE guidance 3.Managers to review all of their break areas to ensure they are compliant with social distancing 4. Additional areas that can be used for breaks to be implemented into break areas.	27/07/2021	Deputy Director of Nursing and Governance

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood	Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Planned	Review date	Risk Lead
827	13/01/2021	Business Continuity	**If the level of activity associated with Welsh specialist activity fall below 25% of prior year levels there is a financial risk to the Trust due to the national agreements put in place (where a percentage of block income will be withheld dependant on the reduction in activity levels). It is more likely that activity will fall below the agreed levels as a result of the 3rd wave of COVID-19 as elective activity is likely to be cancelled to help the region wide response to the pandemic). There is also a financial risk to the Trust if IOM related activity reduces materially (as the IOM administration is paying for activity undertaken).**	Moderate	Likely	Mod 12	1.NHSE/I have agreed a payment mechanism with Wales for months 7-12 which means that block income will be received but with income being withheld if activity falls below agreed percentages compared to last financial year. 2.Close monitoring of activity levels compared to last financial year. 3.On-going dialogue with NHSE/I around the national agreement (and amounts of income withheld if activity falls below certain levels) given the 3rd wave of COVID currently being experienced (and requirement to cancel elective activity to support the region). 4.The Trust has implemented a number of new ways of working to meet COVID guidance including Telehealth.	1.IOM & Welsh affordability likely to be more of a problem going forward and strength of relationship cannot mitigate this. 2.Requirement to cancel elective activity to support region wide response to 3rd wave of COVID-19. 3.Patients unwilling to attend appointments due to fear of COVID-19. 4.Patients access to digital technology. 5.Reduced capacity due to social distancing/ IPC requirements.	1.Regular review of risks at Board level and on-going review of mitigations 2.Monthly report to BoD and BPC regarding income position and any issues with commissioners 3.Regular updates to BPC 4.On-going dialogue with NHSE/I 5.On-going communication with commissioners	1.Uncertainty whether financial framework will be amended as a result of wave 3 covid 2.Uncertainty of financial framework. 3.We have no control over the NHSE/I decisions around the financial framework going forward 4.Previously agreed contracts unlikely to be honoured 5.IOM have stated that they will only pay on a PBR basis	1.Risk will continue to be monitored by Board of Directors and through Business Performance Committee 2.Continue to discuss risk around Wales financial agreement with NHSE/I 3.Financial modelling of finances to be carried out once new financial framework is published 4.Year end financial forecasts regularly undertaken to understand potential financial risks	30/07/2021	Deputy Director of Finance
793	07/07/2020	Business Continuity	**If increased cancellations, capacity/demand and limitations on the number of patient visitors continue, due to Covid-19, then there is a risk of poor patient experience and outcomes.**	Moderate	Likely	Mod 12	1. Divisions working towards getting back to normal activity - via telephone/video consultations in order of patient need. 2. New telephone line in PACs recording calls. 3. Any identified themes and trends are escalated to Deputy Director of Nursing and Governance and Director of Nursing and Governance. 4. Patients receive regular updates and communication from the division. 5. Visiting continues to be restricted due to the increased levels of Covid 19 across Cheshire and Merseyside 6. Recovery plan now commenced alongside the Walton Centre Roadmap	1. As this is a new risks there are currently no identified gaps. Will continue to monitor.	1. Patient Experience Team escalating all new concerns/complaints on a weekly basis in a weekly meeting with both Divisions. 2.Regular communication with patients and families from the Division. 3. Calls to loved ones campaign initiated by the Divisional Nurse Directors using Ipads, mobile phones and social media.	1.Will continue to monitor for gaps in assurance, currently none.	1. None currently identified.	30/08/2021	Deputy Director of Nursing and Governance
813	15/10/2020	Business Continuity	**If the Walton centre is required to support the C&M system with capacity there are several associated risks including training and development – staff may not be experienced in caring for and managing different conditions. Neuroscience patients will have reduced access to services and will wait longer.**	Major	Possible	Mod 12	1.Support system decision making ensuring clinical outcomes are taken into account. 2.TWC CEO is part of the hospital cell 3.TWC MD participates in a weekly call 4.TWC director of operations supports all regional calls 5.Phase 3 plans submitted 6. TWC is currently working in partnership with Cheshire and Merseyside to implement the recovery plan.	1. Overall decision making is made at a system level	1. Commissions aware of TWC clinical decision making and current waiting list size they are supportive are continuing with elective activity Discussions taking place with LUFT about available capacity that would support the system with minimal impact on neurological patients.	1. none currently identified.	1. Currently none identified	30/07/2021	Interim Chief Executive
796	13/07/2020	Business Continuity	**If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19.**	Moderate	Likely	Mod 12	1.Implementation of national guidance to reduce nosocomial infections 2. COVID-19 screening regime 3. Infection Prevention Policies and SOPs. 4. Daily updates via safety huddle and communication bulletin 5. Compliance with Operating framework for urgent and planned services within hospitals 6. Chavasse is designated RED ward 7. SBARs and action plan 8. Observations of PPE 9. All staff offered Covid-19 vaccine 10. Lamp testing available to all staff 11. Roll out of vaccination programme 88% of staff	1. Potential for asymptomatic Covid-19 positive patients to be admitted to trust 2. Non compliance with IPC control measures. 3. Communication process between transferring organisations 4. Core group of staff may not access vaccine/Lamp testing 5. Uptake of LAMP testing sub optimal in clinical staff 6. Cohorting of Green and amber pathway patients on Sherrington	1. SITREP to NHSE/I 2. Surveillance outcomes 3. Screening programme 4. Covid-19 BAF 5. Covid-19 dashboard	1.Non compliance with IPC interventions as per guidance 2.potential of importing COVID-19 cases from the community 3. Delay in transferring symptomatic patients to Chavasse	1.Outbreak meeting held daily as required. 2.Rescreening of patients then repeat screening in 5 days then at 14 days to enhance detectability. 3.Enhanced staff and patient screening 4.Admitted patients must be symptomatic or positive to move onto Chavasse ward (reinstate Chavasse as the red status ward). Symptomatic patients to remain in amber bay 5. Staff breaks reviewed to enable social distancing 6.Ensure enhance cleaning is completed (2 stage process) 7.Daily meeting to be held in the boardroom 9am (1/2 hour) – bed managers to maintain ward patient status on the wall. 8. Continue to liaise with PHE 9. Ensure 2 metre guidance is adhered to. 10. Trust research leads are working to encompass activities within the Liverpool Biomedical Research Centre to address risks (although the precise studies to be undertaken are not yet specified).	29/07/2021	Lead Nurse for Infection Control and Tissue Viability

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood	Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Planned	Review date	Risk Lead
783	05/05/2020	Business Continuity	**If the Covid-19 pandemic continues for an extended period, then there is a risk to staff safety following evidence indicating Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected by Covid-19.**	Major	Possible	Mod 12	1. Staff will be advised to follow guidance on shielding as and when appropriate. These employees cannot remain in work during this time, but if well, may wish to explore home working. 2. Adjustments to working practices may include working remotely or moving to a lower risk area. 3. Actions to be taken for staff will depend upon their medical condition and how stable it is. 4. Where a condition is unstable and there may be an increased risk to staff, Managers may seek support from the Occupational Health & Wellbeing Team and/or HR. 5. Staff redeployed or working from home will be fully supported in completing their role. 6.BAME staff have been offered access to the vaccine as a priority.	1. Currently no gaps in controls	1.Risk Assessment Guidance - COVID-19 made available via communications to staff. 2. All BAME staff have received an individual letter with a risk assessment attached asking them to discuss with their manager. 3. All managers have been asked to ensure they proactively speak to all of their BAME and vulnerable staff to complete a risk assessment 4. Decisions about possible redeployment, special leave, working from home will be agreed with the individual based on the results from the risk assessment. 5. monitor uptake of vaccine.	1. The possibilities of remote working for clinical staff are reducing . Opportunities for redeployment to a lower risk area are reducing.	1. Risk Assessments for all vulnerable staff are now completed . Actions taken for individual staff will depend upon the outcome from the risk assessment. Risk assessments to be reviewed and updated for shielding staff returning to site	30/08/2021	Deputy Director of Workforce and Innovation
779	20/04/2020	Business Continuity	**If an increased demand for oxygen supply continues across the Trust (supplied by Aintree University hospital), due to Covid 19, then there is a risk that oxygen supply to patients may be affected.**	Major	Unlikely	Mod 8	1. Liaison with Aintree to keep consumption levels under review 2. Increased monitoring 3. Increased deliveries from O2 supplier 4. clinical and estates co-ordination	1.Unknown escalation of COVID-19 patients requiring oxygen support 2. Walton Centre dependent upon Aintree Hospital bulk liquid oxygen supply	1. Regular readings taken from back-up oxygen manifold. 2. Feedback from Aintree re:site wide situation and Walton Centre consumption. 3. Predicted calcs undertaken between S Shaw / S Holland & Mike Hill 4. Regular contact between Command and Control, Estates team, Risk team and Anaesthetics team 5. Back up/resilience plan in place 6. Various NHSEI Cas Alerts	1. Aintree Hospital back up plan involves moving Walton Centre onto "older" bulk oxygen supply which is normally reserved for resilience. This may compromise our system resilience options	1. Close communication between Aintree and Walton Centre Estates teams 2. Continual monitoring of VIE and back up supply 3. local agreement with oxygen supplies for top up of VIE and bottle exchange/delivery, as needed 4. Increased maintenance 5. close liaison between clinical and estates teams	30/08/2021	Estates Manager
774	08/04/2020	Business Continuity	**If staffing levels within the Material Management Team are unable to be maintained, as a result of covid 19, then there is a risk to transfers of supplies to clinical areas and service delivery.**	Major	Unlikely	Mod 8	1. Staff situation is monitored by Acting Head of Procurement and Head of Materials Management on a daily basis to ensure that there are sufficient staff to manage delivery of stocks onto wards and clinical areas. 2. A number of finance staff are also being trained in materials management so that they can cover staff absence if required 3 .Ordering of stocks can be done remotely	1. No gaps in controls	1. Deputy DoF constantly monitoring staff situation and ensuring that staff are trained to support this area	1. Given the high infection rate if a number of cover staff from other departments are also unable to support then this may delay stock put away	1. Continue to expand the pool/resource of staff that are trained to cover with stock put away duties.	28/07/2021	Deputy Director of Finance
842	30/03/2021	Business Continuity	**If covid infections continue, then there is a risk that we will not be able to get sufficient stock of shunt valves and monometers. This risk is increased further as a result of Brexit.**	Major	Unlikely	Mod 8	1. Regular stock checks 2. Order stock in plenty of time to allow for delays	1. Staff may forget to order stock when needed	1. ANP to check stock during ward rounds	1. None currently identified.	1. No actions identified	30/07/2021	Operational Services Manager within Neurosurgery
810	09/09/2020	Adverse Event / Incident	**If a neurosurgical registrar were to test positive for COVID then there is a risk that the on call system could collapse. This is due to the office space being too small to accommodate social distancing.'**	Moderate	Possible	Mod 9	1. Registrars to wear masks 2. Meetings via MS Teams to minimise face to face attendance 3. Shared desks in secretariat 4. Roll out of the vaccination programme 88% of staff now vaccinated. 5. Registrars have relocated to a bigger office to aid improved social distancing	1.Mask wearing during breaks	1. None currently identified.	1. None currently identified.	1. Currently no actions	30/07/2021	Divisional Director of Neurosurgery
812	15/10/2020	Business Continuity	**If staffing levels decrease, then there is a risk to staff's health and wellbeing and work life balance not being maintained.**	Moderate	Possible	Mod 9	1. Well established health & wellbeing programme 2. Shiny minds resilience app available for staff 3.Closed staff Facebook for mutual support 4.Regional/National helplines 5.Trust 24/7 counselling 6. Mental Health First Aid training has commenced. 7. Access to Cheshire and Merseyside Resilience Hub 8. implementation of NOSS support programme for staff.	1. No face to face support.	1.Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. 2.Work with NHSP to ensure gaps are covered 3.Testing capacity is sufficient to date.	1. Ability to manage absences across the Organisation	1. On line training for Mental Health First Aiders 2. Debriefs to learn lessons 3. Review of health and wellbeing communications 4. Daily safety huddles. 5. Trusts counselling service are providing a number of workshops for frontline staff on site 6. H&W conversations in place	25/07/2021	Deputy Director of Workforce and Innovation

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood	Risk level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Planned	Review date	Risk Lead
775	20/04/2020	Business Continuity	**If safe staffing levels are unable to be maintained as a result of Covid 19, then there is a risk to patient care.**	Moderate	Possible	Mod 9	1.Specialist Nurses working on wards as appropriate 2.Other clinical staff supporting ward areas i.e. Radiographers, Neurophysiologists, Therapists when required. 3.Admin staff redeployed where possible, register of staff who can support the wards held centrally. 4. Working closely with NHSP. 5.Staffing reviewed through staffing meeting daily	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness or may need to return to their own areas of work	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Work with NHSP to ensure gaps are covered.	1. Being able to manage absences across the organisation. External factors i.e. no summer school clubs for child care	1.Daily Huddle. 2. Daily review of staffing. Redeployment register held centrally. 3.Absence management continues 4. Local and National Health and Well being programme of support in place. 5.Daily communications to staff. 6. Risk assessments to be reviewed for all staff on a regular basis 7. Access to C&M resilience hub	31/07/2021	Deputy Director of Workforce and Innovation
773	08/04/2020	Business Continuity	**If supplies of PPE equipment continue to be of short supply nationally, then the Trusts may not have sufficient PPE for staff to treat patients.**	Moderate	Possible	Mod 9	1. Trust stock levels are now stable, the Trust has additional reusable PPE and clinical consumables. 2. Nationally this is recognised as an issue. This has resulted in the introduction of a national stock recording and ordering system. 3.Regionally Trusts are working together and ensuring that orders of stocks are being received and distributed. 4. A 'mutual aid' system has been implemented across C&M to enable Trusts to share stock where there are shortages. 5. Daily stock returns (including usage levels) are submitted to NHSE and C&M collaborative. 6. WCFT is also working closely with other Specialist Trusts to ensure that all organisations have equitable share of supplies (e.g. WCFT have received a supply 8833 3M masks from Bridgewater and CWP).	1. Trust dependant on the Department of Health/NHSE for deliveries of PPE and critical consumables. The situation has improved in the past months with daily deliveries of PPE. Daily monitoring of stock levels and usage help identify potential shortages in advance.	1. Deliveries for Covid stock are now reaching the Trust, due to increased availability on a national basis. 2. Head of Procurement and Head of Materials Management are in constant contact with Supply Chain and also wards to ensure that stocks are kept as complete as possible moving to a 'push model' of supply (supplying people who need it). 3. Sufficient stock for the majority of PPE items are now received with other key items being monitored on a daily basis. 4. Daily stock levels (and usage) provided to NHSE and C&M collaborative to ensure that all Trusts have adequate stocks (through a mutual aid scheme). 5. Shortages are raised via NHS England's National Supplier Disruption Service to ensure stocks do not deplete.	1. Central Teams/MOD determine PPE to be delivered by Push, therefore they do not always supply the required PPE. Global shortages for specific PPE with no suitable alternative e.g. FFP3 3M 8833 masks. Lack of freedom to source PPE through local procurement as items will be provided through the national route. PPE shipments will not be guaranteed to support increased activity within the Trust. 2. PPE shipments may not be guaranteed to support increased activity within the Trust.	1. In partnership with other Trusts/Social Care etc., potential to work collectively to develop the local PPE supply chain to mitigate risks (in support of anchor institution objectives).	30/07/2021	Deputy Director of Finance
808	01/10/2020	Business Continuity	**Neurology Division - If safe staffing levels are unable to be maintained as a result of COVID 19, then there is a risk to patient care and activity performance within the Neurology division. This includes staff absences due to childcare i.e. children being sent home from school with or without symptoms.**	Moderate	Possible	Mod 9	1. Redeployment of Specialist Nurses working on wards. 2. Identified other clinical staff suitable to work in ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3. Admin staff redeployment where possible, register of staff who can support the wards held centrally 4.Working closely with NHSP. 5. Ward staffing reviewed through daily bed meeting. 6. Testing capacity for household members. 7. Established rotation of working from home practices for key admin staff. 8. Cross Divisional weekly activity performance meeting. 9. Virtual, telephone and face to face outpatient activity in place aligned to phase 3 guidance.	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness/childcare responsibilities/self isolation or may need to return to their own areas of work. 2. Outpatient activity ceasing if COVID surge happens, there is a risk the medical and specialist nurses will be needed to increase staffing numbers in ward areas.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Wards working with NHSP to ensure gaps are covered 2. Testing capacity is sufficient to date. 3. No externally reportable activity breaches.	1. Being able to manage absences across the divisional admin and clinical teams. 2. External factors i.e. school clubs for child care / children being sent home from school.	1. None	25/07/2021	Divisional Director of Neurology

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

REPORT TO TRUST BOARD

Date 01/07/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations and Strategy
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Access & Performance Director
Previously considered by:	• Committee Quality Committee Business & Performance Committee

Executive Summary

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

Key performance highlights are detailed below:

Key Performance Indicators – Caring

High Performing Measures

Complaints – The number of complaints received has significantly reduced over the last eight months, both in raw numbers and when adjusted for total patient contacts.

This reduction has brought the Trust in line with the national average for written complaints received per 1000 WTE at the latest published period (Q2 2020/21).

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – There are currently two 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 27.83 which is significantly above the latest national average (9.39).

There were two C.Diff instances in month which is a total of three year to date against a year end trajectory of 5. The rate per 100,000 bed days is currently at 41.75 which is outside of normal limits.

Key Performance Indicators – Well Led

High Performing Measures

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

Opportunity for Improvement Measures

Nursing Turnover - Although still above the 10% target, performance has improved significantly over the last year and is experiencing special cause variation.

The Nursing vacancy rate is currently 6.47% and Medical is -0.25%. Nursing turnover remains high due to registered staff successfully being recruited into internal specialist nurse positions and career progression externally, two have returned to the ward areas, one from an internal position and one from an external post. The two divisional matrons have recently reviewed the skill mix across all areas and staff have been redeployed to maintain patient safety and to enhance staff clinical development.

Sickness/Absence - Sickness/Absence levels in May 2021 were above the target of 4.75% at 4.85%.

Appraisals – Appraisal compliance in May 2021 is 80.31% which is an improvement when compared with March 2021. The training team are continuing to work with individual departments to improve compliance

Harm Free Care – Incidences of harm remain low and are performance within expected variation. There was one moderate harm fall reported in month.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

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

Underperforming Measures

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

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity –During May 2021 the Trust exceeded all elective activity targets set for the month.

Related Trust Ambitions	• Best Practice Care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	Associated access and performance risks all contained in divisional and corporate risk registers.
Related Assurance Framework entries	Associated BAF entries: • 001 Covid-19

	• 003 Performance Standards • 005 Quality
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

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Excellence in Neuroscience

Board KPI Report
July 2021

Data for May 2021 unless indicated

SPC Chart Rules

The Walton Centre NHS Foundation Trust

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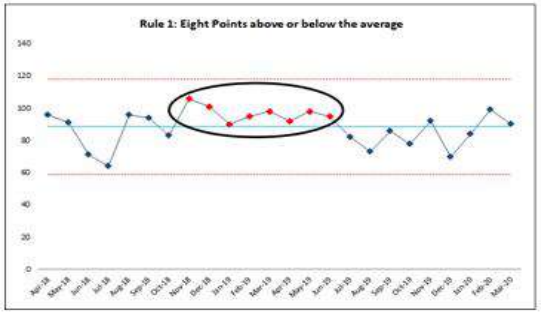
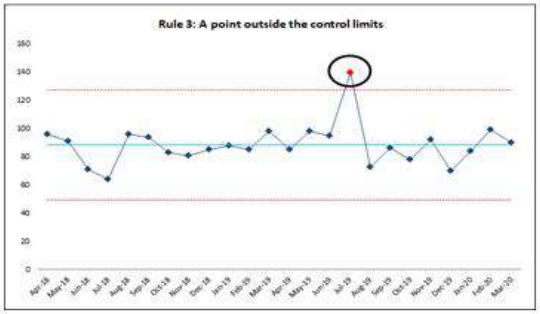
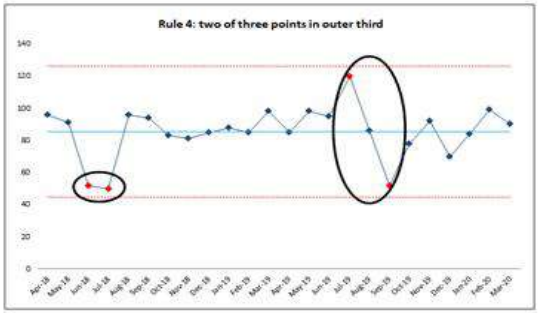
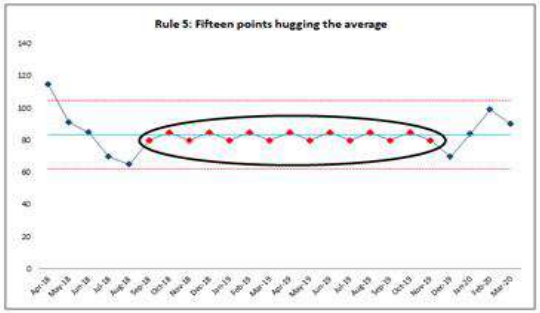
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).









All SPC charts will follow the below Key unless indicated

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

Operational

Effective - Theatres

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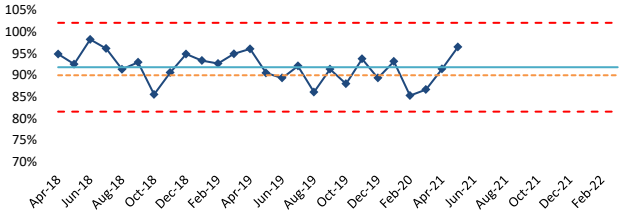
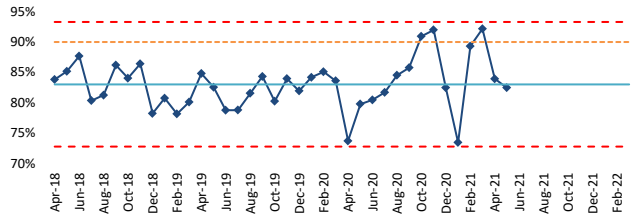
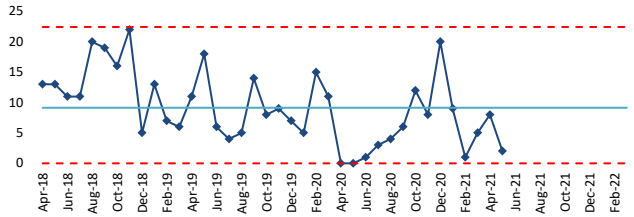
Theatre utilisation of Elective Sessions



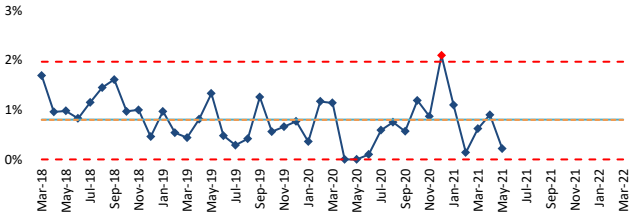
Theatre utilisation of in Session Time



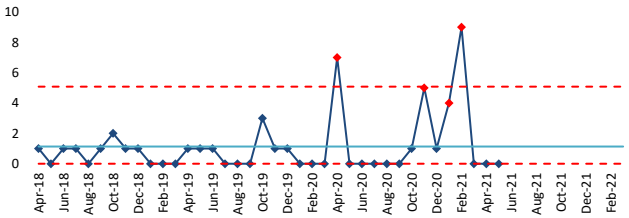
Number of Cancelled operations non clinical (on day)



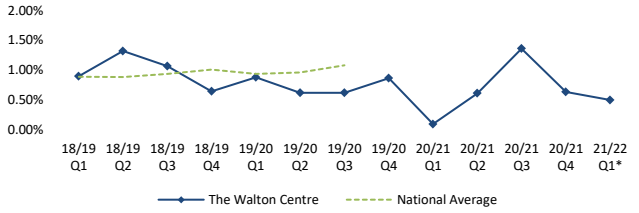
% of Cancelled operations non clinical (on day)



Number of cancelled operations not re-admitted within 28 days



Non Clinical Cancelled Ops as a % of Elective Admissions



Operational

Effective - Activity Recovery Plan

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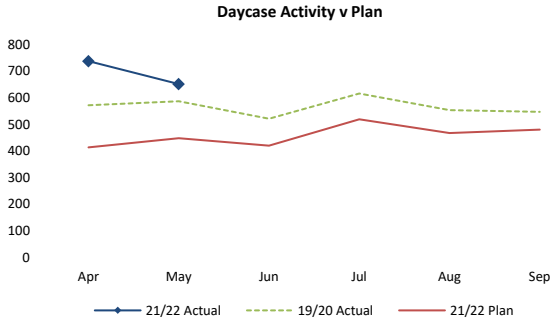

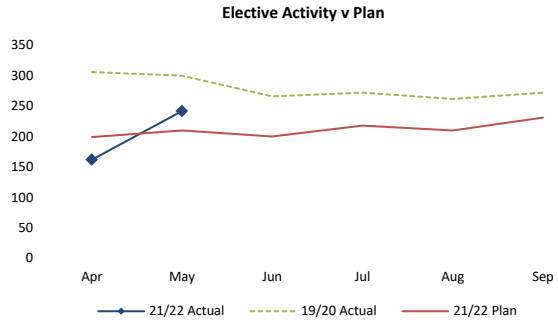

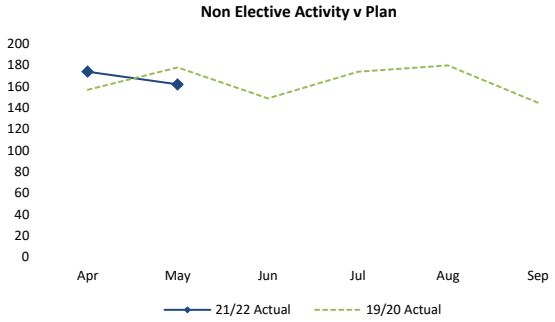

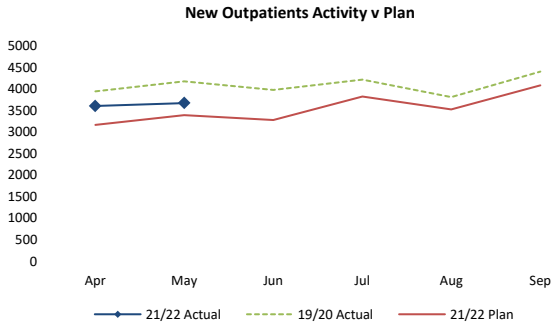

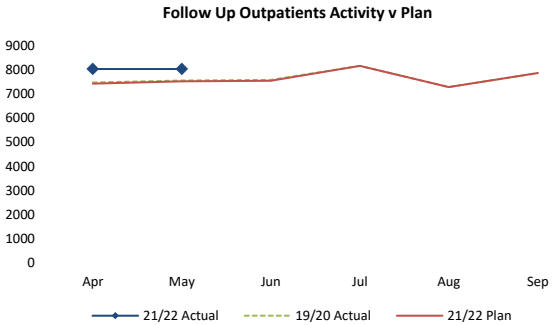

May 21 Activity Performance

POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	111.09%	76.45%
Elective	80.67%	70.00%
Non Elective	91.01%	-
New Outpatients	87.99%	81.27%
Follow Up Outpatients	106.34%	99.49%

Quality of Care

Well Led - Workforce KPIs

NHS
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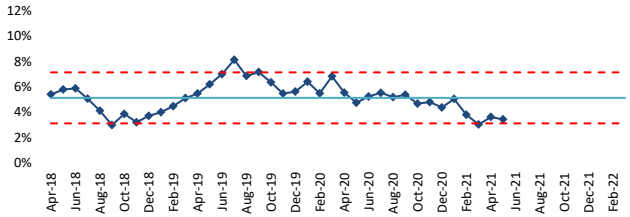
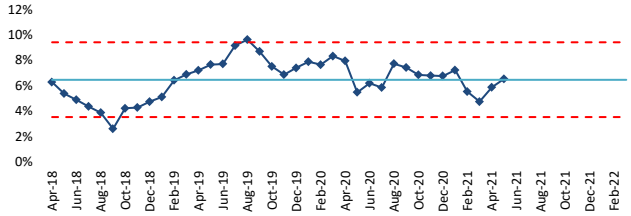
Excellence in Neuroscience

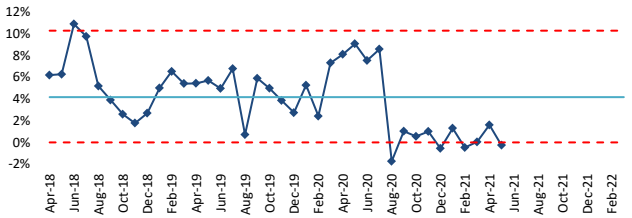
Overall Vacancy Level %



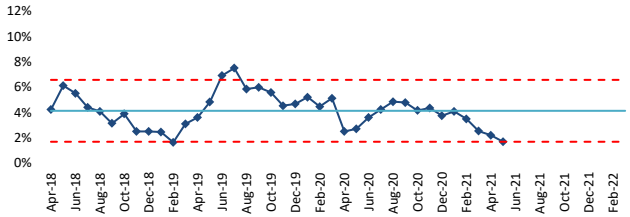
Nursing Vacancy Level %



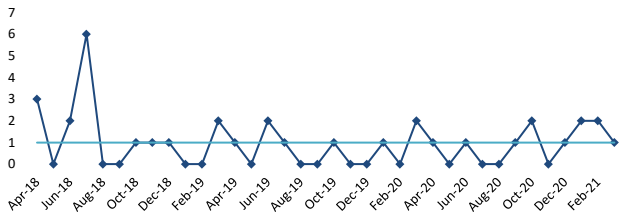
Medical Vacancy Level %



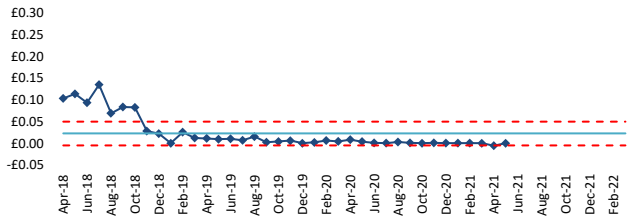
Other Staff Vacancy Level %



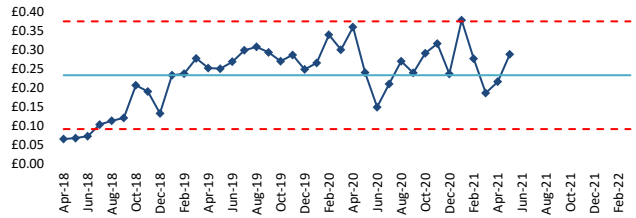
Medical Leavers



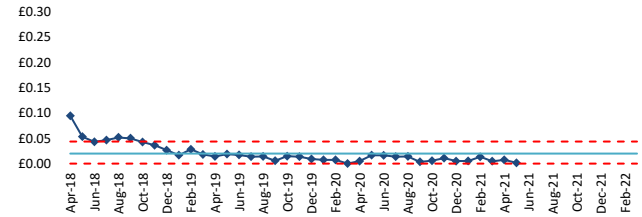
Nursing & HCA Agency Spend (£m)



Nursing & HCA Bank Spend (£m)



Nursing & HCA Overtime Spend (£m)



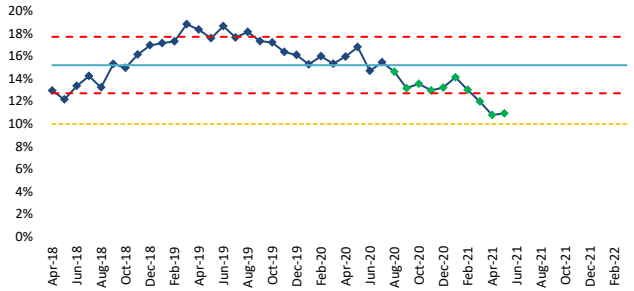
Quality of Care

Well Led - Workforce KPIs

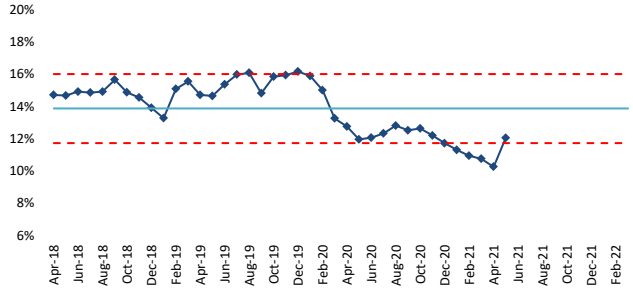
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

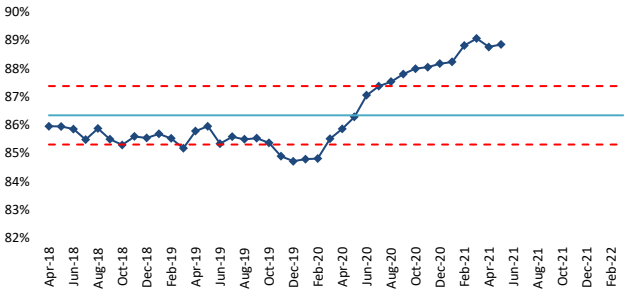
Nursing Turnover (Rolling 12 months)



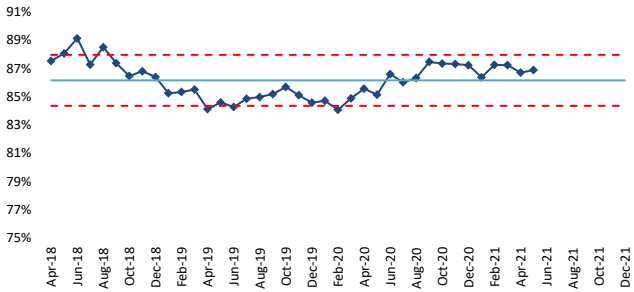
Other Staff Turnover (Rolling 12 months)



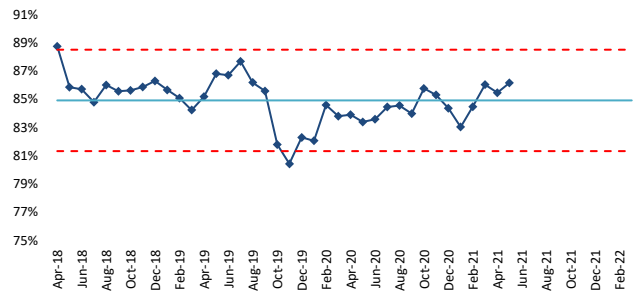
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



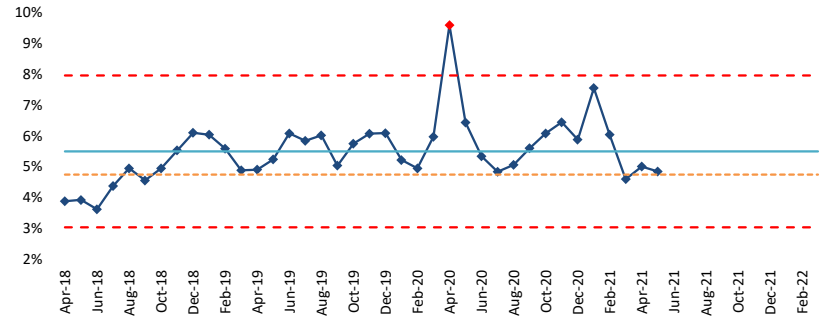
Quality of Care

Well Led - Workforce KPIs

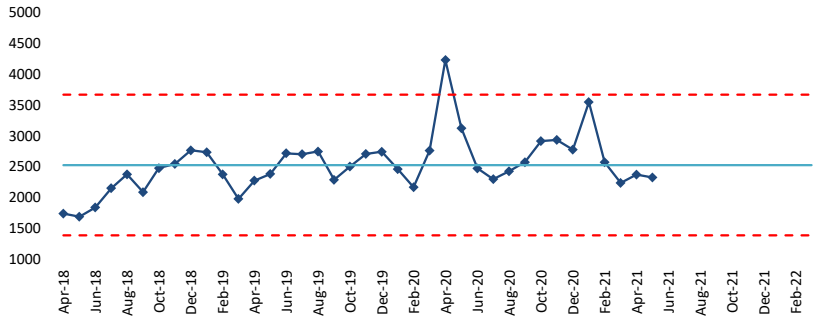
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

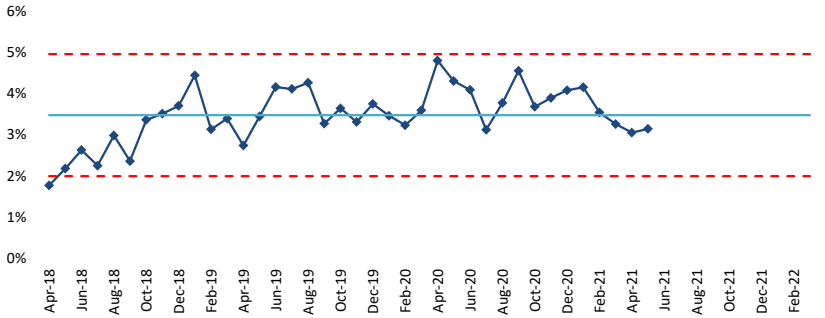
Sickness/Absence (Monthly)



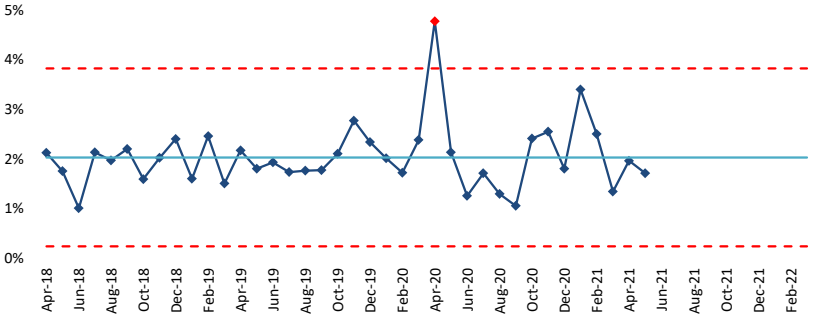
Lost Days due to Sickness/Absence (Monthly)



Long Term Sickness/Absence (Monthly)



Short Term Sickness/Absence (Monthly)



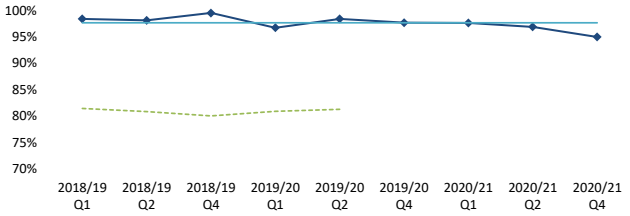
Quality of Care

Well Led - Workforce KPIs

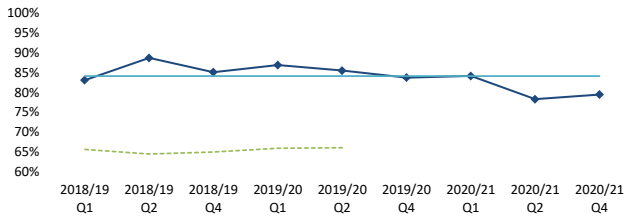
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

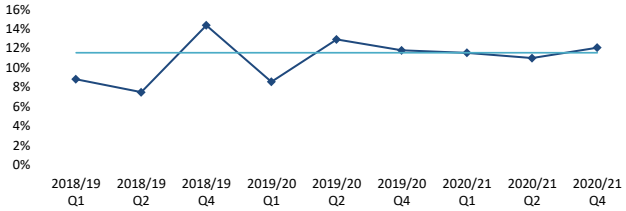
Staff FFT - % Recommend as Place of Care



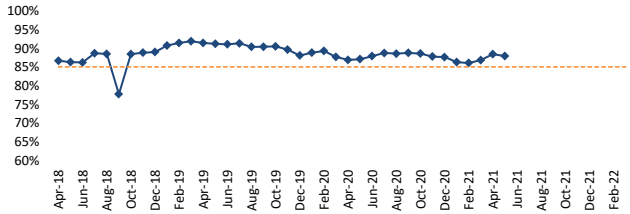
Staff FFT - % Recommend as Place of Work



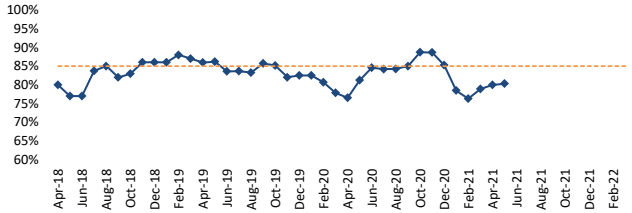
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



Quality of Care

Caring - Complaints

The Walton Centre NHS Foundation Trust

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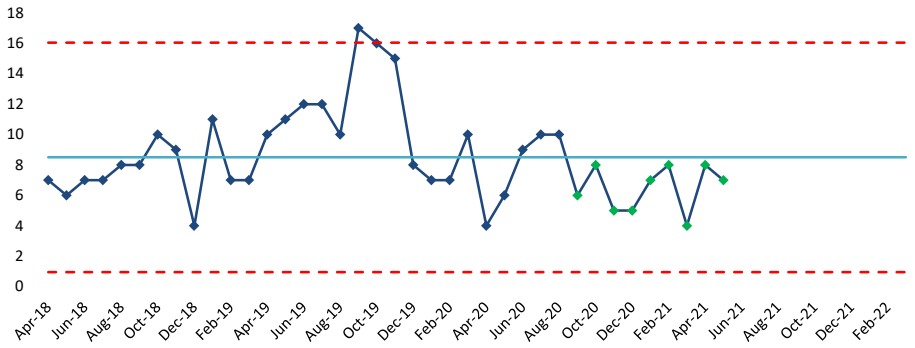
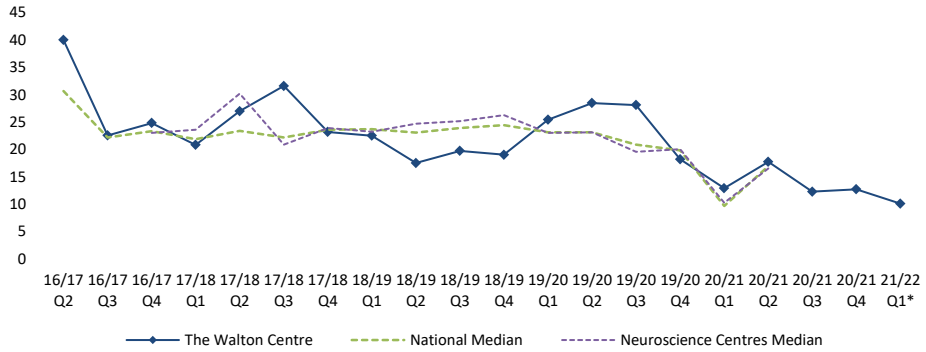
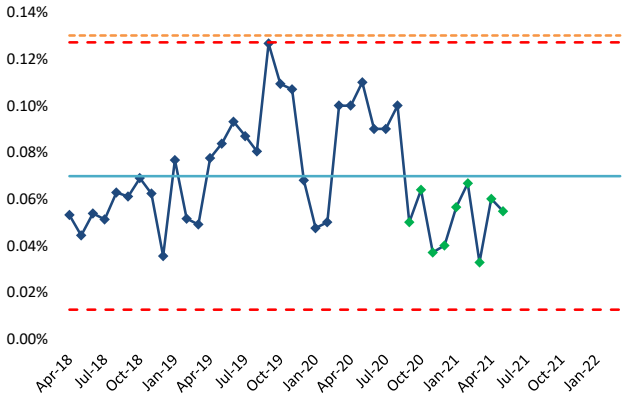
Total Complaints Received in month



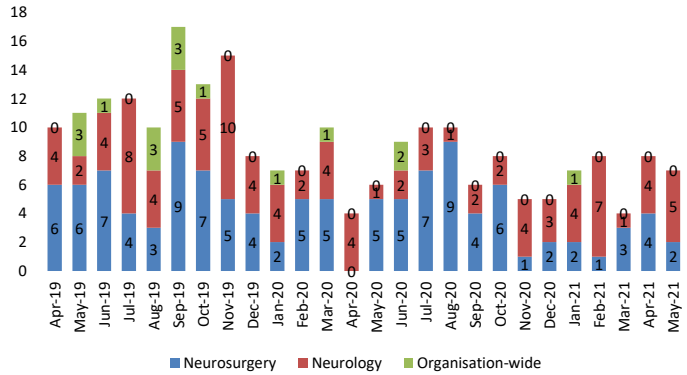
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In May 2021 the Trust received 7 complaints. 5 Neurology (2 reopened), 2 Surgery.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 1 to 16 at an average of 8 per month. The number of complaints received has significantly dropped during recent months.

Due to the reduction seen the Trust is now in line with the national average and neuroscience centres average up the latest published period of Q2 2020/21.

Local data for Q3 and Q4 2020/21 shows a significant reduction in the total number.

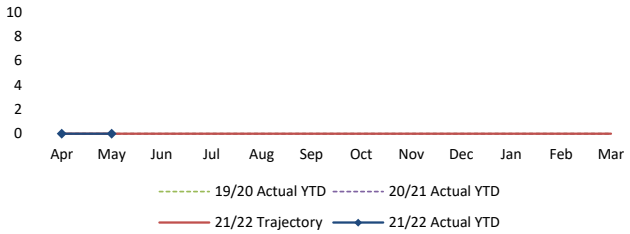
Quality of Care

Safe - Infection Control

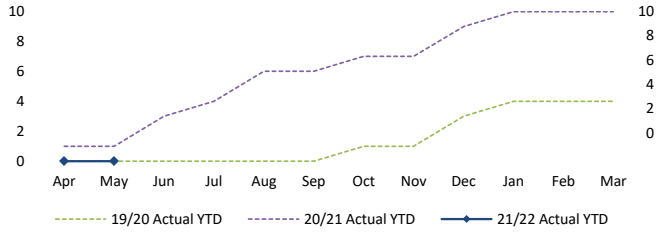
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

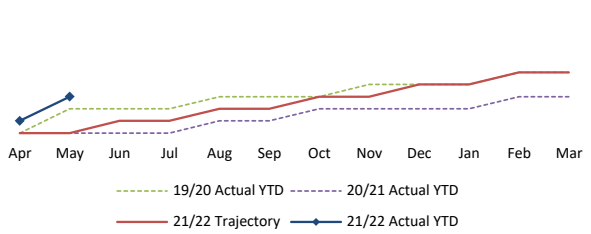
MRSA Bacteraemia



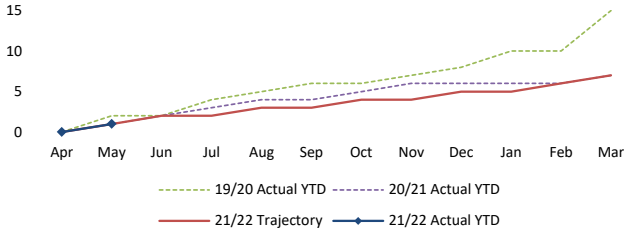
CPE



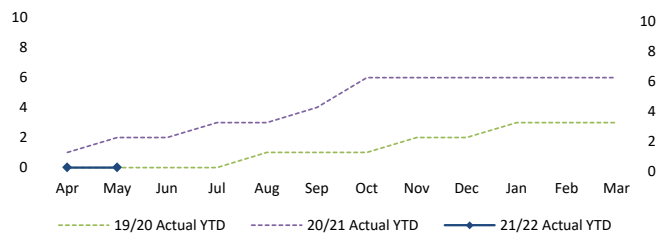
C.Diff



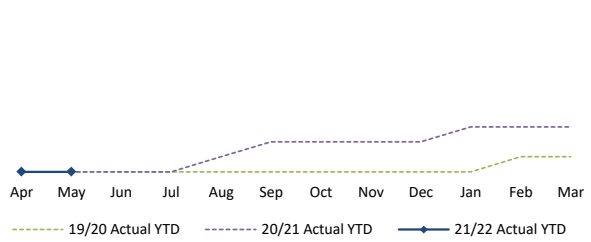
E.Coli



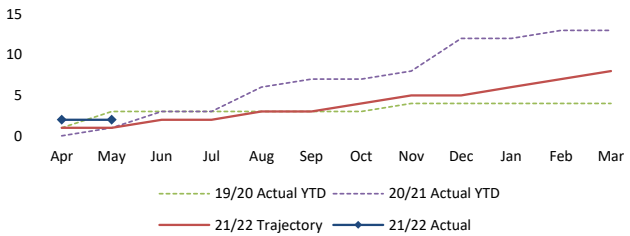
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2021/22

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

May Breakdown by Ward

C.Diff - 2x Horsley
E.Coli - 1x Horsley

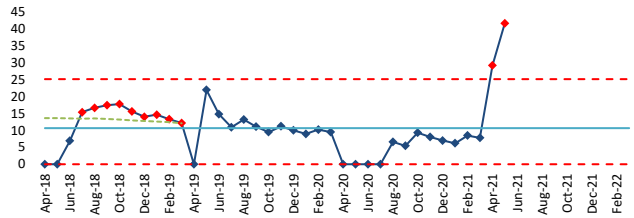
Quality of Care

Safe - Infection Control

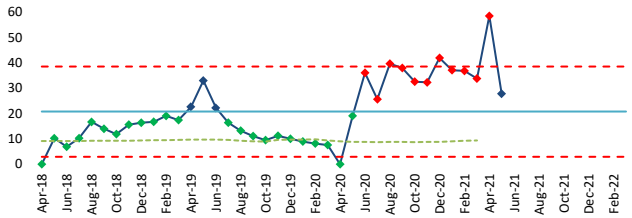
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

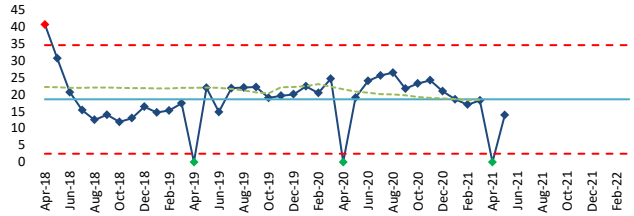
C.Diff Rate per 100,000 Bed Days YTD



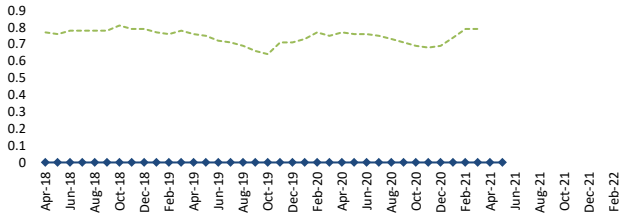
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

There are currently two 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 27.83 which is significantly above the latest national average (9.39).

There was two C.Diff instances in month which is a total of three year to date against a year end trajectory of 5. The rate per 100,000 bed days is currently at 41.75 which is outside of normal limits.

All other infections are within their trajectories. E.Coli rate per 100,000 bed days have typically been better or in line with the average, while MRSA has been consistently better.

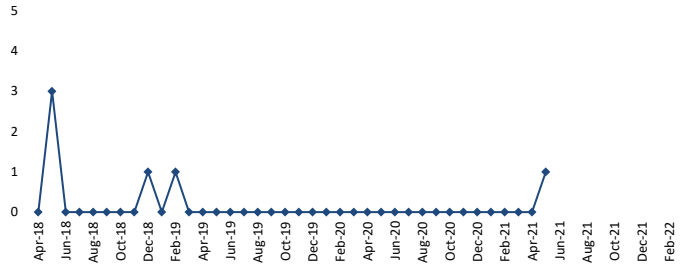
Quality of Care

Safe - Harm Free Care

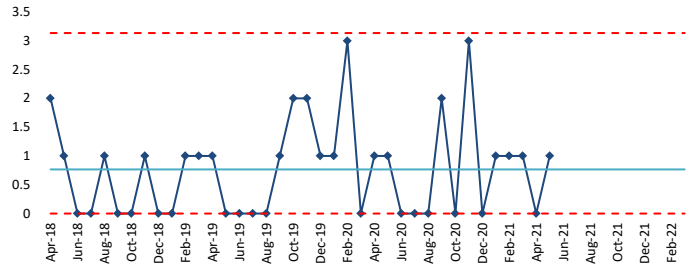
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Total Moderate or Above Harm Inpatient Falls



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



Narrative

There was one falls which resulted in moderate or above harm in month.

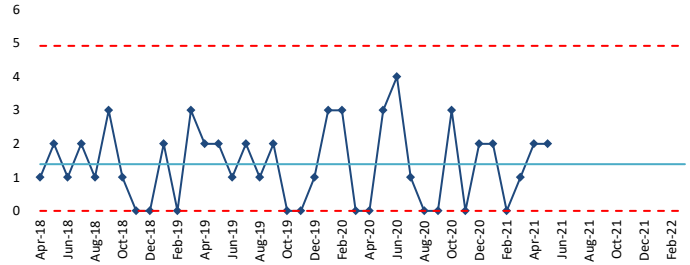
There was one Hospital Acquired Pressure Ulcers in month

There was two CAUTI incidence in month

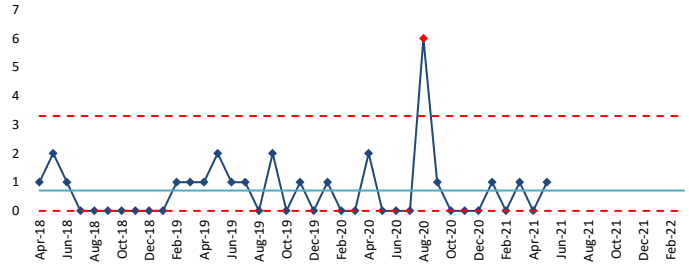
There was one VTE incidences in month

All harm measures are within normal variation.

CAUTI Incidences



VTE Incidences



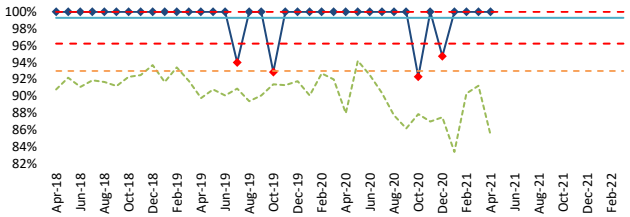
Operational

Responsive - Cancer

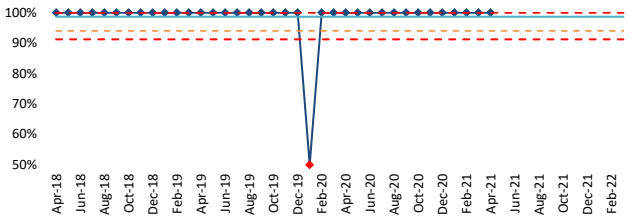
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

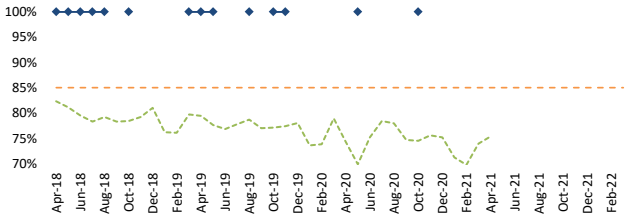
14 Day Performance



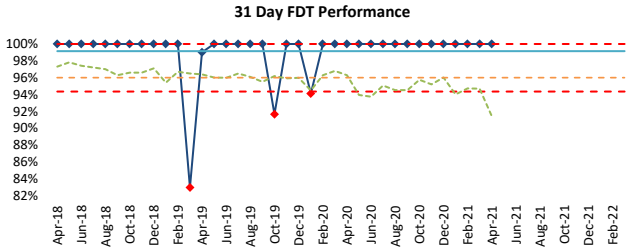
31 Day Subsequent Performance



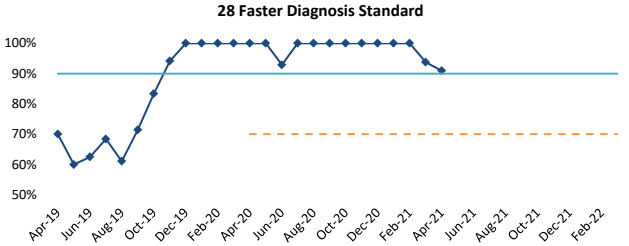
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

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

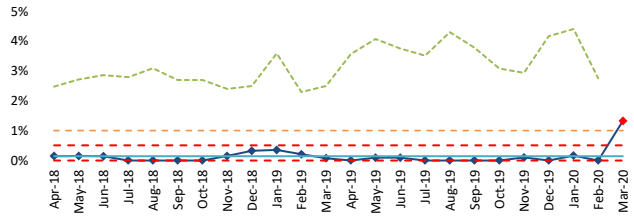
Operational

Responsive - Diagnostics

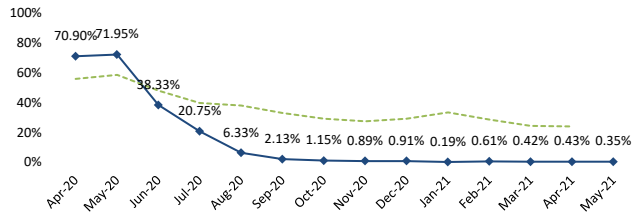
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

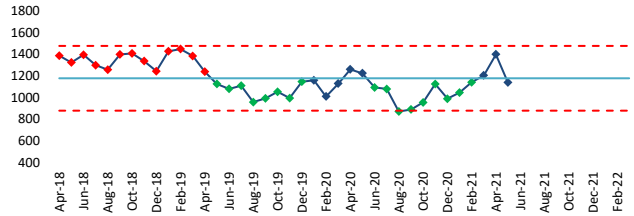
6 Week Diagnostic Performance (18/19 - 19/20)



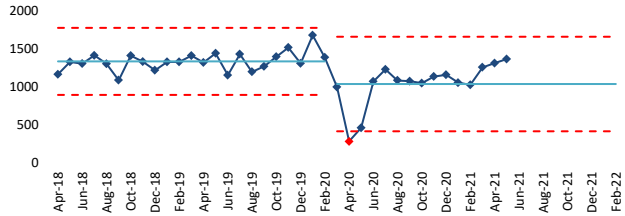
6 Week Diagnostic Performance (20/21 - 21/22)



Total Diagnostic Waits at Month End



Total Diagnostic Activity in Month



Narrative

The Diagnostic 6 week standard has continued to meet the target since November 2020 with performance at 0.35% in May 2021.
Performance has improved significantly since May 2020, however due to Infection Prevention and Control measures Radiology capacity is at 90% therefore any increase in demand may impact performance.

Ward Scorecard

May 2021

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

	Safe Staffing				Workforce		Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Sickness Rate	Vacancy Rate	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	92.0%	154.0%	96.0%	113.0%	7.77%	-4.74%	0	1	0	0	0	0	0	0
Caton	98.0%	109.0%	99.0%	118.0%	2.02%	2.63%	0	0	0	0	0	0	0	0
Chavasse	95.0%	136.0%	93.0%	119.0%	9.12%	2.33%	0	0	0	0	0	0	0	0
Dott	97.0%	126.0%	99.0%	136.0%	10.12%	1.92%	1	0	0	0	0	0	0	0
Lipton	109.0%	121.0%	100.0%	128.0%	3.23%	-9.31%	0	0	0	1	0	0	0	0
Sherrington	97.0%	122.0%	100.0%	115.0%	24.32%	-	0	0	1	0	0	0	0	0
CRU	98.0%	113.0%	117.0%	114.0%	7.08%	8.16%	0	0	0	0	0	0	0	0
Horsley ITU	97.0%	103.0%	100.0%	100.0%	8.16%	1.36%	0	0	1	0	0	0	1	2

WELL LED

Finance

Trust I&E	In month			Year to date			H1 plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Patient Care Income	9,570	9,985	415	18,742	19,270	528	56,223	56,938	715
Exclusions	2,006	2,172	166	4,126	3,900	(226)	12,379	11,156	(1,223)
Private Patients	9	1	(8)	17	1	(16)	52	5	(47)
Other Operating Income	454	470	16	911	952	41	2,734	2,729	(5)
Total Operating Income	**12,039**	**12,628**	**589**	**23,796**	**24,123**	**327**	**71,388**	**70,828**	**(560)**
Pay	(6,147)	(6,495)	(348)	(12,315)	(12,732)	(417)	(37,470)	(38,220)	(750)
Non-Pay	(2,835)	(3,047)	(212)	(5,553)	(5,699)	(146)	(16,691)	(16,903)	(212)
Exclusions	(2,006)	(2,228)	(222)	(4,127)	(4,052)	75	(12,379)	(11,307)	1,072
COVID	(161)	(56)	105	(322)	(166)	156	(966)	(520)	446
Total Operating Expenditure	**(11,149)**	**(11,826)**	**(677)**	**(22,317)**	**(22,649)**	**(332)**	**(67,506)**	**(66,950)**	**556**
EBITDA	**890**	**802**	**(88)**	**1,479**	**1,474**	**(5)**	**3,882**	**3,878**	**(4)**
Depreciation	(510)	(484)	26	(974)	(971)	3	(2,922)	(2,920)	2
Profit / Loss On Disp Of Asset	0	1	1	0	4	4	0	4	4
Interest Receivable	0	0	0	0	0	0	0	0	0
Financing Costs	(55)	(45)	10	(106)	(99)	7	(318)	(311)	7
Dividends on PDC	(127)	(127)	0	(254)	(254)	0	(762)	(762)	0
I & E Surplus / (Deficit)	**198**	**147**	**(51)**	**145**	**154**	**9**	**(120)**	**(111)**	**9**
Capital donations I&E impact	**20**	**9**	**(11)**	**40**	**31**	**(9)**	**120**	**111**	**(9)**
I & E Surplus / (Deficit)	**218**	**156**	**(62)**	**185**	**185**	**0**	**0**	**0**	**0**

Due to COVID, the financial regime remains based on block funding for the 1st 6 months of the financial year (H1) and anticipated spend for the same period (based on average spend in Q3 of 2020/21). The H1 plan is at a break-even position (submitted to HCP and NHS E/I in May).

The current H1 plan includes:

- Elective Recovery Fund income and costs (ERF) 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.

It is also expected that the Healthcare Partnership (HCP) will deliver a balanced financial plan for H1 and the Trust is working with the partnership to achieve this position.

In month 2, the Trust reported a £156k surplus position. This is a £62k deterioration on the planned in month surplus position of £218k. This deterioration in month is due to the impact of excluded drugs and devices. In the new finance regime some excluded drugs/ devices are funded through the block rather than on a cost and volume basis meaning that increased costs will not be matched by income. In month 2 there were a number of devices where costs increased but were not matched by income (e.g. coils)

The position includes £1,244k elective recovery fund against a planned position of £842k, £402k above plan.

The in-month position includes £70k spend incurred as a result of COVID-19.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	May-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	840	(29)
Tangible Assets	86,164	85,340	(824)
TOTAL NON CURRENT ASSETS	**87,033**	**86,180**	**(853)**
Inventories	1,157	1,851	694
Receivables	7,523	6,161	(1,362)
Cash at bank and in hand	35,689	35,922	233
TOTAL CURRENT ASSETS	**44,369**	**43,934**	**(435)**
Payables	(25,914)	(24,570)	1,344
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,616)	(47)
TOTAL CURRENT LIABILITIES	**(27,761)**	**(26,464)**	**1,297**
NET CURRENT ASSETS/(LIABILITIES)	**16,608**	**17,470**	**862**
Provisions	(720)	(713)	7
Finance Lease	(63)	(57)	6
Loans	(23,635)	(23,503)	132
TOTAL ASSETS EMPLOYED	**79,223**	**79,378**	**154**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,917	154
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,377**	**154**

STATEMENT OF CASH FLOW - 2021/22	May-21 plan	May-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**145**	**154**	**9**
Non-Cash Flows In Operating Surplus/(Deficit)	1,290	1,327	37
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**1,435**	**1,481**	**46**
Increase/(Decrease) In Working Capital	193	679	486
Increase/(Decrease) In Non-Current Provisions	0	(7)	(7)
Net Cash Inflow/(Outflow) From Investing Activities	(2,810)	(1,730)	1,080
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(1,182)**	**423**	**1,605**
Net Cash Inflow/(Outflow) From Financing Activities	404	(190)	(594)
NET INCREASE/(DECREASE) IN CASH	**(778)**	**233**	**1,011**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**34,911**	**35,922**	**1,011**

COVID-19 expenditure:

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

In month Actual: £70k.

Year to date Actual: £183k.

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

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	143
PPE	0	0	0
Decontamination	0	7	7
Agile working	0	12	12
Other	20	1	21
TOTAL	**113**	**70**	**183**

Other spend includes providing free car parking for staff.

Capital

In month variance - £353k below plan.

Year to date variance - £754k 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.

CAPITAL

	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	91	2	89	183	5	178	1,100	1,100	0
Estates	0	0	0	0	0	0	850	850	0
IM&T	81	50	31	162	73	89	969	969	0
Neurology	0	9	(9)	0	9	(9)	2,349	2,349	0
Neurosurgery	0	0	0	0	0	0	2,594	2,594	0
Corporate	0	0	0	0	0	0	491	491	0
Capital Slippage	(40)	0	(40)	(87)	0	(87)	(2,150)	(2,150)	0
TOTAL (excl. external funding)	**132**	**61**	**71**	**258**	**87**	**171**	**6,203**	**6,203**	**0**
Donated Assets	12	12	0	12	12	0	12	12	0
Digital Aspirant	303	21	282	604	21	583	3,623	3,623	0
TOTAL (incl. external funding)	**315**	**33**	**282**	**616**	**33**	**583**	**3,635**	**3,635**	**0**
TOTAL	**447**	**94**	**353**	**874**	**120**	**754**	**9,838**	**9,838**	**0**

Capital spend in month is £94k.

- **Heating & Pipework**: £2k – Phase 4 works;
- **IM&T:** £50k - Staffing in relation to specific projects;
- **Neurology:** £9k – Consultant radiology workstations;
- **Charity Funded:** £12k – Cell Path Macro Imager (Labs);
- **Digital Aspirant (PDC funded):** £21k – Datacentre Architecture.

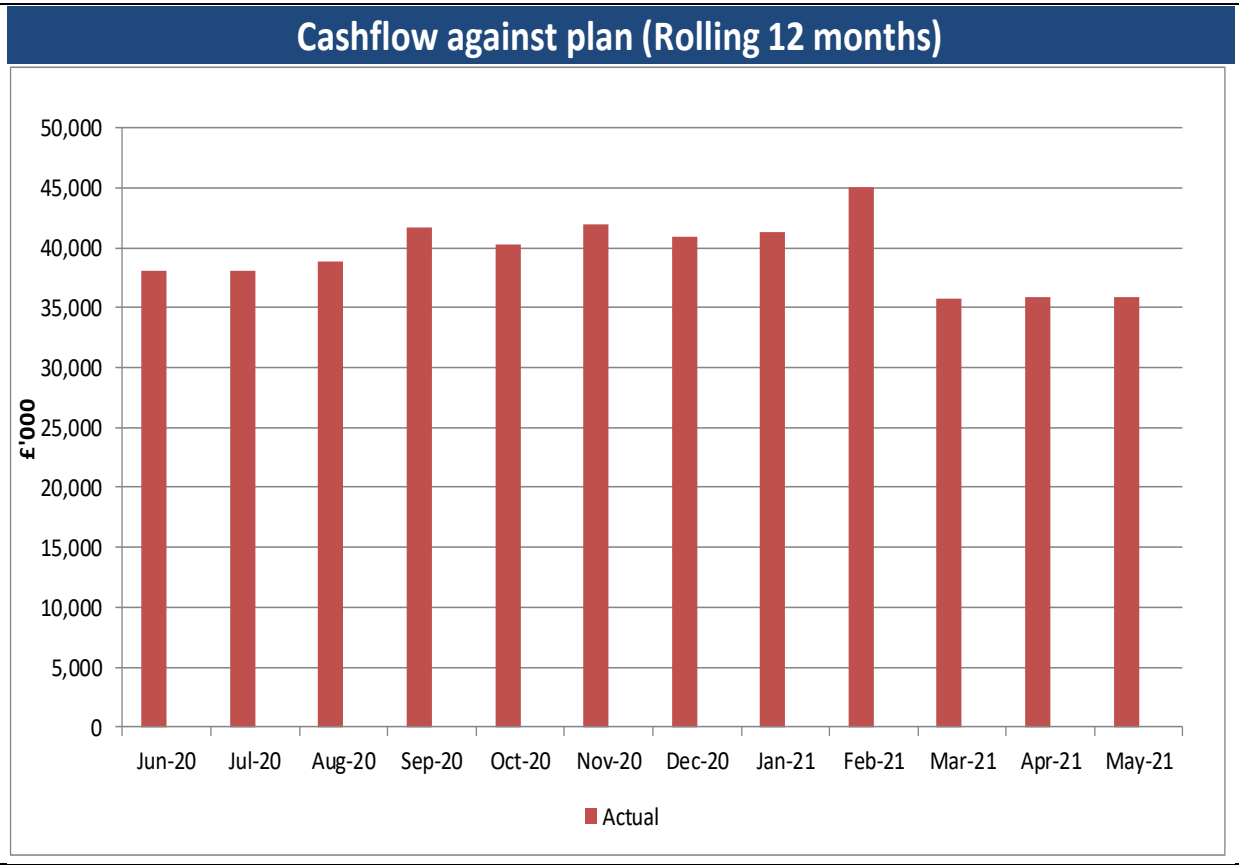
The year-end capital forecast is £9.8m (including external funding) which is in-line with the agreed funding allocations. This assumes that £2.2m slippage is found from current identified plans to bring anticipated spend back in line with the annual capital allocation.

Work is currently being undertaken with clinical and operational leads to prioritise capital spend for 21/22 to ensure that it is delivered in line with agreed funding levels.

As of the end of May:

Actual Cash Balance: £35.9m.

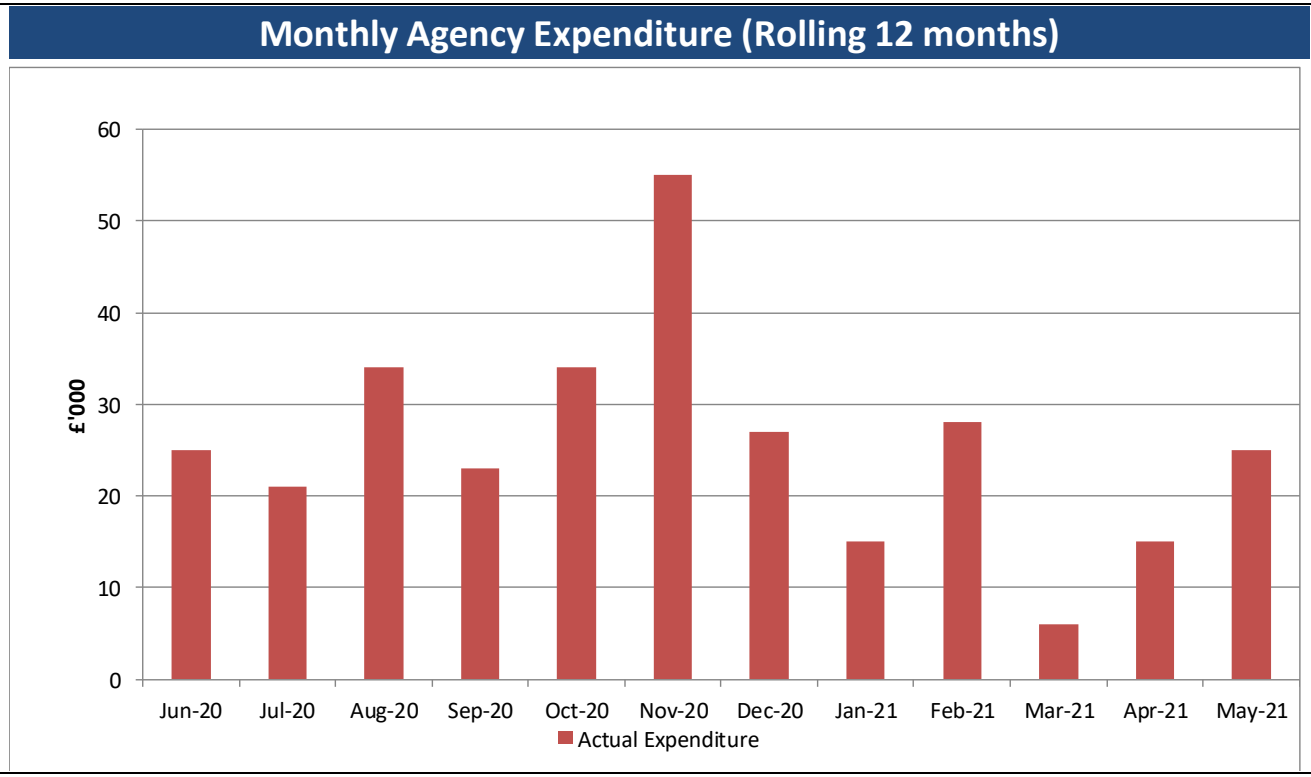
Number of days operating expenses = 98 days.



The Trust cash balance at the end of May was £35.9m. This is consistent with the end of April.

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

Block payments will be made in month and not in advance throughout 2021/22.

Agency Expenditure: In month Actual: £25k. Year to date Actual: £40k.		Agency spend incurred in May was £25k, an increase of £10k compared to April. At the end of May, £3k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions in 2021/22

As a result of the COVID-19 pandemic financial regulations have changed for 2020/21 and H1 2021/22, with the main changes being:

- Delay of 2021/22 business planning until 2nd half of 21/22, with finance regime of 2020/21 to continue for at least 6 months of 2021/22 (H1);
- Payment by Results (PbR) continued suspension for the first 6 months of the year and income being based on block values determined nationally (based on 2020/21 Q3 levels plus 0.5% inflation, incorporating a 0.28% efficiency requirement) and adjusted for the impact of CNST increases;
- System funding has been allocated to C&M HCP for M1-6 which has been distributed to all organisations and included within organisational H1 plans to cover costs in relation to Top-up, COVID-19 (in relation to reasonable COVID-19 expenditure), growth and CNST;
- The trust is currently being monitored against plans for April to September forecast to break-even submitted to NHSE/I and C&M HCP on 26nd May;
- System level financial targets have also been submitted and with a forecast for the system to breakeven at the end of H1;
- 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 will 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 plan (operational and clinical teams will work to deliver these planned activity levels);
- 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.

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

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

RISK	COMMENT/ ACTIONS
Access to Elective Recovery Fund	The operational requirements for 2021/22 to aid restoration of outpatient and elective inpatient services within the NHS, the Trust is required to meet national targets for activity and income as follows: • Overall outpatient and elective activity value against 2019/20: o 70% for April 2021; o 75% for May 2021; o 80% for June 2021; and

	○ 85% from July to March 2022. Elective recovery gateway criteria; in order to receive additional funding for over-performing the national operational requirements per above the following criteria must also be met: • Addressing health inequalities; • Transforming outpatient services; • System-led recovery; • Clinical validation, waiting list data quality and reducing long waits; and • People recovery In addition the elective recovery fund will be managed and monitored at system level, therefore if the trust meets the national recovery targets set there is a risk that if the C&M HCP does not meet the requirements that the Trust will not receive the additional funding to meet the increased levels of activity.
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification has been 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 at least the 1st half of 2021/22. Current national guidance states that H1 funding will be based on Q3 20/21 spend extrapolated for 6 months with system allocations for providers to achieve a breakeven position. Further work has been undertaken to understand the financial forecast for H1 and final financial plans have been submitted to the HCP and NHS E/I. It is currently unclear at what the financial framework will be for H2 onwards.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be in H2 of this financial year and as such planning to deliver recurrent savings is difficult. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements and it is currently not clear what internal

	efficiencies may need to be delivered to meet expected financial plans. However recurrent efficiencies will be required to be delivered in 2021/22 and work is being undertaken to identify these.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as fewer patients will be able to be seen given the additional PPE/ social distancing requirements).

REPORT TO TRUST BOARD

Date: 1 July 2021

Title	Medical Revalidation Annual Report
Sponsoring Director	Name: Dr Andy Nicolson Title: Medical Director/Responsible Officer
Author (s)	Name: Dr Andy Nicolson Title: Medical Director/Responsible Officer
Previously considered by:	None

Executive Summary

The headlines of the Trust's annual report are:

a. 151 doctors had a prescribed connection with the Trust. This had increased by 3 from the previous year.
b. Appraisals were suspended in March 2020 and restarted in November 2020. As a result, 33% of doctors completed an appraisal between November 2020 and April 2021.
c. The GMC deferred the majority of revalidation dates due during this period to the following year and so there were only 3 doctors due for revalidation. In two cases a positive recommendation was made and in one the date was deferred due to insufficient evidence being presented.
d. Deferral is regarded as a neutral act, and does not carry negative connotations.
e. No doctors were referred to the GMC for non-engagement in the appraisal process.

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
Risks associated with this paper	None
Related Assurance Framework entries	None
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) ____N/A_____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____None_____
Action required by the Board	• To consider and note • To confirm compliance with the Responsible Officers Regulations 2010.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 24/09/2020 Action from last year: Await guidance on how quarterly reports are required for 20-21. Comments: Appraisals were cancelled between March and November 2020. No formal AOA is required for 20/21. Action for next year: To return to a position of achieving >90% completed appraisals.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Continue current process. Comments: The Trust RO is also the Medical Director. He undertakes annual appraisals by appointed NHS England appraiser which includes his role as Responsible Officer. The RO has attended the required number of regional RO network meetings. Action for next year: Continue current process.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: To embed the new system into the Trust and look at the introduction of an electronic job planning system that will also be available on the new system. Comments: The Trust went live with the new electronic appraisal system L2P in November 2020. Action for next year: To introduce and implement the Job Planning aspect of the L2P system.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue current process. Comments: GMC Provides a list of all Doctors with a prescribed connection to the Trust. The list is maintained by the Appraisal and Revalidation Co-

ordinator who also receives a monthly list of starters and leavers via the HR Department.

Action for next year: Continue current process.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Whistleblowing Policy (now raising concerns) review date 2021. Complete reviews of the remediation policy and Consultant job planning policy.

Comments: The remediation policy review is complete and approved by LNC. The Consultant job planning policy will be formally reviewed when the new electronic process is in place. This has been delayed due to the Covid pandemic and pause in the appraisal process. It is anticipated to be completed by April 2022.

Action for next year: Complete reviews of the Raising Concerns and Consultant Job Planning policies.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: MIAA to review in late 2021 / early 2022.

Comments: The last review was conducted by the MIAA in 2015. It is recommended that a peer review takes place in each 5 year revalidation cycle. As the Trust have recently embedded a new electronic appraisal system and due to Covid pandemic, it was not considered appropriate to review this year.

Action for next year: MIAA to review in 2022.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue current process.

Comments: Locum and Short Term Doctors are provided with an opportunity for an appraisal whilst at the Trust including those with a prescribed connection to another organisation eg GP with a specialist interest. Data relevant to appraisal is available to them on request if they have their appraisal at their Designated Body. This group of doctors also have access to Educational events within the organisation and receive a Local Trust induction.

Action for next year: Continue current process.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: To restart appraisals when advised by the GMC.

Comments: 151 Doctors had a prescribed connection with the Walton Centre NHS Foundation Trust as at 31.03.21. This has increased by 3 from the previous year and by 47 from 2014.

Appraisals recommenced in the Trust in November 2020. Between November 2020 and April 2021 33% of doctors had an appraisal.

Action for next year: To return to a position of achieving over 90% completed appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None.

Comments: Appraisals were cancelled between March and November 2020 as per guidance.

Action for next year: None required.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None required.

Comments: To revise if and when required.

Action for next year: None required.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Training required for new appraisers.

Comments: 4 new appraisers received training before 31/03/2021 via e-learning and webinar. The number of medical appraisers has increased from 26 to 31 during this year.

Action for next year: Training of additional appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to apply the current process and maintain the QA of appraisals. Comments: All appraisals are reviewed by either the RO or the Trust medical appraisal lead. All appraisees provide feedback on the appraisal and this feeds in to the appraiser's own appraisal. The feedback scores are analysed by the Medical Appraisal lead and the appraisals of any outliers are reviewed in detail. Appraisers received online refresher training in 2020. Action for next year: Continue to apply the current process and maintain the QA of appraisals.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue current process. Comments: Monthly appraisal percentage is collated for NHSI and reported to the Quality Committee as part of the Trust's performance report. Action for next year: Continue current process.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: There are 42 doctors due for revalidation 2020-21. Comments: The GMC deferred the majority of revalidation dates to the following year. This changes the number of doctors due revalidation in 2020-21 from 42 to 3. There were 2 positive recommendations for revalidation in 2020-21, and 1 deferral due to insufficient evidence provided. Action for next year: There are 38 Doctors due for revalidation 2021-22.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue Current Process. Comments: All revalidation recommendations are confirmed promptly in writing to the doctor from the RO, with a summary of the evidence from appraisals during the

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

revalidation cycle. If the recommendation is for deferral then there is also a discussion with the doctor with a clear written action plan agreed. There have been no recommendations of non-engagement but this would not take place without a discussion with the doctor.

Action for next year: Continue Current Process.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue Current Process.

Comments: The RO / Medical Director is also personally responsible for clinical governance for doctors. The "monitoring" aspects required for this part of the RO's role are through the normal reporting processes to the Divisions, Executive, Quality Committee and Trust Board. This provides the formal assurance structure.

Action for next year: Continue Current Process.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To work with the governance and divisional teams to ensure that all SUIs with involvement of doctors are reported to the ARC.

Comments: The Clinical Governance Teams provide data relating to legal claims, complaints, datix incident forms and serious untoward incidents to the Appraisal and Revalidation Co-ordinator (ARC). This data is then redacted and provided to the Doctor or directly uploaded onto their portfolio on the electronic appraisal system.

Action for next year: Continue current process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue current process.

Comments: The Trust's process for responding to concerns about a doctor follows Maintaining High Professional Standards (MHPS). The Trust has an approved MHPS policy that has been discussed and agreed with relevant stakeholders.

Action for next year: Continue current process.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: Continue current process. Comments: If a doctor is investigated with regard to capability or conduct then this is carried out in accordance with MHPS, and as such is reported to Trust Board. Action for next year: Continue current process.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: Continue current process. Comments: The Trusts uses NHS England's Medical Practice Information Transfer form (MPIT) to transfer information to and from other NHS organisations for new starters. Section 2 of the 'Professional work outside the WCFT' is used annually for existing staff who also work outside the Trust. Action for next year: Continue current process.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue current process. Comments: All Trust Policies have an appropriate Equality Impact Assessment, these are quality checked by the Equality, Diversity and Inclusion Lead of the Trust for HR policies. Action for next year: Continue current process.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Review use of Agency checklist.

Comments: The HR Recruitment team have a robust system in place for pre-employment checks and is subject to external Audits in line with NHS 'Safer Recruitment'. The Trust is provided with locum doctors from agencies through the HTE framework who provide written confirmation of their processes as part of monitoring of the contract.

Action for next year: None required.

Section 6 – Summary of comments, and overall conclusion

This year for appraisal and medical revalidation has been significantly disrupted by the Covid pandemic. Appraisals were suspended nationally in March 2020 and were recommenced in the Trust in November 2020. As a result the GMC deferred revalidation dates which were due during that period, and all appraisals due were suspended. Between November 2020 and April 2021 33% of doctors had a completed appraisal.

During this year there were only 3 doctors due for revalidation due to the deferral of the majority of dates by the GMC. 2 positive recommendations were made to the GMC, and 1 recommendation for deferral was made. There were no recommendations for non-engagement.

The appraisal and revalidation process is well embedded, with robust systems in place. The Responsible Officer is well supported in his role by the Medical Appraisal Lead and the Appraisal and Revalidation Coordinator. There are systems in place for peer support of appraisers and Quality Assurance of appraisals.

During this year the Trust introduced a new electronic appraisal tool, L2P. This has been very successfully introduced with excellent feedback.

NHSE provided guidance on the appraisal process in light of the Covid pandemic. The focus for appraisals which have taken place since the restart has been the impact of Covid for the individual and the service, and it has focussed on well-being. The appraisal process has successfully restarted and as a Trust we are on track to achieve the target of >90% completed appraisals in 2021/22.

Overall conclusion:

This year has been dominated by the Covid pandemic, and this has also had a significant impact on the appraisal system for medical staff. This has successfully restarted within the Trust with a new electronic appraisal tool and the Trust's systems for medical appraisal and revalidation are working well. The Trust has a track record of a high rate of completed appraisals within the required timescale, and would anticipate this continuing in 2021/22. There are no areas of concern.

Section 7 – Statement of Compliance:

The Board of The Walton Centre NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: The Walton Centre NHS Foundation Trust

Name: Mrs Jan Ross Signed:

Role: Chief Executive

Date:

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date: 1st July 2021

NHS
The Walton Centre
NHS Foundation Trust

Title	**Safeguarding Annual (Quarter 4) Report 2020/21**
Sponsoring Director	**Name:** Lisa Salter **Title:** Director of Nursing and Governance
Author (s)	**Name:** Debbie Lee **Title:** Safeguarding Matron
Previously considered by:	• Quality Committee
Executive Summary The purpose of this report is to provide: 1. A comparison of annual safeguarding data between 2019/20 and 2020/21 in order to identify themes and trends. 2. A review of key achievements for 2020/21 and identification of key priorities for 2021/22. 3. Assurances that robust policy, processes and practice are in place in order to ensure patient safety and demonstrate that there is a culture of engagement with the safeguarding agenda. 4. Assurance to the Board that issues are being identified and managed effectively.	
Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with multiple Safeguarding related legislation.
Action required by the Board	• To consider and note.

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Safeguarding Annual Report

May 2021

Presented by Debbie Lee – Matron for Safeguarding

Contents

Introduction

All staff within the Walton Centre NHS Trust (WCFT) are committed to ensuring that safeguarding and the assessment of mental capacity of patients is given the highest priority in all that the Trust does. All safeguarding work is underpinned by the Trust values and is embedded throughout the Walton Way.

The Walton Centre remains committed to ensuring safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm.

In order to do this the Trust undertakes collaborative working to ensure that all of the services provided have regard to the duty to protect individual human rights, treat individuals with dignity and respect and safeguard them against abuse, neglect, discrimination, embarrassment or poor treatment. The balance between an individual's rights and choices and the need to protect those at risk, is acknowledged.

The COVID 19 pandemic has created new issues across the NHS. From a safeguarding perspective, the new issues include restrictions with visitors; the often crucial face to face communication and interactions between both patients and staff with relatives has been affected. Visiting restrictions have had negative effects on patients' well-being and has probably stifled the communication of disclosures of abuse from relatives to staff; disclosures are often made when professional relationships are forged with relatives. Both the Trust and visiting organisations e.g. Social Services or Section 12 doctors have had to adapt their processes due to the visiting restrictions which have brought about the need for remote communication. Adaptations have included the use of MS Teams, the use of iPads for assessments, enhanced communication and additional processes for identification checks of external assessors.

Our teams work in an increasingly complex safeguarding environment. It is a challenging time for NHS Trusts but by using existing resources to effectively safeguard those for whom we care, we can work to improve psychological wellbeing, mental health and improve the future of our society as a whole.

Purpose

The purpose of this annual report is to inform the Walton Centre NHS Foundation Trust Board, the Quality Committee and the Local Safeguarding Children and Adults Boards with an annual update on adult and children safeguarding activity across the Trust in the last year (April 2020 - March 2021).

This report summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how WCFT discharges its statutory duties in relation to:

- ✓ Safeguarding children under section 11 of the Children Act (1989, 2004). All staff has a statutory responsibility to safeguard and protect the children and families who access our care.
- ✓ Safeguarding Vulnerable Adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance issues under the Care Act 2014.
- ✓ The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.
- ✓ CQC Regulation 13: Safeguarding service users from abuse and improper treatment
- ✓ Working Together to Safeguard Children (2018

Definition

Safeguarding adults' responsibilities as set out in the Care Act 2014 are to safeguard an individual over the age of 18 whom:

- Has needs for care and support;
- Is experiencing, or is at risk of, abuse or neglect;
- As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

Safeguarding and promoting the welfare of children is now defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health and development;
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes.

Working Together to Safeguard Children (2018)

The Working Together to Safeguard Children was revised in April 2018. This guidance covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children, and a clear framework for action.

Trust Safeguarding Responsibilities

The Trust in its capacity as a specialist Trust has been identified in the role of an alerter organisation and as such has specific responsibilities and duties in respect of safeguarding children and adults.

As an alerter organisation, the role of the Trust is to ensure that staff are aware of what they are accountable for in terms of escalating and reporting any safeguarding concerns within the Trust.

All staff at the Trust have a responsibility to raise concerns with regards to safeguarding to their line manager or appropriate person. This information for staff is contained within the Trust Safeguarding policies.

All staff receive safeguarding training by attending a one off corporate induction session and 3 yearly mandatory safeguarding training via e-learning or face to face sessions, which is dependent upon job role and responsibilities, in line with the Intercollegiate Document 2018 for Adult Safeguarding and Intercollegiate Document 2019 for Children and Young People

Safeguarding Leadership and Accountability

The Executive Lead for Safeguarding is the Director of Nursing and Governance. This person has the responsibility of ensuring the appropriate resources are available to enable the Trust to discharge its safeguarding responsibilities fully. Operational responsibility is delegated to the Deputy Director of Nursing and Governance and the Matron for Safeguarding as the Operational Lead.

The Trust has a quarterly Safeguarding Group which is chaired by the Director of Nursing and Governance. The role of the Safeguarding Group is to ensure processes within the Trust are in line with the current legal framework and national guidance, promoting the well-being and safeguarding of vulnerable patients, whilst in the care of the Trust.

There is also representation from external partners from the CCG designated safeguarding professionals and learning disability primary care facilitators within the local area. This Group seeks to provide assurance on all matters relating to safeguarding and reports to the Board of Directors via the Quality Committee.

The Matron for Safeguarding is the Operational Lead and is a proactive member of the local external Safeguarding Board sub health groups, ensuring the Trust is linked in at all levels to multiagency developments and assurance. A briefing report from attendance at such groups regarding key points is submitted to the quarterly Safeguarding Group to share information and to provide transparency and collaborative working and learning.

Quality Assurance

Safeguarding Vulnerable People in the NHS – Accountability Framework was refreshed in July 2015 by NHS England. It states that all health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- ✓ Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults at risk as appropriate.
- ✓ A suite of safeguarding policies including a chaperoning policy.
- ✓ Effective training of all staff commensurate with their role and in accordance with the Intercollegiate Competences 2018 (Adults) and 2019 (Children and Young People).
- ✓ Effective supervision arrangements for staff working with children /families or adults at risk of abuse or neglect.
- ✓ Effective arrangements for engaging and working in partnership with other agencies.
- ✓ Identification of a named doctor and a named nurse.
- ✓ Identification of a named lead for adult safeguarding and an MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.

- ✓ Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- ✓ Policies, arrangements and records to ensure consent to care and treatment are obtained in line with legislation and guidance including the MCA 2005 and the Children Act 1989 and 2004.

The Trust has the required full complement of safeguarding personnel.

A safeguarding adult and children team structure chart is given in Appendix 1 and Appendix 2.

Statutory Framework and National Policy Drivers

Safeguarding is a statutory responsibility of all NHS organisations, as detailed under the Care Act (2014), Children's Act (1989 and 2004). Legislation and guidance is built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children and vulnerable adults.

Working Together to Safeguard Children 2018

This statutory guidance has been revised in April 2018 and the revisions are reflective of the legislative changes introduced through the Children and Social work Act 2017.

- ✓ Replacement of Local Safeguarding Boards (LSCB) with local safeguarding partners
- ✓ Learning from serious cases and new regulations on local and national reviews
- ✓ Transfer of responsibility for child death reviews from LSCB to new Child Death Review Partners

The Children and Social Work Act 2017

The main purpose of the legislation is to:

- ✓ Improve decision making and support for looked after children in England and Wales
- ✓ Improve joint work at the local level to safeguard children and enable better learning at the local and national levels to improve practice in child protection
- ✓ Promote the safeguarding of children by providing for relationships and sex education in schools
- ✓ Enable the establishment of a new regulatory regime specifically for the social work profession in England.

Lampard Report 2015

The Trust continues to provide updates on recommendation 7 of the Lampard report to NHS England and these actions are monitored through the Trust Safeguarding Group.

`*All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers*`.

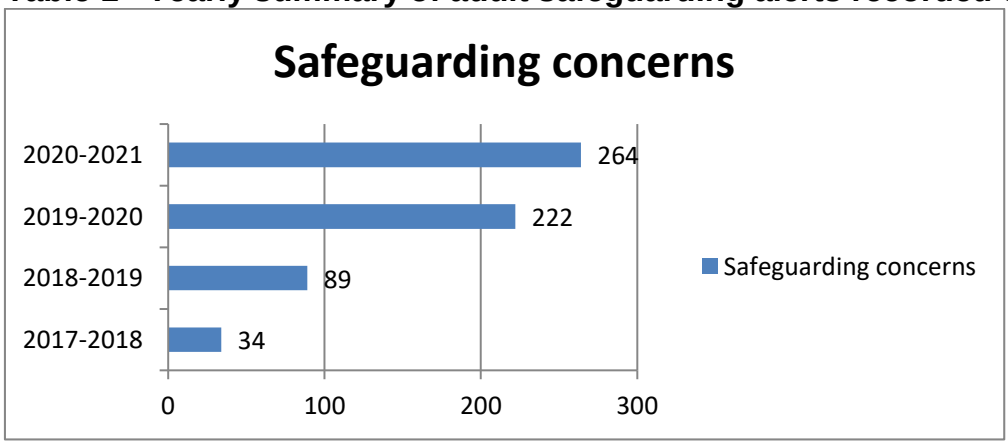
The Trust continues to undertake DBS checks for new starters and continues to require existing staff to complete an annual self-declaration regarding convictions. The DBS update service is currently offered for staff to sign up to at the point of entry to the Trust.

Adult Safeguarding Activity

Prevention, early identification/intervention and promoting the welfare of adults accessing our services are fundamental factors in safeguarding. The Trust's ultimate goal is to ensure that all patients receive care that reflects and responds to their specific needs and wishes, which includes keeping them safe from harm at all times, particularly when they may not be able to make decisions for themselves.

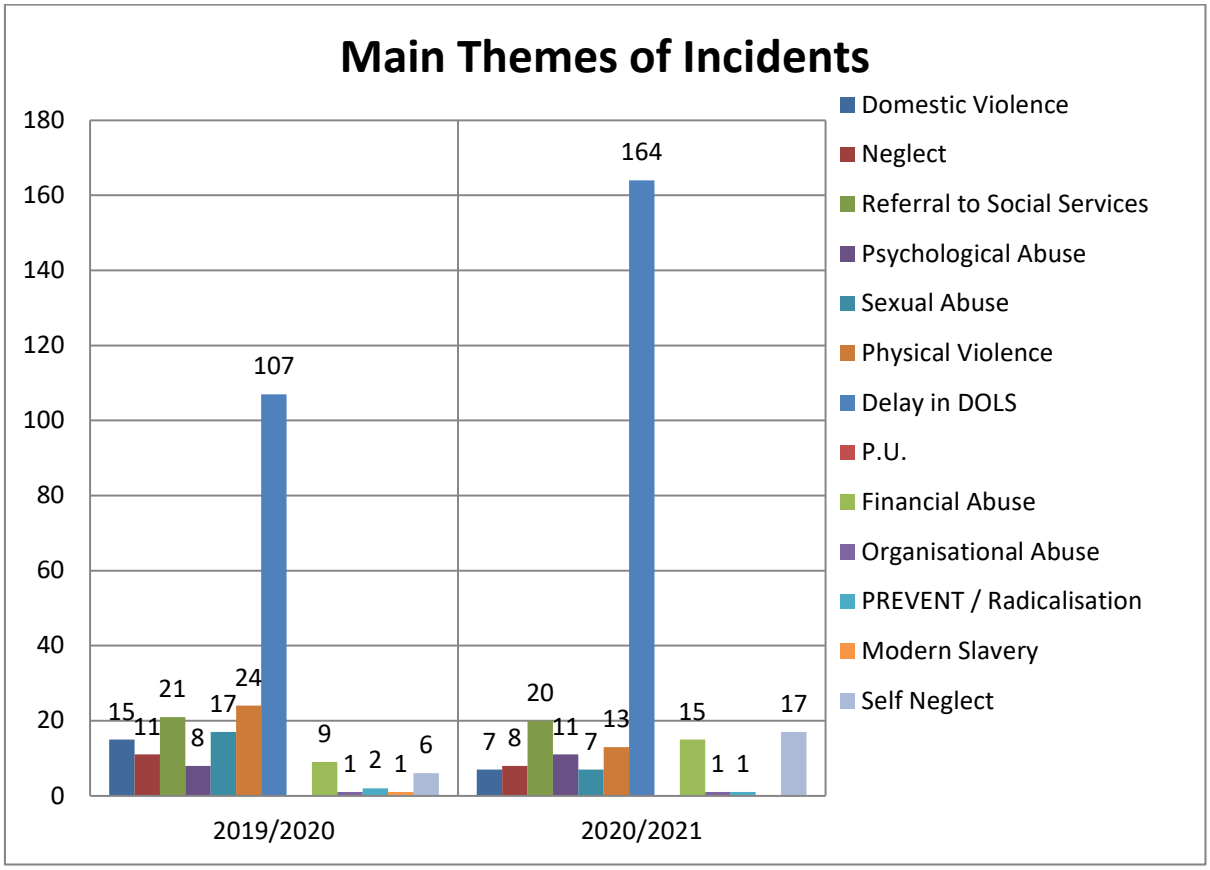
From April 2020 to March 2021, a total of 275 reported safeguarding adult incidents were noted on Datix of which the majority were categorised as minor harm.

Table 1 –Yearly summary of adult safeguarding alerts recorded on DATIX



The table below highlights the key themes/ trends which have been reported in 2020/2021 in comparison to previous years.

Table 2 – Key: Adult – Main Themes of Incidents 2019/2020 and 2020/2021



The Trust has again seen an increase in Datix reporting of safeguarding concerns in 2020/2021 compared to previous years, despite bed occupancy being lower. The overall increase is due to an increased number of delays of Deprivation of Liberty Safeguards (DoLS) authorisations; an increase of 57 breaches compared to the previous year. The issue of DoLS breaches, due to the lack of timely assessment by the Local Authority, is a national issue. It is expected that the implementation of Liberty Protection Safeguards (Mental Capacity Act (MCA) Amendment Bill, 2019) introducing revised governance arrangements and processes, will ameliorate the current situation with legal breaches.

It is believed that staff knowledge around MCA and DoLS has improved and therefore, appropriate mental capacity assessments and DoLS applications have increased. This in turn is reflected with the increase in DoLS breaches.

Safeguarding Adult Reviews (SAR)

A Safeguarding Adult Review, formerly Serious Case Review, takes place when an adult at risk dies, or suffers serious abuse or neglect, and there are concerns about the multi-agency system. Safeguarding Adult Reviews are statutory under section 44, Care Act 2014.

The Trust regularly participates in Safeguarding Adult Review information sharing when requested. The Trust is currently engaging with a SAR that is multi-provider focussed (enquiries commenced last financial year).

Key Achievements for 2020 – 2021

- Training: 90% compliance for level 3 adult safeguarding maintained for the 2020-2021 reporting period.
- Significant increase again in safeguarding themed Datix reporting – demonstrating increased awareness of safeguarding responsibilities of staff at WCFT.
- Staff continue to initiate escalation of significant safeguarding issues and have had positive involvement in a range of complex cases (various themes) resulting in MDT and multi-agency engagement. Safeguarding supervision has been provided for Trust staff during this work – thus enhancing and developing bespoke knowledge and skills across various staff disciplines within the Trust.
- The Safeguarding Matron has been invited to deliver a case study from WCFT to the Liverpool Safeguarding Adults Board. The case study reviews the management of a case involving Honour Based Abuse and demonstrates good practice within the Trust.

Key Priorities for 2021 - 2022

- Review of Trust training needs analysis: to increase training target figures to include band 5 staff and other significant groups of staff, to upskill with safeguarding knowledge and enhance patient safety.
- To align with Intercollegiate documents 2018 (Adults) and 2019 (Children): full review of all safeguarding related training packages / training provision, e.g. contextual safeguarding, children in care (CiC), child exploitation (CE).
- Further develop safeguarding supervision provision within the Trust.
- Re-launch the Safeguarding Champions initiative.
- Work stream to review safeguarding page on intranet.
- Safeguarding adult audit.

<u>Dementia</u>

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia. Their length of stay is longer than people without dementia and they are often subject to delays on leaving hospital.

Whilst work is underway to improve the nature of outcome data, the process of undertaking dementia risk assessment will set an effective foundation for appropriate management of patients.

In 2020 /2021 as part of the Quality Indicator, the Trust was required to screen all emergencies over 75 years of age with a single assessment. There were 205 patients who met the criteria for dementia screening and 127 patients were screened. The Trust achieved 61.95% compliance for 12 months. The low

compliance for screening demonstrates that there is further work to be undertaken to scope the process and address any issues that are affecting compliance.

There are cohorts of patients who meet the screening criteria, however, are not assessed:

- ITU patients, as the majority are sedated and therefore cannot be assessed
- Patients undergoing thrombectomy
- Patients being admitted as a 'treat and transfer' case.

The rational for the issue with these cohorts of patients is due to the quick turnaround and discharge, before the assessment is undertaken. There is further work required to look at the process in order to include these cohorts of patients for assessment.

Key Achievements in 2020-2021

- Dementia awareness training continued as part of mandatory training and has now reached 94% at end of year. To maintain compliance level (90%) with Dementia training.
- Quality Indicator – screening all emergencies over 75 years of age with a single question.
- Continue to signpost Liverpool patients with a diagnosis of Dementia to access post diagnostic support service via Mersey Care NHS Trust through our memory clinics in Outpatients.
- We continue to be signed up to Johns Campaign and welcome carers of patients with dementia in all areas of the hospital, despite COVID 19 pandemic.
- Safeguarding Matron is engaged with the Hospital Charter Dementia Leads Network.

Key Priorities for 2021-2022

- To maintain compliance level (90%) with Dementia training.
- Review the screening process to ensure all cohorts of patients over 75 years of age, are assessed.
- Trust Dementia Strategy to be revised and embedded throughout the Trust.
- To continue to offer and further develop the opportunity for staff and volunteers to become dementia friends / champions within the Trust.
- We will commit to become a dementia friendly organisation as highlighted in the Prime Minister's Challenge on Dementia 2020.
- We will promote the Dementia Friendly Hospital Charter within the Trust.

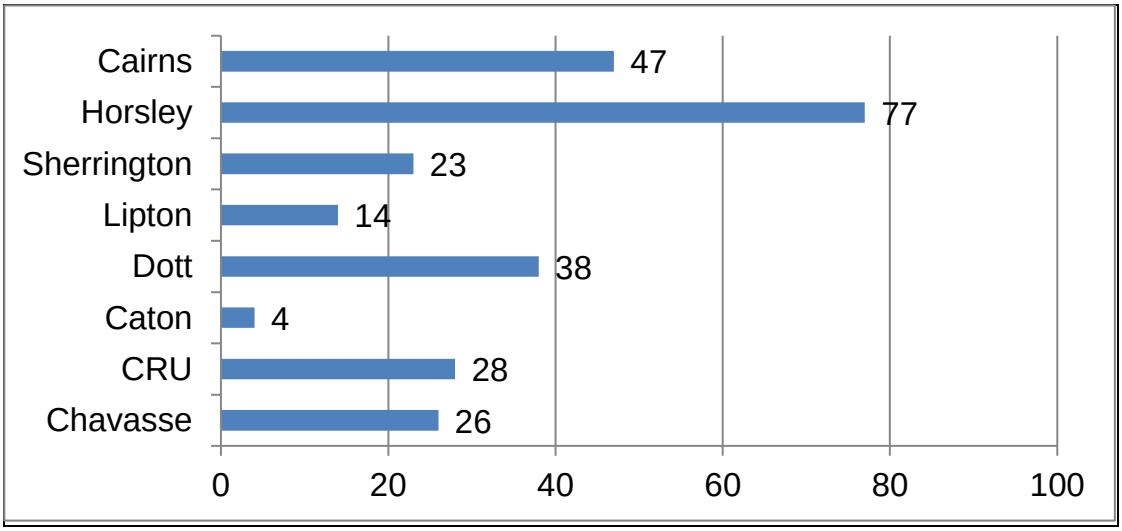
Deprivation of Liberty Safeguards (DOLS)

The Mental Capacity (Amendment) Bill: Liberty Protection Safeguards (LPS), was given Royal Assent on May 16 2019 and was expected to be implemented by October 2020. However, due to COVID-19 outbreak, implementation planning was delayed. Implementation is now expected in April 2022. The LPS Code of Practice is expected to be published in June 2021.

Table 3 - Yearly summary of Deprivation of Liberty Safeguards Applications

2018 – 2019	2019 – 2020	2020 - 2021
187	**196**	**257**

Table 4- DoLS Applications from WCFT in 2020/2021.



The table above highlights the ward areas submitting DoLS applications during the period from April 2020 – March 2021. Overall there were 257 DoLS applications submitted.

DoLS applications data is submitted quarterly as part of the Trust Safeguarding KPI schedule to Liverpool Clinical Commissioning Group.

- 62 applications were urgent applications and not assessed before transfer / discharge of the patient
- 168 patients were not assessed but remained an in-patient at time of the quarterly KPI submission
- 3 applications were authorised
- 15 were declined as the patient was assessed by the Best Interests Assessor (BIA) as having capacity
- 1 withdrawn as patient did not meet the criteria for DOLS
- 7 patients died before being assessed

Horsley unit had the most DoLS applications with 77 in total which would indicate that the applications are being made at an earlier point during the patient admission which is a positive shift (*although the patient is in ICU – the patient would be stable and ready for transfer to the ward when the application is made), indicating that all ward/units are engaging with the DoLS process and the application is being made in a more timely manner.

Caton ward had least applications with 4 in total. Factors over the last 12 months that may have affected the applications from this ward were possibly:

- The ward was closed for a period of time during the last 12 months
- Periods of time with reduced admissions – due to admissions of priority 1 and priority 2 patients only at times – arrangements due to pandemic.
- Ward closed at weekends – arrangements due to pandemic.

It is intended that the safeguarding team will visit all wards to provide mini bespoke refresher sessions around MCA and DoLS to maintain the quality of staffs' knowledge. Sessions will start on Caton to address any potential deficit of knowledge. Additionally, the DoLS ward round has re-commenced (for all wards/units), which promotes discussion and ad-hoc supervision to staff around MCA and DoLS.

It is expected that the implementation of the LPS process will enable timely assessments and authorisations, in order to better protect the rights of the patients involved with the process, thus avoiding legal breaches of the Mental Capacity Act. The high numbers of breaches currently observed at WCFT is a national problem. The Trust recently employed a Safeguarding and Mental Capacity Specialist Nurse, who will support with the implementation of LPS.

Key Achievements in 2020-2021

- DoLS OLM (E-learning) training compliance is at 91% at year end and has remained compliant throughout the year.
- DoLS database and a live working document continues to be a robust and timely source of information for staff to access (read only) and for any audit/external queries or information requests.
- The responsibilities for the safeguarding administrator have been extended to incorporate communication with family members to advise them of a DoLS application submission. This was previously a responsibility for the ward staff, however due to pressures over the last year, this communication was sometimes missed, causing distress to the family. The communication date and record of the family member is now logged on the DoLS database for reference.
- Due to COVID and restrictions in place, assessments and communication have been undertaken remotely. WCFT safeguarding team have set up passwords with regional DoLS teams / BIAs / section 12 doctors to ensure safe information sharing. This process will continue moving forward.
- Bespoke training has been facilitated for any areas requesting this e.g. ICU, CRU.

- The DoLS ward round has been re-introduced: a 'real time' ward round for every area in WCFT fortnightly, to discuss every inpatient in order to identify any capacity issues: does the patient require a DoLS application? This promotes discussion of MCA / DoLS with staff to enable them to apply the principles of MCA and DoLS to their patients with support from the safeguarding team. Any agreed actions e.g. capacity assessment to be completed, are communicated back to the staff members (and ward manager for information) via email. The Safeguarding Administrator ensures that subsequent actions are completed.
- Meetings have commenced with the safeguarding team and the local DoLS teams regarding implementation of LPS at WCFT.
- Ongoing audit of compliance with documentation of DoLS applications and address any areas of concern with ad-hoc/bespoke training.
- The safeguarding team have supported the ward areas during the COVID pandemic by completing DoLS applications when staffing was reduced / very busy on the wards.

Key Priorities for 2021-2022

- Implementation of Liberty Protection Safeguards (LPS): planning for additional workload / staffing / systems / policy / procedures.
- Continue to maintain compliance with DoLS training (>90%).
- Continue to audit compliance of correct documentation of DoLS applications, ensuring correct processes are adhered to.
- The Trust's Matron for Safeguarding will continue to support the Trust's compliance with DoLS legislation, by keeping abreast of changes as they occur and translating the legislative developments into practical guidance for frontline staff.

Mental Capacity Act (MCA**)**

The Mental Capacity Act (2005) is supported by the MCA Code of practice. It is imperative that clinicians adhere to the MCA code of practice when treating and caring for patients. This includes completing a comprehensive assessment of capacity and adhering to the five principles at all times. We must make every effort support our patients who have capacity issues in their decision making.

Key Achievements in 2020-2021

- MCA OLM (E-learning) training compliance is at 91% at year end and has remained compliant throughout the year.
- Positive engagement continues from Consultants and Specialist Nurses during outpatient clinics, regarding MCA and best interest decision making: requesting input or attendance from safeguarding team to ensure robust compliance and use of the MCA and Best Interests framework with complex cases.
- Excellent progress with timely mental capacity assessments, utilising the electronic documentation on EP2.

- Updated and user friendly MCA form introduced on EP2 in February 2021 to enhance the quality of the mental capacity assessments undertaken in WCFT. Previously two forms on intranet; one for WCFT one for Cheshire and Merseyside Rehab Network (CMRN) – now merged.
- The safeguarding Matron and Specialist nurse supported the medical staff during the COVID pressures, by undertaking Best Interest discussions over the telephone with next of kin / family members, regarding the offer of administration of COVID vaccines to patients who lacked capacity. This alleviated pressures from staff and ensured that the MCA framework was adhered to for decision making for this patient group.
- The safeguarding team have supported ward areas during the COVID pandemic by undertaking capacity assessments when staffing was reduced / very busy on the wards.

Key Priorities for 2021-2022

- Continue to maintain compliance with MCA training (>90%).
- Re-launch the Mental Capacity Act/DoLS Champions initiative.
- Re-audit to ascertain if recommendations of previous audit have improved practice.
- Work stream to review safeguarding page on intranet – which will include MCA/DoLS/LPA information and updates.
- Continue work towards there being one process where all mental capacity assessments are recorded electronically (Outpatients system – EP2) – completion imminent.

Court Applications

The Trust made one application to the Court of Protection during 2020 – 2021 in line with the Mental Capacity Act. The application related to a patient whom lacked capacity to consent to an urgent surgical intervention. The patient was assessed as lacking capacity for the particular decision, however, the patient regained capacity prior to the surgery and therefore court intervention ceased.

Domestic Violence and Abuse.

In the Domestic Violence, Crime and Victims Act 2004, it defines domestic violence as ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been intimate partners or family members, regardless of gender or sexual orientation’. The landmark Domestic Abuse Bill was published on 21 January 2019 and is aimed at supporting victims and their families and pursuing offenders. Further amendments to the Bill were confirmed in March 2021, which will strengthen the legislation.

To help tackle the crime, legislation:

- ✓ Provides statutory government definition of domestic abuse to specifically include economic abuse and controlling and manipulative non-physical abuse - this will enable everyone, including victims themselves, to understand what constitutes abuse and will encourage more victims to come forward.
- ✓ Establishes a Domestic Abuse Commissioner to drive the response to domestic abuse issues
- ✓ Provides Domestic Abuse Protection Notices and Domestic Abuse Protection Orders to further protect victims and place restrictions on the actions of offenders.
- ✓ Prohibits the cross-examination of victims by their abusers in the family courts
- ✓ Provides automatic eligibility for special measures to support more victims to give evidence in the criminal courts

Serious Crime Act (2015) section 75

Controlling or coercive behavior may be present in an intimate or family relationship. The law classes' coercive controlling behaviour as a form of domestic abuse and it became a criminal offence in December 2015 under section 76 of the Serious Crime Act, which can be punishable with up to five years custodial sentence.

Key Achievements in 2020-2021

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- Safeguarding Specialist Nurse or Safeguarding Matron continues to provide bespoke support and supervision when staff raise domestic abuse/violence issues relating to patients and families; therefore supporting knowledge and confidence for staff dealing with this sensitive and complex issue.
- The level 3 face to face Adult Safeguarding training session incorporates domestic abuse, including assessment, MARAC process, Clare's Law and harmful practices. Again this is providing staff with improved knowledge and confidence to enable staff to appropriately address this difficult and complex issue.

Key Priorities for 2021-2022

- To continue with work already started, to add `Routine Enquiry` questions to Trust documentation to prompt staff to ask if patient feels safe at home.
- To continue with face to face training and providing ad-hoc and bespoke support and supervision for front line staff when requested or indicated.

<u>Domestic Homicide Reviews (DHRs)</u>

The Statutory requirement related to domestic homicide reviews came into force in April 2011.The focus is a multi-agency approach with the purpose of identifying learning.

The Trust regularly engages with DHR information sharing when requested. There has been no significant engagement with a specific DHR in 2020-2021.

Learning Disability Update

It is recognised that people with learning disabilities are more vulnerable in acute hospitals than the general population due to their additional complex needs. The goal is to continue to improve the safety and quality of healthcare for people with learning disability in The Walton Centre.

Key Achievements in 2020-2021

- Learning disability training figures are compliant at 94% at year end.
- The Safeguarding team supports/co-ordinates support for patients with learning disabilities, families and carers, for in-patients and outpatients, when required.
- The safeguarding Specialist Nurse and Safeguarding Matron continue to attend various meetings: e.g. outpatient clinics, MDTs, Best interests meetings, to support staff with complex cases or potential mental capacity issues, when a patient has a learning disability.
- Good attendance by WCFT representative at the bi monthly Liverpool and Sefton Learning Disabilities Liaison Network meetings.
- Awaiting finalisation of an easy read appointment / admission letter for patients with a learning disability.
- Development and imminent implementation of a reasonable adjustments SOP.

Key Priorities for 2021-2022

- To maintain compliance with training figures >90%.
- To restart the Learning Disability Steering Group. The previous year, the Group had met on a quarterly basis with primary care learning disability facilitators as part of the membership.
- To re-launch and embed the Mencap campaign `Treat me Well` in transforming how the NHS treats people with a learning disability.
- To embed processes re: hospital passports and risk assessments Trust-wide and commence a rolling audit for admissions – to audit documentation 48 hrs after admission.
- Embed the Learning Disability Policy within the Trust and ensure staff are aware of the support required for patients with a learning disability pre-admission and on arrival.
- Offer further opportunities for staff to become Learning Disability Champions within the Trust.
- To re-launch STOMP: the Trust has signed up to 'Stopping Over Medication of People with a learning disability', autism or both (STOMP). This is about all health care providers improving the use of psychotropic

medicine, offering non-drug therapies and making sure that people, families and staff are fully informed and involved.

Prevent

Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

Within health, NHS Trusts and Foundation Trusts are specifically mentioned in the Duty. However, Prevent is part of mainstream safeguarding and therefore all health care staff must ensure vulnerable people are safeguarded.

The Trust has submitted no external Prevent referrals over the last 12 months.

The Prevent Lead for the Walton Centre is the Matron for Safeguarding and represents the Trust at the city wide and regional Prevent meetings. There are two accredited Prevent WRAP 3 trainers for the Trust who are the Matron for Safeguarding and the Practice Educator. Training figures are submitted as part of the safeguarding KPIs on a quarterly basis.

Key Achievements in 2020-2021

- Prevent Lead remains committed to attend the regional Prevent forums to provide feedback of significant information to the Safeguarding Group – however no regional forums have been planned over the last 12 months.
- The Trust continues to submit the Unify data submission for Prevent on a quarterly basis.
- The Trust has remained compliant with Prevent training figures throughout 2020-2021 and remain at 95% and 96% for Basic Prevent Awareness (BPAT) and Workshop to Raise Awareness of Prevent (WRAP) level 3 training respectively, at year end.

Key Priorities for 2021-2022

- Review and continue to provide Health WRAP (Workshop for Raising Awareness of Prevent) level 3 training as an e-learning module to patient facing staff.
- Add Prevent guidance to the (new) Safeguarding page on the Trust Intranet to allow staff easier access to relevant information.
- Raise the profile of Prevent to encourage staff to report concerns regarding Prevent, as the Trust has low reporting activity on this issue.
- For the Prevent Lead to attend at least 2 forums in 2021/22 which is a requirement in the Prevent Training and Competencies Framework.

Safeguarding Children Activity

The Datix system records the number of safeguarding children incidents made in the various departments across the Trust. The system has been updated to allow for identification of how many of those alerts are subsequently generated into formal safeguarding referrals or early help referrals.

During 2020/2021 the Trust has seen a reduction of activity in safeguarding children referrals in comparison with the previous year (as shown in table below). This may be a result of less throughput of patients (including 16 and 17 year olds) due to the COVID pandemic. The restrictions with visiting will have resulted in less face to face engagement of staff with the patients' families, which may restrict the ability to 'Think family' regarding safeguarding concerns. However, the Trust did task designated staff to undertaking daily calls to family members during the pandemic

Table 5 - Yearly summary of safeguarding children alerts recorded on DATIX

2018 - 2019	2019 – 2020	2020 - 2021
13	**24**	**11**

Child Exploitation

The issue of CE has continued to receive high media coverage over the last few years and the Department of Education released new guidance for practitioners, 'Child sexual exploitation: definition and guide for practitioners' (February, 2017). The new definition now includes the irrelevance of perceived consent.

There is however, a commitment within Merseyside to safeguarding children and young people from being sexually exploited or criminally exploited, whilst disrupting and prosecuting individuals who have exploited them.

An overarching term of Child Exploitation is used to encompass both criminal and sexual exploitation of children. A protocol has been developed which provides a set of multi-agency principles for tackling Child Exploitation across Merseyside.

Key Achievements in 2020-2021

- There is a designated SPOC (Single Point Of Contact) within the Trust which is the Matron for Safeguarding.
- All levels for safeguarding children have remained compliant for 20/21 except for Level 4 where the equivalent of one person is outstanding to meet compliance. This will be achieved when there is an opportunity for the member of staff to attend a virtual conference.
- A new daily alert has been commenced, to flag to the safeguarding team that a young person (16 / 17 year old) has been admitted as an inpatient to

the hospital. This allows appropriate safeguarding risk assessing around the young person.
- Safeguarding training includes information about how to identify the signs of sexual exploitation.
- The Trust is part of Liverpool CE (Child Exploitation) Health Forum which is in place to lead on the issue of sexual exploitation, driving work forward and ensuring effective cooperation between agencies and professionals.

Key Priorities for 2021-2022

- Continue to maintain compliance for training figures > 90%..
- Full review of all training packages to ensure up to date legislation, policy and procedures, in particular child exploitation (CE) and Children in Care (CiC).
- Full review and update of all relevant Safeguarding Children guidance to be uploaded onto new safeguarding page on Trust Intranet.
- To further develop supervision processes within the Trust.

Did Not Attend under 18

Missing appointments for some children may be an indicator that they are at an increased risk of abuse. There are many innocent reasons why children miss appointments, but numerous studies have shown that missing healthcare appointments is a feature in many Serious Case Reviews, including those into child deaths.

Within Health there is now a move towards the concept of Was Not Brought (WNB) rather than Did Not Attend (DNA) for children and young people. It is rarely the child's fault that they miss appointments.

Our Trust cares for 16-17-year-old patients in the clinical wards and outpatient's department and in satellite clinics and we have an escalation pathway in place for under 18-year olds who do not attend (DNA) clinic.

Key Priorities for 2020-2021

- Trust 'Was Not Brought' pathway and guidance is awaiting further amendment and to be ratified at the next Safeguarding Group.
- Was Not Brought pathway to be included in pending DNA Policy.

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is child abuse and illegal.

Healthcare professionals must report to the police any cases of female genital mutilation (FGM) in girls under 18 that they encounter in their work. This duty came into force on 31 October 2015.

Staff have been notified of the need for mandatory reporting and there has been an increased focus on FGM in all levels of safeguarding children and adult training.

During 2020/21 the Trust reported 0 cases to NHS England.

Education and Training

The Trust continues to show an on-going commitment in ensuring that all staff receives appropriate safeguarding training. The Safeguarding Training Needs Analysis (TNA) has been developed which sets out the requirements and arrangements for safeguarding training provision for all WCFT employees including those on bank, honorary contracts or volunteers. The TNA has been reviewed to ensure that staff are mapped to the appropriate levels of training as per the Intercollegiate documents 2018 for adult safeguarding and for child safeguarding 2019.

Table 7 – Safeguarding Adult Training Compliance for 2020 - 2021 .

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Adult Training	Safeguarding Training Compliance at end of March 2021 .	Number of staff compliant	Total number of staff
Adults Level 1	93 %	134 2	1436
Adults Level 2	92 %	1026	1120
Adult Level 3	91 %	225	246
Adult Level 4	100%	3	3
Dementia Awareness	94 %	1351	1436
Prevent Awareness	95 %	1369	1436
Prevent WRAP	96 %	1077	1120
MCA/DOLS	93 %	945	1020
Learning Disability Awareness	94 %	1350	1436

Table 8 – Safeguarding Children Training Compliance for 2020 -2021 .

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Children Training	Safeguarding Training Compliance at end of March 2021 .	Number of staff compliant	Total number of staff
Children Level 1	93 %	1342	1436
Children Level 2	93 %	1037	1120
Children Level 3	100%	40	40
Children Level 4	75%	3	4

Key Achievements for 2019-2020

- Training compliance target of 90% was reached for all areas except childrens safeguarding L4 – outstanding equates to one person.
- It has been agreed to increase the target numbers for L3 adult and children safeguarding training, to ensure WCFT has more staff upskilled in this area in order to better support patients and staff/colleagues.

Key Priorities for 2020-2021

- For appropriate staff to attend planned L4 safeguarding children training sessions from NHSE.
- Continue to provide consistency in reporting all aspects of safeguarding training to effectively monitor the delivery of training and identify gaps in training and address as it occurs in year.
- Continue to report training compliance both at clinical and non-clinical level at Committee and Trust Board.
- Monthly monitoring of the level of compliance with safeguarding training to meet and exceed target of 90%.
- To continue to provide a monthly Trust Safeguarding training report.
- Address medical staff low compliance with safeguarding training as a priority and ensure plans to accredit prior learning are in place by training and development team. To set monthly trajectories and link with clinical leads for each division and the Medical Director and present to the Trust Safeguarding Group.

<u>Policies and Procedures</u>

Safeguarding is a rapidly changing and growing area of work. As such it is essential that policies and procedures are revisited and updated accordingly. The Trust has a range of policies that support staff in safeguarding children and young people and adults at risk. Liverpool Safeguarding Adults Board Inter-agency safeguarding adult's policy and procedures is the overarching policy that supports local safeguarding policies.

Over the past 12 months the following policies have been reviewed and refreshed:

- Domestic Violence or Abuse
- Prevent
- Managing Allegations Against Professionals
- DoLS
- Reasonable Adjustments SOP (awaiting Safeguarding Group)

Responsibilities of all staff employed by The Walton Centre Foundation Trust for safeguarding children and adults are documented in WCFT Safeguarding Policies.

Monitoring

External

Adult and Children Safeguarding are required to satisfy the requirements of Key Performance Indicators (KPI) as set by the Clinical Commissioning Group. These include offering assurance on safeguarding activity throughout the Trust. The KPI for Safeguarding requires a quarterly submission to the CCG Safeguarding Service.

Internal

To ensure the Trust has processes in place to discuss and learn from the raising of concerns and to keep up to date with national policy and literature, the Safeguarding Group receives quarterly performance and annual reports.

The membership of the committee includes external representation from the Safeguarding commissioning leads, departmental heads, risk leads, named doctors and named nurses. This group is chaired by the Director of Nursing and Governance.

Safeguarding Audit

The Trust has undertaken the following safeguarding audit in 2020/2021:

- Mental Capacity Act (MCA)
- Learning Disability

The Trust audit plan is to be reviewed by the CCG in Q1 of 2021/22.

Safeguarding Supervision

Safeguarding group supervision within the Trust continues as a standard agenda item on the quarterly Safeguarding Group. The Matron for Safeguarding is accredited to offer safeguarding supervision to Trust staff if required. It is

recognised that staff will often require advice or support in relation to safeguarding adults outside of formal supervision sessions.

The Trust has a Safeguarding Supervision Policy which provides the framework for safeguarding supervision to be provided within the Trust.

Key Priority for 2020-2021

- To review and further develop the Safeguarding Supervision Policy and framework.
- To look at ways to capture data for the different modes of safeguarding supervision currently provided to staff.
- To develop the intranet safeguarding page to disseminate 7 minute briefings for staff, to receive the learning from Serious Case Reviews / Safeguarding Adult Reviews / Domestic Homicide Reviews etc.

Mental Health Act

The WCFT Neuropsychiatry Team has focussed on improving all aspects of the Neuropsychiatry Liaison Service in order to reduce waiting times both for inpatients and outpatients. The Trust has provided additional investment in order to support the team to work across a 7 day period, thus ensuring that the service offers increased accessibility, leading to improved response times and comprehensive provision.

Following a CQC inspection in December 2020 the Trust has implemented recommendations to ensure that we are providing the appropriate provision in order to safely support those who require assessment or treatment under the Mental Health Act.

On-call psychiatry provision has been implemented with a service level agreement (SLA) to provide seamless emergency cover out of hours.
Mental Health Act training commenced in March 2021 and will be offered weekly in order to capture all clinical staff at the soonest opportunity.

Overall Key Priorities for 2021/2022

- Draft an organisational safeguarding strategy with nominated staff as part of a task and finish group.
- Continue to progress work required to achieve KPI requirements for safeguarding.
- Continue to complete actions identified on safeguarding work plan.
- Continue to ensure that safeguarding mandatory training meets 90% compliance by end of 2021-2022.
- Revise and develop Trust safeguarding policies to reflect statutory requirements.
- Continue to develop the use of electronic systems to further improve and develop robust governance around safeguarding data and information

sharing and storage in view of GDPR (General Data Protection Regulation).

- It is recognised that the point of transition from child to adult services is a time of risk for vulnerable young people and we will ensure that the team work involved in transition is robust.
- The Trust is committed to having robust safeguarding processes in place and once a safeguarding concern is escalated, the person is protected, and information is shared appropriately. The Trust will continue to review it's processes considering case reviews and guidance from Liverpool and Sefton Safeguarding Boards.

Conclusion

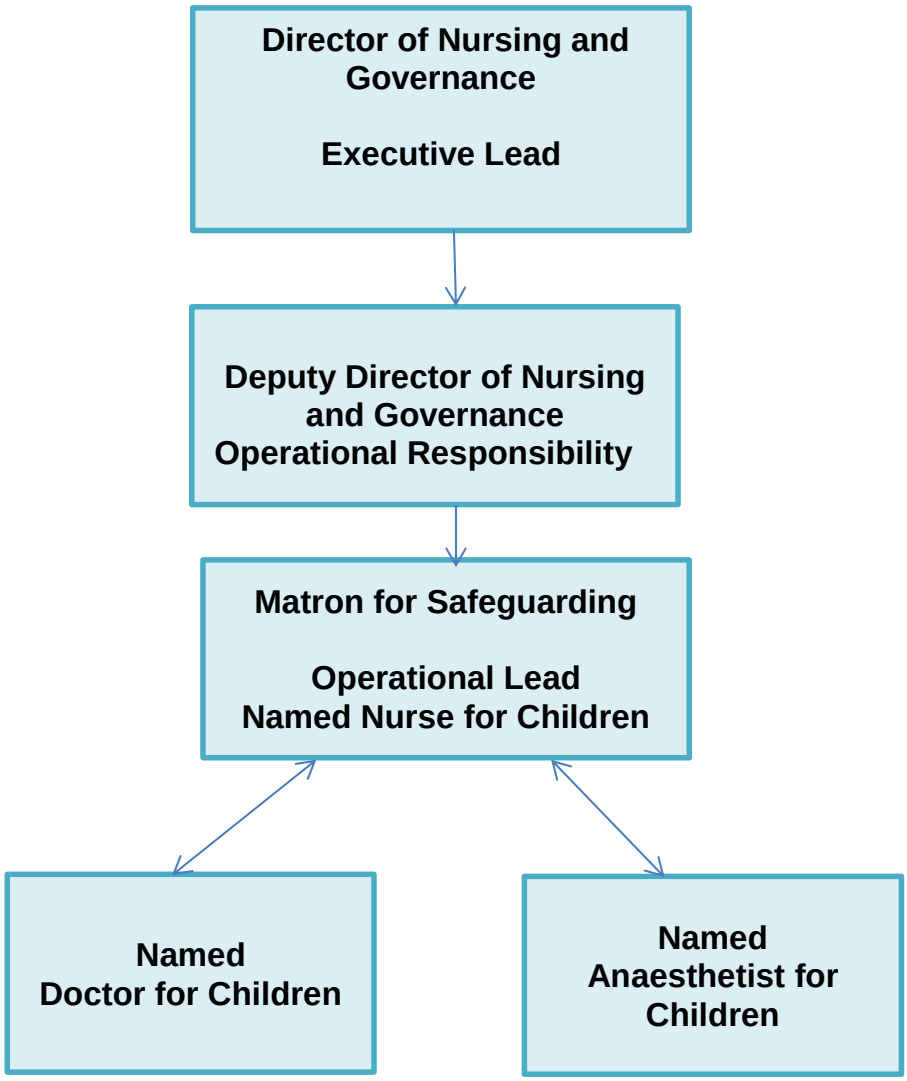
Our Safeguarding work plan demonstrates the progress made however we recognise there is further work required. The underpinning message remains the same in that safeguarding is everyone's business, irrespective of role or position. The safeguarding team will continue to strive to embed the mind-set that safeguarding is not an 'add-on', it is core business. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and adult at risk must remain at the centre and motivation of all our actions.

Despite the issues brought about by the COVID pandemic, the Trust have maintained a high percentage of compliance with the key performance indicators.

The Annual Report has provided an insight into the complex areas of safeguarding and progress made over the last 12 months. In doing so it aims to provide assurance to the Trust Board that we remain fully committed to ensuring we meet and exceed our statutory responsibilities in relation to safeguarding all our service users.

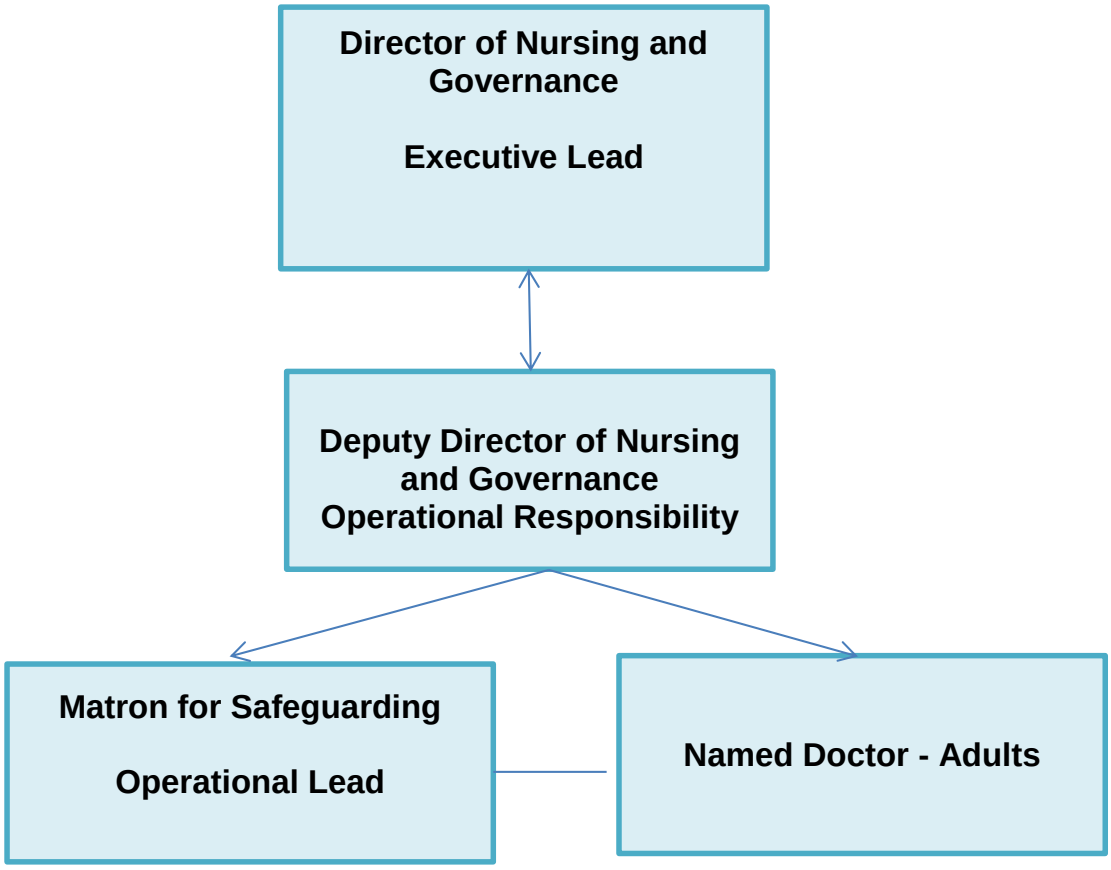
Appendix 1

Safeguarding Structure for Children



Appendix 2

Safeguarding Structure for Adults



The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 1st July 2021

Title	**Major Incident Plan**
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations
Author (s)	Name: Tom Fitzpatrick Title: Head of Risk & EPRR
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____
Executive Summary To provide assurance to the Board that the plan has been reviewed and seen by the Board annually. This is separate to EPRR core standard declaration, which will come to Board in due course.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	N/A
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To be received and noted

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Major Incident Plan

Author and Contact details:	**Head of Risk** **Tel:** 0151 556 3082 **Email:** tom.fitzpatrick@thewaltoncentre.nhs.uk	
Responsible Director:	**Deputy Chief Executive**	
Approved by and date:	**Resilience and Planning Group**	**April 2021**
Document Type:	**POLICY**	**Version 3.1**
Target Audience:	All trust employees.	
Document Approval, History/Changes	**See Appendix 8.** For further information contact the Governance Department on **Tel:** (0151) 556 3082	

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

If a major incident is taking place and you are unfamiliar with this policy, **do not try and read it now.**

Executive Summary

This Policy is laid out in 2 distinct sections:

Section 1. Major Incident response including an overview for incident Commanders and Action Cards.
Section 2. The underpinning Policy organisation and arrangements for Major Incident Planning.

A high level overview of actions on receipt of a Major Incident message is provided below, read this and go to the respective action card for detailed next steps.

Contents

SECTION 1 - MAJOR INCIDENT OVERVIEW & RESPONSE

1. Major Incident Plan overview

1.1 A major incident can be defined as:

- any emergency that requires the implementation of special arrangements by one or more of the Emergency Services, and the NHS for: the rescue and transport and treatment of a large number of casualties, and/or
- that requires a response over and above the norm - stretches the services - can't be managed within normal routines

Note: This can be either an external or internal incident e.g. fire.

1.2 You are strongly advised to read the Trust's Major Incident Plan. There is a Summary section and it is essential you read the section covering your Department.

The Trust Major Incident response is led by the Director or, if out of hours the Director on call.

The ITU, Theatre and Radiology Departments have specific local plans that outline the main responsibilities of their staff and escalation arrangements.

The remainder of departments and wards have bespoke action cards which describe the key actions for Departmental Managers or Deputies.

The response in Clinical Departments is led by the Clinical Director or, if out of hours the Consultant On call.

1.3 The most likely type of major incident is a Mass Casualty Incident.

A Mass Casualty Incident is defined as a disastrous event where normal Major Incident responses must be augmented by extraordinary measures in order to maintain an effective, suitable and sustainable response. By definition, such events have the potential to rapidly overwhelm, or threaten to exceed the local capacity available to respond, even with the implementation of major incident plans.
Factors that distinguish a mass casualty are:

- most likely associated with terrorist incidents or transport
- the scale, duration, intensity of the Incident
- loss of infrastructure services
- shortage of supplies or civil dislocation

Normal standards of care provided by the Emergency Services and the NHS may not be achievable. The requirement is to achieve the best possible outcome for the greatest number of people with the available resources.

2. Major Incident Plan Activation

A major incident message will usually be a structured "METHANE" message:

- **M**ajor incident declared or stand-by; time of incident
- **E**xact location of incident
- **T**ype of incident
- **H**azards (e.g. chemicals) involved
- **A**ny problems with access that may impede staff or patient journeys

- **N**umbers of estimated casualties involved
- **E**mergency services involved, any special resources required (e.g. burns/paediatrics), other hospitals involved

2.1 The Major Incident Plan will be triggered by the relevant Director or Executive on Call - Strategic Commander (Gold). There are two stages to the Alert:

- Major Incident Standby - preliminary advice that a Major Incident might be occurring to enable the hospital to anticipate a Major Incident.
- Major Incident Declared - a decision that a Major Incident has occurred and e.g. casualties will arrive requiring implementation of the Plan. A Major Incident Declared can occur without a prior Major Incident Standby notification.

2.2 Major Incident Standby Message

On the receipt of a confirmed Major Incident Standby, the Plan expects:

- the formation of a Major Incident Control Team which will consist of:
  - Strategic Commander (Gold) - Director or Executive On Call
  - Tactical Commander (Silver On call)
  - an administration manager
  - Communication Manager
  - a loggist
- a review of bed capacity and assessment of inpatients for potential discharge
- communication of the Standby message to all departments via email, telephone or via runners
- in a mass casualty the deployment of a Forward Liaison member of the Surgical Department to the Aintree Emergency Department

2.3 Major Incident Declared - External Incident requiring Walton Centre response

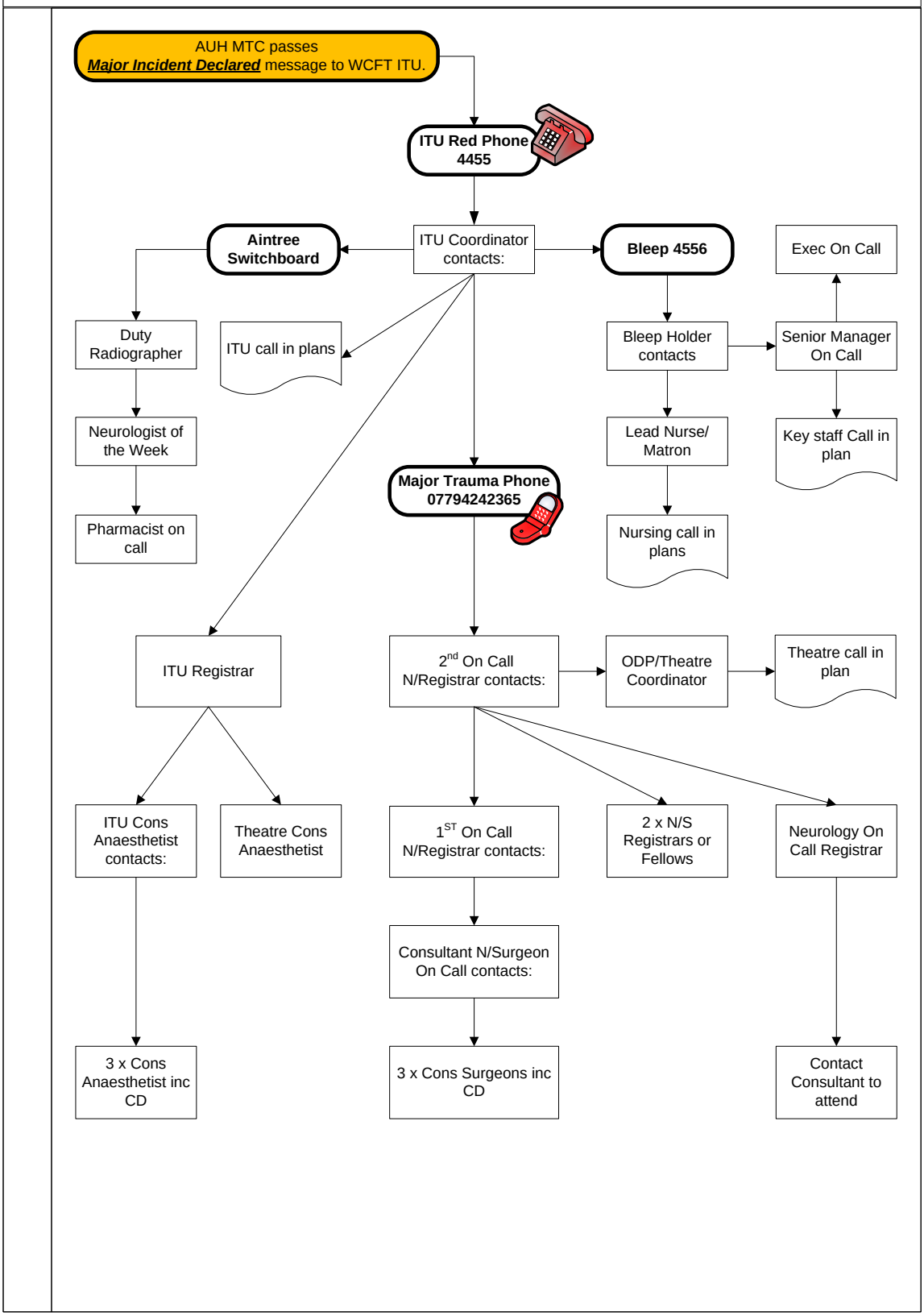
The most likely escalation will be as a result of the Major Trauma Centre (MTC) in Aintree receiving mass casualty trauma patients that require Walton Neurosciences support.

The MTC will contact the ITU Red Phone (4455) and confirm a Major Incident message. The ITU Coordinator escalates message to the Bleep holder (for Senior Manager and Exec On Call) and then notifies:

- the 2nd On Call Neurosurgical Registrar via the Major Trauma Phone who will initiate the Neurosurgical/ Theatres response
- ITU Registrar who will initiate the ITU response
- Lead Nurse/Matron
- Pharmacy, Radiology and Neurologist of the Week

See algorithm diagram below:

MTC contact – "Major Incident Declared" – WCFT call cascade



3. Walton Centre Response

3.1 Control Room

The Major Incident Control Room will be set up in the Boardroom on the 2nd Floor in The Walton Centre, which acts as the central point for control and communication throughout the Trust and with external agencies.

A secondary room should the Boardroom be unavailable is located in the Lecture Theatre in the Sid Watkins Building on the 2 floor. Access to both of these rooms is via Swipe access and out of hours via Security Reception.

Major Incident Telephone numbers (Boardroom)

There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

a. Major Incident number is (0151) 556 3690 and:
b. Boardroom (0151) 556 3688
c. Theatre Seminar room (0151) 566 3689
d. **NB in the event that the above numbers are not available, use the Red Phone (0151) 529 4245.**

Fax: 0151 529 6434 (Located in Exec office).

3.2 Strategic Commander (Executive Director or Director on call out of hours)

3.2.1 The Strategic Commander controls **ALL** activity throughout the entire Trust. In a confirmed Major Incident - the Director or Executive On call will assume the role of Strategic Commander and declare a Major incident for the Trust. This is done by:

- contacting NWAS Health Control Desk on **0345 113 00 99** (Option 2 for Merseyside & Cheshire) and ask for the ***NHS England 1st on call for Merseyside*** leave a number for a return call (Email eprr.communications@nhs.net)
- and then inform CCG Duty Officers for North Mersey **0845 124 9802** of Major Incident declared and give details
- then inform Spec Comm (England) On Call Manager **0191 266 7733** of Major Incident declared and give details (Email england.spoc@nhs.uk)

The Strategic Commander will communicate with the Tactical Commander and key members of the Incident Control Team via pre-agreed meetings in the Boardroom. The frequency will be determined at the initial meeting dependent on the nature of the incident.

These meetings will establish the severity of the incident, number of likely casualties, patient flow, staffing, and impact on business as usual activity.This information will inform communication with Aintree, NHS England, Critical Care Network and external Situation Reports.

3.3 Situation Reports (SITREP)

NHS England coordinate the NHS response to a Major Incident. They will agree in advance the timings of SITREPs and method of submission, depending on the severity of the incident. This may be done initially via telephone conversation/email and when there is suitable support, via regular teleconferences.

3.4 Tactical Commander

This role in hours will be fulfilled by the Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.

Out of hours the Senior Manager on call (Silver) will escalate the message to the Director on call who will then decide who is to assume the role of Tactical Commander. They will come into the hospital and set up the incident control room and await further direction.

3.5 Bleep Holder (Operational)

If notified of a Major Incident, the Bleep Holder will contact the relevant Director via the Executive Office in hours and if out of hours the Senior Manager and Executive On Call via the Aintree Switchboard.

3.6 Departmental Response

3.6.1 Neurosurgery

The Consultant On Call assumes the role of **Surgical Commander**. He or she calls in the Clinical Director, a Cranial Consultant, a Spinal Consultant and supporting colleagues and allocates roles for them between Theatres, discharge and Aintree. The Surgical Commander based in the theatre complex will:

- provide coordination and prioritisation;
- ensure time limits for futility of intervention;
- be available for second opinion

3.7 Theatres

The Theatre Coordinator/Senior ODP will initiate the local staff call in procedure (algorithm) which is a pre-prepared document which details teams according to skill mix. They initially prepare one theatre for immediate transfer from Aintree followed by a further two theatres once sufficient staffing resources are in place.

3.8 Critical Care

The ITU Registrar calls in the ITU Consultant On call. He or she calls in 3 colleagues (including Clinical Director), liaises with Aintree ITU and Neurosurgery and allocates colleagues on arrival.

The ITU Coordinator/Matron initiates the Escalation Policy to set up extra beds as required, sequentially in SSU, SIM Room, Theatre Recovery and Jefferson Ward infusion bay.

3.9 Wards

The Matron will initiate the local staff call in procedure (algorithm) which is a pre-prepared document which details teams according to skill mix. They will prepare to receive major trauma patients, discharges from ITU and/or potentially other wards due to cohorting requirements. Ward staff will manage patient visitors according to the protocols held within the action card.

The main Outpatients Department will become the Discharge Lounge for in patients that require discharge. The Outpatients Manager will coordinate this role in hours and out of hours by a CST (SHO) and a clinical Pharmacist.

3.10 Radiology

The Radiology Manager or deputy in hours will initiate the local staff call in procedure (algorithm) and if out of hours, the Duty Radiographer. They prepare the radiology response in liaison with the Theatre Coordinator.

3.11 Support Services

Specific information regarding e.g. security, linen, surgical supplies (including instrumentation) and ward consumables, are detailed within specific action cards within the Major Incident Plan.

4. Access & Communication

4.1 Departmental Managers are responsible for assessing staffing requirements and calling in as necessary (or coordinating out of hours).

4.2 Staff report to their normal area. In the event of a Lockdown, they report to the designated staff reporting area. This will be signposted and controlled by ISS Security.

4.3 Families, media and press enquiries, coordination of affected patient families, a pre-prepared social media and website message will be provided by the Communications Team. A standard message will be prepared and disseminated to Heads of Department for onward cascade.

For on site reporters or media press enquiries; the Communications Team will be the first point of contact. Any external messages will require the Executive Director to coordinate with NHS England.

5. Post incident response

5.1 Major Incident Stand Down

The Strategic Commander will issue the Stand Down message throughout the Trust. The incident control room and incident logs will be closed and all relevant documentation (including evidence of decision making) will be collated and stored appropriately.

5.2 Debriefing

A debrief is held after an incident to establish learning points and draw up an action plan to enable the review and revision of emergency plans.

A hot debrief is held immediately after Stand down is declared within the location where responders have been working.

A formal organisational debrief will be held within a week after the event. The Strategic Commander and Head of Risk will prepare an organisational report for the next Executive Team and subsequent Board.

5.3 Staff support

Support of staff welfare and counselling will be a priority throughout the actual incident, stand down and post incident phases. Access to Occupational Health support will be provided by the Trust for all staff, particularly those involved in a major incident, which will include counselling if required.

ACTION CARD 001 - Bleep Holder (Operational) Out of hours

(Will act as Bed Manager until relieved - see Bed Managers Action Card).

Location: **Unit based**

Role Description:

This role will:

1. Manage the immediate local response.
2. Out of Hours refer to the Bed Manager Action Card (**Action Card 022**) until relieved.
3. Contact the Senior Manager on call - Tactical (Silver Command).
4. Co-ordinate the organisations resources onsite by gathering as much information as possible related to:
   - staffing
   - patient flow, transfer from critical care (OOH)
   - discharges of all patients within ward area
   - escalation (utilise support from SMART Team if required)
   - support Silver Commander and provide them with the up to date patient information / updates on care, availability of beds, capacity and infection control status
   - prepare for on site meeting in ITU or Theatre Office
   - liaise with Senior Nursing Team (not on call)

Incident Standby

1. Prepare staffing information for additional staff (to ensure adequate nursing resources are available for level of care required).
2. Consider which patients may be suitable for discharge or transfer.
3. Liaise with ITU Co-ordinator/ Theatre Co-ordinator / Onsite Medical Lead and Infection Control Lead (On call) to ensure that the bed capacity is at full potential.
4. Attend meeting in ITU/Theatre Seminar Room.
5. Liaise with Senior Manager On call - Silver command.

Incident declared

1. Prepare to receive transfers from Critical care as directed. These patients must be accepted immediately on request and a nurse should be sent to assist with transfer.
2. Prepare to receive admissions from Theatres that do not require ITU admission.
3. Arrange to transfer existing in-patients to other wards.
4. Request additional staff as required (consider use of agency staff).
5. Support relevant on-call medical registrar with discharge of identified patients.
6. Keep a record of all actions and decisions taken during the incident.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.

2. Join the Trust hot debrief.

ACTION CARD 002 - ITU Nurse Coordinator

Location: ITU

Role Description:

1. To implement, in conjunction with senior medical staff, the escalation strategies outlined in the Trust Major Incident Plan.
2. To assist in the recruitment and deployment of additional staff according to the likely requirements of the incident (in conjunction with Nurse Manager ITU).
3. To organise the setup of extra ITU bed spaces to take predicted casualties.

Incident Standby

1. The Major Trauma Centre will call on the Emergency Red Telephone (4455) and ask to speak to the coordinator. They will pass the message "Major Incident Stand By or Declared"
2. On receiving the message, the coordinator should inform the following:
    a. Neurosurgery 2nd On Call Registrar via the Major Trauma Phone 07794242365
    b. ITU Nurse Manager.
    c. Duty ITU Registrar.
    d. Radiology On call.
    e. Bleep Holder.
3. And pass the message "***Major Incident Stand By or Major Incident Declared"*** Action cards are kept in the CD cabinet in the bay.
4. Assess bed state and current staffing levels and report these to ITU Nurse Manager.
5. Commence setup of beds 21 & 22 (SSU) to take 2 ventilated patients.
6. If Nurse Manager not on site, attend ad hoc meeting with Theatre Coordinator / Nurse Manager, ITU and Anaesthetic Consultants and Consultant Neurosurgeon in Theatre Seminar Room when senior staff arrive.

Incident declared

1. Complete actions detailed above under standby.
2. Commence calling in nurses to staff extra beds after liaison with Nurse Manager ITU / Duty Consultant ITU following an estimation of likely bed demand.
3. Call in ITU Technician if available.
4. If Escalation 2 procedure seems to be necessary, direct extra staff and ITU technician (if available) to set up Jefferson Infusion bay to take 4 level 2 patients using beds from Jefferson ward bays.
5. If Escalation 2 procedure started, arrange for extra staff to collect reserve monitors and ventilators from storage in Sid Watkins building (**see Appendix 1 "Location of reserve equipment").**
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Matron.
2. Join the Trust hot debrief.

Appendix - Supplementary Action Card: Location of ITU Reserve Equipment.

If it seems necessary to implement the **Escalation 2** plan to increase critical care bed capacity, then it will be necessary to utilise the reserve equipment kept in Sid Watkins Building (SWB) to allow this to happen. Proceed as follows.

1. When extra staff arrive after being called in, form a team of 4 nurses / HCA's and ask them to go over to Sid Watkins with this card.

2. On arrival at SW, inform the security staff of the purpose of your visit and go to the Outpatients department on the first floor. The security staff may need to facilitate entry out of hours.

3. Walk into Outpatients and on reaching the reception desk, turn right and go to the end of that corridor to a door marked "DO NOT ENTER."

4. Go through this door into the unfinished area of the building, the monitors and ventilators are on the left hand side of the room.

5. Carefully move the 4 ventilators across to HDU and the four monitors to the infusion bay on Jefferson Ward.

6. The ventilators should remain in reserve until all other available Evita ventilators are in service. They will need to be set up for use by the ITU technician, or by an ODP.

ACTION CARD 003 - Tactical Commander

Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse or Senior Manager On Call (out of hours).

Location: Based in the Boardroom (in the event the Boardroom is unavailable within the Lecture Theatre in the Sid Watkins Building).

Role Description:

1. Working with the Incident Management Team, you are responsible for:
    a. The Trust's Tactical response to a major incident.
    b. The collection, collation and transmission of information during the incident response
    c. Action tracking.
2. You must establish contact with the emergency services where appropriate, major incident receiving hospitals and other agencies to ensure full operational awareness.
3. Ensure that correct information is made available to the **Strategic Commander** (Executive Director or Director on call out of hours), who will work with the Communications Manager to establish arrangements to brief the media.
4. Work with the Strategic Commander to ensure that a recovery plan is formulated and implemented.

    Major Incident Telephone numbers (Boardroom)

    There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

    a. Major Incident number is (0151) 556 3690 and:
    b. Boardroom (0151) 556 3688
    c. Theatre Seminar room (0151) 566 3689

Incident Standby:

1. Having been alerted you now need to lead the Tactical response until you are stood down or relieved.
2. If appropriate proceed to the Hospital immediately.
3. Inform Strategic Commander who will provide immediate advice on the information you will be required to gather.
4. If appropriate contact Head of Risk/Deputy Head of Risk and instruct to attend the Hospital.
5. Keep an accurate record of messages received from the bleep holder on your personal log sheet within your on call pack until an incident log is running.
6. Consider immediate threat to business as usual (next 24 hours) as follows:
    a. Number of TCI's (both same day admissions and inpatients)
    b. Number of outpatient clinics scheduled
    c. Number of routine radiology investigations scheduled
7. Maintain regular contact with the Strategic Commander throughout the incident.

Incident Declared:

1. Receive **"Incident Declared"** message from Bleep Holder with the likely number of casualties and the nature of the incident declared as well as the number of teams ready to mobilise and the initial potential threat on business as usual.
2. Set up the Major Incident Room in the Trust Boardroom and inform the WCFT reception (if in hours) that the control centre is operational.
3. If our of hours, the Strategic Commander may replace the Senior Manager On Call with a more appropriate Tactical Commander.
4. Key Components of your role:
    - implementation of the actions set by the Strategic Commander
    - allocation of tactical resources including personnel and equipment
    - establish clear communication and location of the operational leads in theatre, Critical care, wards and bed management plus support services and ensure they are fully briefed and command and control hubs set up as appropriate within the trust
    - oversee the response of theatres, ITU, HDU and Radiology appropriate to the incident
    - oversee the discharge process for current inpatients
    - identify and communicate to the Strategic Commander the need for additional support or assistance as required
    - Multi-agency tactical liaison with NWAS, Fire, Police and PHE
    - providing situation reports (SitReps) to the strategic commander and/or NHS England
    - manage the incident support team
5. Start a Major Incident Control Centre log and ensure a robust record (log) is kept of the major incident or emergency to include:
    - date and time
    - major Incident
    - information received – incoming phone calls, emails and faxes
    - request for assistance received and responses
    - instructions received
    - decisions made
    - actions taken
    - ensuring the Strategic Commander signs the log after key decisions and following Major Incident team meetings
    - assign staff tasks as appropriate
6. Briefing / initial meeting of Incident management Team
    - brief on arrival the Incident Management Team; this will include an Administration Manager, a loggist and support from the Division and Governance
7. Chair initial meeting of Incident Management Team
    - assess impact on trust services - if they have been or will be affected by the incident and ensure they are informed of the situation
    - priority is to ensure that services required to respond to the emergency are maintained as well as other essential services

- if deemed necessary ensure that the normal roles of staff working as part of the incident are covered
- provide hand over to appropriate manager if the incident is prolonged
- hand the log to the Control Room Administration Manager once the incident has been closed or you are no longer on-call
- provide handover report to the manager replacing you

8. Support ***For your Information***

a. You will be supported by the Head of Risk or Deputy who have specialist knowledge of the Major Incident Plan and associated Procedures. They will advise you on options available to you, possible courses of action and potential consequences of decisions taken.

b. An Administration Manager will ensure support functions are co-ordinated to provide adequate support to both the Strategic Commander and Tactical Commander.

c. You will work in conjunction with a Loggist to ensure all actions and decisions are captured. All meetings held should also be minuted.

d. The ITU, HDU, Theatres, Radiology and Wards have call in procedures in place.

Public enquiries

2. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. Decide when to stand down in consultation with Strategic Commander and ensure stand down message is communicated.
2. Work with Administration Manager to ensure all information and documentation is collected and safely stored.
3. Agree actions for follow up of staff following the incident and debriefing.

ACTION CARD 004 - Strategic Commander (Director or Executive On Call)

Location: Based in the Boardroom (in the event the Boardroom is unavailable within the Lecture Theatre in the Sid Watkins Building).

Role Description:

1. Provide Strategic leadership to WCFT during a response to a major incident.
2. Provide Support and response as directed/requested by NHS England as part of the health economy response.
3. To direct the Tactical Commander.

Major Incident Standby:

1. You will be contacted via the Executive PA or by the Senior Manager On call out of hours.
2. On being alerted confirm details of current situation:
   - What has happened?
   - Where is the incident?
   - What time did it begin?
   - What are the immediate consequences?
3. Proceed to Incident Control Room (Board Room) and consider the situation with Tactical Commander and other Incident Control Team members.
4. Decide what action is required to prepare the hospital.

Major Incident Declared:

1. The most likely scenario will be providing Neurosurgical support to Aintree Major Trauma Centre with casualties etc.
2. **INTERNALLY** - Declare a **Major Incident** to Trust staff via an all user email message, out of hours do this via a runner to departments and wards.
3. **EXTERNALLY**
   a. Call NWAS Health Control Desk on **0345 113 00 99** and ask for the ***NHS England 1st on call for Merseyside*** leave a number for a return call. Email eprr.communications@nhs.net
   b. Inform CCG Duty Officers for North Mersey **0845 124 9802** of Major Incident declared and give details.
   c. Then inform Spec Comm (England) On Call Manager 0191 430 2498 of Major Incident declared and give details (Email england.spoc@nhs.uk).
4. Report to Incident Control Room and take over from Senior Manager in Charge you are now the Strategic Commander.
5. Commence your incident log.
6. Designate a Tactical Commander; this may be a Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse or Senior Manager On Call (out of hours).
7. You will receive and send intelligence reports, instructions and regular SITREPS to and from NHS Silver Command.

8. Contact ***NHS England Merseyside 1st on call*** to inform them that the Trust Incident Control Room is set up and the contact number and the generic Trust email to use incident@thewaltoncentre.nhs.uk
9. Brief the Command & Control Teams and determine a shift rota as necessary.
10. You will receive and send intelligence reports, instructions and regular Sitreps to and from the incident control room.
11. Strategically direct the **whole** Trust's Major Incident response.
12. Notify other executive directors/non-executives as appropriate and North Mersey CCG on **0845-124-9802** of Major Incident declared and provide details.
13. Monitor response of:
    a. Support services.
    b. Media response with the Communications Team.
    c. Any VIP visits.
14. Call and chair Command meetings every 2 hours.
15. Lead the hospital's liaison with external bodies, e.g. NHSI/CQC etc.
16. Consider use of radio communication between key areas e.g. to cover any blackspots in the Hospital. These can be accessed via the Head of Facilities.

Major Incident Stand Down

1. When the emergency is over declare and cascade to all staff and key stakeholders "Major Incident Stand Down."
2. Inform NHS England Merseyside 1st on call.
3. Conduct a hot debrief in situ in the Boardroom.
4. Arrange and chair a formal Trust wide debrief in a week's time.
5. Compile a formal incident debrief and report with the Head of Risk (including lessons learnt).
6. Send report to the next Trust Board.

ACTION CARD 005 - Communications Manager (In and Out of Hours)

Location: **Incident Control Room**

Role Description:

1. To coordinate communications across the organisation.
2. To coordinate media communications.
3. To support the Strategic Commander in relation to Trusts media response.

Communications resources/equipment:

1. The Communications on-call Lead will have remote access to the Trust's network, to enable them to update the intranet and send all user emails.

Incident Standby/Declared:

Out of hours:

1. The Strategic Commander (Executive on Call) will:
    a. Contact (out of hours/major incident media enquiries or any urgent requirement to inform staff and/or stakeholders) Communications on-call Lead.
    b. Notify the switchboard to direct any media enquiries to the Communications lead.
    c. Establish a protocol with any External Multi-agency/NHS Organisations Communications Lead to ensure that any relevant information/media from The Walton Centre is shared with the Trust's Communications Lead, before circulation (if practicable).

In hours:

1. The Communications Lead will take all necessary steps to prepare for internal and external enquiries, including any or all of the actions below:
    - set up a message on the intranet providing information and assurances
    - send an all-users email providing information, stating when more information will be sent, and directing staff to the intranet
    - liaise with Multi Agency/NHS Gold Communications Lead (e.g. Merseyside Police press office) to agree who will be the first point of contact, which will depend on the scale of the incident
    - consider using web updates for key media messages - e.g. linking to the Merseyside Resilience Forum webpage
    - identify key stakeholders to be notified and circulate a message to all relevant stakeholders
    - erect signs in and around the hospital site
2. Maintain communication and report any issues to the Strategic/Tactical (Silver) Control Team.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Incident stand down

1. Gradually reduce the frequency of briefings (internal and external).
2. Continue to liaise with communications leads at key partner organisations about key messages and media protocol.

3. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the TACTICAL (Silver) COMMANDER.
4. Join the Trust hot debrief.

ACTION CARD 006 - Administration Manager

Location: **Incident Control Room**

Role Description:

1. To set up Incident Control Centre.
2. To provide administrative and clerical support.
3. To collect, collate and display information.
4. To establish and maintain liaison with internal and external services.

Incident Standby

1. Agree roles and immediate action with Director.
2. Agree on operating base either Boardroom or, if not available 2nd Floor Lecture Theatre SWB.

Incident declared

1. Alert relevant staff as instructed (including Loggists) - ask them to report to Incident Control Centre.
2. Set up the Incident Control Centre.
3. With the Director / Divisional Director, Divisional Manager or Deputy Director of Nursing/Lead Nurse confirm room layout, set out communications system, log sheets, incident status boards.
4. Layout three telephones for team members, contact details are as follows:

   Major Incident Telephone numbers

   There are 3 dedicated VOIP phone lines within a dedicated Major Incident Ring Group as follows:

   a. Major Incident number is (0151) 556 3690 and:
   b. Boardroom (0151) 556 3688
   c. Theatre Seminar room (0151) 566 3689
   d. **NB in the event that the above numbers are not available, use the Red Phone (0151) 529 4245.**

5. Use mobile telephones for outgoing calls if necessary. Supply of log sheets to be available.
6. Set up an incoming fax, and an outgoing fax if required.
7. Set up incident status boards and record initial details, incident location, brief statement of situation, names, organisations and contact numbers of responders.
8. Display any relevant maps where necessary.
9. Create a file directory and give it the name of the incident. Use this directory for all the documents relating to the incident.
10. Ensure all communication is documented.
11. Tasks:

    - Confirm the dedicated telephone numbers for calls to be received / made, dedicated fax line.
    - Make list of the Incident Control Centre staff and their telephone numbers (include direct incoming lines and extension numbers)

- Refer to a list of internal and external contacts. Add these as they call in or as reported by incident managers

12. Incoming call taking:

- Record caller's details and time of call on your log sheet or on the standard message sheet.
- Record name, organisation and contact numbers. Check spelling of unfamiliar names with caller. As well as their landline number, ask for their mobile phone and pager numbers
- Ask if email contact is possible. Take email details.
- Answer queries or divert calls to appropriate person as necessary

13. Other tasks:

- Where requested, provide secretarial support to Strategic/Tactical Commander.
- Where requested, arrange telephone and incident briefings
- Delegate a colleague to reschedule the appointments and commitments of the Executive Director
- Provide stationery / materials

14. Staffing considerations (with Strategic/Tactical Commander)

- Consider staffing requirements to allow critical functions to continue
- Arrange and maintain rota for the staff in the Incident Control Centre
- Ensure there are catering arrangements and refreshments
- Make arrangements for the support of staff in the short or long term

15. At the end of your shift

- Hand over this action card to your replacement.
- Brief them on the current situation on Incident Control Centre procedures and on liaison needs.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical/Strategic Commander.
2. Join the Trust hot debrief.

ACTION CARD 007 - Loggist

Location: Incident Control Room

Role Description:

1. To maintain an accurate combined log of messages received in the Incident Control Room.
2. To maintain an accurate combined log of decisions and actions taken by Tactical/Strategic Commander.

Incident Standby

1. Agree roles and immediate action with the Administration Manager.
2. Confirm room layout, communications system, log sheets to be used and collection system.
3. Issue a log book for the Incident Control Room (held in the Major Incident Cupboard).

Incident declared

1. At the initial meeting:
    - Confirm your role and that of others, staff locations, communications system, log keeping system.
    - Ensure that all members of team are keeping an accurate individual log.
    - Ensure that all details are being entered on the log - Messages details - time of call, name of caller (check spelling), their contact number, spelling of technical names, spelling of locations and company names.
    - Actions taken
    - Challenge anything you are unsure about.
2. Compile a combined log of messages sent and received and actions taken.
    - Collect, collate and store individual log sheets - via updating status board.
    - Record chronologically all information in the incident log.
3. At the end of your shift:
    - Hand over this action card to your replacement. Brief them on the current situation on incident room procedures and on liaison needs.
    - Ensure all communication is documented.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Strategic Commander.
2. Collect all log books.
3. Complete the combined log for the Incident Control Centre and ensure passed on to the Administration Manager or Director.
4. Join the Trust hot debrief.

ACTION CARD 008 - 1st on-call Neurosurgical Registrar (on-site)

Location: Theatre reception

Role Description:

1. Support clinical teams as directed by Surgical Commander.
2. Inform appropriate colleagues as detailed below.
3. Prepare to attend theatre.

Incident declared

1. Attend Major Incident Control Room (theatres) and meet ITU Coordinator.
2. Call two other Registrars/Fellows (see attached) and inform “Major incident declared – you must attend Theatre Incident Room (Theatre Seminar Room).”
3. Assist in the preparation of three Neurosurgical theatres, ensuring appropriate equipment available.
4. On arrival of Discharge Consultant assist in the discharge ward round in conjunction with Discharge Consultant, Bleep holder and Senior Nurse, CST
5. Return to Major incident control room and await further instructions from SURGICAL COMMANDER.
6. Be prepared to attend theatres in Aintree if required with theatre team and necessary equipment.
7. Be prepared to scrub in theatres at Walton to assist or operate as directed by SURGICAL COMMANDER.
8. Ensure all communication is documented.
9. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 009 - 2nd on-call Neurosurgical Registrar (on-site)

Location: Theatre reception

Role Description:

1. Receive call on Major Trauma Phone (07794 242365) from ITU Coordinator. Who should indicate that **"this is not an exercise."**
2. Support clinical teams as directed by Surgical Commander.
3. Inform appropriate colleagues as detailed below.
4. Prepare to work across sites (Aintree).
5. Act as Forward Liaison between Aintree and Walton.

Incident Standby

1. Attend Theatre Incident Room (Theatre Seminar Room) and meet ITU Coordinator, Senior ODP, Bleepholder to assess the current incident state based on information received from MTC.

Incident declared

1. In the event of an escalation to Major Incident Declared call:
    a. Consultant Neurosurgeon on call.
    b. 1st on call Neurosurgical Registrar.
    c. Neurology On call Registrar (BLEEP 5573).
    d. Radiographer on call (contacted via Aintree Switchboard).
2. Attend Aintree Resusc in the Emergency Department as forward liaison (assist TRIAGE CONSULTANT on arrival).
3. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
4. Liaise with ED Commander to assess scale of events and number of expected casualties and update **Surgical Commander** on Theatre Major Incident Room phone - 5790.
5. Log-on to PACs.
6. Remain insitu and await attendance of TRIAGE CONSULTANT.
7. Be prepared to attend theatre as TRIAGE CONSULTANT sees fit.
8. Await further instructions and respond flexibly as required.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Confirm this with the Surgical Commander in ED.
3. Join the Trust hot debrief.

ACTION CARD 010 - Surgical Commander - Consultant On Call Neurosurgeon (on-site)

Location: Theatre reception

Role Description:

1. Receive call from 2nd on-call Neurosurgical Registrar to inform “Major Incident Declared - attendance required immediately.”
2. Assume role of Surgical Commander – to direct the surgical teams in response to the incident as required.
3. To remain within Incident Command Room (theatres) and receive casualty information from Forward Liaison (2nd on-call Reg / allocated Triage Consultant).
4. To ensure surgical personnel are allocated appropriately and responsively.
5. Liaise with Theatre Co-ordinator, Lead Anaesthetic Consultant, ITU Co-ordinator, Senior Nurse, on-site bleep holder and regularly debrief with the clinical teams.
6. Ensure operations are proceeding in a timely manner and adequate support is available to all surgical teams.

Incident Declared

1. Attend Major Theatre Incident Room (Theatre Seminar Room).
2. Assume role as SURGICAL COMMANDER.
3. Conduct on site major incident planning meeting with Theatre Co-ordinator, ITU Co-ordinator and Lead Anaesthetic Consultant, Senior Nurse, on-site bleep holder in attendance.
4. Ensure you are in possession of designated wireless surgical command phone (5790) in order to receive information from Forward Liaison team (2nd on-call Reg & Consultant).
5. Contact the following people within own team immediately (see below):
    a. Clinical Director for Neurosurgery (if available, if not, any other Team Consultant).
    b. 1x team Cranial Consultant Neurosurgeon.
    c. 1x team Spinal Consultant Neurosurgeon.
6. Be prepared to receive calls from Forward Liaison (2nd on-call Reg) with expected number of casualties.
7. Allocate responsibilities and duties as follows:
    a. On arrival of first Consultant
        i. Present with action card for Consultant 1 – Discharge Consultant.
        ii. Duties to assess and identify discharges from wards.
    b. On arrival of second Consultant
        i. Present with action card for Consultant 2 – ED Forward Liaison Consultant.
        ii. Duties to attend Aintree ED as Forward Liaison Consultant.
    c. On arrival of third Consultant
        i. Present with action card for Consultant 3 – Theatre Consultant.
        ii. Ensure Consultant 3 is ready and prepared to operate on Aintree or Walton sites as required.
8. Monitor theatre activity regularly and update surgical teams on the scale of incident and expected casualties.

9. Ensure all Surgeons have adequate support particularly to make decisions regarding futility of surgery (aim to keep surgical time less than 1 hour).
10. Continually assess in conjunction with forward liaison Consultant, Theatre Co-ordinator and Lead Anaesthetic Consultant, the need for expansion in theatre availability and staffing requirements.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of incident stand down from Forward Liaison team at Aintree ED.
2. Prepare to stand your team down.
3. Join the Trust hot debrief.

ACTION CARD 011 - Consultant 1 - Discharge Consultant (on-site)

Location: Theatre Seminar Room

Role Description:

1. Assume role as Discharge Consultant.
2. To assess the discharge requirements of current inpatients in conjunction with the designated discharge team.
3. Liaising with Surgical Commander at WCFT and attend Trust Incident Control Room (Boardroom).
4. Flexibly undertake duties which may include operating on Walton or Aintree sites as instructed by Surgical Commander.

Incident declared

1. Call received from Surgical Commander (Consultant Neurosurgeon on-call) to inform "Major Incident declared – attendance required immediately."
2. Attend Theatre Incident Room (Theatre Seminar Room) and liaise with Surgical Commander.
3. Undertake ward round with Bleep holder (Bed manager in hours), Senior Nurse and SHO to identify potential discharges.
    a. Be aware of emergency discharge arrangements for current inpatients
    b. A discharge lounge will be set up
    c. An SHO will be available in the discharge lounge to ensure appropriate discharge paperwork completed.
    d. A clinical pharmacist will be allocated to the discharge lounge to ensure prescriptions are available for patients.
    e. Arrangements will be made for ANP's to conduct telephone follow up within 24-48 hours to ensure no problems have arisen.
4. Liaise with on-site bleep holder to confirm that patients assessed as fit for discharge can be transferred to discharge lounge (Main Outpatients Department).
5. Return to Theatre Seminar Room.
6. Prepare to undertake surgery at Aintree or Walton site as instructed by Surgical Commander in conjunction with theatre teams.
7. Ensure all communication is documented.
8. Attend Operational debriefing in the Boardroom.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 012 - Consultant 2 - Forward Liaison Consultant (on-site)

Location: Theatre Seminar Room

Role Description:

1. Assume role as Neurosurgical Triage Consultant.
2. Triaging major incident patients at Aintree ED.
3. Liaising with Surgical Commander at WCFT.
4. Operative duties may be necessary as instructed by Surgical Commander.

Incident declared

1. Call received from 2nd on-call Neurosurgical Registrar to inform “Major Incident has been declared – attendance required immediately.”
2. Attend Theatre Incident Room (Theatre Seminar Room) for briefing from Surgical Commander.
3. Attend Aintree Resusc in the Emergency Department, joining the Forward Liaison (2nd on-call Reg).
4. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
5. Report to ED Command and locate Neurosurgical triage station note the following will be available:
    a. Dedicated telephone (or hand held radio).
    b. Dedicated computer with PACS access.
    c. Obtain login details for Aintree PACS system, contact the Duty Consultant and request visitor log in.
6. Triage incoming casualties as required and in communication with ED Commander.
7. Instruct Forward Liaison regarding information to be relayed to Surgical Commander at WCFT – 5790.
8. Ensure all communication is documented.
9. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ED Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 013 - Consultant 3 (and additional incoming Consultants)

Location: Theatre Seminar Room

Role Description:

1. Flexibly undertake duties which may include operating on Aintree or Walton sites as instructed by Surgical Commander.
2. Liaising with Surgical Commander at WCFT.

Incident declared

1. Attend Theatre Incident Room (Theatre Seminar Room) for briefing from Surgical Commander.
2. Obtain login details for Aintree PACS system (if required).
3. Identify Theatre team in liaison with Theatre Co-ordinator.
4. Ensure preparedness of theatre to receive surgical casualties.
5. Adapt role as communicated by Surgical Commander.
6. Conduct WHO team brief with complete theatre and anaesthetic team.
7. Clarify appropriate equipment, sterile and available.
8. Ensure PACS access and imaging available.
9. Operate on emergency cases as requested by surgical commander.
10. Communicate operative progress when required by surgical commander, constantly evaluating futility of treatment.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander
2. Join the Trust hot debrief.

ACTION CARD 014 - Theatre Co-ordinator (In-Hours)

(If out of hours – Refer to Theatre Action Card 015).

Location: Operating Theatre

Role Description:

1. Co-ordinate Theatre Major Incident Plan **(See: "Theatre: Major Incident Folder" in Recovery CD Cupboard).**
2. Co-ordinate with "surgeon of the week" to cancel/ postpone elective & non-life threatening surgery.
3. Activate "Theatre Team Algorithm" if extra staffing required.
4. Facilitate the safe opening of 3 Major Incident operating Theatres.
5. Facilitate standby staff.

Incident Standby

1. Receive call from ITU Registrar **(Log time and name of person relaying message).**
2. Contact Band 7 immediately.
3. Liaise with "Surgeon of the week" & "Anaesthetist of the day."
4. Liaise with Recovery Co-ordinator, prepare for safe discharge of patients.
5. Review theatre staffing numbers so as to allow the opening of 3 Theatres **(See: "MIP Algorithm/ MIP Team Algorithm).**
6. **Do not** send for any further elective/ non-life threatening surgery.
7. Begin planning for standby/ relief staff **(See: "MIP Team Algorithm").**
8. Consider sending staff home if viable to accommodate 3 shift plan **(See: "MIP Team Algorithm").**
9. Await Major Incident declaration.

Incident declared

1. Cancel all elective/ non-life-threatening surgery.
2. Facilitate the safe discharge of patients from Recovery unit **(Liaise with Bed manager Bleep: 2009).**
3. Open 3 Theatres ASAP **(See: "MIP Algorithm: Appendix 1)**
4. Once 3 Theatres are open Liaise with Silver Command
5. Once 3 Theatres are ready prepare transfer teams **(See: "MIP Algorithm: Appendix 2)**
6. Prepare staff for initial response.
7. Activate "Standby" staff for following shifts.
8. Maintain communication and report any issues to the Tactical (Silver) Control Team regarding Theatre availability.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 015 - Theatre Co-Ordinator (Out of Hours)

(If in hours – Refer to Theatre Action Card 014).

Location: Operating Theatre

Role Description:

1. Co-ordinate Theatre Major Incident Plan **(See: "Theatre: Major Incident Folder" in Recovery CD Cupboard).**
2. Co-ordinate with "on-call surgeon/ anaesthetist" & "on-call consultant" to cancel/ postpone non-life threatening surgery.
3. If Major Incident is declared activate **"MIP Algorithm."**
4. Facilitate the safe opening of 3 Major Incident operating Theatres **(See: MIP Algorithm Appendix 1).**
5. Facilitate standby staff **(See: MIP Algorithm/ MIP Team Algorithm).**

Incident Standby

1. Receive call from ITU Registrar **(Log time and name of person relaying message).**
2. Contact Band 7 immediately.
3. Liaise with "On-Call Surgeon & Anaesthetist."
4. If a patient is already in theatre liaise with hospital bleep holder stating.

   "Patient in theatre we will require assistance initiating "MIP Algorithm" (Bleep: 2009).
5. If a patient is in Recovery liaise with Hospital Bleep Holder **(Bleep: 2009**) to facilitate safe discharge of patients ASAP.
6. Review theatre staffing numbers and plan to open of 3 Theatres **(See: "MIP Algorithm/ MIP Team Algorithm).**
7. **Do not** send for any further non-life threatening surgery.
8. Begin planning for standby/ relief staff **(See: "MIP Team Algorithm").**
9. Await Major Incident declaration.

Incident declared

1. Cancel all non-life-threatening surgery.
2. If a patient is already in theatre liaise with hospital bleep holder stating:

   "Patient in theatre we will require assistance initiating "MIP Algorithm" (Bleep: 2009)."
3. Facilitate the safe discharge of patients from Theatre/ Recovery unit **(Liaise with "Hospital Bleep Holder" Bleep: 2009).**
4. Activate **"MIP Algorithm."**
5. Open 3 Theatres ASAP **(See: "MIP Algorithm: Appendix 1).**
6. Once 3 Theatres are open Liaise with Silver Command.
7. Once 3 Theatres are ready prepare transfer teams **(See: "MIP Algorithm: Appendix 2).**
8. Prepare staff for initial response **(Continued on next page).**
9. Activate "Standby" staff for following shifts **(See: MIP Team Algorithm).**

10. Maintain communication and report any issues to the Tactical (Silver) Control Team regarding bed availability.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 016 - Duty Anaesthetic Fellow / SpR

Location: ITU

Role Description:

4. To initiate the call protocol for the Duty Consultant Anaesthetist.
5. To assist the Duty Consultant Anaesthetist in responding to the likely workload from a major incident.

Incident Standby

1. On receiving a call from the ITU SpR, collect action cards from the CD cupboard in Recovery.
2. Call the Duty Consultant Anaesthetist. If they are off site, read the contents of their card to them and **advise them to attend the hospital.**

Incident declared

1. Call in one extra fellow from the rota.
2. If current workload permits, assist theatre coordinator and duty ODP in setting up extra theatres.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ITU Consultant.
2. Join the Trust hot debrief.

ACTION CARD 017 - Duty Consultant Anaesthetist

Location: ITU

Role Description:

1. To coordinate, in conjunction with the Duty Consultant Neurosurgeon / Surgical Commander and Nurse Manager Theatres, the anaesthesia response to a major incident.
2. To liaise with Critical Care to ensure adequate resources are in place to cope with expected workload.

Incident Standby

1. On receiving a call from the duty theatre anaesthetist, attend the hospital immediately if off-site.
2. Liaise with neurosurgery and critical care to ascertain possible oncoming workload.
3. Call the Clinical Director (or acting Clinical Director) to inform them of the situation.

Incident declared

1. Call in two colleagues from the Theatre Rota.
2. Attend meeting in theatre seminar room with duty consultant neurosurgeon, duty consultant ITU, nurse coordinator theatres, ITU nurse manager/ coordinator and Bronze and Silver control if available. Ascertain workload, plan any possible discharges.
3. Liaise with duty ODP and Critical Care, and assist in setting up two stabilisation and retrieval teams to attend the MTC and retrieve patients for surgery if necessary.
   Team composition is:
   a. Team 1: Consultant anaesthetist, consultant neurosurgeon, ODP.
   b. Team 2: Consultant Intensivist, consultant neurosurgeon, ACCP/ ITU nurse.
4. Despatch first team as soon as possible to act as on-site liaison in the MTC. Use them to ascertain likely nature and extent of workload.
   As casualties arrive, allocate theatre resources in conjunction with Theatre Nurse Coordinator / Nurse Manager. Liaise with Duty ITU consultant over requirement for critical care beds.
5. As the incident progresses, liaise with Nurse Manager Theatres, Senior Management and Clinical Director to ensure that sufficient staffing and resources are available to provide ongoing higher level of service.
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgeon Commander.
2. Join the Trust hot debrief.

ACTION CARD 018 - Duty ITU Consultant

Location: ITU

Role Description:

1. To implement the escalation strategies outlined in the Major Incident Procedure to allow the unit to receive casualties in excess of normal capacity.
2. To liaise with colleagues from Neurosurgery and from the Major Trauma Centre (MTC) to provide a coordinated response to the incident.
3. To provide Mutual Support to Critical Care at Aintree Hospitals.

Incident Standby

On receiving a call from the ITU registrar or Nurse Coordinator:

3. Call the Clinical Director (or acting Clinical Director) to inform them of the situation.
4. **Attend the hospital immediately** if off site.
5. (On Arrival) Ensure that all elements of the Call Protocol have been initiated.
6. Liaise with the MTC and Aintree Critical Care to try and ascertain potential oncoming workload.

Incident declared

8. Call in **two** consultants from ITU rota. Call in more *if potential workload seems very large.*
9. Attend meeting in theatre seminar room with duty consultant neurosurgeon, duty consultant anaesthetist, nurse coordinator theatres, ITU nurse manager/ coordinator and Bronze and Silver control if available. Ascertain workload, plan any possible discharges. Decide, on the basis of information available, whether to implement **Escalation 1 or Escalation 2** plan to increase bed numbers. Update Aintree ITU on potential bed state.
10. When consultant colleagues arrive, one stays on ITU, one goes to a stabilisation & retrieval team.
11. Assist ITU Nurse Coordinator / ITU Matron with setup of extra bed spaces and commissioning of reserve equipment.
12. As patients arrive, liaise with Surgical Commander and Duty Consultant Anaesthetist over admissions to ITU.
13. As the incident progresses, liaise with ITU Matron, Senior Management and Clinical Director to ensure that sufficient staffing and resources are available to provide ongoing higher level of service.
14. Ensure all communication is documented.
15. Attend Operational debriefing.

Public enquiries

3. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

3. You will be informed of the stand down from the Major Incident by the Surgeon Commander.
4. Join the Trust hot debrief.

ACTION CARD 019 - Duty ITU SpR

Location: ITU

Role Description:

1. To coordinate the response to a Major Incident Standby or Declared call in conjunction with the ITU Nurse Coordinator pending the arrival of senior staff.
2. To oversee the start of the Call protocol which initiates the start of the Major Incident Procedure, in conjunction with the ITU Nurse Coordinator.
3. To assist in the preparation of the ITU to receive casualties.

Incident Standby

On receiving a message “Major incident Standby” from the Nurse Coordinator, obtain the action card set from the CD cupboard and proceed as follows:

1. Call the Duty Theatre Anaesthetist, inform them and advise them to follow the actions on their card.
2. Call the duty ITU consultant. Read the actions on their card to them, and **instruct them to attend the hospital immediately** if they are off site.
3. Assist the Nurse Coordinator to set up 2 extra bed spaces in SSU.
4. Make a list of any potential ward discharges and liaise with the Bleep Holder about moving these patients, if an incident is declared.

Incident declared

1. Act as directed by the Duty ITU Consultant to help prepare the unit to receive potential casualties.
2. If the consultant has not yet arrived, liaise with the 2nd-on Neurosurgeon and Duty ITU Consultant, Aintree to try and get an idea of likely incoming workload.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the ITU Consultant.
2. Join the Trust hot debrief.

ACTION CARD 020 - Neurosurgical CST (SHO)

Location: Theatre reception

Role Description:

1. Support clinical teams as directed by Surgical Commander.
2. To assess the discharge requirements of current inpatients in conjunction with the designated discharge team.
3. Liaise with Discharge Consultant and/or Surgical Commander at WCFT to update as required.

Incident declared

1. Attend theatre incident room and receive instructions from Surgical Commander and/or Discharge Consultant
2. Undertake ward round with Discharge Consultant, Bleepholder and Senior Nurse, Neurosurgical Registrar to identify potential discharges.
    a. Be aware of emergency discharge arrangements for current inpatients
    b. Assist in the set-up of a temporary discharge lounge (Main Outpatients Department).
    c. A clinical pharmacist will be allocated to the discharge lounge to ensure prescriptions are available for patients
    d. Arrangements will be made for ANP's to conduct telephone follow up within 24-48 hours to ensure no problems have arisen.
3. Liaise with on-site bleep holder to confirm that patients assessed as fit for discharge can be transferred to discharge lounge (Main Outpatients Department).
4. On completion of ward round be available in discharge lounge to ensure appropriate discharge paperwork is completed.
5. Communicate effectively and reassure patients of discharge plan and follow up arrangements.
6. Report back to Discharge Consultant as necessary
7. Ensure all communication is documented.
8. Attend Operational debriefing in major incident control room (theatres seminar).

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander.
2. Join the Trust hot debrief.

ACTION CARD 021 - Consultant Neurologist (Neurologist of the Week)

(Onsite Monday 09:00 - 19:00 - If out of hours – contact via Aintree Switchboard).

Location: **Own base & Wards**

Role Description:

1. To assist the bed management team in maximising the number of available beds for incoming casualties.
2. To support the front line Surgical, Anaesthetic and Critical Care responses to an incident by coordinating available medical staff resources from Neurology.

Incident Standby

1. On receiving a call from Switchboard via the Bleep holder or Bed Manager.
2. Depending on the local situation call the Clinical Director (or acting Clinical Director) to inform them of the situation.
3. Attend the hospital immediately if off site.

Incident declared

1. Make yourself known to the Surgical Commander (Duty Consultant Neurosurgeon), who will be in the Theatre Suite.
2. Discuss the likely need for beds, then conduct a “Board round” of the neurology patients with the duty neurology registrar and identify any patients who can be reviewed and potentially discharged.
3. As the incident progresses, liaise with Neurosurgery and Critical Care over the need to provide extra medical staff support from Neurology for ward duties in Neurosurgery or Critical Care.
4. Ensure all communication is documented.
5. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Surgical Commander or Neurology Clinical Director.
2. Join the Trust hot debrief.

ACTION CARD 022 - Bed Manager - In hours

(If out of hours - Bleep Holder #2009).

Location: **Chavasse Ward**

Role Description:

1. Provide up to date bed capacity information to the **Tactical Commander** - this role will be fulfilled by the Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.
2. Have an oversight of patient flow in regard to delayed discharge or potential discharge.
3. Ensure adequate bed management cover is available to continue with the Trust's return to normal function.
4. Co-ordinate the organisations resources onsite by gathering as much information as possible related to:
   - ITU capacity - discharges to ward
   - staffing
   - potential discharges of all patients within ward area
   - liaise with ITU Co-ordinator regarding Critical Care beds/network capacity

Incident Standby

1. Inform Tactical Commander of potential situation.
2. Prepare current bed state to inform Tactical Commander.
3. Assess current staffing levels and potential requirements for the initial 24 hours.
4. Co-ordinate support from the Matrons, Discharge Co-ordinator and Rehab team to consider which patients may be suitable for immediate transfer to maximise bed capacity.
5. Await further instructions from ITU co-ordinator regarding incident stand-down / declared.

Incident declared

1. Inform Tactical Commander "Major Incident declared."
2. Attend Boardroom and receive full briefing of incident.
3. Undertake ward round with Discharge Consultant(s), Matrons, Discharge co-ordinator and Neurosurgical SHO, Bed Management Administrator.
4. Ensure B6 Bed Management staff are available to assist with patient flow across all wards.
5. Identify numbers of potential discharges and inform Tactical Commander.
6. Maintain communication and report any issues to the Tactical Commander regarding bed availability/flow.
7. Ensure all communication is clear for the logging Administrator.

Support ***for information only***

1. A discharge lounge will be set up in Main outpatients.
2. An SHO will be available in the Discharge lounge to ensure appropriate discharge paperwork is completed.

3. A clinical Pharmacist will be available in the Discharge Lounge to ensure prescriptions are available to patients.
4. Arrangements will be made for ANP's to conduct a telephone follow-up with 48 hours to advise further.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the Silver Commander.
2. Join the Trust hot debrief in the Boardroom.

ACTION CARD 023 - Matron (out of hours)

(This person may not be on call - but may be contacted in the event of a Major incident).

Location: **Boardroom or the Theatre Seminar Room**

Role Description:

1. To support the Senior Manager / Executive On Call, until a Tactical Commander is appointed by the Executive On Call (Strategic Commander).
    a. NB the Tactical Commander will be one of the following roles; Divisional Director, Divisional General Manager or Deputy Director of Nursing/Lead Nurse.
2. To support the Trust's Tactical incident response.
3. Support the Surgical Command Teams.

Incident Standby

1. To be contacted by the Bleep Holder.
2. If appropriate proceed to the Hospital immediately and report to the Boardroom or Theatre Seminar Room.
3. In conjunction with the Surgical Commander, ITU Lead Nurse, Theatre Co-ordinator and Bleep Holder decide what action is required to prepare the hospital.

Incident declared

1. Report to Boardroom/Theatre Seminar Room.
2. Assume role as Senior Nurse within the discharge team, which consists of the following:
    a. Discharge Consultant (Surgeon)
    b. Consultant Neurologist
    c. Bleep holder.
    d. Neurosurgical Registrar
    e. SHO
3. Instruct Ward Managers (if in hours) to identify number of visitors and their locations.
4. With assistance from Bleep Holder, ensure staffing has been identified, appropriate to the incident and its likely longevity.
5. Maintain contact with Tactical Commander and report any issues or requirements.
6. Support Ward Managers/Nursing teams.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident via the Tactical Commander.
2. Ensure all relevant staff attend operational debriefing.
3. Join the Trust hot debrief.

ACTION CARD 024 - Outpatients Manager

In and Out of Hours

Location: **Outpatients Department in the Walton Centre main building**

Role Description:

1. To facilitate the rapid discharge of the Outpatient Department in order to receive discharges from the wards.
2. Ensure that follow up arrangements are made for patients in conjunction with the Neurosurgical SHO and Clinical Pharmacist.

Incident Standby

1. Alert all staff in Outpatients Department.
2. Undertake an assessment of current patients/visitors within the department.

Incident declared

Out of Hours

1. Report to Outpatients Department in the Main Building for further instructions.

In working hours

1. Alert all staff in Outpatients department.
2. Inform current patients/visitors that Trust has invoked its Major Incident Plan.
3. Commence clearing the department and provide follow up appointment advice.
4. Prepare all relevant areas/suites to receive discharges from wards.
5. Ensure whole area is prepared.
6. Allocate staff to appropriate tasks and duties as instructed by the Neurosurgical SHO and Clinical Pharmacist.
7. Reception staff to ensure all inpatient discharges are provided with standardised letter (see appendix), and this information is returned to the appropriate Divisional Management Team for follow arrangements.
8. Inform the Matron of any transport requirements for existing outpatients who arrived by Patient transport Services (PTS).
9. Report any issues and maintain communication with the Matron.
10. Ensure all communication is documented.
11. Attend Operational debriefing as instructed.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Matron.
2. Join the Trust hot debrief.

ACTION CARD 025 - Radiology Manager (Out of hours – refer to Action Card 26).

(Or in their absence MR Superintendent radiographer/ Principal Radiographer receiving the call in-hours).

Location: RADIOLOGY

Role Description:

1. Co-ordinate Radiology Major Incident plan.
2. Co-ordinate with “Radiologist of the day”/ Principal radiographers to cancel/ postpone elective & non-urgent Imaging.

Incident Standby

1. Receive call from ITU Registrar (Log time and name of person relaying message).
2. Contact Principal radiographers.
3. Liaise with “Radiologist of the day.”
4. Liaise with PAC Diagnostic, to cancel elective outpatients.
5. Review rota, allocate staff according to outpatient lists.
6. **Do not** send for any further elective patients.
7. Begin planning for standby/ relief staff (contact staff on shift days off and part time staff as required).

Incident declared

1. Cancel all elective / outpatient imaging.
2. Facilitate the cancellation of outpatients from Radiology.
3. Prepare staff for initial response.
4. Activate “Standby” staff for following shifts.
5. Maintain communication and report any issues to the Tactical (Silver) Control Team
6. Ensure all communication is documented.
7. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the (Tactical) Silver Commander.
2. Join the Trust hot debrief.

ACTION CARD 026 - Radiographer On Call (Out of Hours)

Location: Radiology Department

Role Description:

1. Receive Major incident message and initiate the Radiology Department response.
2. Co-ordinate Radiology Incident response with Radiologist On-Call and Radiology Manager/ MR Superintendent Radiographer.
3. Radiology Manager / MR Superintendent Radiographer will activate “Radiology Call Cascade” if extra staffing required.
4. Switch on all imaging equipment.

Incident Standby/Declared

1. Call to activate a Major Incident will come to Radiographer on-call.
2. Ask how many patients expected and approximate timescale.
3. Radiographer On Call phones:
    a. Radiologist On Call.
    b. Radiology Manager or if not available phone MR Superintendent and confirm that they are **FIRST** call).
4. Radiographer On-call heads for hospital and switches on ALL equipment.
5. Radiology Manager (or MR Superintendent) will start call cascade.
6. Principals will be advised to start their cascade depending on incident type and number of casualties expected.
7. If you are not called through the night, please attend for your normal shift.
8. Remember to bring your hospital pass with you (depending on incident type you may need it to get through police cordons).
9. On arrival Radiology Manager or Principal Radiographer will allocate work areas (2 Radiographers per area). Anyone arriving after staffing is allocated will be asked to wait in the tearoom. This means that if the incident goes on over several hours we can rotate and have some rest breaks.
10. Activate “Standby” staff for following shifts.
11. Maintain communication and report any issues to the Tactical (Silver) Control Team.
12. Ensure all communication is documented.
13. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the Stand down from the Major Incident by the Hospital Control Team either directly or via the Silver Commander.
2. Join the Trust hot debrief.

ACTION CARD 027 - IT

(If out of hours contact 0151 556 3017).

Location: **IT Department/Wards**

Role Description:

1. 1st line support to staff (Accounts / Passwords / Software issues).
2. 2nd line support of IT Equipment (Desktops / Laptops / Printers / iPads).
3. 3rd line support of IT Infrastructure (Servers / Networks).
4. 2nd & 3rd line support of Telephony (Mitel VOIP System).

Incident Standby

1. Call the IT Service desk (24hr) on 0151 556 3017.

Incident declared

1. Report to the incident Control Room in the Boardroom for further instructions.
2. Provide technical support to Tactical Commander.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 028 - Head of Facilities (In and Out of hours).

Location: Facilities Office

Role Description:

1. Provide service support to the Major Incident Response.
2. Working with the Tactical Commander and Strategic Commander to provide Facilities support to the Hospital.

Incident Standby

1. Support the Tactical Commander to estimate potential number of patients.
2. Work with the ISS General Manager to establish rotas call in of staff.
3. Review current holdings of stock, catering supplies etc.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area - Outpatients.
2. Obtain briefing from Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Liaise with:
    a. Bed Manager - identify estimated number of patients
    b. Estates Manager
    c. ISS General Manager
    d. ISS Logistic Manager for:
        i. Security
        ii. Portering
        iii. Laundry
        iv. Car parking
    e. ISS Domestic Manager for:
        i. Catering
        ii. Cleaning
    f. Head of Procurement/Team.
    g. Key contacts within AUH Facilities
    h. Mortuary and Funeral Directors
5. Site Security liaise with the:
    a. LSMS/ISS Logistics Manager in relation to Lock Down.
    b. Police regarding traffic control on the approach routes to the hospital. Inform the Hospital Major Incident (Silver) Control Team of any decisions made.
6. Ensure rooms are opened/closed as applicable.
7. Provide rooms for briefings as requested.
8. Have access to the Trusts Credit card for emergency purchases

9. Work collaboratively with other members of the Incident Control Team.
10. Ensure all communication is documented.
11. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 029 - ISS General Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Provide ISS Managerial support to the Head of Facilities/Tactical Commander.
2. Co-ordination of the provision of the ISS response.

Incident Standby

1. Work with the Head of Facilities to estimate potential number of patients, incident duration, staffing and resource requirements.
2. Brief the ISS Logistics Manager and ISS Domestic Services Manager on the incident intent. Establish incident roster and prepare to evoke staff call in arrangements.
3. Brief ISS Divisional Director on incident intent.
4. Review food and non-food stock holdings and liaise with suppliers.
5. Provide incident continuity plan to sustain the response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from Head of Facilities or Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Establish the following ISS managerial posts and brief each on their responsibilities:
    a. ISS Logistic Manager for:
        i. Security and Security Reception.
        ii. Portering.
        iii. Laundry - including off site linen at Ormskirk.
        iv. Medical gas supply.
        v. Car parking and external cordons.
    b. ISS Domestic Manager for:
        i. Catering – Patient Catering. Courtyard Bistro restaurant, briefing/holding rooms catering as required.
        ii. Cleaning – Wards and public areas. Improvised treatment areas as required.
5. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
6. Implement shift rosters for efficient utilisation of staff labour.
7. Liaise with:
    a. The ISS Divisional Director.
    b. Key suppliers/agency.
8. Report any difficulty in maintaining services in any areas to the Head of Facilities.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 030 - ISS Logistics Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Support the Head of Facilities/ISS General Manager.
2. Co-ordination of the ISS Logistics incident response.

Incident Standby

1. Work with the ISS General Manager to estimate potential number of patients and additional staffing and resource requirements.
2. Establish logistics staff roster and prepare to evoke staff call in arrangements.
3. Review current logistics stock holdings.
4. Provide a logistics continuity plan to sustain the service response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from Head of Facilities or Tactical Commander (Silver).
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Ensure that the following posts are filled and that they are aware of their tasks:
    a. Security and Security Reception.
    b. Portering.
    c. Laundry - including off site linen at Ormskirk.
    d. Medical gas supply.
    e. Car parking and cordon control.
5. If not, appoint suitably senior members of staff as necessary until key personnel arrive.
6. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
7. Ensure that shift systems are instituted as soon as possible to enable staff to get maximum rest.
8. Report any difficulty in maintaining services in any areas to the ISS General Manager/Head of Facilities.
9. Ensure all communication is documented.
10. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 031 - ISS Security Supervisor/Officer (In and Out of hours).

Location: Security Reception

Role Description:

1. Support the ISS Logistics Manager/ISS General Manager.
2. Co-ordination of the Security response.

Incident Standby

1. Work with the Head of Facilities/Incident Commander to estimate security response and additional security and service staff call in.
2. Work with the ISS Logistics Manager/ ISS General Manager to establish rotas and call in arrangements for staff.
3. Prepare reception to accept incident response.
4. Prepare to setup and maintain car parking and cordon areas
5. Locate and check Major Incident equipment box and check communication radios.

Incident declared

1. Alert ISS Logistic Manager/ISS General Manager of the Major Incident activation.
2. Ensure high visibility ISS Security vest are worn by all staff at all times
3. Evoke 'lock-down' of The Walton Centre Main Building and Sid Watkins Building and ensure
4. Evoke incident immediate staff call-in.
5. Deploy radios and relevant keys to Outpatients and meet Bleep Holder.
6. If Out of Hours, open the staff rear entrance and Link Bridge.
7. Cordon and secure car parking for arriving emergency vehicles.
8. Assess traffic problems within the hospital and take any necessary action.
9. Liaise with the Police regarding traffic control on the approach routes to the hospital.
10. Assess the parking situation within the hospital and in the visitors' car park, and take any necessary action.
11. Ensure all communication is documented.
12. Attend Operational debriefing.

Guards

1. Ensure full uniform with jacket is worn at all times.
2. Assume traffic duty at main road entrance.
3. Admit only essential staff with Identity Badges (in the event staff cannot be verified escalate to Logistics Manager).
4. Advise security control of parking availability.
5. Advise On-Call staff on arrival of parking availability.
6. Staff arriving without identification badges must not be allowed access.
7. Keep Radio traffic to a minimum.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 032 - ISS Domestic Services Manager (In and Out of hours).

Location: ISS Service Corridor

Role Description:

1. Provide ISS Managerial support to the ISS General Manager/Head of Facilities.
2. Co-ordinate the ISS Catering and domestic cleaning response.

Incident Standby

1. Work with the ISS General Manager to estimate potential number of patients and additional staffing and resource requirements.
2. Establish catering staff roster and prepare to evoke staff call in arrangements.
3. Review current catering and non-food stock holdings and liaise with suppliers to sustain catering throughout.
4. Provide a catering and cleaning continuity plan to support the response.

Incident declared

1. On receipt of the Major Incident declared report to the Major Incident Control Room (Boardroom). If Out of Hours, report to the Staff Reporting Area – Outpatients.
2. Obtain briefing from the ISS General Manager or Head of Facilities.
3. Ensure all information/decisions/actions taken are recorded in the incident log book.
4. Ensure that the following posts are filled and that they are aware of their tasks:
    a. Housekeepers/cleaning staff.
    b. Catering.
5. If not, appoint suitably senior members of staff as necessary until key personnel arrive.
6. Advise key personnel on necessary staffing levels and likely duration of the response once this becomes clear.
7. Ensure that shift systems are instituted as soon as possible to enable staff to get maximum rest.

Cleaning (Supervisor)

1. Obtain briefing from ISS Domestic Manager/ISS General Manager following Incident activation on catering requirements.
2. Evoke staff call in.
3. Prepare incident period catering rosters.
4. Check stock holding and plan contingency feeding for the advised period.
5. Liaise with suppliers for food non-food resources
6. Coordinate the service of meals for patients and staff and adhoc requirements for briefing holding rooms.
7. Attend operational briefings with ISS Domestic Services Manager.

Catering

1. Assess the likely initial catering requirements and the current capabilities.

2. Liaise with the Senior Nurse/Manager regarding any immediate catering requirements.
3. Liaise with the Volunteer Co-ordinator regarding the use of Volunteers to assist in the Catering department.
4. If necessary institute a shift system to provide 24 hour staffing at the required level.
5. Prepare drinks and snacks for the following areas:
    a. Discharge area.
    b. Outpatients.
    c. Briefing/holding rooms as required
6. Catering requirements of staff involved in the Major Incident Response e.g. consider open catering if required.
7. Catering requirements as dictated by the Head of Facilities/ISS General Manager.
8. Maintenance of the catering for non-major Incident patients.
9. Ensure all communication is documented.
10. Attend Operational debriefing from ISS General Manager.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Head of Facilities or the ISS General Manager.
2. Join the Trust hot debrief.

ACTION CARD 033 - Records Manager

Location: **Records Department**

Role Description:

1. To provide case notes for incoming major incident patients.
2. To support wards and departments.

Incident Standby

1. Report to the incident Control Room in the Boardroom for further instructions

Incident declared

1. Alert all staff to Major Incident.
2. Work with divisions to support the evacuation of the whole of the OPD.
3. Allocate staff from medical records to support Wards.
4. Assist with re location of existing in patients and relatives from Wards to the Outpatients department.
5. Ensure that all Clinic lists are taken to major incident room.
6. Work with PAC/division to cancel clinics if appropriate either via telephone or posting out cancellation letters.
7. Allocate appropriate staff to all other tasks and duties working with division.
8. Work with ward clerks and IT to initiate colour coding system on PAS to identify major incident patients if deemed necessary.
9. In the event of system outage, emergency packs located in Medical Records office (above TCI shelf) would be used.
10. Report any issues to Tactical Commander.
11. Ensure all communication is documented.
12. Attend Operational debriefing.
13. Ensure all case notes are returned to the Health Records department.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 034 - Pharmacy

Job Title: **Pharmacist - out of hours**

Location: **Pharmacy Office or within Aintree Pharmacy**

NOTE:

Pharmacy services are provided to the Walton Centre by a Service Level Agreement by Aintree University Hospital (AUH). If a mass casualty incident occurs, it is likely that there will be pharmacy needs for both Hospitals (Pharmacy have a bespoke Major Civilian Disaster Procedure).

The Tactical Commander/Surgical Commander will liaise with Aintree's incident Control Room to discuss the immediate requirements until sufficient numbers of pharmacy staff can be deployed.

Role Description:

1. To support discharge rounds with Consultant Neurosurgeon or Neurologist.
2. To prepare TTOs for discharge patients.

Incident Standby

1. If the incident affects Aintree, Pharmacy will already have been alerted via AUH major incident pathways.
2. If not, bleep the on call pharmacist via Aintree switchboard.
3. Liaise with the on call or senior pharmacist regarding the Walton Centre's needs, this may include extra stocks, dispensing of discharge prescription or clinical advice

Incident declared

1. The senior pharmacist on duty will determine what services can be offered or personnel made available depending on the local situation and staffing available.
2. Pharmacist to attend the Theatre Seminar Room and assist the Discharge Consultant and team.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 035 - Local Security Management Specialist

Role Description:

1. To provide advice to the Tactical and Strategic Commanders in relation to security management and lock down arrangements.

Incident Standby

1. Report to the incident Control Room in the Boardroom for further instructions.

Incident declared

1. To provide competent security management advice to:
    a. Incident commanders;
    b. Head of Facilities;
    c. ISS General Manager.
2. Liaise with Aintree Hospital LSMS in the event of a major trauma incident or site incident e.g. bomb threat etc.
3. In the event of a Lock Down, the LSMS has devised a Lockdown Procedure based on locking down key areas e.g. Main entrances or individual specific e.g. departmental access & egress. See **ACTION CARDS 036 and 037 below**.

1. Liaise with Police, Counter Terrorism Support Agency (CTSA) or Explosive Ordnance Disposal (Army Bomb Disposal).
2. Report any issues to Tactical Commander.
3. Ensure all communication is documented.
4. Attend Operational debriefing.

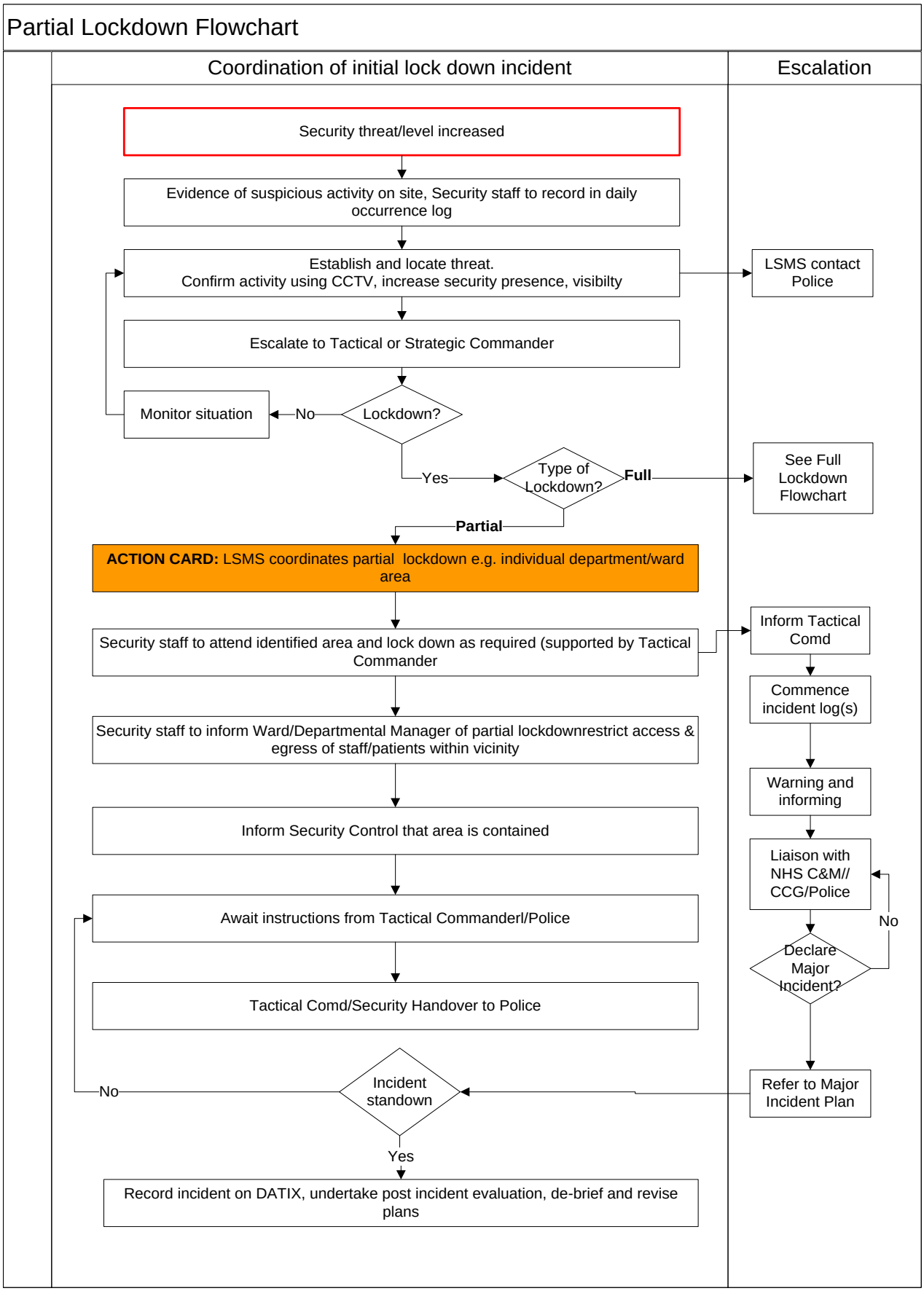
Public enquiries

1. All enquiries by the Press should be directed to the Communications Manager (based in the Incident Control Room).

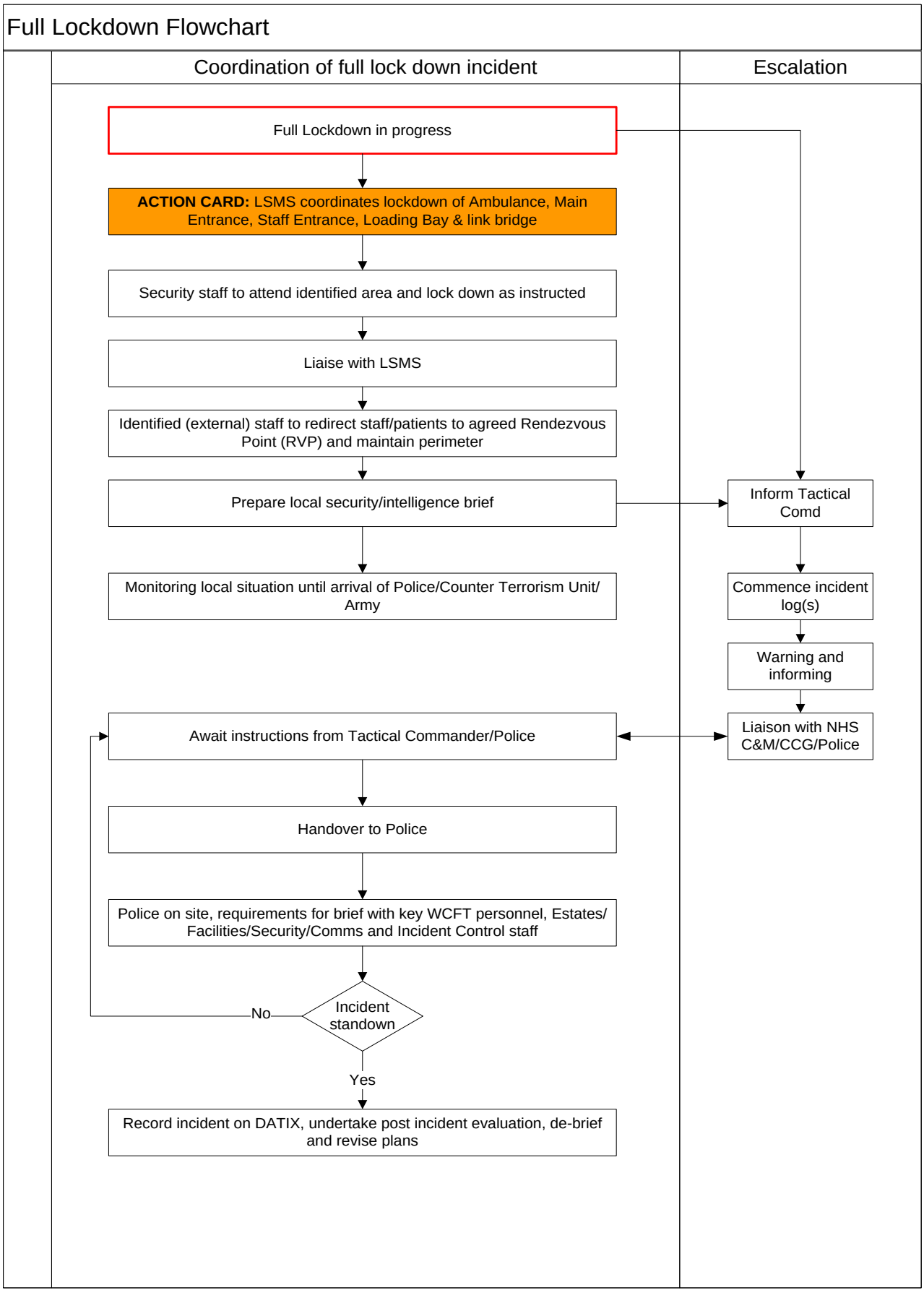
Incident stand down

1. You will be informed of the stand down from the Major Incident by the Tactical Commander.
2. Join the Trust hot debrief.

ACTION CARD 036 - Lockdown procedure (partial)



ACTION CARD 037 - Lockdown procedure (Full)



ACTION CARD 038 - List of Red Phones (Resilient Network)

Walton Centre Main Building:

All phones are standard analogue.

Sid Watkins Building (SWB):

All phones in the SWB are MITEL VOIP.

The following phone numbers in the table below are analogue emergency phones. All numbers have the prefix 529

No:		Ext no:	Department:	Site:	Floor:	Notes:
1	4245	5385	Boardroom	W	2	Diverted to Outcomes Office
2		4245	Executive Offices	W	2	No dial tone
3		8292	Main Reception	W	G	No phone in place
4		6236	Main Reception SWB	SWB	G	
5		8261	Cairns	W	1	
6		8321	Caton	W	1	
7		8262	Chavasse (Left)	W	1	
8		4241	Chavasse (Right)	W	1	
9		6207	CRU Nurse station (Green)	SWB	G	
10		6208	CRU Nurse station (Purple)	SWB	G	
11		5380	Dott	W	1	No phone in place
12		5946	Estates Plantroom	W	3	
13		5010	IT Copy Room	SWB	2	Requires labelling
14		4455	ITU Nurse base	W	G	
15		8301	ITU Modular	W	1	
17		5382	Jefferson	W	G	Requires labelling
19		5381	Lipton	W	1	
20		5236	Mersey Care Nurse Base	SWB	1	
21	8276	8274	N/Physiology	W	1	
22	5404	8293	OPD Main	W	G	
23		6259	OPD SWB	SWB	G	
24		6352	PMP Meeting Room	SWB	1	No ringer
25		5383	Radiology MR	W	G	
26		5538	Radiology Reception	W	G	
27		5941	Radiology Room 2			
28		6236	Reception Desk	SWB	G	
30		6257	Security Office	SWB	G	
31		5388	Secretaries Kitchen	W	2	
32		8276	Sherrington	W	1	
33		8268	Sutcliffe Kerr	W	2	
34		6383	T&D Copy Room	SWB	2	Requires labelling
35		6407	T&D Lecture Theatre	SWB	2	No ringer/requires labelling
36		8295	Theatre reception	W	G	Not working, needs labelling

SECTION 2 - MAJOR INCIDENT PLAN

1. Introduction

The Walton Centre is unique to the NHS in that it is the only specialist Neurosciences Trust in the UK. The catchment population is over 3.5 million and is drawn from Merseyside Cheshire, part of Lancashire and Greater Manchester, the Isle of Man and North Wales. The Trust treats patients with trauma, spinal tumours, spontaneous intracranial haemorrhage, epilepsy, multiple sclerosis, brain tumours, Parkinson's disease, stroke, cancer, chronic pain and other neurological diseases.

This Major Incident Plan (MIP) has been established to provide an incident response structure, underpinned with documented procedures, supported by management with the authority and necessary competence to manage a disruptive event such as a major emergency, regardless of its cause.

The Walton Centre NHS Foundation Trust (WCFT) is classed as a **Category 1 Responder** under the Civil Contingencies Act 2004 (CCA) and has a duty to produce and review its emergency and business continuity plans in the light of emerging local, regional and national guidance.

This plan has been developed within a context of achieving multi-agency working across Merseyside which includes emergency services, NHS services, local authority departments and voluntary organisations.

The NHS service-wide objective for Emergency Preparedness, Resilience and Response (EPRR) is to ensure that the NHS is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the victims, and minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.

1.1. Core standards

1.1.1 The minimum core standards, which NHS organisations and providers of NHS funded care must meet, are set out in the NHS England Core Standards for EPRR. These standards are in accordance with the Civil Contingencies Act 2004, the Health and Social Care Act 2012, the NHS England planning framework ('Everyone Counts: Planning for Patients') and the NHS standard contract.

1.1.2 NHS organisations and providers of NHS funded care must:

- nominate an accountable emergency officer who will be responsible for EPRR;
- contribute to area planning for EPRR through local health resilience partnerships;
- contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents
- reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys, they must be made through the organisations' formal reporting structures;
- have suitable, up to date incident response plans which set out how they plan for, respond to and recover from significant incidents and emergencies, the plans should fulfil the testing schedule as detailed in the CCA 2004;
- have suitably trained, competent staff and the right facilities (incident coordination centres) available round the clock to effectively manage a major incident or emergency;

- share their resources as required to respond to a major incident or emergency

1.2. Business Continuity

1.2.1 The CCA 2004 places a statutory duty on organisations to develop a comprehensive approach to business continuity.

1.2.2 The aim of business continuity planning is to enable planning and reaction in a coordinated manner to ensure that services can be maintained at the highest level for as long as possible whatever might happen to the infrastructure. There is a range of problems that might affect services, for example loss of water or power, flooding or criminal activity. A business continuity event is any incident requiring the implementation of special arrangements to maintain or restore services.

1.2.3 It is the role of the Chief Executive, or nominated deputy, to ensure business continuity is maintained wherever possible during a declared major incident, and to return to normal working as soon as possible after the event. This will form part of the collective tasks of the Major Incident Team. Business continuity planning enhances the Trust's ability to withstand the effects of potential widespread disruption as a result of an unpredictable event(s).

1.3. Purpose

This policy is part of a suite of emergency plans which provide a framework to enable effective and co-ordinated planning and response to any incident *up to and including* a Major or Catastrophic Incident as defined by the Civil Contingencies Act 2004 and follows the NHS Emergency Planning Resilience & Response Framework 2013 and other relevant guidance (see bibliography). All Major Incident planning is carried out in consultation, coordination and cooperation with partner agencies such as:

- Other hospital trusts
- ISS, Health Informatics Systems, Contractors and suppliers, e.g. Synergy
- The NHS England Merseyside Area Team
- Cheshire & Merseyside Commissioning Support Unit
- Public Health England Cheshire & Merseyside Team
- NHS North of England
- Department of Health (DH)
- North West Ambulance Service (NWAS)
- Liverpool & Sefton Clinical Commissioning Group
- other Merseyside community health providers
- other acute hospitals,
- Mersey Care NHS Trust & local Specialist Trusts
- Merseyside Police
- Merseyside Fire & Rescue Service (MFRS)
- Voluntary agencies under the **UNITY Protocol**
- Utilities companies (United Utilities, Scottish Power, National Grid Gas)

2. Scope

This plan covers incidents up to and including the following three categories of Major Incident:

- a Major, Mass or Catastrophic Incident which affects the local community (i.e. within the footprint of the Trust which as a Tertiary Centre Hospital provides services across Merseyside, parts of Cheshire, West Lancashire, North Wales and the Isle of Man)
- a Major Incident which affects the health services in Merseyside
- a Major Incident which threatens the continuity of critical Trust services and requires the invocation of the Trust Business Continuity Plans and other Contractors'

Business Continuity plans (ISS, Informatics, local NHS providers and NHS Supplies, etc.

This plan should be read in conjunction with Departmental/ Ward Business Continuity Plans which cover the risk assessment process, identification of critical functions, alerting arrangements, activation of staff and resources and incident management of an internal Major Incident.

3. Definitions

3.1. Emergency - The Civil Contingencies Act 2004 defines an emergency as - 'An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, all war or terrorism which threatens serious damage to the security of the UK.' For the NHS, *'major incident'* is the term commonly used. With the implementation of the Civil Contingencies Act, the term 'emergency' may be used by other organisations instead of 'incident'. However, the NHS continues to use the term 'major incident' to avoid confusion with other elements of the services provided.

3.2. Major Incident - NHS definition is 'Any occurrence, which presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or Clinical Commissioning Groups (CCG).'

3.3. Major Incident standard messages - the four categorisations will be used for all major or potential major incidents whether multi-agency or internal within the Trust are:

- **Major incident - standby -** This alerts the NHS that a major incident may need to be declared. Major incident standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang' or 'rising tide'.
- **Major incident declared -** activate plan - this alerts the NHS of the need to activate its plans and mobilise additional resources
- **Major Incident cancelled -** this message cancels either of the first two messages at any time.
- **Major Incident Stand Down -** all receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route.

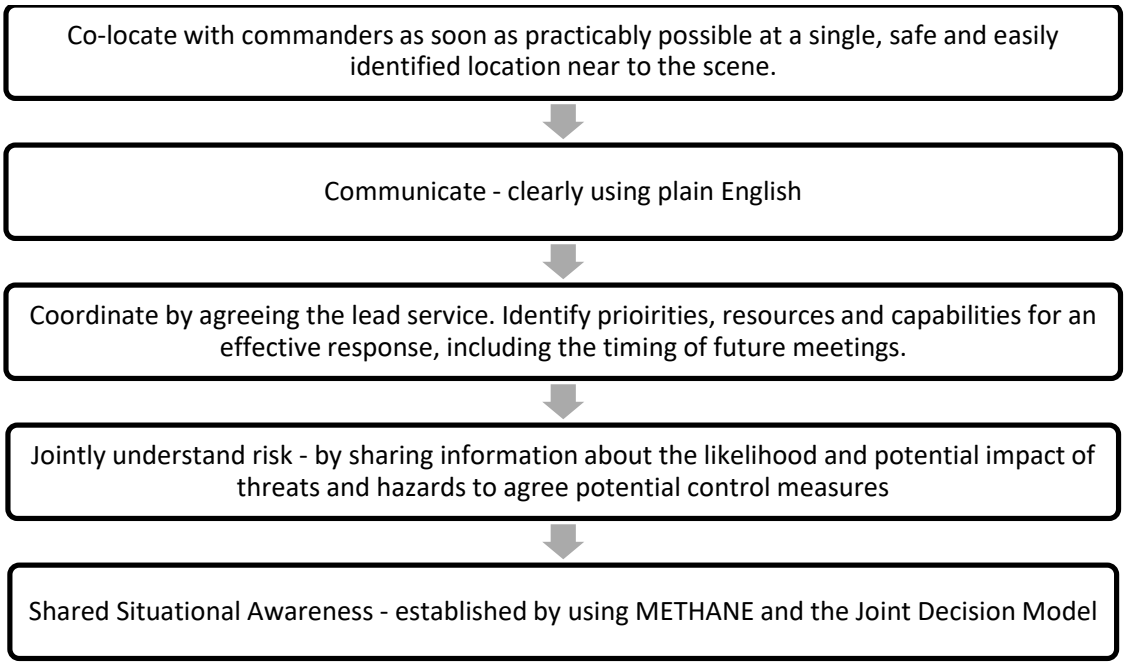
3.3.1 While ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each NHS organisation to assess their own organisation's appropriateness to stand down.

3.4. The Joint Emergency Services Interoperability Programme (JESIP)

3.4.1 JESIP was established in 2012 to address the recommendations and findings from a number of major incident reports.

3.4.2 Principles for joint working. Commanders arriving at the scene take too long or don't make contact with commanders from the others services. This leads to poor information sharing, lack of communication and no joint understanding of the unfolding emergency

3.4.3 The Five Principles of JESIP are:



3.4.4 If the principles are followed then the result should be a jointly agreed working strategy where all parties understand what is going to happen when and by who, this strategy should include:

- What are the aims and objectives to be achieved?
- Who by – police, fire, ambulance and partner organisations?
- When – timescales, deadlines and milestones
- Where – what locations?
- Why – what is the rationale? Is this consistent with the overall strategic aims and objectives?
- How are these tasks going to be achieved?
- For the Joint Decision Model see http://www.jesip.org.uk/joint-decision-model

3.5. The Scale of a Major Incident in the NHS

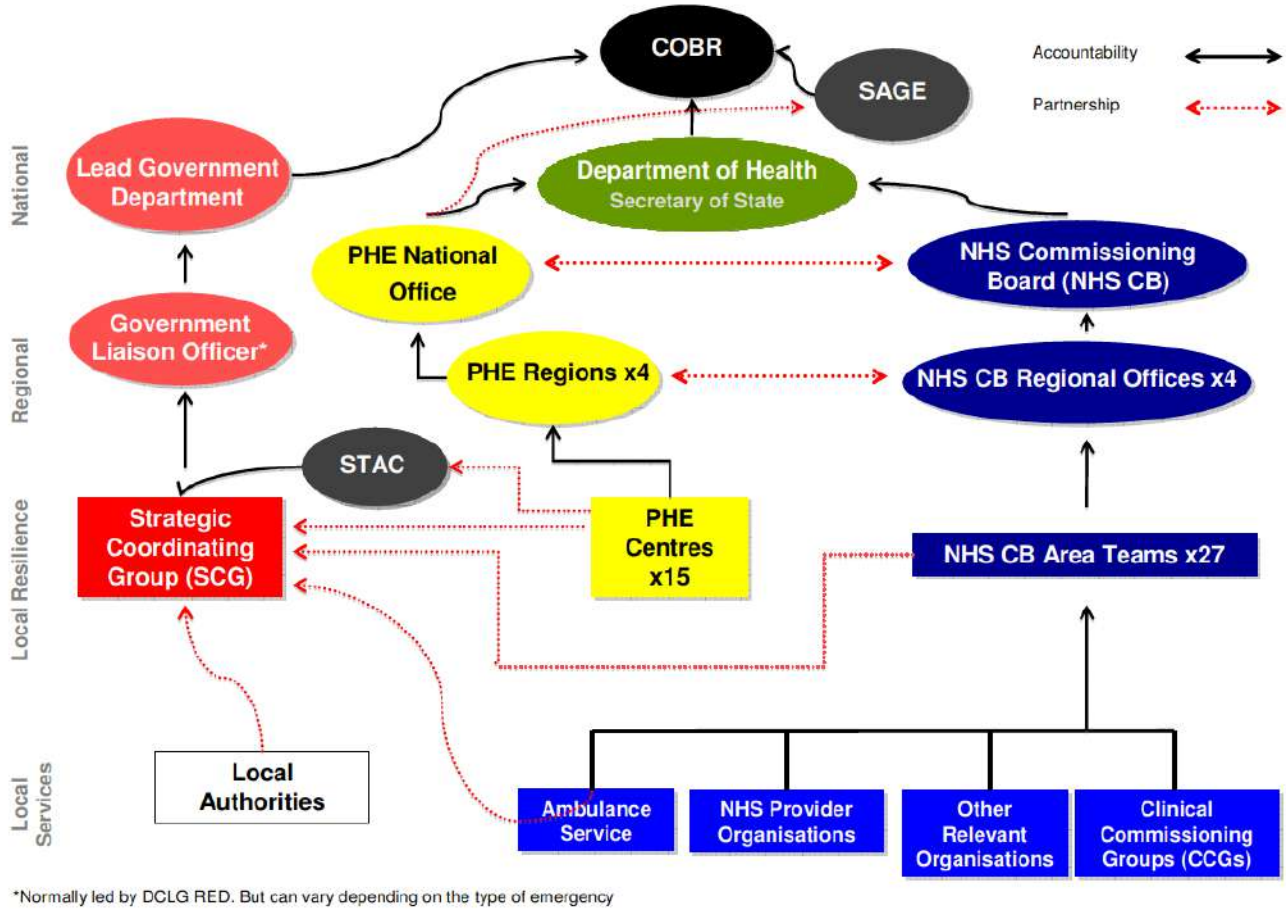
NHS organisations are accustomed to normal fluctuations in daily demand for services. Whist at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of established management procedures and escalation policies. The levels of incident for which NHS organisations are required to develop emergency preparedness arrangements are:

- **Major** – individual ambulance trusts and acute trusts are well versed in handling incidents such as multi-vehicle motorway crashes within the long established major incident plans. More patients will be dealt with, probably faster and with fewer resources than usual but it is possible to maintain the usual levels of service.
- **Mass** – much larger-scale events affecting potentially hundreds rather than tens of people, possibly also involving the closure or evacuation of a major facility (for example, because of fire or contamination) or persistent disruption over many days. These will require a collective response by several or many neighbouring trusts.
- **Catastrophic** – events of potentially catastrophic proportions that severely disrupt health and social care and other functions (for example, mass casualties, power, water, etc) and that exceed even collective local capability within the NHS.

In addition, there are pre-planned major events that require planning for. Although not formally described, there may be events occurring on a national scale, for example fuel

strikes, pandemic or multiple events that require the collective capability of the NHS nationally.

3.6. Overview of National Emergency Structure



3.7. MERM - Merseyside Emergency Response Manual

3.7.1 The aim of this Merseyside Resilience Forum (MRF) Manual is to set out the response arrangements of agencies who are Category 1 and 2 Responders, as defined in the Civil Contingencies Act 2004 (CCA), to an emergency or other incident that requires multi-agency co-ordination at any one or any combination of Operational, Tactical and Strategic levels.

4. Duties

4.1. The Trust

The Trust is a specialist Neurosciences Trust and has a specific role as a partner within the Merseyside Trauma Network to:

- fulfil the requirements as ***a Category 1 Responder*** under the Civil Contingencies Act
- implement national policy and guidance in the local context
- ensure that the Trust's own escalation plans for dealing with pressures recognises the higher-level requirements of a Major Incident including suspension of non-emergency work
- demonstrate a high level of preparedness and plan in conjunction with local NHS partners, local partners in the independent healthcare and staffing sector and external multi-agency partners (including the emergency services, local authorities and voluntary agencies)

- establish and maintain working relationships with other NHS partners, emergency services, local authorities, local major organisations and other key stakeholders
- train and exercise as an organisation with all partners to an agreed schedule in agreement with the Local Resilience Forum (LRF)
- develop a command and control structure that allows appropriate linkages to local resilience arrangements including operational (NHS Bronze) command
- participate in Merseyside, North West emergency planning forums
- be accountable to NHS North of England (NHS NE) via NHS Merseyside Resilience
- implement national policy and guidance in the local context
- develop contingency plans for business continuity in the event of a protracted incident or failure of utilities and supplies
- take into account the needs of vulnerable groups of patients whose treatment may need to continue despite a major incident being in progress. This is particularly important in the event of a sustained major incident (see Trust Business Continuity Plan)

4.2. Resilience Planning Group is responsible for:

- ensuring the major incident plan remains appropriate for the currently identified risks to the organisation, that appropriate training is provided for relevant staff, and for reviewing and updating the policy and procedure on a bi-annual basis
- ensuring that the annual work programme is developed and reviewed in the light both emerging internal and external risks linked to the Community Risk Register (See 5.1 below)
- reviewing, testing and updating the Trust's Major Incident and Business Continuity plans. This includes development of a training programme that meets national requirements, ensuring that lessons are learnt from exercises and incidents, and that appropriate major incident reports are produced for the Board
- ensuring divisions and services are represented at this forum
- providing the Business & Performance Committee with regular assurances that Emergency Planning and Business Continuity Management (BCM) is embedded within the trust

4.3. Chief Executive is responsible for ensuring:

- that the Trust has a Major Incident Plan that is built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing
- this plan has been tested in accordance with Department of Health Guidance and reviewed regularly
- the Board receives regular reports, at least annually, regarding emergency preparedness including reports on exercises, training and testing undertaken by the Trust, and that appropriate resources are made available to allow discharge of these responsibilities
- the declaration of a major incident, and stand down. The Chief Executive will determine the most appropriate members of the Major Incident Team, which will be based at a pre-determined location (i.e. Trust Boardroom or at a more appropriate venue depending on the circumstances of the incident)

4.4. Director of Strategy & Planning

This director is the Trust Accountable Emergency Officer (AEO) and has been designated to:

- take responsibility for emergency preparedness as the designated Accountable Emergency Officer; this includes attendance at the Merseyside Local Health Resilience Partnership (LHRP)

- ensure that the trust has identified funding streams in advance in order to support an incident response e.g. for additional staffing, call off orders, equipment suppliers
- ensure that there are arrangements for timely legal advice, in the event of a business disruption or the requirement for interpretation of specific statute e.g. HSWA 1974, CCA 2004 etc
- ensure that an Annual Resilience Report has been completed and reported to the Board/Committee of the Board and interested parties e.g. governors, commissioners etc
- establish and maintain:
  - an on-call rota for Executives and Senior Managers
  - a 24 hour switchboard facility (maintained via AUH)
  - a bleep system that responds to the switchboard
  - a key contact list for Execs & senior managers On-call
  - ensure there is an internal communications test between operation and strategic by way of a twice yearly test

4.5. Finance Director

4.5.1 Finances - if warranted when responding to an emergency situation, a separate cost centre will be set up in agreement with the Director of Finance.

4.6. Executive Directors

It is recognized that there are a number of scenarios that will require leadership to be delegated to any specific Executive Director e.g. for Clinical Incidents the Director of Operations and Nursing etc.

4.7. Head of Risk

The Accountable Emergency Officer is supported by the Head of Risk who will:

- provide advice for emergency and business continuity planning
- deputise in the absence of the AEO at the LHRP Strategic and Trust Resilience Planning Group meetings
- fulfil the role of competent lead for Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity within the Trust
- is the point of contact with other health and social care partners and attends Merseyside Health Resilience Group meetings in the capacity of WCFT Emergency Planning Lead
- will liaise with partner organisations (including the Trauma Collaborative Network) to share planning information in order to ensure that documentation is accurate
- will review the contents of EPRR documentation in order to ensure this plan is reflective of strategic partners

4.8. On Call system

The Trust has an established on-call system mirroring the command and control structure. Clinical, non-clinical managers and Directors are included in a weekly rota covering both in hours and out of hours. In the event of a significant disruption these arrangements will be reviewed to ensure effectiveness. The on-call system is reviewed at least annually or in the event of a significant organisational change.

4.9. External Emergency Planning forums:

4.9.1 Merseyside NHS Emergency Planning Forums

- Merseyside Local Health Resilience Partnership (LHRP) Secretariat hosts, chairs and administrates the Merseyside LHRP at the NHS England Area Team offices in Regatta Place, Liverpool. This forum comprises the emergency planning Executive

leads from all local NHS bodies including commissioners, Public Health England and other agencies (e.g., emergency services, local authorities and voluntary agencies)
- the LHRP ensures that key priorities from joint working with the MRF are reviewed, discussed and agreed

4.9.2 Merseyside NHS Health Resilience sub groups

- the Merseyside Local Health Resilience Partnership Practitioners (LHRPP) is the NHS emergency planning practitioners' forum, this forum is chaired by the Cheshire & Merseyside Commissioning Support Unit (CSU) and hosted and administered by the LHRP Secretariat
- the Trusts RSM attends Merseyside Local Health Resilience Partnership (LHRP) Practitioners (LHRP-P) meetings and other sub groups and working groups under the LHRPP and the Merseyside Local Resilience Forum, as required

4.9.3 Merseyside (Local) Resilience Forum (MRF)

- the NHS England Area Team Exec Lead for emergency planning represents the local NHS economy at the Merseyside Resilience Forum (strategic multi agency forum chaired by Merseyside Police)
- NHS England Resilience Officer represents the NHS economy at the MRF General Working Group which is the joint tactical forum of the MRF
- other NHS Emergency Planning officers take on NHS representation at Merseyside Resilience Forum sub groups also and report back to the HRG with any issues

4.9.4 Informal Emergency Planning Network and Liaison Meetings

- The Civil Contingencies Act and regulations specify that emergency planning practitioners must interact, liaise and network regularly both formally and informally. They must share information and good practice and support all partner agencies (not just NHS) and take part in training and exercising in each other's organisations to ensure properly integrated and consistent, coordinated emergency management and planning and effective mutual aid

5. Inputs into Major Incident Planning

5.1. Community Risk Register (external)

The ***Merseyside Resilience Forum (MRF)*** has a number of multi agency sub groups including the Risk Assessment Group (chaired by the Fire & Rescue Service) which meets regularly and has drawn up the ***Community Risk Register*** for the County. This is based on hazard mapping of the County area and potential risks that may require a coordinated major incident response. The model of risk assessment used is the Australian Emergency Management model and is heavily weighted by the impact analysis of each risk. Disasters, thankfully, do not occur very often but their impact can be catastrophic, so the likelihood criteria used by most insurance companies is less applicable to emergency management risk assessment. To see the Local Community Risk Register click here.

5.2. External Incidents potentially affecting the Trust[1]

Transport Hazards

- Loss of cover due to industrial action by workers providing a service critical to the preservation of life (such as emergency service workers)

[1] Source Merseyside Community Risk Register

- Emergency services: loss of emergency fire and rescue cover because of industrial action
- Significant or perceived significant constraint on the supply of fuel at filling stations e.g. industrial action by contract drivers for fuel, refinery staff, or effective fuel blockades at key refineries / terminals by protestors, due to the price of fuel
- Unofficial strike action by prison officers
- Industrial action by key Rail workers

5.3. Human Health

The following risks have the potential for a severe to catastrophic impact in terms of disruption, damage to the built and natural environment, large scale numbers of casualties and deaths:

- Influenza type disease (pandemic)
- Major outbreak of a new or emerging infectious disease
- Localised legionella / meningitis outbreak

5.4. Industrial Technical Failure

- Technical failure of a critical upstream oil/gas facility, gas import pipeline terminal, or Liquefied Natural Gas (LNG) import reception facility leading to a disruption in upstream oil and gas production
- Failure of water infrastructure or loss of drinking water
- No notice loss of significant telecommunications infrastructure in a localised incident such as a fire, flood or gas incident
- Technical failure of national electricity network
- Technical failure of electricity network due to operational error or bad weather causing damage to the system

5.5. Risk Assessment & Hazard Mapping (internal)

Risk issues will be managed in the first instance via Incident Logs and then transposed onto DATIX Risk Register at the first available time post incident.

5.6. Planning for risks

Emergency plans are prepared on the foundation of risk assessment including hazard mapping and coordinated multi agency response required for expected impacts of an event. Risks identified (internal and external) during the planning process, exercise, or incident debriefs and are placed on the risk register for the affected ward/ department.

5.7. Trust Risk Register

Trust wide risks can be recorded on the Trust Risk register using the Datix System and will be managed in line with the Trusts Risk Management Policy and underpinning Departmental Risk Protocols.

Emergency Planning and Business Continuity risks are identified on departmental and ward risk registers which are scrutinised as part of the overall Trust governance arrangements, which then gives assurance to the Board and the Quality Committee (board sub-committee) regarding the management of the risks.

5.8. Business Continuity Risks (identified from Business Impact Analysis [BIA])

Every department in the Trust has specific business continuity plans and has carried out a Business Impact Analysis. BIAs are entered on the Datix system and Ward and Department managers are be responsible for managing and Directorate Managers being accountable for them.

6. Activation Emergency Roles

The following roles are identified within the action cards above:

- Chief Executive/Director in Charge - Strategic Commander
- Staff supporting the Tactical Commander,
- Operational Command Team
- Switchboard staff and Control Room staff (including loggists)

Note: These documents contain sensitive information so are only distributed to the staff undertaking these emergency roles but can be requested from the Head of Risk by email to tom.fitzpatrick@thewaltoncentre.nhs.uk

6.1. Major Incident Board

A Major Incident white board is now available for use in the Board Room which allows for ease of writing changing bed states and number of casualties expected. The board can be used to document changing events as the incident progresses but should not be used to replace a timed, hand written log.

6.2. Major Incident Log Book

During the major incident and immediately afterwards it is essential that a suitably trained “loggist” is allocated to record all agreed major decisions taken within the Incident Control Room in the ‘official log book’ which will need to be established and maintained by the loggist.

The designated Senior Manager in charge of the incident room will be required to collate incident logs after the event. These in turn will be submitted to the Resilience & Safety Manager who will prepare and submit a report to the next available RPG.

7. External Declaration

A Major Incident can be declared externally by either NWAS or via the Major Incident Command Structure by NHS England Area Team NHS Tactical (Silver) Command or NHS Strategic (Gold) Command.

The NHS England Merseyside Area Team will support these commanders by establishing an NHS Silver/ Gold Command in their headquarters. Trusts and other providers will report to and obtain instructions and intelligence from this Command Centre when reacting to a Major Incident. An external declaration is most likely in a Mass Casualty event involving a number of Receiving Hospitals (and all other partner agencies) or an event that affects a number of agencies (not necessarily NHS).

8. Mutual Aid/Support & Capacity Management

8.1.1 Mutual Aid can be defined as an arrangement between Category one and two responders, other organisations not covered by the CCA 2004, within the same sector or across sectors and across boundaries, to provide assistance with additional resource during any incident that may overwhelm the resources of a single organisation. The NHS England (Merseyside) will be responsible for the co-ordination and implementation of mutual aid requests during a major incident, significant incident or emergency.

8.1.2 Events involving Trauma may involve support from/to the Trauma Network and Critical Care Network. (Trauma and critical care leads use these contact details frequently and will activate the arrangements for their services). Mutual aid can be arranged by:

- The local Public Health Departments will provide advice and support on public health and epidemiological issues. The Scientific & Technical Advisory Cell provides advice to NHS Gold command but can be accessed via the command structure once in place
- ***Public Health England (PHE)*** Cheshire & Mersey Unit on call Duty Officer can access and provide advice on hazardous material ***(HAZMAT)*** and ***CBRNe*** issues.
- Assistance from Local Authority Social Care Departments with accelerated and early discharge.
- Inform the ***NHS Bronze Command*** of any safe, secured or protected routes for staff called in, as advised by fire, police or military.
- Request assistance from the voluntary agencies under the ***UNITY Protocol*** (***primacy*** agency British Red Cross) for help with general humanitarian assistance.
- NHS Gold Command co-ordinate the Merseyside NHS strategic response to major incidents for the County and can provide county and regional resources (via NHS England North of England) as required.

8.2. Mass Casualties

8.2.1 NHS Merseyside has in place a (interim) Mass Casualties Plan which describes the arrangements agreed by Merseyside LHRP as part of a multi-agency response to a mass casualty incident arising from a sudden, focal, time-limited event - such as a rail / plane crash, an explosion or a terrorist attack - which overwhelms normal local response capabilities.

8.2.2 The incident may occur outside of Merseyside, but may still require Merseyside's resources to be utilised.

8.2.3 The objectives of this plan are to:

- provide an overview of the mechanisms available to deliver the local response in the event of a mass casualty incident
- explain how these mechanisms can be activated
- describe command and control within across NHS organisations and other co-ordination arrangements within Merseyside for a mass casualty incident, and;
- provide an overview of the roles and responsibilities of individual agencies involved in a response to a mass casualty incident

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9. Communications & sharing information

9.1. Staff Communications

The Communications Team will ensure that staff and managers are made aware of progress in a major incident and issue urgent global emails and leaflets, posters etc as appropriate.

9.2. Major Incident Communications (NHS Bronze Command)

The Communications Team will be present in the Bronze Control Room and the Head of the Team will be part of the Command Team.

9.3. Media Communications

The Trust Communications Team will provide a point of contact for the media and will provide bulletins and press statements for issues affecting the Trust after first discussing the matter with the NHS Gold Communications team if it has been set up,

according to the ***Merseyside Press & Media Protocol***. This process will also be used for messages on health advice to the general public.

The Communications Team will brief the Trust's spokespersons before interviews and deal with the press on behalf of the Trust. Trust spokespersons will be media trained Execs (usually the Medical Director) or appropriately trained Senior Managers.

They will work together with Health Informatics to produce global emails and 'ticker tape' news on the intranet, update the Trust website, and manage the Trust social networking accounts on e.g., Facebook and Twitter.

The designated ***Media Liaison Point*** for press and media interviews and briefings will be determined at the time by the Communications team.

9.4. Regional & National Incidents

In the event that the incident is regional or national level media messages will be available via NHS Gold Communications to ensure consistent messages.

9.5. Public /Local Community Communications

The Communications Team will notify the local community and the public of major events occurring or due to occur at the Trust (like live exercises) and issue leaflets, press releases, posters and letters as appropriate.

9.6. Telecommunications Plans

There are numerous means of communications that can be used in the alert and later stand down, these include:

- Bleep/pagers
- landlines
- trust mobile phones that can be used in a major Incident
- major Incident radios (via Security Staff)
- mobile phones
- satellite telephones in the Major Incident Rooms (when installed can be used by the Bronze Command Team as a fall back communications system when other methods have failed)
- runners
- email

9.7. Sharing information

9.7.1 Under the CCA 2004 local responders have a duty to share information and this is seen as a crucial element of civil protection work, underpinning all forms of co-operation.

9.7.2 The sharing of information will include, if required for the response, details of vulnerable people. The general definition of a vulnerable person is a person:

- "present or resident within an area known to local responders who, because of dependency or disability, need particular attention during incidents"

9.7.3 Sensitive data not in this plan will be made available to key Trust personnel by confidential email to relevant groups or individuals. Partner agencies and members of the public may request a sanitized copy by email from the Resilience & Safety Manager. The Trust is signed up to the Merseyside Major Incident Information Sharing Protocol.

10. Considerations during, or in the aftermath of an incident

10.1. Surge and demand - See Escalation Policy.

10.2. Counselling:

10.2.1 Staff

Access to Occupational Health support will be provided by the Trust for all staff, particularly those involved in a major incident, which will include counselling if required

10.2.2 Patients & Relatives

Those who have been involved in an incident either as victims or responders may be traumatised and suffering from shock intense anxiety and grief. Some may also need social support such as contacting family and friends, transport, finding temporary accommodation and financial assistance.

The incidence of Post-Traumatic Stress Syndrome in survivors and responders has been recognised from past experiences such as Hillsborough and the London Bombings.

Liverpool City Council is responsible for coordinating both professional and voluntary sector welfare response, particularly when people have been evacuated from their homes.

Patients and visitors may require support in the event of an incident occurring on the Trust site. Trust Chaplains, trained staff and volunteers will be able to assist but also, advice should be sought from your local GP, Mental Health Services, CCG and Liverpool City Council.

Independent support organisations and their services include:

- Local 111 provider can provide further advice and information: Tel: 111
- The Samaritans offer a 24 hour helpline for those in crisis: Tel: 08457 909090
- Disaster Action provides both support and guidance: Tel: 01483 799066
- Assist Trauma Care offer telephone counselling and support to individuals and families: Tel: 01788 560800

10.3. Staff

Responding to incidents puts staff under more pressure than normal. It is therefore vital that staff welfare issues are given a high priority. In order to achieve this, those staff with management responsibility will ensure that the following issues are continually addressed:

- the availability of food and other refreshments
- working hours (consideration will be given to extended shifts)
- rest breaks
- travel arrangements
- consideration of personal circumstances
- emotional support during and after the incident
- sleeping arrangements e.g. impacts to travel caused by adverse weather

To assist staff in the response to an incident, regular briefings will be given by senior staff, particularly at the start of a shift, or at shift changes and handovers.

10.4. Visits by VIPS

During the response to an incident or during the recovery stage, visits by VIPs can be anticipated. A Government minister may make an early visit to the scene or areas affected to mark public concern and to report to Parliament on the current situation.

Depending upon the scale of the incident, visits by members of the Royal Family and Prime Minister may take place. Local VIP visitors may include religious leaders, local MPs, mayors and local authority leaders. If foreign nationals are involved, their country's Ambassador, High Commissioner or other dignitaries may visit.

Visiting ministers and other VIPs will require comprehensive briefing before the visit and will require briefing before any meetings with the media. VIPs are likely to want to meet patients who are well enough and prepared to see them. This will be dependent upon medical advice and respect for the wishes of individual patients and their relatives.
In the case of such visits to hospitals it is common for VIP interviews to take place at the hospital entrance to cover how patients and medical staff are coping.

Merseyside Police are experienced in handling VIP visits and are likely to be involved and would be the main contact point so far as the arrangements are concerned.

The relevant Communications Manager in consultation with the Chief Executive and Medical Director is responsible for managing VIP visits.

10.5. Vulnerable People

The guidance relating to the Civil Contingencies Act 2004, Emergency Preparedness sets out the responsibilities placed on Category 1 responders to plan for and meet the needs of those who may be vulnerable in emergency situations.

The section concerning making and maintaining plans for reducing, controlling or mitigating the effects of an emergency specifically covers the vulnerable as 'people who are less able to help themselves in the circumstances of an emergency.'

The section concerning warning and informing outlines how the needs of vulnerable persons, including those who may have difficulty understanding warning and informing messages, need to be taken into consideration by those Category 1 responders responsible for communicating both pre-event and during an emergency.

Other legislation may interact with the Trust responsibilities under the Civil Contingencies Act, in particular the Disability Discrimination Act 1995 and 2005 and the Human Rights Act 2000.

The Civil Contingencies Act allows the sharing of certain information for emergency planning purposes, although sensitive information (which would include some personal data within the meaning of the Data Protection Act and patient records) needs to be subject to controls on the way it is handled, and the purposes to which it is put. The restrictions that need to be placed on sharing information at the planning stage are different from those applying in an emergency. For instance: it can be necessary to provide partner agencies like the police documentation teams with details like the name, address, age, gender and description of casualties for the good of the patient so that they can be reunited with their families from whom they have been separated by the event.

10.6. Patients

Most patients either in-patients or attending the Trust, outpatients etc in a hospital are vulnerable and their care and support in conjunction with other agencies is normal daily business.

10.7. Health & Safety

During a major incident the Trust's Health and Safety Policy will apply.

Staff will not be expected to undertake any task for which they are not trained or skilled for. All staff have the right to decline, remembering they have a duty of care for themselves and to that others.

During any response to a major incident, members of staff involved **must wear their identity badges throughout**, and those with Trust mobile phones and laptops should ensure that this equipment is available for use.

10.8. Switchboard Failure

In the event of a switchboard failure staff will utilise the designated trust issued mobile phones to ensure continuity of communications.

10.9. Pandemic Flu Planning

See Trust Pandemic Flu Plan. The Pandemic Influenza Plan is enhanced by multi agency element specific plans and 'Managing the H1N1 Flu Pandemic September 2009'. (See DoH website) and is consistent with Merseyside Pandemic Influenza Plan 2013 and the National Pandemic Influenza Plan and should be read in conjunction with the Trust's Infection Control policies (see intranet under infection control policies).

10.10. Lockdown

The LSMS has devised a Lockdown Procedure based on locking down key areas e.g., Radiology, Theatres, ICU, secure side-rooms (police incidents) or a rolling lockdown according to the exigencies of the incident concerned. See **ACTION CARDS 036 and 037 above**.

10.11. Recovery

The Trust recovery and restoration arrangements from an incident will form a vital component of the overall response. Whilst the Exec in charge is dealing with the immediate issues affecting the Trust or its partner agencies, the Chief Executive will consider the establishment of a Recovery and Restoration Team.

The Team responsibilities would involve the consequence management of the incident including the identification of issues that could continue to disrupt the services provided by the Trust.

The effective management of these consequences should provide a successful recovery and restoration process. The team would identify a strategy for the recovery and restoration stages by considering the consequences and the impact of the incident on the Trust in the immediate and longer term.

The team will consider the following issues:

- managing the return to normal service delivery
- managing the restoration of any structural damage
- consider the priority of elective services including the impact on targets

- communication with patients affected by the incident including the rebooking of cancelled appointments
- staffing levels in the immediate future
- identifying patients who require further surgical intervention
- management arrangements of beds occupied by patients decanted from other hospitals
- support of staff welfare and counselling
- re-stocking of supplies and equipment & audit issues

11. Training

11.1.1 In order to identify or maintain competencies and awareness, this is included within the Personal Development Review (PDR) process.

11.1.2 Training is provided for key staff that may be required to carry out essential tasks in response to a major incident. Staff are provided with training that ensures they understand the role they are to fulfil in the event of an incident and have the necessary competencies to fulfil that role e.g. national Occupational Standards for Civil Contingencies.

11.1.3 Training is provided on induction for all staff on general principles of EPRR and BCM. On Call managers and executive have 1:1 sessions.

11.1.4 Staff members that are likely to follow an Action Card are sent an annual reminder that cards should be reviewed if there are internal changes to process or staff structures. Staff are also be given the opportunity to participate in NHS and multi-agency exercises.

12. Monitoring

12.1. Audit

The Trust undertakes an EPRR self-assessment annually, with a statement of compliance against the self-assessment to Board for sign off. This is then returned to NHS England C&M.

12.2. Exercising (internal)

All of the Trust's Major Incident plans are exercised by at least a table top style exercise annually and a live exercise every 3 years (or more frequently) as per the requirements of the Civil Contingencies Act 2004 in order to:

- continually refresh key staff in its use and equip them with the skills to use the plan
- ensure the contingency plan continues to be updated and meets the needs of the trust
- familiarise new staff with the plan and its function
- it will be the responsibility of the Director of Strategy & Planning or nominated deputy to ensure the MIP is tested every 12 months
- the test should take the form of a mock emergency and be division/trust wide

An objective observer will be invited to each test to help evaluate the process. The outside evaluator should have some experience in emergency planning.

Some exercises are internal e.g., Exercise First Responder and others are conducted in cooperation with partner agencies e.g., with AUH and may include communication via the Major Incident Command Structure to report upwards and access expert advice, resources and assistance from partner agencies that are part of that structure.

The Trust is working collaboratively with partners since it became a Category 1 responder, and will actively support and take part in testing the plans of partner agencies exercises including those conducted by the NHS England Area Team.

13. Consultation

This plan has been developed in accordance with the Trusts Document Control Policy, which in the first instance will seek comments from the Resilience Planning Group, and Business & Performance Committee. For external partners this will seek comments from colleagues from the StH & K, RLUH & AUH as part of the Trauma Collaborative. This document will also be shared with Commissioners and other interested parties on request.

14. Review

This document will be reviewed in two years (this is applicable to new or revised documents on approval of this policy revision), or sooner in the light of organisational, legislative or other changes e.g. changes in risks or in the event of significant findings from internal or external incidents/reviews.

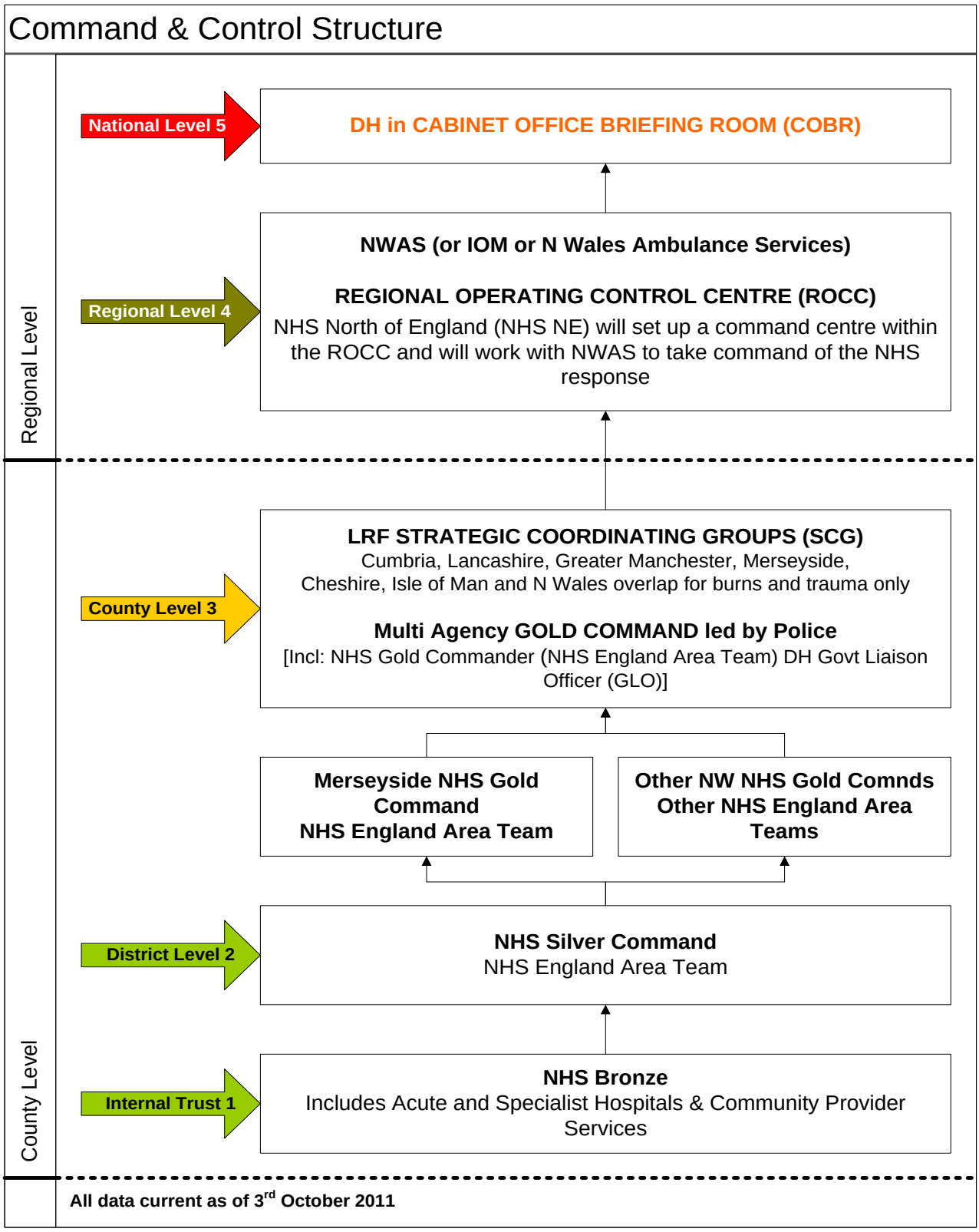
15. References

- Civil Contingencies Act 2005.
- NHS Standard Contract;
- Everyone counts: Planning for Patients 2013/14;
- Arrangements for health emergency preparedness, resilience and response from April 2013 (to be read to support NHS Emergency Planning Guidance 2005);
- NHS Commissioning Board Command and Control Framework for the NHS during significant incidents and emergencies;
- NHS Commissioning Board Business Continuity Management Framework;
- NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response;
- Memorandum of Understanding for Emergency Preparedness, Resilience & Response between NHS CB Local Area Teams and providers of NHS-funded care;
- The NHS England Business Continuity Framework http://www.England.nhs.uk/ourwork/gov/eprr
- Role of the Accountable Emergency Officer https://www.england.nhs.uk/wp-content/uploads/2012/12/eprr-officer-role.pdf
- Role of EPO (including competencies)
- JEIP Joint Doctrine http://www.jesip.org.uk/uploads/resources/JESIP-Joint-Doctrine.pdf
- Merseyside Infectious Diseases Management Plan 2014
- MRF Merseyside Emergency Response Manual (MERM) 2013[1]
- Merseyside Mass Fatalities Plan – Interim Excess Deaths Protocol
- http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_063393.pdf
- NW Critical Care Network Pandemic Influenza: Critical Care Plan
- NHS Shelter and guidance information https://www.england.nhs.uk/wp-content/uploads/2015/01/eprr-shelter-evacuation-guidance.pdf
- MRF Community Risk Register 2017 http://www.merseysideprepared.org.uk/media/1406/2017-merseyside-crr-v1-0-17.pdf

15.1. Supporting policies/documents

- Health & Safety Policy
- Trust Business Continuity Plan
- Departmental Business Continuity Plans
- Pandemic Influenza Plan
- Fire Policy
- Security Policy
- Risk Management Strategy
- NHS NW Critical Care Contingency Plan
- Incident Reporting Policy
- Partner trust/agency Emergency Plans
- Trust Emergency Plans (i.e. Pandemic Flu, Fuel Shortage)
- Infection Prevention Policies
- Data Sharing Policy
- Escalation Policy
- Winter Plan
- Transfer of patients into WCFT due to Major Incident Situation by AUH (Internal document)

Appendix 1 - Command & Control Structure



National Level

The Prime Minister will convene the Cabinet including a rep from the DH and specialist advisors in Cabinet Office Briefing Room (A) supported by staff officers from the Civil Contingencies Secretariat to develop and deliver policy and a national response to catastrophic events (e.g. Foot & Mouth epidemic, London Bombings, major flooding events, large scale civil unrest, etc).

Regional Level

The NHS in the North West has a Command and Control Structure that will be operated to coordinate Mass and Catastrophic Level Incidents.

NHS North of England (NHS NE) will take overall Command and Control of any Major/Significant Incidents that affect more than one county or if the incident is believed to be caused by a terrorist event.

Depending on the time or day of the incident the NHS NE will exercise its Command and Control functions from various places across the North of England. In the North West they will operate from ***North West Ambulance Service (NWAS) Regional Operational Control (ROCC)*** room at Broughton, Preston or from their offices in central Manchester or Leeds.

The NHS NE will brief the DH as required.

Depending on the type of incident the team will consist of:

- On Call Director
- On call Communications Lead
- Regional Director of Public Health (if appropriate)
- A member of the Critical Care Networks (to oversee Critical Care issues)
- Administration support

This NHS Regional team will communicate throughout the incident with:

- Local Adult & Paediatric Critical Care Networks
- Northern Burn Care Network
- National Burn Bed Bureau and
- Trauma Networks.

Merseyside County Multi Agency Gold Command

Where the incident is contained within the county the Local NHS Gold Commander from NHS England Area Team will have strategic responsibility for Merseyside NHS economy. In addition an NHS North of England Government Liaison Officer (GLO) *may* attend the ***Strategic Coordinating Group (Gold Command)*** of the county affected.

The term 'Gold' refers to the person in overall executive command of each service (health, fire, police, etc.) and is responsible for formulating the strategy for the incident response. Each strategic command (Gold) has overall command of the resources of their own organisation, but delegate tactical decisions to their respective tactical commanders (Silver(s)).

The ***Merseyside Gold Command*** or ***Strategic Co-ordinating Group (SCG)*** is a multi agency group that meets at ***Merseyside Gold Control Centre*** in
Merseyside Police HQ, Liverpool. This is usually chaired by the Chief Constable as the Police normally have ***'primacy'*** over all other agencies in a Major Incident. It will be attended by the ***NHS Merseyside Gold Commander***. Please note the health economy represented by the Merseyside NHS Gold Commander extends beyond Merseyside boundaries.

The primacy agency and chair of the LRF may change to the Local Authority or NHS Gold Commander if appropriate.

NHS Gold Command (Greater Merseyside)

The Chief Executive (or nominee) of NHS England Area Team is the NHS Gold Commander. S/He will strategically lead the NHS response in the County from an ***NHS Gold Command***

Centre at Regatta House, Brunswick Business Park, Liverpool set up and staffed by ***NHS Merseyside Resilience Team***.

The NHS Gold Commander will attend the Strategic Coordinating Group when it meets and will represent the entire Greater Merseyside NHS economy including Wirral, Warrington and Halton.

NHS Tactical (Silver) Command

In Merseyside the NHS command structure reflects the multi-agency structure as follows:

The term 'Silver' refers to those who are responsible for formulating the tactics to be adopted by their service (NHS economy in this case) to achieve the strategic direction set by strategic command. Tactical command will oversee but not be directly involved in managing the operational response to the incident.

NHS England Area Team will also provide a rota of Silver Commanders who may operate from Regatta House or a control centre.

NHS Operational (Bronze) Command

The term 'Bronze' refers to those who provide the frontline operational response and/or direct service provision, and control the resources of their respective service within a specific area of the incident. They implement the tactics defined by the NHS Silver Command Team.

In Merseyside the executive/ strategic command within Hospital Trusts (Acutes and specialist) and Community Health Provider Services are the NHS Bronze Command. These teams are chaired by a Trust Executive. In the Trust the Exec in Charge becomes the Bronze Commander once the Command & Control Centre is up and running.

The Exec in Charge for the Trust is:

Office hours	Operational Director (or executive nominee)
Out of hours	Exec on Call

Appendix 2 - UK Roles of Partner Agencies

Introduction

Pre-planning, training and exercising on a multi-agency basis enables plans and procedures to complement each other and enables agencies to have an understanding of each others roles, responsibilities and capabilities.

All Major incident plans for Category One Responders are peer reviewed with partner agencies before full publication.

NHS agencies play an important role in this multi-agency approach to emergency planning. The roles of the Trust's partner agencies are as follows:

NHS North of England (NHS NE)

NHS North of England (NHS NE) may convene meetings of incident leads from the NHS organisations (which may use telephone or video-conferencing).
The role of the NHS NE is to:

- activate North of England and sub regional (e.g., North West Ambulance Service footprint area) Major Incident Plans
- give priority to the incident, relative to meeting of targets and achievement of standards that would otherwise be imperative
- assume that resource adjustments would flow to recognise extraordinary expenses incurred in responding to the incident
- stand down their emergency response.
- at the recovery stage ensure that any commitments made during the incident are honoured.

Local NHS Community Health Care Providers

(E.g. Mersey Care and Community Health Care Provider Services)

Local NHS Community health care providers will provide community health care service to casualties and to displaced persons. They may provide healthcare input to people with minor injuries, and to persons at (Local Authority managed) Rest Centres and will support acute hospitals by diverting minor injuries away from Emergency Departments and into walk in centres, provide an integrated specialised emergency response for e.g., therapy services. Provide more hours and different working practices in community health care to reduce admissions.

NHS England Area Team (NHE AT) Merseyside

NHSE AT is responsible for an NHS countywide response and provides strategic and tactical (borough wide) decisions; command and control for the entire NHS economy in Greater Merseyside and arranges mutual aid on behalf of NHS North of England.

It provides an NHS Gold Control Room and staff to support the Gold Commander in a Major incident. NHSE AT Resilience Officer in conjunction with the Commissioning Support Unit Resilience Officer coordinates Multi agency emergency plans for the NHS in Merseyside, support Trusts with emergency planning, exercises and training, provide a conduit /is a filter for information/ instruction from DH and provides help and advice to Trusts.

When a major incident is declared, NHSE AT Silver/Gold Team will:

- set up and staff the NHS Gold Control Room in Regatta House
- initiate and support the public health response to the incident if this is appropriate

- mobilise CCGs, primary care and community resources in response to the incident
- support Acute Trusts by taking steps to relieve pressure on them
- communicate with the media and public
- assess the impact on health and health services of the incident
- provide the health service input to the strategic and borough wide tactical management of the incident (may be in conjunction with the Public health England Cheshire & Merseyside Health Protection Unit)
- arrange follow-up if needed of persons affected or exposed to risk during incident
- activate the major incident procedure including the setting up of the major incident room
- ensure that the Merseyside Local Health Resilience Partnership Major Incident plans are co-ordinated with those of other relevant organisations.

In the event of the Trust requiring access to secure transport routes and accommodation facilities in a Major Incident, the consultation will take place with the Silver/ Gold NHS Team.

Scientific & Technical Advice Cell (STAC)

A Scientific and Technical Advice Cell may be established during an incident to bring together technical experts from those agencies involved in the response to provide advice to the Gold Command where there may be wider health and /or environmental consequences. It is chaired by a Director of Public health and can be staffed by the HPA, local authority Environmental Health Officers, NWAS, representatives from other emergency services, and experts from other government agencies and the military. Local experts like the Nuclear Physicist at the Royal may also be required.

The Trust may be requested to send a representative to meetings of the STAC particularly if the Trust is experiencing a Major Incident.

Public Health England (PHE)/ Cheshire & Merseyside Health Protection Unit (HPU)

The HPU provides HAZMAT, CBRN(e) and poisons advice to Category One Responders like Acutes via a Duty Officer system. This can be accessed in an emergency via Ambulance Control.

North West Ambulance Service NHS Trust (NWAS)

NWAS attend the scene, provide on-site healthcare, decontaminates casualties where necessary (the Fire and Rescue services would assist by decontaminating affected individuals who are not ill or injured), and transport patients to hospital.

They also provide a Hospital Ambulance Liaison officer (HALO) at the ED to provide a link to the scene and inform the Coordinators about the numbers and types of casualties en route and their estimated time of arrival. This facility may be requested when the Trust is dealing with a mass casualty or CBRN(e) or HAZMAT incident.

Merseyside Police

In a disaster or serious Major Incident involving casualties/ hospital premises, the police have ‘primacy’ i.e. control and a coordination role over all other agencies involved including the Trust.

The primary areas of response are:

- the saving of life in conjunction with other emergency responders
- coordination and communication between the emergency responders and other agencies acting in support at the scene of the incident or elsewhere during the response phase
- secure, protect and preserve the scene through the use of cordons

- investigation of the incident and obtaining and securing evidence
- collation and dissemination of casualty information
- identification of the dead on behalf of HM Coroner
- short term measures to restore normality
- provision of advice and guidance from the local ***Counter Terrorist Advisory Office (CTSO).***

Merseyside Fire & Rescue Service

The primary areas of support are:

- Fire fighting, fire prevention and Search and Rescue (SAR)
- decontamination and mass decontamination of uninjured people
- provision of specialist advice and assistance where hazardous materials are involved (especially the Detection Identification and Monitoring or DIM teams operating at the scene)
- provision of specialist equipment (pumps, rescue equipment and lighting)
- safety management within the *Inner Cordon* of an incident

Liverpool City Council (LCC)

The primary areas of response are:

- support the emergency services and those engaged in the response to an incident
- use resources to mitigate and relieve the effects on people, property and infrastructure
- resource Reception Centres for the temporary accommodation of survivors/ evacuees
- provide humanitarian assistance
- activate and coordinate voluntary sector support
- arrange emergency mortuaries
- maintain the provision of essential services

As the emphasis moves from response to recovery, take the lead role to facilitate recovery and the restoration of the environment

Government Decontamination Service

The Government Decontamination Service has been established to help agencies prepare for and recover from CBRNe (chemical, biological, radiological, nuclear or explosive) or significant HAZMAT (hazardous materials) incidents by providing advice, guidance, management support and contractual arrangements.

In response to an incident requiring decontamination equipment, the Government Decontamination Service can provide expert advice on the capability and capacity of its framework of contractors, their services and where relevant, the different remediation or decontamination methodologies available.

Contact Details: The Government Decontamination Service, MoD Stafford, Beaconside, Stafford, ST18 OAQ
Tel: 08458 501323, Fax: 01785 216363, Email: gds@gds.gsi.gov.uk

Military Aid to the Civil Community

The Military is authorised to provide assistance in the response to an incident if there is a threat to life. The immediate assistance the Military is able to provide will depend upon the resources available at the time. Requests for assistance will normally be made by via the Command Structure.

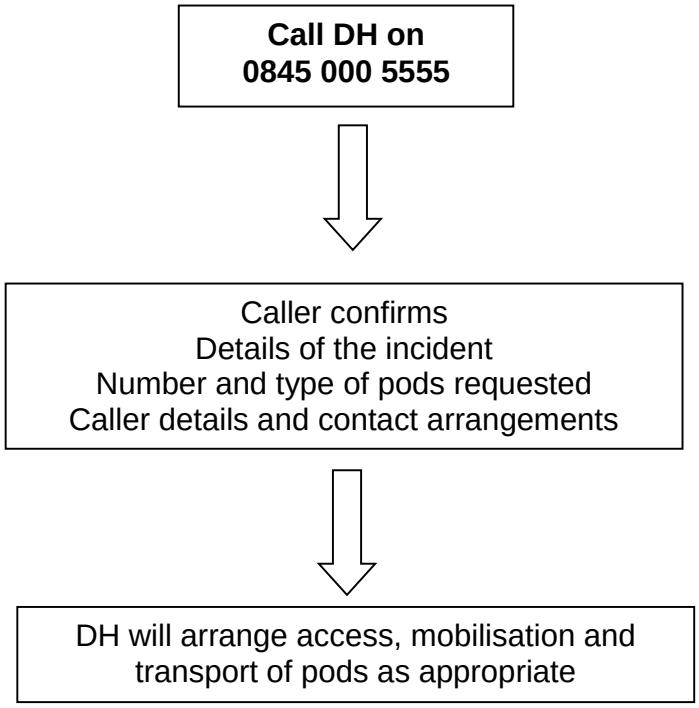
Merseyside Integrated Voluntary Agencies under the UNITY Protocol

The British Red Cross (Merseyside District Branch Offices in Bradbury house, Brunswick Dock Estate, Liverpool) have 'primacy' over other voluntary agencies and faith and community organisations with a stated emergency response role and will coordinate and manage the integrated voluntary agencies response in any humanitarian crisis and provide specific services and support to the Trust and other NHS providers in such events. They can be activated via a call from NHS Bronze to Knowsley Council to request assistance.

A British Red Cross 'Unity' Coordinator will attend Silver &/or Gold Command (Strategic Coordinating Group) to coordinate voluntary humanitarian assistance across the entire County/ Borough.

Appendix 3 - UK Reserve of National Stock for Major Incidents

Items Accessed Centrally (Summary)



The decision to deploy these medical supplies will normally be taken by the local Consultant in Communicable Disease Control, Director of Public Health or Consultant in Public Health Medicine.

The Regional Director of Public Health must be informed of all decisions to use/access centrally managed countermeasures.

Customer Procedure

Case of emergency during normal working hours

Monday to Friday between the hours 8.30am and 5.00pm contact your local Supplies Manager who will respond to your emergency in the most appropriate way and in line with local procedures.

Case of emergency out of hours

Outside of normal working hours as indicated above the Customer must obtain the appropriate permission from budget holder, Manager in charge etc. Once permission has been obtained you should contact the local Distribution Centre by telephone not by facsimile (see overleaf)

All such demands will be charged to the local emergency GL code to be apportioned according to local procedures. As a necessity, the emergency procedures are designed to allow authorised personnel to obtain their emergency issues without the encumbrance of normal requisitioning.

Procedure for case of emergency during office hours

Before pursuing an emergency delivery from the NHS Logistics Distribution Centre, consider the following:

- Are the goods needed urgently?
- Could the goods be obtained quickly from another department?

Procedure to be followed by Supplies Manager/ Officers for an emergency during office hours

Investigate the request and ascertain if the goods required can be obtained more quickly from another Ward/Department or Hospital.

Use the enquiry facility on LOL (Logistics Online) or local legacy system to determine where any delivery of the items required has been made recently.

Once it is apparent that a delivery is required from the Distribution Centre, obtain the following:

- Authorising Officer's name
- location name and telephone number
- requisition point
- NSV code for each commodity required
- description of product with issue pack size
- quantity required
- delivery if different from normal delivery location
- precisely when the item/s are needed

The procedure to be followed by customers depends upon the time of day the emergency arises. An emergency is defined as a Major Incident or an unforeseen circumstance where delivery is required the same day or within 5 hours. There is no charge for genuine emergencies.

Appendix 4 - National Emergency Purchasing Scheme

NHS Supply Chain Emergency Procedure

Contact the Distribution Centre and your usual Customer Service advisor.
You must clearly state that it is an emergency situation and that you require an urgent delivery from the Distribution Centre.

Your Customer Service advisor will then ask the questions listed above and read back the answers to you, to confirm the request.

The Customer Service advisor will confirm the warehouse pick of the goods by telephoning either the customer or the Receipts and Distribution point and give details of the transport to be used and the estimated time of arrival at the delivery location.

Upon receipt the customer will be asked to sign the delivery note, printing their full name, job title and normal telephone number - a copy of which will be given to the customer.

An emergency is defined as a major incident or an unforeseen circumstance. This is usually a same day delivery.

Procedure to be followed by the ***customer*** for an emergency outside of 'normal' hours - security manned site.

Authorisation must be obtained for any emergency request.
Obtain the following information ***before*** contacting the Distribution Centre:

- Authorising officer's name
- location name and telephone number
- requisition point and requisition code
- NSV code for each commodity required
- Description of product with issue pack size
- quantity required
- delivery if different from normal delivery location
- precisely when the item/s are needed

Contact the Distribution Centre. (Facsimile messages are not acceptable)
Security Manned Distribution Centres – Alfreton, Maidstone, Normanton, Runcorn, Bury and Bridgwater. Once the facts are confirmed, the Security Gatehouse Officer/depot on call officer will ring the number given by the caller to confirm that the call is genuine; having first checked that the telephone number given is in the directory of Hospital numbers. Whenever the afternoon shift is in work, contact the Shift Manager or Charge-hand.

Contact Telephone Numbers for Distribution Centres - Out of Hours

Manned Sites

Alfreton	01773 724000	Normanton	01924 328700
Runcorn	01928 858500	Bury	01284 355923
Maidstone	01622 402600	Bridgewater	01278 464000

Operations to provide Security with a detailed list of contacts for each Distribution Centre.

Appendix 5 - Multiple incidents Emergency Response summary

Code Name Alert

Multiple site incidents like the London Bombings in 2005 will require a coordinated multi agency regional response from all standing agencies. The alert to the Trust from either NWAS or the NHS Silver or Gold Commander will contain **a code name known only to key officers of the Trust**.

Upon hearing this code name the Exec in Charge will ensure that the Trust is immediately fully prepared to respond to a large scale Major Incident or series of incidents.

Possible Required Responses to Multiple Incidents

If the incident occurs within a 20 mile radius it is fairly certain that the Trust will be required to receive a potentially large number of the most serious casualties, the ***Priority or P1s*** requiring emergency care, surgery and ITU.

However, there are a number of possible responses required from the Trust dependent upon whether it is a ***Receiving Hospital*** for the casualties or not.

Actions by the Trust on Declaration of Multiple Incidents by NWAS

If it is anticipated that the Trust will be receiving large numbers of casualties the Exec in Charge will activate the full range of the Major Incident Plans including:

- Establish a Bronze Command Team supported by a Control Support Team in the Major Incident Suite.
- Establish lines of communication with the NHS Merseyside Resilience Gold and Silver Command Centres to receive intelligence about the incidents and set up situation reporting up the command structure.
- Obtain as full a picture of the incidents as possible from Silver Command including traffic conditions, any hazards and safe or clear routes recommended by the emergency services.
- Alert staff to a Major Incident by instructing the Switchboard to issue a Major Incident alert (Majax alert)
- Apprise all Tactical Managers of the situation.
- Instruct all managers to:
- Brief staff and be prepared to ensure that they are issued with Major Incident action cards, tabards, relevant PPE and other equipment,
- Create capacity (being careful to coordinate and not adversely impact on other departments and services – e.g., ITU, Theatres)
- Cease and cancel non-essential services to free up key staff for redeployment.
- Allocate staff to deal with the emergency whilst others continue treating patients already in the progress.
- Ensure access to current essential stocks and initiate plans in place to obtain more supplies quickly in consultation with the Materials Management Team.
- Call in extra staff.
- Liaise with other providers for a coordinated response.
- Take business continuity measures like charging electrical equipment and having paper documentation systems handy.
- Convert the Outpatient's Dept into a Major Incident Discharge Lounge
- Liaise with the emergency services and other responding agencies

Emergency Communications

Alerts and global emergency messages can be transmitted via Switchboard to all Trust mobile telephones.

The Trust has 1 Mobile Telephone Preference Access Scheme (MTPAS) enabled mobile phones kept in the Major incident Cupboard in the Major Incident Room (Boardroom).

MTPAS (formerly ACCOLC) can be invoked by police to cut off mobile phone signals of all phones except those with SIM cards registered by responding agencies. However, Vodaphone mobiles can still be used if accessed via a computer.

Debriefs

After Stand Down has been declared by the Bronze Commander all areas/departments Managers/Coordinators, including the Bronze Command Team, will conduct a 'Hot Debrief' in their location. These hot debriefs will include other agencies present.

As a result of these debriefs all Tactical Managers will send a brief and concise report to the Resilience & Safety Manager highlighting what happened, what went well, areas for concern and actions to be taken to rectify these, by whom and when.

The Bronze Commander will call a formal debrief of all Tactical Managers/Coordinators and key staff within a week of the Stand Down.

The Bronze Commander and Resilience & Safety Manager will attend the formal NHS Merseyside Debrief.

The NHS Gold Commander will attend the Merseyside Multi Agency Debrief on behalf of the NHS Merseyside economy and regional debriefs.

Appendix 6 - Glossary of Emergency Planning Terms

Emergency planning terms are highlighted in ***bold and italic*** throughout the plan. Some of these terms are used in supporting plans

BASICS Doctors

Immediate care doctors are specialists, trained in pre-hospital care and to provide medical support at the scene of an accident or major medical emergency, or while patients are transit to hospital. They also provide medical support at mass gatherings.

Category One Responder

Emergency Services, Local Authorities, CCG's and Acutes plus the Environment Agency and Marine & Coastguard Agency are all Category One responders under the Civil Contingencies Act and must plan and work together to provide a coordinated response to emergencies.

Category Two Responder

The NHS NE, Utilities companies, Telecoms companies, some government departments and Transport executives are Category Two agencies that must work with, support and inform Category One Responders and each other to provide a coordinated response to emergencies.

CBRN(E)/ HAZMAT

These are Chemical, Biological, Radiological, Nuclear and Explosion incidents caused by deliberate criminal or terrorist acts. As opposed to HAZMAT incidents which may have the same hazards, characteristics and response but are accidents.

Civil Contingencies Act 2004 (CCA)

The act that determines which agencies are Category One and Two Responders to emergencies and how they should work together to provide a coordinated response with each other and other partners like the voluntary sector and private contractors.

Cloudburst (Operation Cloudburst)

A multi agency major incident response to incidents involving a release of toxic HAZMAT substances. Declaring Operation Cloudburst unlocks resources and sets in motion a formalised response in regard to sites where this has occurred (e.g., see below COMAH sites). There are currently Cloudburst sites on Merseyside and a further 36 in Cheshire.

Command & Control

The Command & Control Structure during a Major Incident has 3 levels:

- Bronze - Operational
- Silver - Tactical
- Gold - Strategic.

Bronze Command

These are the teams that manage the operational response to a Major Incident. At the scene it is fire crews attending the fire, police staffing the cordons, paramedics dealing with casualties, Environmental Health Officers and other local authority responders etc providing advice and finding resources for clean up, etc.

NHS Bronze Command

In the NHS command structure NHS Bronze Command is the exec team of the Acutes, specialist hospitals and community health service providers that manage their own

organisation's strategic response to an incident. They report to NHS Merseyside Resilience who provides both the NHS Silver and NHS Gold Command Teams.

NHS Gold Command

The Chief Exec of NHS Merseyside (or nominee) is the NHS Gold Commander. They will operate from an NHS Gold Control Room (supported by admin staff), which is the NHS Merseyside Resilience for emergency planning in Merseyside. They will attend the Strategic Coordination Group (SCG) to represent the NHS economy in Merseyside.

NHS Silver Command

The NHS Silver Commander and Control Room will be provided by NHS Merseyside Resilience but may operate from a control room within the local authority district where the incident occurred (unless it is a regional or national event like pandemic flu).

Hospital Incident Control Team (NHS Bronze Command)

This consists of the Exec in Charge, Medical Director, Exec Nurse, Ops Director and other Execs.

Control Room (Bronze) Support Team

Call Takers

Trained call takers who complete Major Incident enquiry forms with a précis of telephone, fax and email messages and pass these to the Log Keeper for numbering, noting and passing on to the Bronze Command Team (see above).

Control Support Team (Manager)

The Manager of the admin support team for Bronze Command.

Loggist

Trained loggist for the Bronze Command team who takes down all decisions and actions and key information at Bronze meetings.

Log Keeper (General)

Member of Bronze Control staff who numbers and notes all communications into the Bronze from outside.

Situation Board Writer

Admin officer trained to keep the situation board up to date in the Bronze Command room.

Welfare Officer

Officers of the Trust in each area of activity who arrange refreshments and catering for staff and ensure that breaks are taken and monitor staff for stress.

Control of Major Accident Hazards Regulations 1999 (COMAH)

Top tier COMAH site

A top tier COMAH site, as defined by the Health & Safety Executive, is an industrial or storage premises that holds substantial quantities of hazardous materials that if released have the potential to cause a catastrophic off site effect.

Lower tier COMAH site

A lower tier COMAH site, as defined by the Health & Safety Executive, is an industrial or storage premises that holds substantial quantities of hazardous materials that if released have the potential to cause a serious on site effect.

Community Risk Register

A register of risks and hazards in the County devised by a Risk Assessment Sub Group of all the responding agencies that make up the Local Resilience Forum.

Debrief

A debrief is held after an incident or an exercise to establish learning points and draw up an action plan to enable the review and revision of emergency plans. A hot debrief (see hot debrief) is held immediately after Stand down is declared within the location where responders have been working and a formal organisational debrief will be held within a week after the event. A multi-agency debrief will be held within a month and chaired by a senior officer of the Strategic Coordinating Group.

Exec in Charge

The Chair of the strategic Hospital Bronze Command Team and the officer of the Trust who takes ultimate responsibility for declaring a Major Incident for the Trust and the strategic response to the incident.

Emergency Centres (Established/ run by Local Authorities)

Emergency Rest/ Reception Centre

This is a designated centre to accommodate displaced persons staffed by local authority and voluntary agencies. A place of safety and shelter where people can be accommodated and care for from a few hours to days, weeks or months, dependant upon the incident.

Survivor Reception Centre

This is any initial place of safety near the incident scene that survivors have reached themselves or the emergency services have directed them to, e.g., a church hall, a car park, a supermarket café, etc. It is not necessarily a shelter.

Humanitarian Assistance Centre

This is a drop in centre for anyone affected by the incident that can be an advice centre plus a combination of other centres.

Family & Friends Reception Centre

A centre (usually a hotel or conference centre) where the victim's families are interviewed by police supported by the local authority/voluntary agency crisis support teams, to ascertain the identity of the dead and injured and where they can receive information and emotional and practical support.

Emergency Mortuary

The mortuary at Liverpool Royal Hospital is the designated primary Emergency Mortuary for Merseyside (and in some circumstance North West England). Whiston Mortuary has an Alternative Emergency Mortuary Plan under development for the event that Royal Liverpool is unable to take on this role because it is part of or within the zone of the incident or due to the exigencies of the rebuild of the new hospital. The mortuary can also carry out this function for Cheshire if requested. Being the largest mortuary in the North West, Whiston can also support

the Royal Liverpool with extra cold storage and viewing and Family & Friends Reception and pastoral care.

Emergency Services

North West Ambulance Service (NWAS)

Ambulance Incident Commander (AIC)

This is the officer in charge of the operational response for the ambulance service at the scene.

Hospital Ambulance Liaison Officer (HALO)

This officer will be dispatched to the ED of a receiving hospital where s/he will liaise with the ED Coordinator and other staff and keep them informed of the number, severity and type of incoming casualties and other vital information from the scene.

Hazardous Area Response Teams (HART)

The teams are specialist trained and equipped to work in conjunction with Search and Rescue Teams to triage and treat casualties within the 'hot zone' (on a fire ground) or inside the 'inner cordon' (see the Scene below) in incidents involving hazardous materials or in hazardous places needing special rescue equipment and training.

Casualty Clearing Point/ Area

This is an area that can be on the edge of either the 'inner' or 'outer cordons' where casualties can be brought away from the danger to be treated and transported away to hospital.

Casualty Clearing Centre (Advance)

A building near the scene that provides shelter for casualties awaiting distribution to the most appropriate health care facility and were MERIT teams can stabilise and treat Priority 1 casualties who can't be moved far.

Medical Incident Commander

The MIC will take command of and coordinate all non-ambulance clinical staff at the scene and all casualty points and centres.

National Capability Mass Casualty Vehicles (NCMCV)

These are available to Ambulance Trusts and Hospital Trusts in the event of a mass casualty incident. The following is a brief overview of the capability.

"The NCMCV are part of the governments capabilities programme. Each vehicle contains enough medical equipment to provide emergency treatment for: 100 x either P1/ P2 Casualties and 250 x P3 Casualties

Merseyside Fire & Rescue Service (MFRS)

Detection Identification and Monitoring Team (DIM)

Merseyside Fire & Rescue Service (MFRS) DIM team is a specialist team of HAZMAT officers, deployed to the scene of any incident, which specially equipped and trained to detect, identify and monitor suspected hazardous substances potentially found at the scene. They may have a communications link to the Health Protection Unit Duty Officer direct or via the STAC (see below).

Decontamination (Mass)

The fire service is responsible for mass decontamination at the scene of an incident. They can use the 'New Dimensions' specialist demountable units (2 in Merseyside, stored at the Fire Service Training Academy in Storrington Road, Liverpool) or a system using 2 fire engines, a ladder, a hose and modesty screens. Decontamination of casualties is undertaken at scene by the Ambulance Service and self presenters by the Receiving Hospital.

Merseyside Police

Casualty Bureau

The Police Casualty Bureau is designed to gather information from the public phone calls from concerned family and friends of people who are missing and whom they believe may be affected or caught up in a Major Incident and registration documentation from emergency centres (see above).

For incidents in the NW, the Police Casualty Bureau will be convened near Manchester, supported initially by officers from the affected force area and later by CASWEB which is a national arrangement for receiving calls - when a Major Incident involving a large number of people occurs. A number for the Bureau will be broadcast on radio and TV once it is set up.

Counter Terrorist Security Advisors (CTSA)

The local police Counter Terrorist Security Advisor works with all emergency responders and local communities, etc to advise, inform and train people in how to be vigilant with regards to terrorism and security issues. S/he also advises on ways of responding/ managing your working area/ neighbourhood after an incident has occurred. They run Project Argus sessions to this end.

Documentation Teams

Merseyside Police may send documentation teams to the hospital when a mass casualty incident occurs.

Family Liaison Officers

These are police officers normally allocated to the families of homicide or road traffic collision victims. They are a single point of contact for that family and part of the investigative team. They are supported in Major Incidents by Local Authority/Voluntary Agency Core Crisis Teams. These officers may be part of the response at the hospital.

Force Incident Manager (FIM)

A police inspector in a separate control room to the area control rooms who coordinates the response to a Major Incident as Silver Commander in the initial stages until senior officers are in place.

Health Protection Agency (HPA)

This is a government agency that provides expert assistance and advice in all chemical, biological, radiological and nuclear incidents. The HPA has a useful website that can be used by clinical staff dealing with HAZMAT incidents.

Health Protection Unit (HPU)

This is the local operational version of the above which has a Duty Officer on call who can be accessed via Ambulance Control for advice and assistance.

Hot Debrief

A hot debrief is a short meeting of responders within the location they have been working immediately after the Stand Down, convened to capture learning points while they're still fresh in the mind and to thank the responders.

Local Resilience Forum (LRF)

This is a group of generally high ranking officers from each type of the Category One Responders in a police force area (county) that meets quarterly to discuss emergency planning on a countywide basis and has multi agency sub groups.

Major Incident

This is any incident that requires an emergency response by a number of agencies that will stretch resources and requires special arrangements and procedures to be enacted.

Major Incident Command & Control Structure

See UK National Resilience Structure at Appendix 4.

Medical Coordinator

A Senior Clinician who supports the Exec in Charge/ Bronze Commander on behalf of the Medical Director if the Medical Director his/her deputy or assistant Medical Directors are not available.

S/He will activate and strategically coordinate the medical teams and clinical response to a Major Incident until the Medical Director arrives to take over.

Mobile Telephone Preference Scheme (MTPAS)

Mobile Telephone Preference Scheme can be invoked by police to cut off mobile phone signals of all phones except those registered by responding agencies.

Meteorological Office (Met Office) (see also Weather)

The Met office issues to all Category One responders as required: Severe weather warnings, Extreme rainfall warnings, Flood warnings and Heatwave warnings

Police Link Officer

A member of ED admin team, designated by the ED Coordinator who will liaise with and facilitate police officers in the ED, gather the police pink copies of the casualty Major Incident casualty documentation and supply it to the police documentation team.

Scene (of the incident)

Advance Casualty Centre (ACC)

Any suitable public building near the scene that can be set up to accommodate casualties that require immediate triage, stabilisation and treatment and which due to the grid lock or destruction of the local infrastructure and/or sheer scale of casualty numbers, may take some time to transport to acute hospitals. They can be kept safe and receive vital immediate treatment and be dispersed to the most appropriate hospitals, etc from this centre, in a more coordinated manner.

Casualty Clearing Point

A point on the edge of the Inner Cordon (see below) where NWAS will set up an initial casualty triage, first aid and dispersion point (usually a specialist vehicle or initially regular ambulances).

Cordon (Inner and Outer)

The Inner Cordon is a line around the Hot Zone (see below) where the impact of the event is most apparent. Access through this cordon is controlled by the Fire & Rescue Service and the Fire Incident Commander is the authority within this cordon.

The Outer Cordon is determined by the police at some distance from the Inner Cordon and access points will be controlled by the police who may be supported by local authority officers or highways contractors under contract.

If the police are present at the scene, the most senior police office on site will become the Police Silver Commander and is the overall Commander of all agencies operating from the scene within the Outer Cordon. S/He works in close liaison with the Fire Incident Commander and the Ambulance Incident Commander (if present).

Hot Zone

The area within the Inner Cordon (see above) controlled by the Fire & Rescue Service where the main impact of the event has or is occurring, e.g. a major fire, chemical release, transport crash, explosion.

Incident Control Point (ICP)

A point set up near the outer cordon at the scene where the Silver Commander or Incident Commander operates from to tactically manage the scene.

Rendevous Point (RVP)

A safe or convenient point that responders report to for a briefing before responding to their location of operation.

Stand Down

Stand Down is declared when the response to the incident is no longer required.

UNITY Protocol (see Voluntary Agencies)

The Unity Protocol is a Merseyside plan which provides access to voluntary agencies with an emergency response under the primacy of the British Red Cross. The UNITY Protocol can be activated by the local authority via Silver Command. (Hard copy held in the Major Incident Cupboard in the Bronze Control Room).

Voluntary Agencies

See UNITY Protocol

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NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

https://www.england.nhs.uk/?s=eprr%20core%20standards

Merseyside Community Risk Register

http://www.merseysideprepared.org.uk/media/1406/2017-merseyside-crr-v1-0-17.pdf

Major Accident Hazards (COMAH) Regulations 1999

Response and Recovery Guidance

http://www.cabinetoffice.gov.uk/sites/default/files/resources/recovery-plan-guidance-template.doc

NHS Commissioning Board Emergency Preparedness Framework

Emergency Response and Recovery, Non statutory guidance accompanying the Civil Contingencies Act 2004

https://www.gov.uk/government/publications/emergency-response-and-recovery

Annex 7 A: Communicating with the public: News Co-ordination Centre

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Annex 7 C: Checklist of suggested protocols

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Annex 7 D: Duty to communicate with the public – The Ten Step Cycle
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Appendix 8 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
1.0	Whole document	Full document review in the light of: • changing NHS Landscape and C&C arrangements • lessons from Exercise Jubilee	14/10/13	T. Fitzpatrick/ I. Neill
1.1	Review of Appendix 1 & 2	Review of internal and external reporting, discussion at executive management team and subsequent meeting with Medical Director.	11/06/14	T. Fitzpatrick
1.2	Review of Appendix 3	Review action cards to take into account review at Executive Team meeting.	30/06/14	T. Fitzpatrick
1.3	Review of Appendices 1 & 3	Change to NWAS Helpdesk telephone number to 0345-1130099	07/07/14	T. Fitzpatrick
1.3	Appendix 1	Update flowchart with NWAS revised helpdesk number.	07/07/14	T. Fitzpatrick
1.3	Appendix 3	Update with NWAS revised helpdesk number.	07/07/14	T. Fitzpatrick
1.3	Appendix 3	Update AC011 - Action Card Communications Manager, after update from Communications group update.	07/07/14	T. Fitzpatrick
2.0	Cover	Update contacts change of role for Resilience & Safety Manager and contact details. Update of references throughout.	25/06/15	T. Fitzpatrick
2.1	Appendix 4	Update of Lockdown flowcharts		
2.2	Cover	Update contacts change of role from Director of Governance & Risk to Director of Operations & Performance and throughout document.	28/09/15	T. Fitzpatrick
2.3	AC011 - Action Card Comms Manager	Update Senior Communications Officers contact details	19/10/15	T. Fitzpatrick
3.0	ALL	Full review of content following learning from national mass casualty incidents	June 17 - Dec 17	T. Fitzpatrick
3.1	3.2.1	then inform Spec Comm (England) On Call Manager **0191 430 2498** of Major Incident declared and give details (Email england.spoc@nhs.uk)	Nov 18	T. Fitzpatrick
	3.2.1	Spec Comm number		

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطّلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。

The Walton Centre NHS Foundation Trust
Trust Board Meeting
01 July 2021

The Walton Centre NHS Foundation Trust

Title	Research, Innovation and Medical Education 2020/21 Annual Report
Sponsoring Director	Michael Gibney Director of Workforce and Innovation
Author (s)	Emily Hethington Interim, Lead Research Nurse Jonathan McGregor, Research Data Co-ordinator Liz Doherty, Medical Education Development Manager Dr Andrew Rose, Head of Commercial Engagement and Marketing Dr Rhys Davies, Clinical Lead for Research and Consultant Neurology
Previously considered by:	RIME Committee 5 May 2021 (Research Content Only)

Executive Summary

The report provides details of the Trust's RDI finances, activity and studies for calendar year 2020. It is important to note that the numbers and details of publications for this calendar year will be reported on in September 2021.

In addition, it provides an overview of the year in Medical Education and for the first time, Innovation.

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
Risks associated with this paper	The three risks identified for Innovation, Medical Education and Research.
Related Assurance Framework entries	Risk 011 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. Risk 014 Ensuring the ongoing quality, capacity and capability of Medical Education for the Trust that is sustainable over the longer term. Risk 009 – If the Trust does not identify innovative methods of delivery then it will not maintain its centre of excellent stated to meet the future needs of patients.
Equality Impact Assessment completed	No – Not as an individual summary
Any associated legal implications / regulatory requirements?	Potential failure of research governance
Action required by the Board	To consider and note

THE WALTON CENTRE NHS FOUNDATION TRUST

Research, Innovation and Medical Education 2020/21 Annual Report

Research
& innovation

CONTENTS

FOREWORD

The Walton Centre NHS Foundation Trust is the only specialist trust dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services.

We have a dedicated Neuroscience Research Centre which facilitates cutting edge research to discover new tests, treatments and technologies in all areas of neuroscience that can benefit our patients. The Trust is proud to be involved in a number of collaborative studies with universities and commercial companies at local, national and international level.

2020/21 was an unprecedented year for the trust and the NRC team. We were pleased to support a number of COVID trials and can report we recruited 580 patients for period March 2020 – April 2021. We look forward to resuming non covid research studies as the pandemic eases and continue to conduct research that provides tangible benefits for patients.

We have an innovation programme that is supporting a range of commercial and non-commercial initiatives, which is delivered with clinical teams and supported by the Neuroscience Research Centre and many other Trust functions (including IT, IG and procurement).

We work in partnership with a number of collaborators and stakeholders across the North West footprint to support the translation of research into practice and facilitate the adoption of innovation to transform services and this report also provides details of the innovative projects our staff have undertaken.

Medical Education consistently receives accolades from stakeholders for the quality of teaching and overall learning environment afforded by the Trust for both undergraduate and postgraduate training. Despite challenges presented by the COVID-19 pandemic and the implementation of new training programmes and education curricula, Medical Education has continues to facilitate the educational experience for which it is known.

Mr Seth Crofts Non Executive Director & Chair for RIME Committee
Dr Andrew Nicolson Medical Director & Executive Lead for RIME
Dr Rhys Davies Clinical Director for Research & Director of Medical Education
Dr Shagufay Mahendran Clinical Director for Innovation

RESEARCH

OUR YEAR IN NUMBERS

Research covers the 2020 calendar year. The calendar year has been chosen to reflect progress made before Covid and the subsequent impact of the Covid crisis. This is reported on in 2 ways:

- Quarter 4 2019/20 (Pre-Covid)
- Quarters 1-3 2020/21(During Covid)

Reporting in this way is not suitable for income and expenditure purposes, therefore for clarity income and expenditure will be reported separately for both the 2019/20 and 2020/21 fiscal years.

	2019/20	**2020/21**
Number of participants recruited into clinical research	1272	580
Number of active studies	*unavailable*	54
NIHR Funding	214,407	150,222
CRN funding	363,523	404,401
Research Capability Funding	175,700	102,702
Commercial Income	207,668	83,540
Income from Charities	158,581	96,703

INTRODUCTION

The Trust has a unique status as a specialist clinical neuroscience trust with an established reputation for delivering research and supporting innovation. This Annual Report captures activity over the course of 2020/21, illustrating our contribution to delivering the Trust's Strategy whilst recognising the substantial challenge presented by organisational change and the impact of / response to the COVID pandemic.

The Trust has a well-established record of investing in research based on our clinical strengths and strategic priorities, all of which supports patient services. We continue to work with clinicians and managers to consolidate the delivery of activities and build a sustainable programme of work aligned to the RIME agenda, the newly established Research, Innovation and Medical Education Committee.

We are committed to supporting research and innovation in the region and have developed a number of collaborations and partnerships especially with Universities across Liverpool and throughout the UK. We are a member of Liverpool Health Partners and have been an active collaborator in a range of external initiatives for the advancememnt of clinical research e.g. participating in the University of Liverpool's Clinical Research Review to align the Universities' research strengths with NHS research priorities.

The recent development of a Single Point of Access to Research and Knowledge (SPARK) brings together the Liverpool Health Partners (LHP), NHS trusts and universities research support functions to facilitate and deliver high quality, world-class health research, capitalising on the commitment locally to drive research based on population need. A burgeoning relationship between the NRC clinical research team and SPARK has begun to develop. This will be further consolidated by the proposed creation of an Infection Liverpool Biomedical Research Centre, of which WCFT will be a significant contributor and collaborator demonstrating the pivitol role WCFT has in the wider system.

FOCUS ON RESEARCH DEPARTMENT -

Organisational Change Process

Prior to the emergence of the pandemic in March 2020 the Neuroscience Research Centre was experiencing significant flux within its workforce. Established members of the NRC team left and along with long term sickness resulted in staffing gaps across the team structure. This was, and remains, a difficult stressful period for staff. Despite this the team successfully recruited,1,272 participants into clinical research studies during 2019/20, the majority being recruitment into non-commercial studies such as TONIC.

Nonetheless there was still strong sense of low morale and well-being within the team. It was apparent an OD intervention was needed in order for the department to move forwards affirmatively. A successful team building collaboration exercise with the LHP SPARK team took place this was then followed by the instigation of an organisational change process in February 2020.

COVID

March 2020 saw the onset of the Government led COVID pandemic response plan and the organisational change process was suspended. The consequences of lockdown were felt across the department:

- Low team morale further exacerbated
- WCFT site patient flow reduced to zero halting trials
- Commercial / non-commercial trial sponsors suspended recruitment to studies
- NIHR / NWCRN redirected available resource – staffing and infrastructure – to support UPH Covid studies

The team worked from home where possible, which enabled the backlog of administrative work for individual clinical trials to be undertaken. Commercial and non –commercial trial sponsors suspended recruitment into the majority of the studies on our portfolio, a decision backed by the NIHR and NWCCRN. National guidance by this stage had changed to instructing research teams across the UK to prioritise the opening of Urgent Public Health (UPH) Covid studies. At time of writing this remains in place.

FOCUS ON RESEARCH -

As a specialist neurosciences Trust our staff are committed to working in partnership to lead and undertake academic and commercial research in all aspects of neurological, neurosurgical and pain conditions to provide our patients with opportunities to participate in and benefit from research studies.

Most of the expected activity and growth identified in 2019 was suspended following the restrictions on non-Covid studies in March 2020. NIHR and NWCRN targets were put on hold whilst focus turned to Covid Urgent Public Health (UPH) studies. The NRC proved responsive and adaptable to the changing national and local guidance over this period and have successfully supported recruitment into the following UPH studies:

- RECOVERY (Randomised Evaluation of COVID-19 Therapy)
    - 2 patients successfully recruited. Low numbers due to patient pathways
- ISARIC (International Severe Acute Respiratory and Emerging Infection Consortium) – Clinical Characterisation Protocol for Severe Emerging Infections
    - 76 participants
- Covid Chest Imaging Database
    - 76 participants

Both the workforce change and pandemic have delayed some of the emerging developmental research workstreams such as exploration of new grant opportunities via analysis of national and internation trends, early phase trial collaborations with commercial and non commercial sector partners and internal projects such as the development of a research engagement programme designed to publicise participation in research. Head of Research is to lead Industry Working Group (LHP) with work commencing January 2021. It is proposed this group will initiate and direct strategic projects currently suspended due to the pandemic.

Opportunity during this time has been taken to review and strengthen governance processes in particular around GCP training and oversight of sponsorship. A process to track GCP training for research active staff has been created and along with sponsorship is now monitored by the Sponsorship & Oversight Committee. Work continues to reach out to research inactive clinical areas to support development of new PIs

To address the issue presented by research nurse capacity, to support delivery of non commercial trials, agreement with CRN NWC was achieved to use slippage monies to fund 2.0wte Band 5 research nurse posts to support the Band 7 research nurses. To encourage engagement in research activity and enable the sharing of research opportunities research nurses are now members of trust wide Sharing and Learning Forum.

There has been notable work to consolidate key relationships internally and externally to the Trust. Exploratory work with trust colleagues within Innovation and Procurement has commenced with implementation of the ERNST and VERA pilot studies, In addition there has been a mini-lab created within the NRC and the team now have a presence on the Liverpool Neuroscience Labs committee. External collaboration will be discussed furterh on but it is important to recognise NRC role on high level regional groups, tangibly strengthening links with academic, industry and

clinical partners such as ARC and LHP. Opportunity will be maximised to access skills and experience available, e.g. SPARK, to support development of trust staff in future planning and completion of grant applications.

FOCUS ON RESEARCH FUNDING -

The emergence of Covid has had a huge financial impact on clinical research income, notably commercial income dropped by two thirds between 2019/20 and 2020/21. This has been unavoidable and a financial recovery plan is being considered but is contingent on the national Covid situation and on guidance from NHSE and NIHR.

NIHR

The Trust received NIHR funding of £150,222 in 2020/21 (in comparison 2019/2020 £214,407). The decrease is due to fewer NIHR grants in the previous year and end of Professor Solomon's term as a Senior investigator. Below are highlights of Trust's sponsored research studies funded by the National Institute for Health Research:

- Radiation versus Observation following surgical resection of Atypical Meningioma: a randomised controlled trial (the ROAM trial); Chief Investigator: Mr Jenkinson. Study has now met its recruitment target despite reduced activity in the past year, and is now moving into follow-up stages.

- Dr Janine Winterbottom's PREP study into women with Epilepsy

Research Capability Funding

The Trust attracts Research Capability Funding (RCF) in proportion to the amount of NIHR funding secured, in 2020 this was £102,702 compared with £175,700 in 2019.

Clinical Research Network: North West Coast Funding

In 2020 the Trust received service support funding of £404,401 (£363,523 2019/20) from the Clinical Research Network: North West Coast (CRN: NWC) to support the delivery of clinical research.

Professor Young is the Specialty Group Lead responsible for supporting the delivery of clinical research in dementias and neuro-degeneration, and neurological disorders and Professor Marson is the Specialty Group Lead for health services and delivery research. Mr Jenkinson is one of the Sub Specialty Group Leads for cancer. Dr Sekhar is deputy lead for hyper acute stroke research centre for Cheshire & Merseyside

Commercial Research Funding

The Trust received £83,540 from pharmaceutical and technology company sponsored projects in 2020/21 in conditions such as multiple sclerosis, migraine, cluster headache and backpain. This was a significant decline from 2019/20 which saw income of £207,668 generated from commercial trials but perhaps inevitable given the context of the pandemic.

Funding from Charities

The Trust received £96,703 in 2020 from Charities to support research studies such as the Trajextories of Ourcome in Neurological Conditions (TONiC) study. The TONiC study is a national study examining the factors that influence quality of life in patients with neurological conditions. It is one of the larges studies on quality of life in neurolligcal conditions ever delivered in the UK and involves patients with multiple sclerosis, motor neurone disease and neuromuscular conditions.

Study Delivery

The Trust aims to excel at translating research findings into clinical practice to create new diagnostic investigations, treatments and technologies for the benefit of our patients and in 2020 there were 54 active studies (101 including open and follow studies).

Recruitment to Research Studies

Pre covid the Trust exceeded targets with 1262 recruited in 2019/20 (appendix A). Due to COVID routine studies were suspended from March 2020. Figure 1 shows monthly recruitment figures for COVID studies between April 2020 and March 2021.

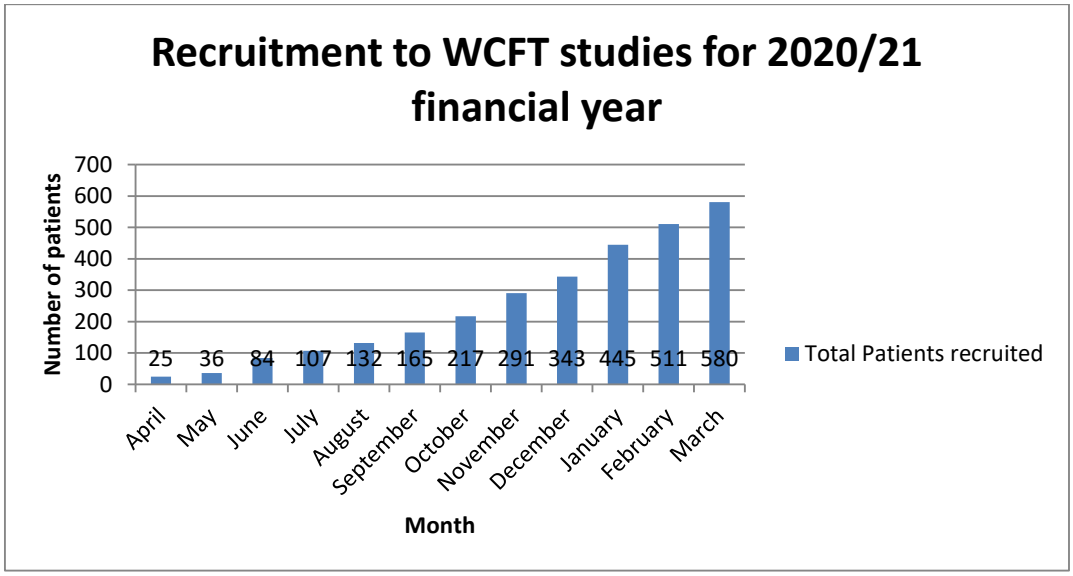


Figure 1 Recruitment to WCFT 2020/21

Research Publications

The Trust strongly supports the promotion of research and dissemination of results to improve clinical practice. We are in the process of collating research publications and will be pleased to report this in in full to RIME committee in September 2021.

INNOVATION

INTRODUCTION

Innovation is central to the Trust maintaining its position as the outstanding centre of excellence for Neuroscience in the UK. The Trust's first Innovation Strategy, approved by the Trust Board in January 2020, focuses on establishing a culture of innovation and developing a range of initiatives that reflect the scope of services across the Trust as a whole. Following the appointment of key members of staff over recent years (Clinical Lead for Innovation, Head of Commercial Engagement and Marketing, and an Innovation Co-ordinator), the Trust has increased its capacity to innovate.

The COVID-19 pandemic has delayed some innovation activities with the Clinical Lead for Innovation clearly having to prioritise clinical demands and the Co-ordinator seconded to support Trust testing and vaccination activities. However, other innovation activities have progressed despite COVID-19 due, in large part, to a recognition across the organisation that innovation will help us to continue to deliver excellent care. Innovation resourcing will need to more closely match Trust strategic intent going forward for the programme to be sustained and developed.

ACTIVITIES

Key Innovation activity this year are listed below:

- Electronic Routine Nutritional Screening Tool (ERNST) - This digital product will enable patients at risk of malnutrition and obesity to access appropriate care and treatment more efficiently and consistently. With partners, this year we secured funding to develop a prototype, completed IT development and organised a pilot clinical study to evaluate the prototype (study close to completion mid 2021/22). This project has the potential to generate income for the Trust.
- Virtual Engagement Rehabilitation Assistant (VERA) - An interactive digital platform that supports holistic rehabilitation of patients and carers in in-patient and community settings. Again with partners, we secured funding to develop a prototype, progressed IT development and started organised a complex pilot clinical study to evaluate the prototype (study to commence mid 2021/22). Again, this project has the potential to generate income for the Trust.
- Spinal Improvement Partnership (SIP) - A new mechanism to provide reports to medtech companies on implanted spinal devices to improve quality and patient safety. Initiative delayed due to COVID-19 impacts on spinal surgery, but negotiations with medtech companies are now progressing to generate income for the Trust and provide other benefits. Some Trust resourcing challenges being resolved.
- Chatbots/Artificial Intelligence projects – A range of digital chatbots (conversational agents) are in development to facilitate patient interactions with the Trust and support their care. Initial chatbot and other Artificial

Intelligence projects are being defined, with programmes to be initiated in 2021/22 subject to Trust approvals/funding.

- Multitom Rax – The world's first twin robotic X-ray imaging system that enhances both patient care and productivity. It has the capability to performing numerous x-rays in one room and the ability to image in 3D, whilst requiring less patient positioning and transfers. The equipment was installed at The Walton Centre in early 2020. The Trust is the first health care provider in Europe to have a Multitom Rax.
- Movement Analysis Laboratory Business Case - The Trust has being engaging key stakeholders on its proposed and ambitious new improvement for complex rehabilitation services. COVID-19 has impacted on the engagement of clinical colleagues. However, the initiative will be a primary focus for innovation in the coming year.
- A range of additional commercial and non-commercial initiatives are also being explored.

MEDICAL EDUCATION

OUR YEAR IN NUMBERS

Period covered - Academic Year 2020-2021

Doctors in Training	Core - 7	GP - 1	Specialty - 41
Medical Students	Year 4 - 180	Year 5 - 35	Elective N/A
# Consultants who are GMC Approved Educational / Clinical Supervisors	85 (/140 68%)		
#GoSW Education exception reports made by Doctors in Training	0		
UG Placement RAG Report Overall satisfaction / I would recommend this placement to another student	Year 4 1.98 - Green outlier Ranking - 2nd of all sites	Year 5 Not available	
*GMC Enhanced Monitoring	No		
*GMC NTS Overall Satisfaction	Within national average		

*CQC indicators

INTRODUCTION

This section on Medical Education covers the academic year 2020-21. The effects of COVID have been wide ranging upon the delivery of education with undergraduate clinical placements suspended in April 2020 and many postgraduate training programmes interrupted, with the redeployment of doctors in training in the spring/summer of 2020. Fortunately education and training of undergraduate and postgraduate medics at Walton has continued largely without interruption, albeit in an adapted format with socially distanced MS Teams facilitated teaching and meetings replacing the useful onsite activity.

Responsibility for medical education and training at The Walton Centre sits with the Director of Medical Education and the faculty of Lead Educators, Clinical Tutors and Educational Supervisors. In April 2021 Dr Charlotte Dougan stepped down as DME and was succeeded by Dr Rhys Davies. Managerial support is provided to the faculty by the Medical Education Development Manager, Liz Doherty with operational

services administered by Medical Education Officers, Judith Dennis and Yasmin Harris, and Medical Education Administrator Amy Chapple.

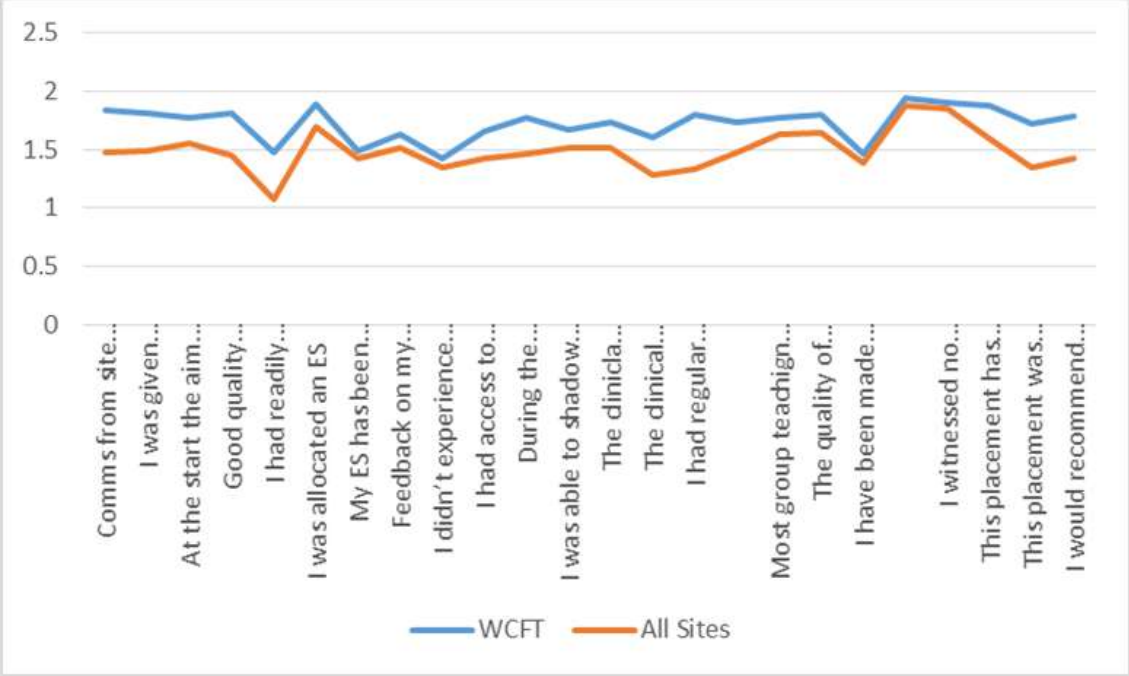
Commissioning of medical education is by Health Education England via Health Education North West local office. Nationally, there has been a system wide review of health education finance and a new contract including both undergraduate and postgraduate training implemented from April 2021. For undergraduate education a new tripartite agreement within the contract between HEE, placement providers and HEIs has been established, setting out specific expectations for each party. For postgraduate training there is a distinct alignment with the Academy of Medical Educators professional standards in regard to outcomes for placement providers. A bi-annual trust report will form part of the performance monitoring processes of the new contract moving forwards.

There is ongoing development at a national level to create an annual quality report for health education. This is due to be rolled out following the release of the revised Health Education Quality Framework, due to be shared later this year. It is anticipated the education quality report will align with the aforementioned bi-annual education contract report.

FOCUS ON UNDERGRADUATE EDUCATION:

Year 4

University of Liverpool resumed the undergraduate medical MBCHB programme in September 2020 and Walton welcomed the first undergraduate cohort to experience the new 4th year Neuroscience programme. Despite the challenges posed by COVID restrictions to actual time spent on site and experiential learning, student feedback has been excellent. The university collects formal evaluation data for each rotation which feeds into a placement RAG report and tracks student experience through the year. Walton has consistently received excellent results through the year for the standard of teaching available and the enthusiasm and engagement of the staff both medical and administrative. Below is a graph which shows Walton's annual average scores compared with the all site average for the period:



Source: University of Liverpool Placement RAG Report, 2020-21

Students reported timetabling problems early on in the academic year with clinics clashing and supervisor availability however the administration team and education leads where able to mitigate with additional measures to address the problems and this lessened as the year progressed.A common theme that remained however was the impact of not being on site for prolonged periods and lack of access to direct patient interaction creating gaps in student skills and knowledge.

Year 5

The current Year 5 is the last of the old curriculum and we've had confirmation the new programme as from September 2021 fifth year will feature 1 SAMP placement as opposed to the 2 placements of the present programme. Feedback from the 2020-21 cohort has been very positive, the impact of covid generating the only 'negative' - a call for more on-site teaching, which was evaluated as excellent.

FOCUS ON POSTGRADUATE:

Redeployment due to covid has had minimal effect on Walton's postgraduate training programmes and if this did occur trainees were relocated within programme, not to another clinical specialty. The GMC ran a survey in late summer 2020 which focused on the spring period of the pandemic. The survey was an abridged version of the usual National Training Survey and had additional questions around health and wellbeing and organisational support. Neurosurgery trainees reported issues in regard out of hours supervision. Extensive discussion with HEE NW to identify if this was higher or core training reporting was unsuccessful due to the way the report was collated. However, conversation also took place with the trust lead educators (higher

and core neurosurgery); they were advised the current group had not reported any similar problems and were confident that it had been resolved. Feedback reports from Medicine and Anaesthetics trainee doctors were both incredibly positive, with high levels of satisfaction in the level of health and wellbeing provision available through the trust and did not report significant negative impact to their working lives during this time. Inevitably there was a negative impact reported on their access to curriculum development which the trust education leads have sought to remedy over subsequent months.

Early in the academic year IMT trainees (SHO grade) reported via the Junior Doctor Forum of reduced on site clinical activity affecting the number of clinics they were able to access. This led to measures including extending agile working space to trainees so they could access Attend Anywhere clinics. There is however a tension between undergraduate and postgraduate regarding clinic access due to what is a limited shared resource. Education administrators are now working with divisional coordinators to avoid clashes when allocating clinics.

There have been several good news stories to come out of 2020-21. A Neurology Registrar led initiative, NeuroPodCasts, was successful with a bid for HEE NW funding in December 2020. The bid was put together by Dr Sarah Healy and has enabled the team to purchase kit to enhance the production quality of the resource. The online podcast discussion series focuses on Neurological conditions and has been accessed by users internationally. Dr Rhys Davies introduced a Neurology Registrar education rotation to support ward-based education. This has been well received with the undergraduate students noting via the RAG reports the valued pastoral as well as academic support this has brought over this year.

WALTON CENTRE NHS FOUNDATION TRUST'S RESEARCH, INNOVATION AND MEDICAL EDUCATION COLLABORATIONS AND PARTNERSHIPS

WCFT Research, Innovation and Medical Education Committee – RIME

In 2020 the RD&I committee was reinvigorated and became the Research, Innovation and Medical Education Committee to reinforce links between functions and consolidate trust strategic aim to lead in research education and innovation

Liverpool Health Partners (LHP)

Liverpool Health Partners (LHP) brings together clinical and scientific expertise to develop world-leading research that draws on the strength from within each of the founding partner organisations. The Trust is a member of LHP which aims to create a strategic partnership for improving health and pursuing excellence in the delivery of health care research and education.

The Trust has implemented LHP's Standard Operating Procedures to support more streamlined approaches for improving the setup of commercial research.

WCFT have committed support to the development of an Infection Biomedical Research Centre for Liverpool

Clinical Research Network: North West Coast

The CRN: NWC supports the Government's Strategy for UK Life Sciences by improving the environment for commercial clinical research in the NHS. The CRN: NWC supports the Trust in undertaking academic and commercial neurosciences research to ensure the Trust sets up studies quickly, conducts studies efficiently and meets study recruitment targets.

The Trust is committed to increasing the opportunities for patients to participate in clinical research and recognises the important contribution patients make to our research success and supports NIHR's Patient Research Ambassadors initiative.

The Trust supports the CRN NWC's Building Research Partnerships Programme and participates in the annual NIHR Patient Research Survey.

Innovation Agency

The Trust works closely with the Innovation Agency, the Academic Health Science Network (AHSN) for the North West Coast, one of England's 15 AHSNs. We are represented on the Innovation Agency Board and support a range of initiatives the organisation leads.

Liverpool City Region (LCR) Growth Platform and Local Enterprise Partnership (LEP)

The Trust works closely with the LCR Growth Platform and LEP. We are represented on strategic LCR Boards and support a range of initiatives related to local companies and employment that the organisations collectively lead.

Everton Minds

Innovation and Research colleagues have been supporting the Everton Minds initiative. This initiative is being developed and will provide research and innovation opportunities for dementia patients and families, whilst regenerating the Goodison Park area of Liverpool in the wake of the development of the new Everton FC stadium.

North West Coast Genome Medicine Centre

The Government's 100,000 Genomes Project has committed to sequencing 100,000 whole human genomes to accelerate the benefits arising from innovations in genomics for NHS patients and contribute to economic growth by establishing the UK as the leading international base for genomics science and industry.

The Trust is a local delivery partner in the North West Coast NHS Genomic Medicine Centre (NWC GMC) which is hosted by Liverpool Women's NHS Foundation Trust. The Trust has reached its recruuiment target of 206 DNA samples from patients with rare inherited neurological diseases and samples from patients with rare brain tumours.

Collaboration for Leadership in Applied Health Research and Care: North West Coast (CLAHRC: NWC)

The Trust is a partner in the Collaboration for Leadership in Applied Health Research and Care: North West Coast (CLAHRC: NWC) in partnership with local universities, other NHS organisations and local government.

The focus is on improving patient outcomes through the conduct and application of applied health research. One of the Trust's Specialist Nurses has secured an internship to undertake a project to explore wellbeing in patients with motor neurone disease which builds on the success of the Trajectories in Outcome in Neurological Conditions (TONiC) study.

The Brain Charity

The Trust recognises the importance of promoting research and has worked closely with The Brain Charity to raise awareness of the wide research undertaken at the Trust through its coffee mornings and other events.

The Trust held a number of Open Meetings with members which were used to further promote research more widely.

University of Liverpool

Medical Education has developed a distinct network within the Medical School and the university beyond the formal relationship as clinical placement provider. NeuroSoc, the undergraduate medical society and the Medical Education Team have worked closely in recent years in facilitating and hosting the annual undergraduate conference as well as other undergraduate training events.

Liverpool Neuroscience Group - LNG

The Trust is a key member of the local neuroscience stakeholder network and has collaborated with the LNG in recent years to host events such as the Sutcliffe Key showcase lecture and the LNGS seminar and conference series.

LOOKING AHEAD TO 2021/22

The NRC is going through a major transition and the next 12 months will be a period for recalibration of work streams post covid and adjustment for the wider team as the structure becomes clear.

Covid will influence how well the NRC is able to return to pre 2020 activity levels but workforce transformation work will help to ensure there is sufficient workplace capacity to grow, develop and maintain the research function. Our staff are integral to sustaining our research strengths and essential in ensuring we attract, retain and develop new talent to undertake clinical research to develop the pioneering treatments that benefit our patients.

We will endeavour to establish a sustainable financial model that balances income stream, in particular the untapped commercial study capability. We will take advantage of the unique expertise available through our professional networks to develop skill set of research staff in regard to grant planning and application.

We will ensure there is clear alignment of research with the WCFT brand and Trust ambitions. We will ensure the research portfolio is informed by and supports key Trust and regional strategic priorites eg spinal centre of excellence and demographic needs associated with neuroscience related ill health.

In addition to the effects of the pandemic, there are local and national political factors we will need to consider. The implications of Brexit are yet to be understood but will need to be borne in mind amid competing and emerging system change.

We will endeavour to effectively promote our research to raise awareness of the range of research and innovative projects we undertaken to encourage patients to participate in our studies in collaboration with the CRN:NWC and voluntary groups.

In terms of innovation, we will continue to develop innovation projects and wider initiatives, with an emphasis on strategic developments, synergising with Trust IT initiatives, undertaking further research on prototypes and commercialisation.

We will work to realign resources dedicated to innovation in the wake of COVID-19 to ensure the continued success of programmes. We work to empower and engage Trust colleagues to get involved in innovation projects.

We will continue to work in partnership with LHP and the University of Liverpool in the development of its application to establish the Biomedical Research Centre for Liverpool in which we will be a key partner, helping to translate research into tangible benefits for our patients.

We will continue to be an active partner in LHP and support the endeavour to establish a Joint Research Service for the region to promote and support delivery of research.

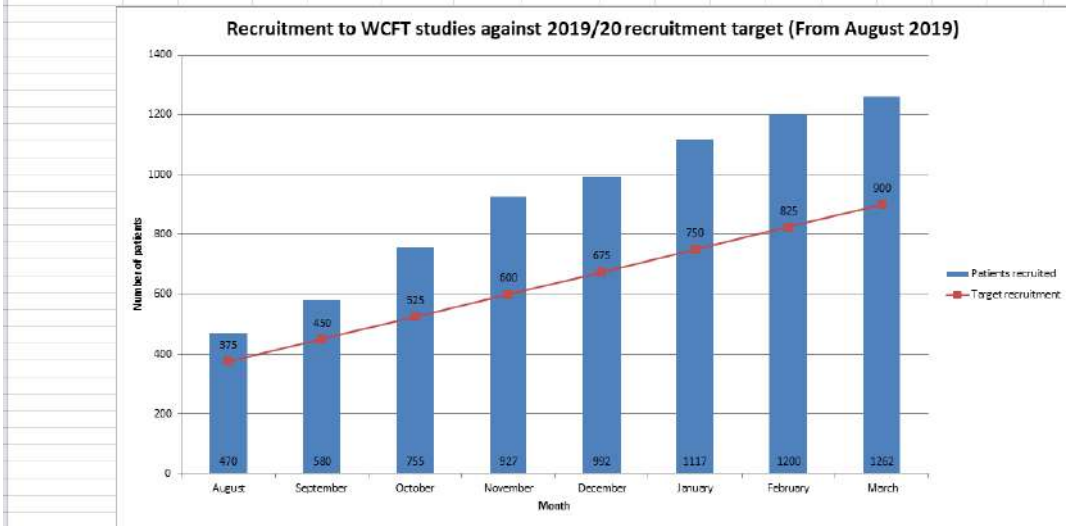
We will work in collaboration with the Innovation Agency to support the uptake and spread of innovation to improve health care and outcomes for our patients.

Medical Education will work to consolidate our internal relationships and encourage engagement from all specialties within the trust. Further to this, we will be reponsive to external changes affecting medical education and training and continue to build effective entworks with stakeholders from across the health education system.

APPENDICES

Appendix A - 2019/2020 Recruitment to WCFT studies Data

Patients recruited	470	580	755	927	992	1117	1200	1262
Target recruitment	375	450	525	600	675	750	825	900



REPORT TO
The Trust Board
1st July 2021

The Walton Centre NHS Foundation Trust

Title	Equality, Diversity and Inclusion Annual Report 2021
Sponsoring Director	Mike Gibney, Director of Workforce and Innovation
Author (s)	Andrew Lynch, Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary This report is summarises how the Trust meets its General and Specific Duties under the Equality Act 2010.	
Related Trust Ambitions	Be recognised as excellent in all we do
Risks associated with this paper	See performance assurance framework (separate report)
Related Assurance Framework entries	**N/A**
Equality Impact Assessment completed	No – This report makes no recommendations for changes. This report publishes information about the Trusts equality related activities and equality profile in line with the Specific Equality Duty under the Equality Act 2010, as such its positive affect on equality is axiomatic.
Any associated legal implications / regulatory requirements?	Yes – The publication of this EDI Annual report is mandated as a Specific Equality Duty under the Equality Act 2010.
Action required by the Board	To consider and note

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Public Sector Equality Duty

Equality, Diversity and Inclusion Annual Report 2021

Contents

1 Introduction

I am pleased to introduce The Walton Centre NHS Foundation Trust Annual Equality Diversity and Inclusion (ED&I) Report 2021, which sets out the Trust's approach to ED&I and how the Trust meets the Public Sector Equality Duty (PSED).

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

1.1 Our Vision

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

1.2 Our Purpose

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

1.3 Our Ambitions

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

We will:

- 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.

1.4 Our Equality Diversity and Inclusion Vision

The Walton Centre's commitments to equality, diversity, and inclusion can be encompassed in the following statements:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity.
- We are committed to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre.
- We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

Walton Way:

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

The Walton Centre is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place in 2020/21 and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity. We will continue to monitor our equality diversity and inclusion progress against our action plans and report annually and openly.

Lisa Salter

Lisa Salter
Director of Nursing and Governance,
Executive Lead for ED&I

2 Equality Act 2010

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

The Act protects people from discrimination on the basis of 'protected characteristics', which vary slightly depending upon whether a person is at work or accessing services. For example, 'marriage and civil partnership' is a protected characteristic for employees but not for people using services.

The nine protected characteristics are:

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

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

2.1 The General Duty

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

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

2.2 The Specific Duty

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

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

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

The information below provides an update regarding some important ways the Trust works to meet the requirements of The General Equality Duty and to ensure equality of service delivery. In the interests of brevity and readability it is not possible to include all actions that we take throughout the year, so this report only highlights some of the more significant actions taken by the Trust in meeting the Equality Duty. More information can be found on the Trust's website.

3.1 Eliminating discrimination, harassment, victimisation and other prohibited conduct

3.2 Policies & Training

The Trust continues to work to improve the way we identify and address potential discrimination, to ensure that our staff, patients, and their families and carers, experience care or employment that is free from any prohibited behaviours, and that redress is transparent and open for all.

- The Trust has policies and procedures in place to tackle discrimination, harassment, bullying, victimisation, abuse, violence and aggression. These policies are both for staff, and for patients and their families.
- Equality Impact Assessment/Analysis (EIAs) are carried out in regard to all policies and significant changes to the services provided by the Trust. Guidance is made available to all staff completing EIAs. Staff are also signposted to the Trusts Equality and Inclusion Lead to advise them on the process if needed.
- Both the induction for new starters and the three yearly mandatory eLearning equality and diversity module raise awareness of discrimination and highlight that such behaviour is not permitted. The refresher training also ensures that all staff are maintaining awareness of equality and remain up to date with any changes in legislation. In response to feedback from staff the need for additional equality awareness training has been delivered to both staff and managers in 2019-2020. Further additional equality and diversity training is planned for the last quarter of 2021.

3.3 Activities

Delivering on our Equality, Diversity, and Inclusion Vision continues to be a high priority for the Trust.

Race equality

Following the death of George Floyd, the Trust reaffirmed our commitment to tackling racism whenever we encounter it. The safety and wellbeing of our patients and staff is of paramount importance to us. We've taken a number of steps forward in this area, but we're conscious that we still have a long way to go.

- We have established a race equality sub-group of the Trust Board. Led by the CEO, it will develop specific responses to the health impact of COVID-19 on Black, Asian and minority ethnic communities, and racial inequalities.
- The Trust has separated out and analysed Black, Asian and minority ethnic patient data to ensure equality of access.
- The Trust has engaged with voluntary sector partners to ensure that both medical and non-medical information support and advice is accessible to Black, Asian and minority ethnic communities.
- The Trust has separated out Black, Asian and minority ethnic recruitment statistics to ensure that black communities are fairly represented in the recruitment of Black, Asian and minority ethnic staff.
- By using the website https://bmejobs.co.uk/ the Trust has acted to boost targeted online advertising of its job opportunities to Black, Asian and minority ethnic communities
- The Trust will continue play a leading role in the development and implementation of regional and national initiatives to eliminate racism and race-related health inequalities.
- We continued to respond to the to the disproportionate impact that COVID-19 has had on Black, Asian and minority ethnic communities in both the first and second wave of the pandemic. We took steps to ensure our Black, Asian and minority ethnic staff are safe, well informed, listened too and vaccinated.
- The Trust has participated in the Black, Asian and minority ethnic Insight Research Steering Group, to increase our knowledge of the relevant diverse communities and facilitate more targeted engagement regarding health inequalities and preventative work e.g. promoting COVID-19 vaccine uptake.
- The Trust will continue to ensure that the views of Black, Asian and minority ethnic individuals and communities are reflected in the development and implementation of the race equality actions above, facilitated by regular dialogue between our Non-Executive Directors and Black, Asian and minority ethnic staff regarding decision-making at the Trust.
- The Trust marked Black History Month online by posting information and profiles of Black people who have made a notable and positive contribution to our society.
- We have launched 'We say no to racism' badges for our workforce, to help publicise the Trust's zero tolerance approach to racism and discrimination.

3.4 Continuing Activities

A significant challenge for the rest of 2021 will be sustaining and building on the progress we have made over 2020 and since the murder of George Floyd. George Floyd's murderer has been brought to justice and Black Lives Matter is no longer a nightly news item. UK COVID-19 death and serious illness rates are currently much lower than their peak and people want to get back to more normal ways of working and acting. In the process of the Trust's systems moving to post-covid conditions, there is the possibility that equality will receive less focus, so the Trust will take steps to maintain a high level of attention on equality and diversity.

- We will continue to work to consolidate each of the steps mentioned above and maintain race equality as a high priority for the Trust

- We will work to ensure that, in the aftermath of the COVID-19 pandemic, we maintain a focus on the physical and mental wellbeing of our staff from Black, Asian and Ethnic Minority backgrounds
- We will use the Trust website and intranet more effectively to inform staff of the Trusts race equality performance e.g. by giving a greater prominence to the reporting of Workforce, Race and Equality Standards (WRES), which are to be published later in the year
- We will support our Black, Asian and minority ethnic staff network in dialogues to continually identify and carry out positive more actions which will ensure that our Black, Asian and minority ethnic staff feel empowered and able to bring their whole self to work at The Walton Centre

3.5 Support for Staff with a Disability

Trust currently holds DWP, Disability Confident Scheme Level Two certification.

Through implementing Disability Confident, the Trust is working with to ensure that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations.

This scheme also helps the Trust to recruit and retain from the widest possible pool of talent and help us to keep their valuable skills and experience. Under the scheme the Trust can use the Disability Confident Committed logo on the Trust stationery, correspondence and website, and can also display the Disability Confident Committed certificate to demonstrate our commitment.

Recruiting managers do not see any applicant's personal demographics, including their name, prior to the shortlisting stage. This helps to ensure that any potential discrimination at this stage is prevented. In addition, the Trust has taken steps to include diverse interview panels in the recruitment process for senior managers and NEDs to further ensure fairness in recruitment.

Access to Work is promoted within the Trust to support staff with disabilities with regard to accessing reasonable adjustments. All staff can also access Occupational Health and counselling support, as well as the support that can be provided by the HR. This includes the completion of a Tailored Reasonable Adjustment template which looks at what changes can be made to support an individual to remain in work and to have the same opportunities as employees who do not have a disability

3.6 Workforce Disability Equality Standard (WDES)

The Trust reported and published performance data in regard to disability equality in 2020. The WDES Report was discussed by the Trust Board and appropriate actions were drawn up to advance equality further in relation to workforce disability. A copy of the Trust's 2020 WDES report can be found on the Trust's website at:
http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/corporate/WDES%20Report%202020%20Final%20(4).pdf

3.7 ED&I Champions

The Trust has reviewed and relaunched its EDI Champions Group in 2020/2021.
The EDI Champions are a diverse group of staff from across the organisation; their aim is to create a higher profile for ED&I and to drive positive culture change to further support the Trust's equality commitments. The role of the Equality and Diversity Champions are:

- To support Walton Centre patients and colleagues to make positive improvements.
- To actively influence the way in which the hospital operates, monitors, plans and develops its services and staff to reflect the value of equality and diversity.
- To promote awareness of equality and diversity issues within our services, and across the Trust as a whole and the wider community; to act as a two-way communications channel between the Trust, colleagues, people who use our services and those who care for them.
- To develop knowledge of equality and diversity issues and educate others on the value of these
- To provide information and advice on equality and diversity issues and/or signpost people to alternative sources of information and advice within the Trust.

The EDI Champions Group reports to the Trust's EDI Steering Group, which in turn reports to Quality Committee.

3.8 Navajo Chartermark

This Chartermark is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA people in Cheshire and Merseyside. Navajo looks at employment practices and how services are inclusive for LGBTIQA people. Since the Trust successfully obtained Navajo reaccreditation in March 2018 further steps have been taken to embed this work and spread best practice. COVID-19 put a halt on the Trusts planned reaccreditation in 2020. The Trust was given the option of having a further postponement of Navajo reaccreditation in 2021; however the Trust volunteered to undertake Navajo reaccreditation in the summer of 2021 as we are keen to keep up momentum regarding sexual orientation equality.

3.9 Gender Pay Gap

The Trust has met its Gender Pay Gap reporting obligations in 2020 and is on target to report meet the COVID-19 delayed 2021 reporting deadline of October 2021. The 2020 results are published on the Trust's website:
http://www.thewaltoncentre.nhs.uk/uploadedfiles/Gender%20Pay%20Gap%20Report%202020.pdf

The 2020 results continue to show a gender pay gap, however there is no indication that this is the result of any current direct discrimination by the Trust. The gap appears to be more connected with generalised features of gender differences in different professions e.g. most of our nursing staff are female which is a feature of the current demographic of the profession rather than any bias in the recruitment practices of the Trust. The Trust Board is, however, committed to understanding the data in more detail in order to find the most appropriate actions to close the Gender Pay Gap. To this end, the Trust Board has examined figures for Gender Pay Gap reporting for previous years to identify any relevant trends.
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3.10 Reciprocal Mentoring

The Trust has suspended Reciprocal Mentoring activity in 2020/2021 due to the need for social distancing. However, plans are being developed to reintroduce the programme in late 2021 as the situation normalises post the COVID-19 pandemic.

4 Advancing Equality of Opportunity between People who share a Protected Characteristic and People who don't

4.1 Access to Services – Inpatients

The Trust has undertaken an analysis of accessibility to our service regarding race and ethnicity via the Trust's Strategic BAME Advisory Committee, which indicated that fewer patients from Black, Asian and Minority Ethnic backgrounds are currently accessing our service when compared with their proportionate demographic percentage of the population we serve.

Area	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White	BAME
Liverpool	4.30%	2.86%	2.89%	1.97%	87.98%	12.02%
Merseyside	2.33%	1.16%	1.78%	0.81%	93.92%	6.08%
Cheshire & Merseyside	2.06%	0.80%	1.53%	0.56%	95.06%	4.94%
North West	6.70%	1.53%	1.90%	0.70%	89.18%	10.82%
England & Wales	7.96%	3.56%	2.63%	1.07%	84.78%	15.22%

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	BAME	White	All
Daycase	339	170	262	205	**976**	47089	48065
Elective	69	40	73	81	**263**	12774	13037
Non Elective	38	41	41	71	**191**	7589	7780
Total Admissions	**446**	**251**	**376**	**357**	**1430**	**67452**	**68882**

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	BAME	White
% Daycase	0.71%	0.35%	0.55%	0.43%	2.03%	97.97%
% Elective	0.53%	0.31%	0.56%	0.62%	2.02%	97.98%
% Non Elective	0.49%	0.53%	0.53%	0.91%	2.46%	97.54%
% Overall	0.65%	0.36%	0.55%	0.52%	2.08%	97.92%

4.2

The Trust has taken steps to ascertain the reasons for this disparity with relatively fewer numbers of Black, Asian and minority ethnic patients accessing the service.
The following barriers have been identified by the Trust through networking with voluntary sector organisations such as the Neurological Alliance:

- A lack of knowledge in some newer communities as to how the health system works and how to access health services e.g. refugees and asylums seekers.
- Language can be a barrier for people who have English as a second language. Basic information as to how to navigate the health system can be more difficult to access, resulting in patients not being referred on from primary care in the numbers we might expect.
- Different ways of understanding illness and describing symptoms in some communities leading to greater difficulties in diagnosis of some conditions e.g. in some languages there is no separate word for a neurological condition and a mental health condition.
- Stigma and a reluctance to come forward for diagnosis because of fear of being stigmatised in some communities.
- A greater emphasis in some communities on families taking care of their own family members rather than relying on health care services, leading to later presentation at health services and later diagnosis.

The Trust is continuing to network with the Neurological Alliance and other organisations to find ways to address these barriers e.g. The Trust has participated in the Steering Group of the Cheshire and Merseyside Health and Care Partnerships, community insight research "Getting Under the Skin" which though primarily aimed at measuring the impact of COVID- 19 on Black, Asian and minority ethnic communities, will lead to better mapping of and engagement with these communities in relation to a wide variety of health conditions including neurological conditions.

4.3 Disability Patient Accessibility

Disability **Accessibility** will be enhanced by the introduction of new Reasonable Adjustments Standard Operating Procedure in 2021, which will help ensure that the Trust continues identify and accommodate accessibility needs of patients.

4.4 ED&I 5 Year Vision

The Trust is currently 3 years into its ED&I 5 Year Vision which it published at the end of 2017. This document can be found by following the link: http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/EDI%20Vision%202017.pdf

Good progress continues to be made in relation to the commitments made in that vision:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard

- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity
- We are committed to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre
- We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

4.5 Organisational Context

This Vision is additional and complimentary to the many other key objectives, action plans and reporting that the Trust undertakes to ensure that it remains compliant with ED&I relevant statutory requirements and reporting frameworks.

The Equality Act 2010, Public Sector Equality Duties: general and Specific Duties:

General Duty:

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

The Specific Duties

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

Reporting:

- EDS 2 submissions to NHS England and published in the ED&I Annual Report online
- Workforce Race Equality Standards (WRES) published annually online
- Gender Pay Gap Reporting Published annually online
- Forthcoming Workplace Disability Equality Standards 2019 to be published online

These other key ED&I activities are progressed and monitored via The ED&I Steering Group and Operational group, the Senior Management Team and The Board.

4.6 Narrative

The table below outlines the progress to June 2021. The Trust is tracking progress against 24 goals associated with the ED&I 5 Year Vision.

The Goals that have been achieved are tagged Green. Goals that are achieved in part or are continuing on track towards achievement are marked in Amber. There are no goals that are in danger of not being achieved which would be marked red.

Goal 1	**Goal description: We have an ED&I 5 year strategy developed by staff and launched. Achieved in 20I7 There has been no significant change.**	
Goal 2	**Goal description: We have ED&I champions roles defined and recruited to add value to our efforts to realise the Trust's ED&I 5 Year Vision. Achieved in 20I7. There has been some change.** The COVID-19 outbreak and the disproportional impact on people with certain protected characteristics makes traditional face to face meetings impractical so the Trust is exploring ways to engage with champions/staff digitally etc.	
Goal 3	**Goal description: We have year on year improvement of our measurements (in National Surveys relating to In-Patients and Staff) Ongoing.** **There has been no significant change. The Gender Pay Gap, WRES and WDES reporting are completed published for 2020 and on target for 2021's reporting cycle.** This goal is only realistically achievable by the end of the 5 Year Vison. http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/corporate/WRES%20Report%20%202020%20Final.pdf http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/corporate/WDES%20Report%202020%20Final%20(4).pdf http://www.thewaltoncentre.nhs.uk/uploadedfiles/Gender%20Pay%20Gap%20Report%202020.pdf	
Goal 4	**Goal description: We are the employer of choice for staff with protected characteristics. Ongoing.** **There has been no significant change, the WRES and WDES are due for publication later in 2020/2021.** WRES monitoring demonstrates that the Trust has maintained a workforce that is more diverse than the local community in terms of race/ethnicity. The distribution of BME staff, however, remains much more evident in clinical and in medical roles and there are also comparatively fewer BME non-medical managers. Gender monitoring has shown that we have more females than males at the Trust, but despite an incremental closing of the Gender Pay Gap, male earnings are disproportionately higher because their distribution in clinical and medical posts is different. WDES analysis has highlighted that Disabled staff are underrepresented in all areas of the Trust, however, due to there being a significant numerical difference between the numbers of Disabled staff recoded on ESR and Disabled staff responding to the staff survey, it is suspected that there is a large measure of under reporting of disability on ESR: The percentage of Disabled staff on ESR is (2.72%) compares with a (3%) average measured from trust's ESR records across England. The percentage of Disabled staff responding to the Walton Centre Staff Survey was (18.11%). Like most other trusts The Walton Centre seems to have ESR underreporting of disability of	

	approximately (15%). The Trust continues to liaise with Disabled staff to better understand and tackle under reporting of disability.	
Goal 5	**Goal description: We have good engagement and working relationships with 3rd sector expert groups. Achieved/Ongoing. There have been some difficulties encountered this year due to COVID-19.** This is a goal that requires ongoing action to maintain its effectiveness into the future. 3rd Sector Engagement was a key piece of work done by the Trust to inform the local health economy across Merseyside about health inequalities as part of joint working. The Trust is continuing to work with Local Healthwatch to develop more effective community engagement across Merseyside Trusts. Covid-19 continues to badly affect engagement activity. Many 3rd sector workers who would normally be involved in engagement are furloughed or redeployed at present e.g. most Healthwatch engagement officers, so there is little scope at present for detailed engagement work, however the Trust is continuing to maintain contacts with key Healthwatch officers in readiness for the end of the current COVID-19 epidemic. The Trust has also been able to network effectively with the Neurological Alliance both on a National and a Cheshire and Merseyside footprint.	
Goal 6	**Goal description: We have an increase in Equality Impact Assessments (EIA) undertaken for planning and projects. Achieved 2018. There has been on significant change.** All Trust policies, procedures, strategies, projects, CIPs and service changes are now accompanied by an EIA prior to their approval and publication. The Equality and Inclusion Lead now has to sign off all CIPs prior to their implementation. The Chair and the CEO have made themselves aware of the Brown Principles and EIA guidance has undergone further revision and is now comprehensive. The Equality and Improvement Lead provides one on one guidance and support to managers completing EIAs om request.	
Goal 7	**Goal description: We have set up and established terms of reference for the ED&I Steering Group Achieved 2017.** **The EDI Steering Group has been reinvigorated by new Terms of Reference and input from senior leaders. Meeting are now taking place on a regular basis.**	
Goal 8	**Goal description: We complete action plans for data and track progress and impact. Ongoing. There is no significant change.** The Trust has action plans and tracks data in accordance with the Public Sector Equality Duty (See above). Data monitoring and action planning has also increased as a result of the introduction of the	

	WRES, WDES, Gender Equality Reporting and the Trust's new B.A.M.E Strategic Advisory Committee (SBAC).	
Goal 9	**Goal description: We complete action plans for WRES findings and track impact. Achieved/Ongoing There is no significant change.** The WRES is an annual reporting mechanism, so this work is never fully achieved; however the Trust is fully compliant to this point in time.	
Goal 10	**Goal description: Our Public Sector Equality Duty is met (PSED) Achieved 2018.** **There is no significant change** Please see; Equality and Inclusion Annual Report 2020 for continuing assurance. http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/corporate/EDI%20Report%202020%20Final.pdf The Trust has continues to pay due regard to the PSED during the 2020 COVID-19 epidemic. The Trust has taken steps to ensure that staff who are in COVID-19 higher risk groups due to disability race, pregnancy etc. are risk assessed and control measures are agreed to allow them to continue to work safely. The Trust is also conducting an EIA on its response to COVID-19 to learn any lessons and make any changes required to maintain PSED compliance. The Trust has also published its Gender Pay Gap report this year and will report on the WRES, WDES and publish its 2020 EDI Annual Report despite the disruption caused by COVID-19.	
Goal 11	**Goal description: We are successful in our reaccreditation for Navajo or have an action plan for future accreditation. Achieved 2018.** **There has been some difficulty encountered in 2020 due to COVID-19.** This Chartermark is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA people in Cheshire and Merseyside. Navajo looks at employment practices and how services are inclusive for LGBTIQA people. Since the Trust successfully obtained Navajo reaccreditation in March 2018 further steps have been taken to embed this work and spread best practice. COVID-19 put a halt on the Trusts planned reaccreditation in 2020. The Trust was given the option of having a further postponement of Navajo reaccreditation until, however the Trust volunteered to through Navajo reaccreditation in the summer of 2021 as we are keen to keep up momentum regarding sexual orientation equality.	
Goal 13	**Goal description: We have met Accessible information standard. Ongoing. There has been some positive progress for this goal.** Evidence from the Trusts intranet http://intranet/intranet_new/586/accessible-information-standard.html Also, the Interpretation & Translation and Accessible Information Policy, April 2018 indicates that the	

	Accessible Information Standard has been achieved; however, this goal requires ongoing monitoring to ensure that it is maintained. The Trust is currently participating in CCG a patient focussed Reasonable Adjustments task and finish group which will likely identify further actions relation to accessible information. The Trust has now completed its review of its Accessible Information Standard and is taking steps to adopt a new Standard Operational Procedure for the making of reasonable adjustments, which has been developed in partnership with local CCGs and NHS Trusts.
Goal 14	**Goal description: We have an increase in staff with protected characteristics in our workforce over the life of the Vision. Achieved 2018** in regard to race, however this work is **ongoing. There has been no significant change.** In 2019 there was a small decline in the Trusts percentage of BME staff in the workforce as reported by the WRES, however, the Trust remains in line with regional demographics. This metric will be monitored closely to ensure that the recent fluctuation is not the start of a negative trend. WRES reporting is due later in 2020. That WRES Report will show any improvements from previous year's figures. The WDES has now given the Trust a 2019 baseline figure to measure progress regarding the measurement of disability equality progress in coming years. WDES reporting is due later in 2020. The WDES will show any improvements from previous year's figures.
Goal 15	**Goal description: We have improved experience of patients with learning difficulties, brain injuries & protected characteristics. Achieved 2018. There has been no significant change.** The Trust is currently participating in talks with other local trusts and Liverpool CCG to jointly procure Translation and Interpretation services and the Trust is in the process of adopting Translation and Interpretation Standards developed jointly with local CCG and trust partners.
Goal l16	**Goal description: We have expanded training in unconscious bias/cultural competency. Ongoing. There has been progress on this goal.** In January 2020 The Trust has conducted ED&I training with a particular focus on, unconscious bias and cultural competence. The Trust also provided equivalent EDI training for managers in the first quarter of 2020. Unconscious bias training was suspended during the Covid-19 pandemic; however the trust is currently reviewing how unconscious bias/civility training can be reintroduced during the second half of 2020.
Goal 17	**Goal description: Our staff feel equipped with skills and knowledge on ED&I. Ongoing.** Please see the answer given in Goal 16 above.

Goal 18	**Goal description: We have a place on a national campaign – e.g. Building Leadership for Inclusion or alternative. Achieved 2018. There had been progress on this goal.** The Trust successfully participated in the NHS Employers Diversity and Inclusion Partners Programme in 2018 and the Trust's application has now been accepted to participate on the 2019 programme. The Trust is actively engaged in the networking, sharing of best practice that this provides. The Trust has now graduated to participating in the NHS Employers Diversity and Inclusion Partners Alumni Programme. The Trust is currently planning to start an initiative relating to disability equality and neurodiversity awareness with NHS Employers in 2021.	
Goal 19	**Goal description: We have increased/improved patient data monitoring Achieved/Ongoing.** **There has been progress on this goal.** The Trust has updated the PAS System to enable the better recording of patient data in line with national data standards, e.g. on Sexual Orientation Monitoring SOM). https://www.datadictionary.nhs.uk/web_site_content/navigation/main_menu.asp The Trust has also completed improvements to its equality monitoring forms based on patient's feedback.	
Goal 20	**Goal description: We have increased/improved workforce monitoring (particularly disability). Achieved/ Ongoing.** Please see the answers given in Goal 3 and 4 above.	
Goal 21	**Goal description: We have greater awareness of key cultural dates and events. Achieved/Ongoing. There has some difficulty with this goal due to COVID-19 but the work continues.** The marking of key cultural events has been adversely affected by the COVID-19 epidemic, nevertheless, the Trust carried out actions to mark Holocaust memorial day in January 2020/2021 and Ramadan in April/May 2020/2021. The Trust is exploring ways to participate in Virtual Pride and to mark other cultural dates virtually.	
Goal 22	**Goal description: We have equivalent to CQC 'Outstanding' and IiP Gold in Equality and Diversity. Wellbeing Ongoing.** **There has some difficulty with this goal due to COVID-19 but the work continues.** Due to the disruption caused by COVID-19 e.g. it has not been possible to engage with many 3rd sector partners properly for months and face to face engagement with staff and the public has been badly affected too. So it is not now realistic to expect to reach Goal 22 in 2020. 2021 Is a more realistic target for this goal given the current COVID-19 situation.	
Goal 23	**Goal description: Our staff feel happy and confident, supported and not judged by the Trust in relation to ED&I, that inclusion is our everyday practice. Ongoing. There has been no significant change.** The WRES data is significantly better in most respects this year including BME staff perceptions as	

	measured by the staff survey. The WRES data on this goal will be updated later in 2020 with the publication of this year's WRES report. No significant improvements in the happiness and confidence levels of Disabled staff were identified in 2020 in the publication of the second WDES monitoring report. The Trust now has Staff Equality Networks relating to Disability, Race, LGBT+ Equality. It is hopes that these networks will have an impact on staff feeling happy and confident in 2021/2022.	
Goal 24	**Goal description: We celebrate diversity and see our strength in inclusion as one of our core strengths. Ongoing. There has been no significant change.** This is not a goal that we would expect to achieve until the later years of the 5 Year Vision. Consideration should be given as to how this goal is to be measured effectively and if no adequate measure is identified consideration should be given to dropping this goal.	

4.7 Conclusions regarding progress on the ED&I 5 Year Vision.

Despite some difficulties arising from the COVID-19 epidemic, the Trust continues to make steady progress towards achieving the goals in the 5 Year ED&I Vision.

4.8 Professional Interpretation and Translation Services

The Trust contracts with professional interpreting and translation service providers who can be contacted 24 hours a day e.g. we have a contract with Action on Hearing Loss who provide sign language interpretation and translation to support our staff and patients. We recognise that this provision is essential for effective and safe communication in people whose first language isn't English and for signers. We also ensure that this provision promotes equality of opportunity as well as ensuring that dignity, respect and privacy is maintained. Looking forward, the Trust is working with other local trusts and CCGs to ensure that high standards of translation and interpretation services are maintained across the local health system. To that end the Trust is engaging fully with steps procure these services via a joint approach to tendering in 2021.

4.9 Complaints

Complaints data is monitored in respect of discrimination and other prohibited conduct via the Trusts Patient Experience Group (PEG). Any patterns identified would be addressed accordingly.

5 Fostering Good Relations between People who Share Protected Characteristics and People who don't

Many of the actions detailed in the Five Year ED& Vision mentioned above also support this aim, however detailed below are a few of the extra things the Trust does in support of fostering good relations:

- The Trust has a Patient Experience Group. Membership includes governors as members as well as staff, Board members and local Healthwatch. This allows active dialogue and engagement between the Trust and the people using our services.

The Trust marked Black History Month UK by promoting online profiles of notable Black high achievers. The aim was to address the long standing unfairness and lack of recognition for the contribution made by people of African descent to life, development and history of the UK by celebrating the achievements and contributions of the black community over the years.

5.1 ED&I Patient and Engagement

Due to the COVID-19 epidemic, it has been difficult to maintain relationships with community organisations. Many 3rd sector workers who would normally be involved in engagement are furloughed or redeployed at present e.g. most Healthwatch engagement officers, so there is little scope at present for detailed engagement work, however the Trust is continuing to maintain contacts with key Healthwatch officers in readiness for the end of the current COVID-19 epidemic. The Trust has also networked with the Neurological alliance on a National and local level to address health inequalities Equality continues to be a standing item on the Patient Experience Group agenda. Involvement with other local networks and charities has included regular engagement with the Brain Charity, epilepsy patients and Navajo etc.

The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings.

6 The Specific Duty and the Walton Centre

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

6.1 EDS 2

The Trust's EDS 2 review of priorities is currently being undertaken for 2020/21; however progress on this has been slowed by the disruption caused by the COVID-19 epidemic. The Trust is, therefore, not seeking to increase its grades on any of the sub-goals in 2020 as the COVID-19 slowed or paused much of the cooperative working that we have been doing with other Merseyside Trusts. Despite these difficulties, much progress has been made in regard to updating our arrangements for making Reasonable Adjustments for both disabled patients and staff.

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

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

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

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

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

6.2 The current equality objectives are:

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

Recent EDS 2 gradings for the vast majority of patient and public related services (Goals 1, 2 & 4) for The Walton Centre have been assessed as ***developing.*** The currently proposed 2021 EDS2 grades for The Walton Centre can be viewed in the table immediately below and in the Appendix.

6.3 Current 2020/21The Walton Centre EDS2: The Goals and Outcomes			Grade Status
Goal	**Sub**	**Description of outcome**	
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing
	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
	2.3	People report positive experiences of the NHS	Achieving
	2.4	People's complaints about services are handled respectfully and efficiently	Developing
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Developing
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing

	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed**	Developing
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination**	Developing

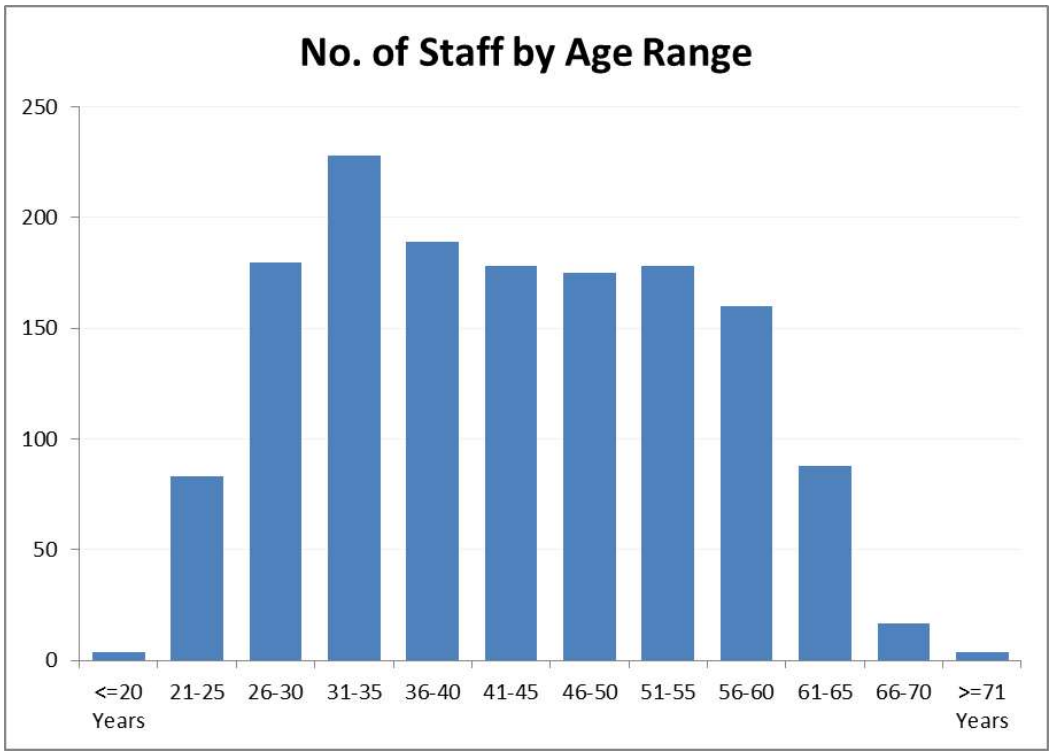
7 Workforce ED&I Profile

Workforce ED&I Profile 1st June 2021.

7.1 Workforce by Age

Age Range	No. Of Staff
<=20 Years	4
21-25	83
26-30	180
31-35	228
36-40	189
41-45	178
46-50	175
51-55	178
56-60	160
61-65	88
66-70	17
>=71 Years	4
Grand Total	**1484**

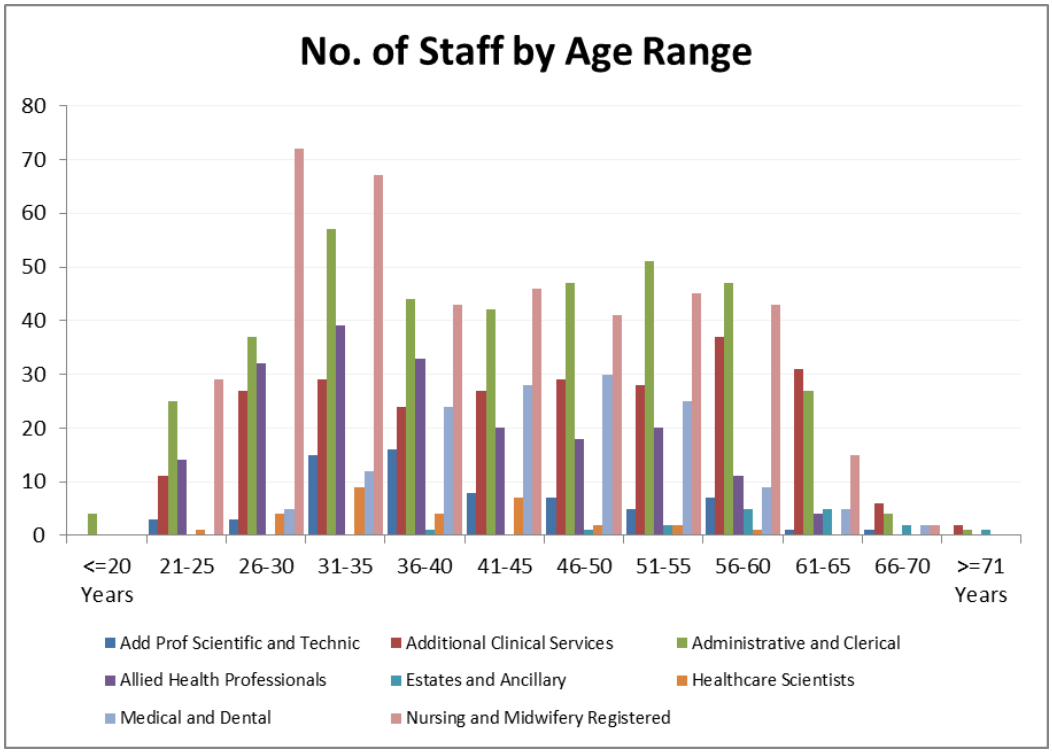
7.1.1


No. of Staff by Age Range
250
200
150
100
50
0
<=20 Years
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71 Years

7.1.2 Staff Group by Age

Age Range	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
<=20 Years			4						4
21-25	3	11	25	14		1		29	83
26-30	3	27	37	32		4	5	72	180
31-35	15	29	57	39		9	12	67	228
36-40	16	24	44	33	1	4	24	43	189
41-45	8	27	42	20		7	28	46	178
46-50	7	29	47	18	1	2	30	41	175
51-55	5	28	51	20	2	2	25	45	178
56-60	7	37	47	11	5	1	9	43	160
61-65	1	31	27	4	5		5	15	88
66-70	1	6	4		2		2	2	17
>=71 Years		2	1		1				4
Grand Total	**66**	**251**	**386**	**191**	**17**	**30**	**140**	**403**	**1484**

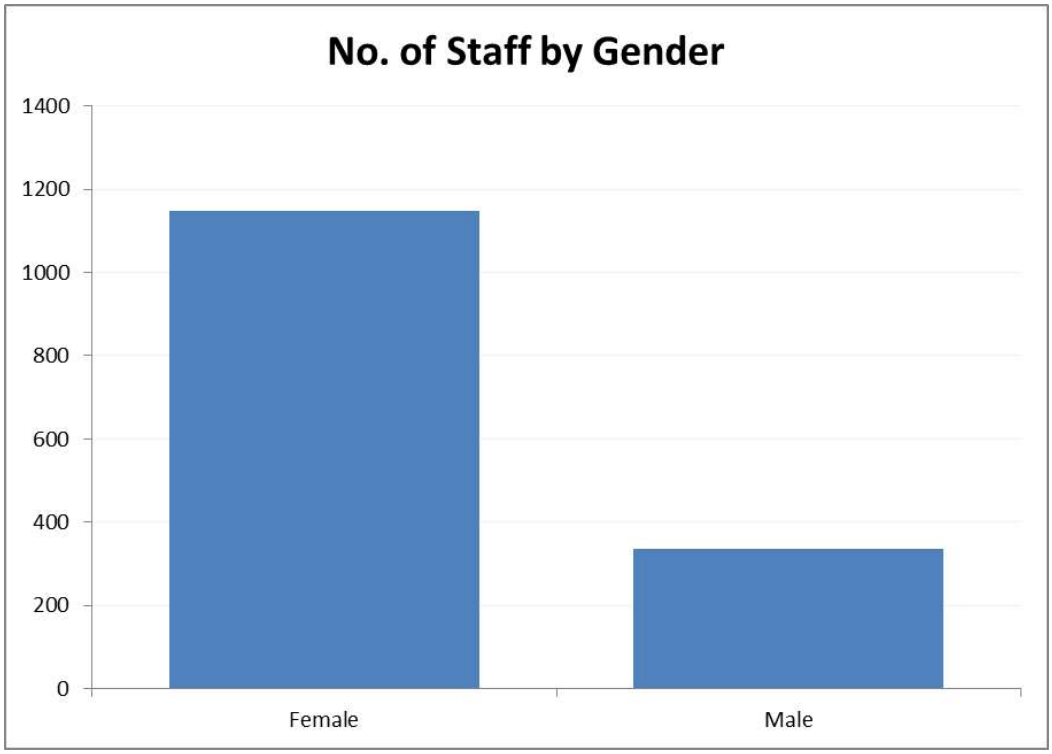
7.1.3


No. of Staff by Age Range
80
70
60
50
40
30
20
10
0
<=20 Years
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
>=71 Years
Add Prof Scientific and Technic
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing and Midwifery Registered

7.2 Workforce by Gender

Gender	No. Of Staff
Female	1147
Male	337
Grand Total	**1484**

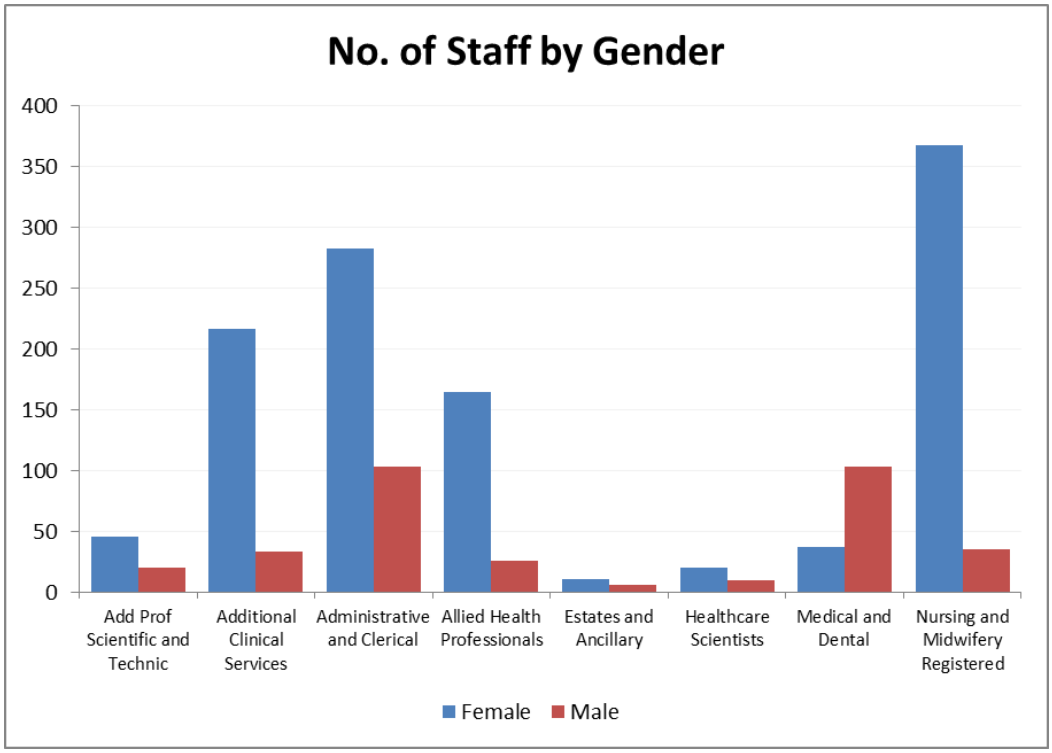
7.2.1



7.2.2 Staff Group by Gender

Staff Group	Female	Male	Grand Total
Add Prof Scientific and Technic	46	20	66
Additional Clinical Services	217	34	251
Administrative and Clerical	283	103	386
Allied Health Professionals	165	26	191
Estates and Ancillary	11	6	17
Healthcare Scientists	20	10	30
Medical and Dental	37	103	140
Nursing and Midwifery Registered	368	35	403
Grand Total	**1147**	**337**	**1484**

7.2.3

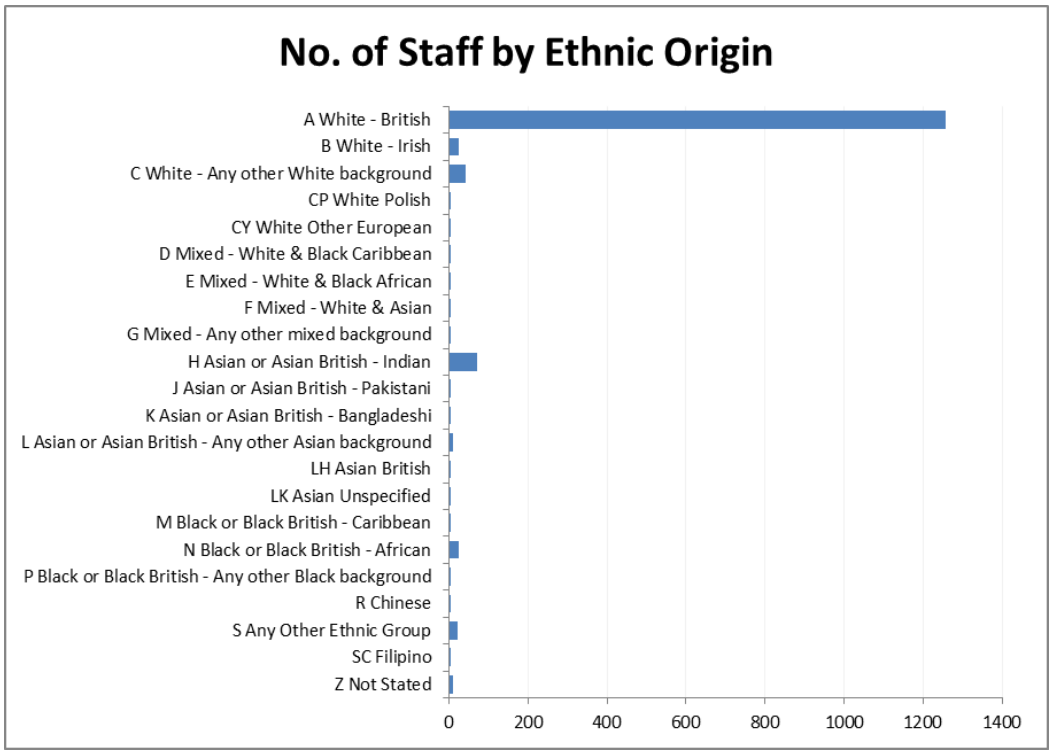


7.3 Workforce by Ethnic Origin

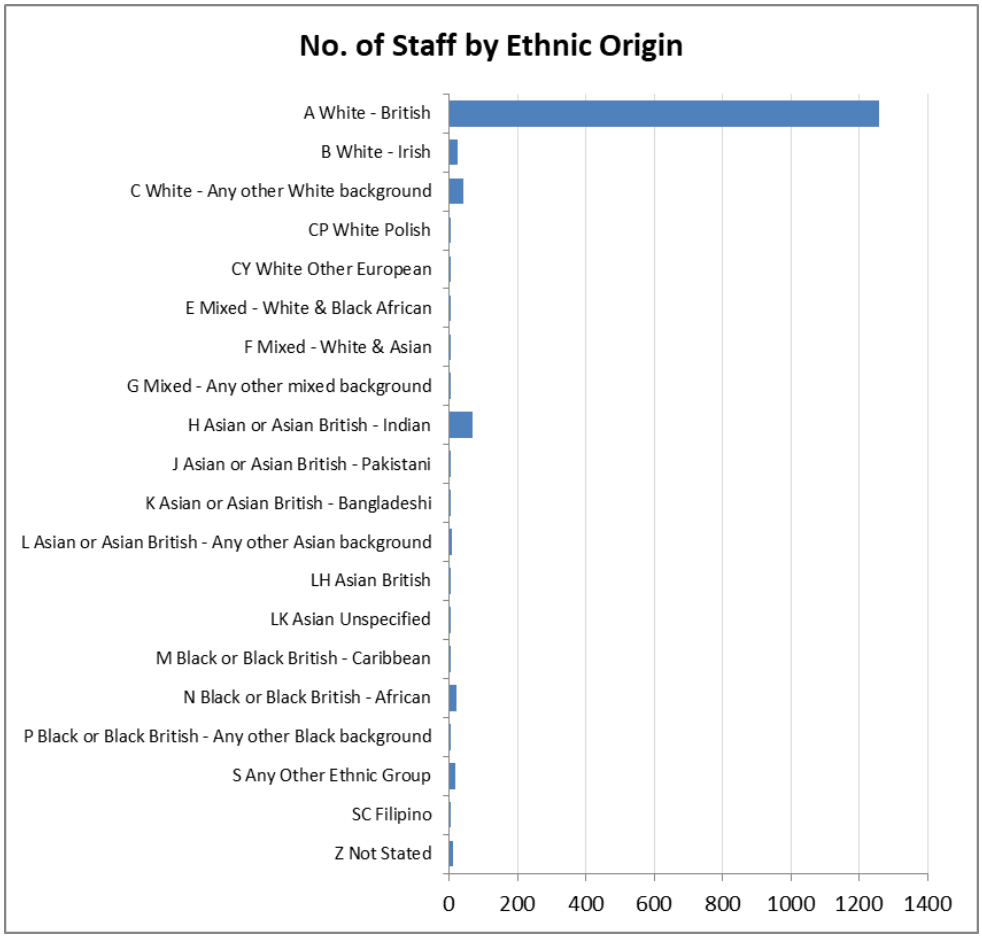
Ethnic Origin	*No. Of Staff*
A White - British	1257
B White - Irish	25
C White - Any other White background	41
CP White Polish	1
CY White Other European	2
D Mixed - White & Black Caribbean	1
E Mixed - White & Black African	3
F Mixed - White & Asian	1
G Mixed - Any other mixed background	5
H Asian or Asian British - Indian	72
J Asian or Asian British - Pakistani	3
K Asian or Asian British - Bangladeshi	1
L Asian or Asian British - Any other Asian background	11
LH Asian British	1
LK Asian Unspecified	1
M Black or Black British - Caribbean	1

N Black or Black British - African	24
P Black or Black British - Any other Black background	1
R Chinese	1
S Any Other Ethnic Group	21
SC Filipino	1
Z Not Stated	10
Grand Total	***1484***

7.3.1



7.3.2



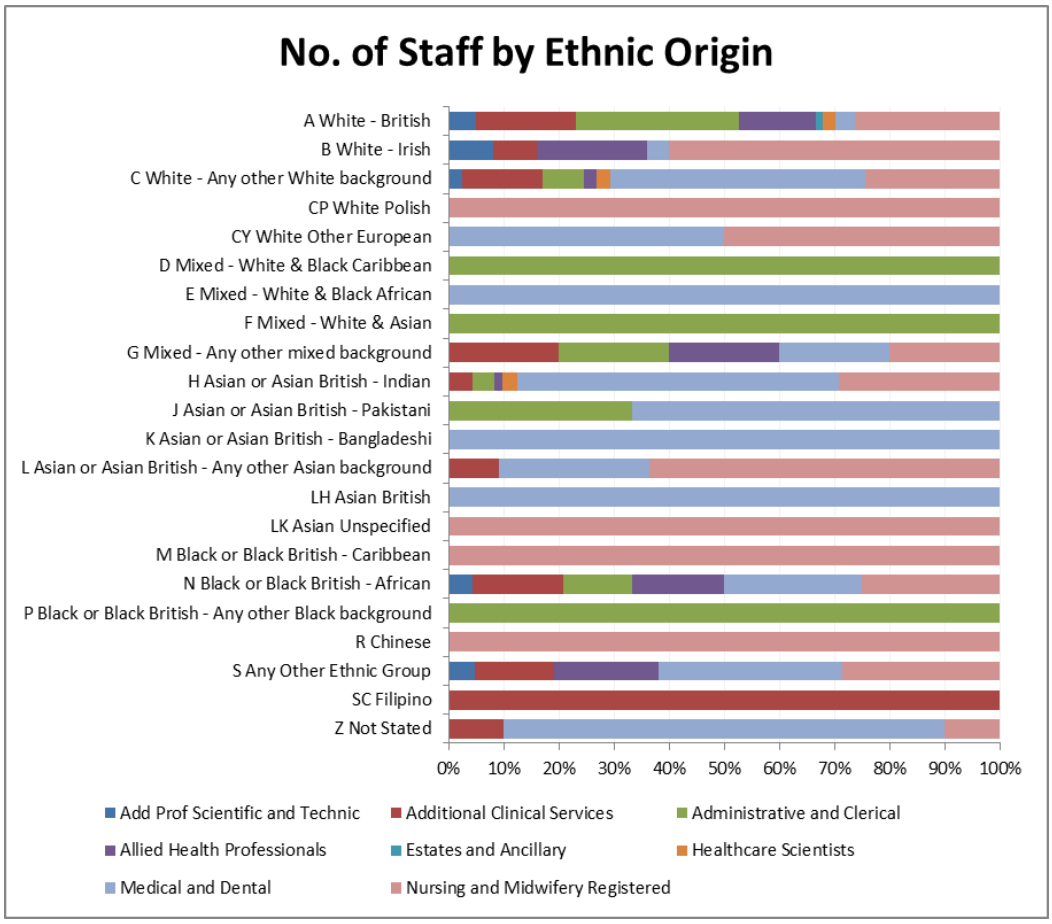
7.3.3 Staff Group by Ethnic Origin

Ethnic Origin	*Add Prof Scientific and Technic*	*Additional Clinical Services*	*Administrative and Clerical*	*Allied Health Professionals*	*Estates and Ancillary*	*Healthcare Scientists*	*Medical and Dental*	*Nursing and Midwifery Registered*	*Grand Total*
A White - British	61	229	372	175	17	27	45	331	1257
B White - Irish	2	2		5			1	15	25

C White - Any other White background	1	6	3	1		1	19	10	41
CP White Polish								1	1
CY White Other European							1	1	2
D Mixed - White & Black Caribbean			1						1
E Mixed - White & Black African							3		3
F Mixed - White & Asian			1						1
G Mixed - Any other mixed background		1	1	1			1	1	5
H Asian or Asian British - Indian		3	3	1		2	42	21	72
J Asian or Asian British - Pakistani			1				2		3
K Asian or Asian British - Bangladeshi							1		1

L Asian or Asian British - Any other Asian backgro und		1					3	7	11
LH Asian British							1		1
LK Asian Unspecif ied								1	1
M Black or Black British - Caribbea n								1	1
N Black or Black British - African	1	4	3	4			6	6	24
P Black or Black British - Any other Black backgro und			1						1
R Chinese								1	1
S Any Other Ethnic Group	1	3		4			7	6	21
SC Filipino		1							1
Z Not Stated		1					8	1	10
Grand Total	**66**	**251**	**386**	**191**	**17**	**30**	**140**	**403**	**1484**

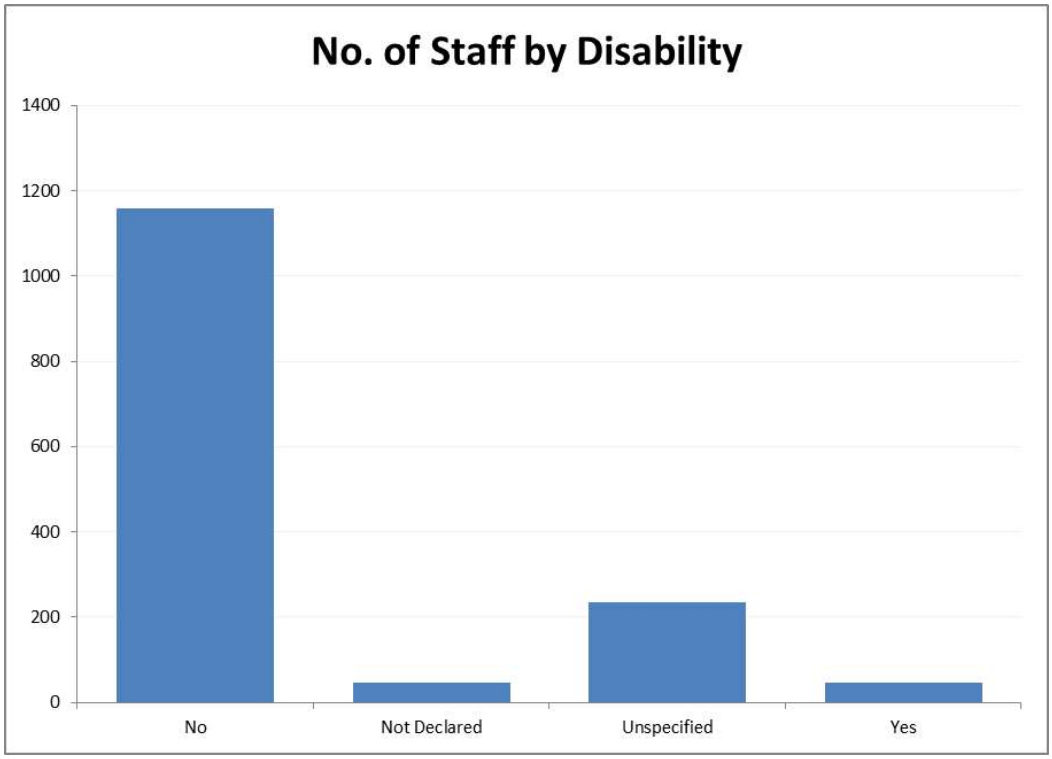
7.3.4



7.4 Workforce by Disability

Disability	*No. Of Staff*
No	*1159*
Not Declared	*45*
Unspecified	*234*
Yes	*46*
Grand Total	***1484***

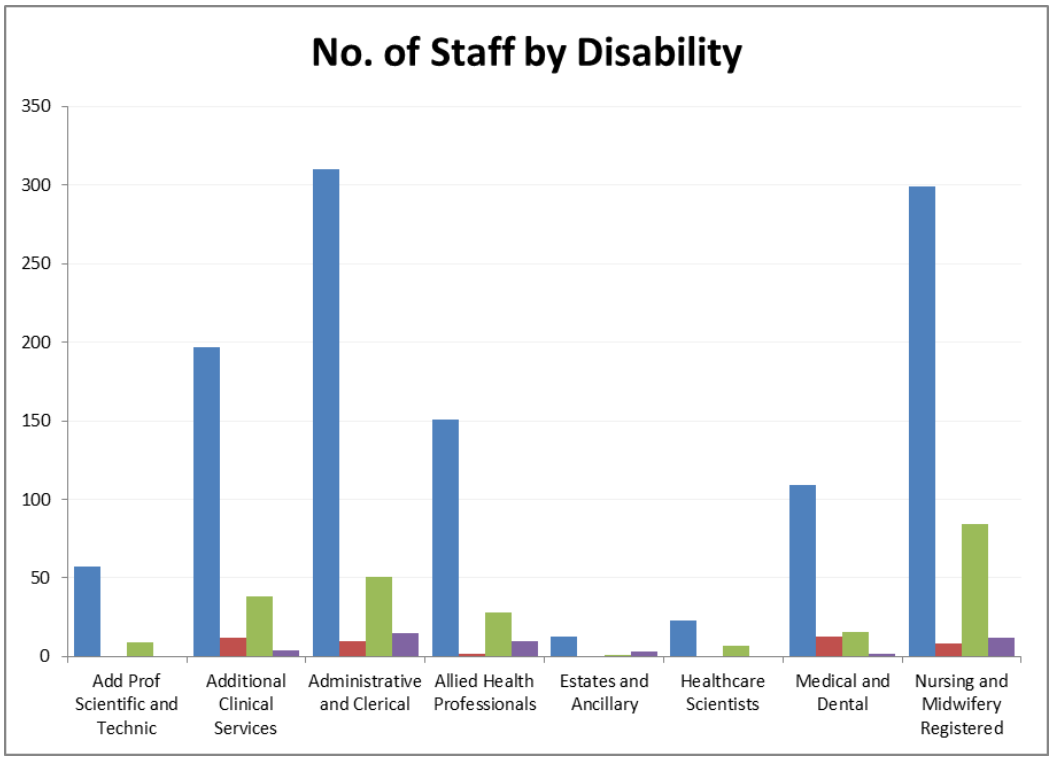
7.4.1



7.5 Staff Group by Disability

Staff Group	*No*	*Not Declared*	*Unspecified*	*Yes*	*Grand Total*
Add Prof Scientific and Technic	57		9		66
Additional Clinical Services	197	12	38	4	251
Administrative and Clerical	310	10	51	15	386
Allied Health Professionals	151	2	28	10	191
Estates and Ancillary	13		1	3	17
Healthcare Scientists	23		7		30
Medical and Dental	109	13	16	2	140
Nursing and Midwifery Registered	299	8	84	12	403
Grand Total	**1159**	**45**	**234**	**46**	**1484**

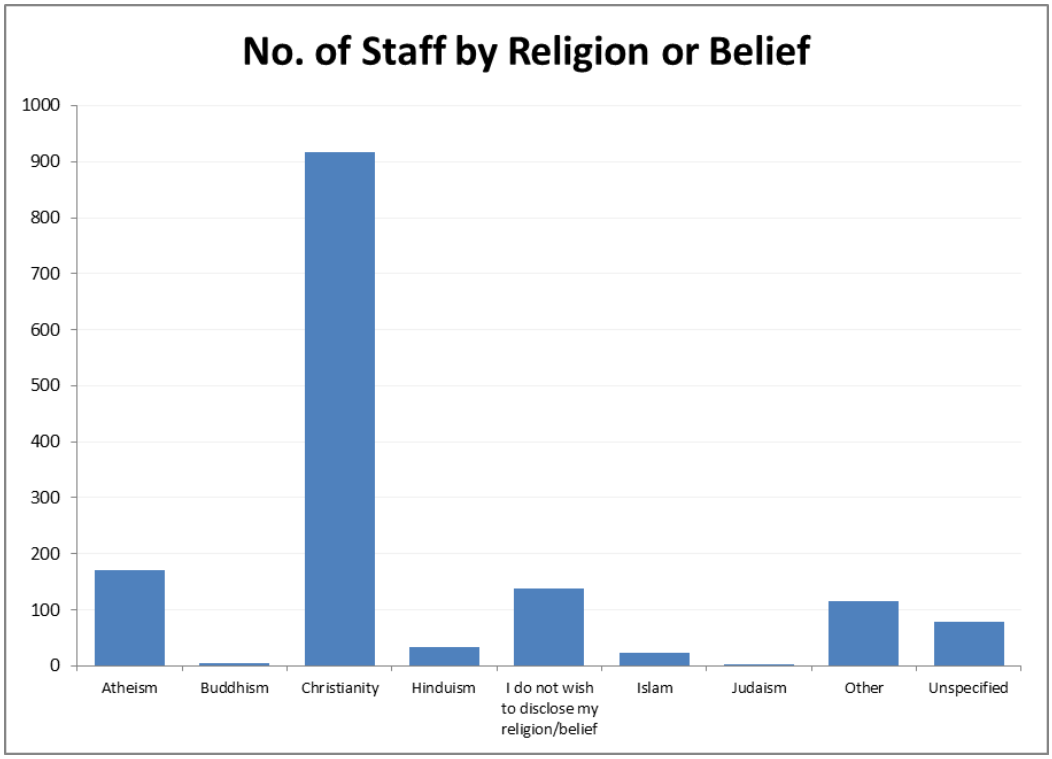
7.5.1



7.6 Workforce by Religion or Belief

Row Labels	*No. Of Staff*
Atheism	171
Buddhism	4
Christianity	916
Hinduism	34
I do not wish to disclose my religion/belief	138
Islam	24
Judaism	2
Other	116
Unspecified	79
Grand Total	**1484**

7.6.1

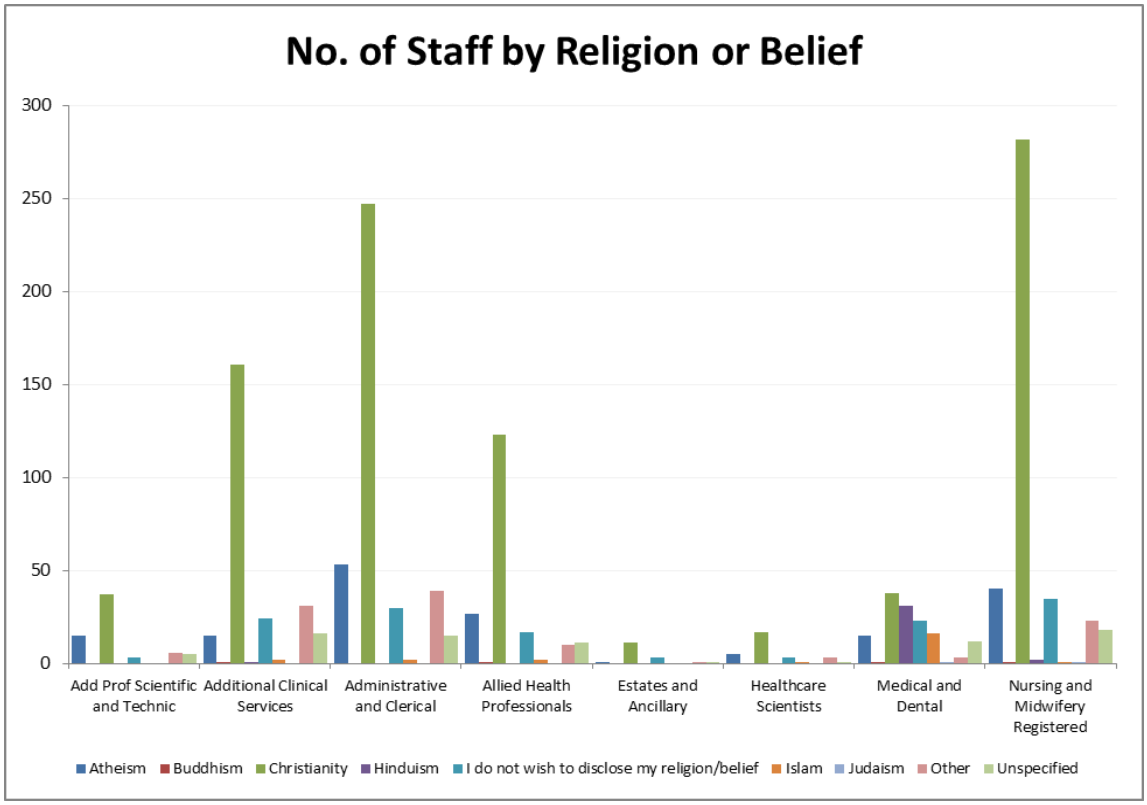


7.6.2 Staff Group by Religion or Belief

Staff Group	Atheism	Buddhism	Christianity	Hinduism	I do not wish to disclose my religion/belief	Islam	Judaism	Other	Unspecified	Grand Total
Add Prof Scientific and Technic	15		37		3			6	5	66
Additional Clinical Services	15	1	161	1	24	2		31	16	251

Administrative and Clerical	53		247		30	2		39	15	386
Allied Health Professionals	27	1	123		17	2		10	11	191
Estates and Ancillary	1		11		3			1	1	17
Healthcare Scientists	5		17		3	1		3	1	30
Medical and Dental	15	1	38	31	23	16	1	3	12	140
Nursing and Midwifery Registered	40	1	282	2	35	1	1	23	18	403
Grand Total	**171**	**4**	**916**	**34**	**138**	**24**	**2**	**116**	**79**	**1484**

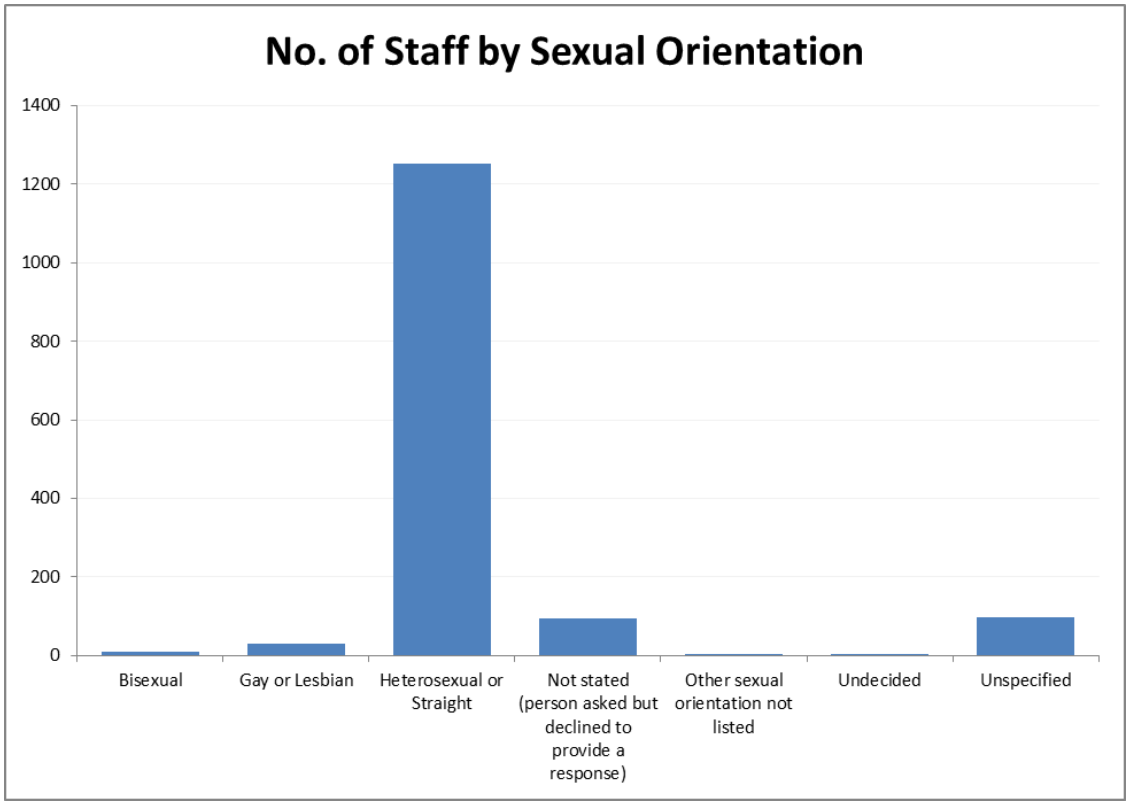
7.6.3



7.7 Workforce by Sexual Orientation

Sexual Orientation	*No. Of Staff*
Bisexual	10
Gay or Lesbian	31
Heterosexual or Straight	1251
Not stated (person asked but declined to provide a response)	93
Other sexual orientation not listed	1
Undecided	1
Unspecified	97
Grand Total	**1484**

7.7.1

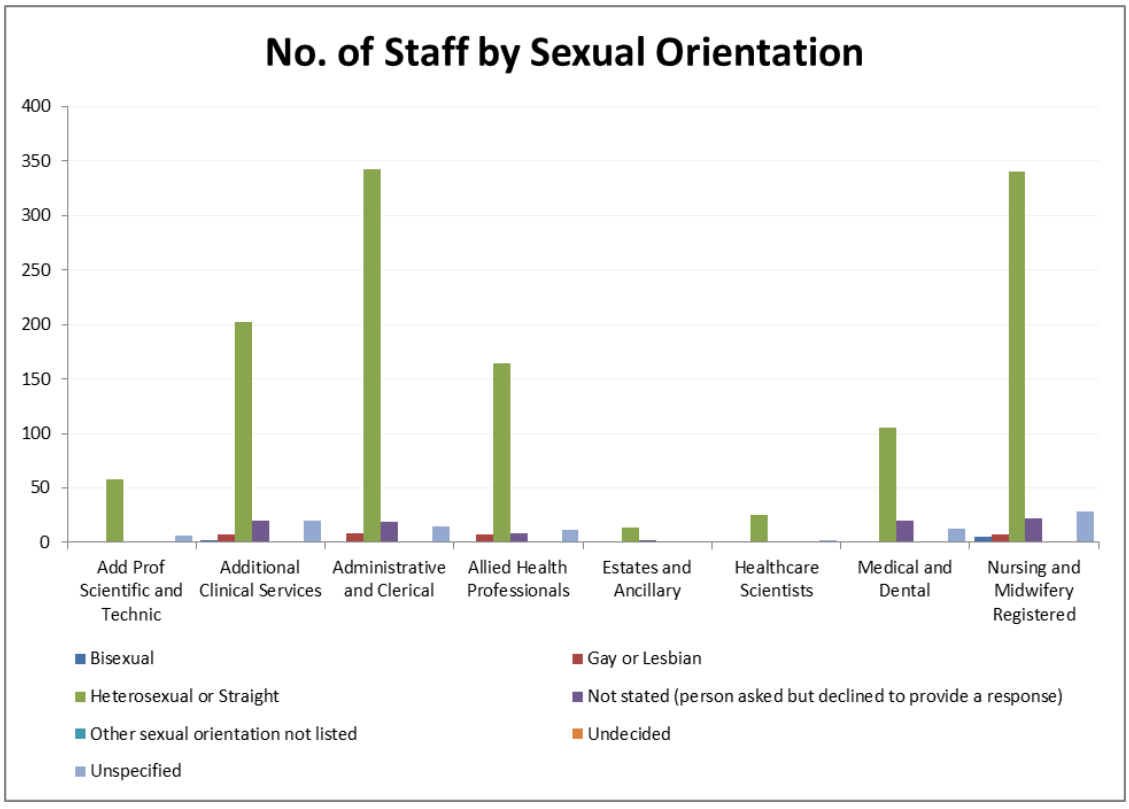


7.7.2 Staff Group by Sexual Orientation

Staff Group	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	Undecided	Unspecified	Grand Total
Add Prof Scientific and Technic			58	1		1	6	66
Additional Clinical Services	2	7	202	20			20	251
Administrative and Clerical	1	8	343	19			15	386

Allied Health Professionals		7	164	8			12	191
Estates and Ancillary			14	2			1	17
Healthcare Scientists	1	1	25	1			2	30
Medical and Dental	1	1	105	20			13	140
Nursing and Midwifery Registered	5	7	340	22	1		28	403
Grand Total	**10**	**31**	**1251**	**93**	**1**	**1**	**97**	**1484**

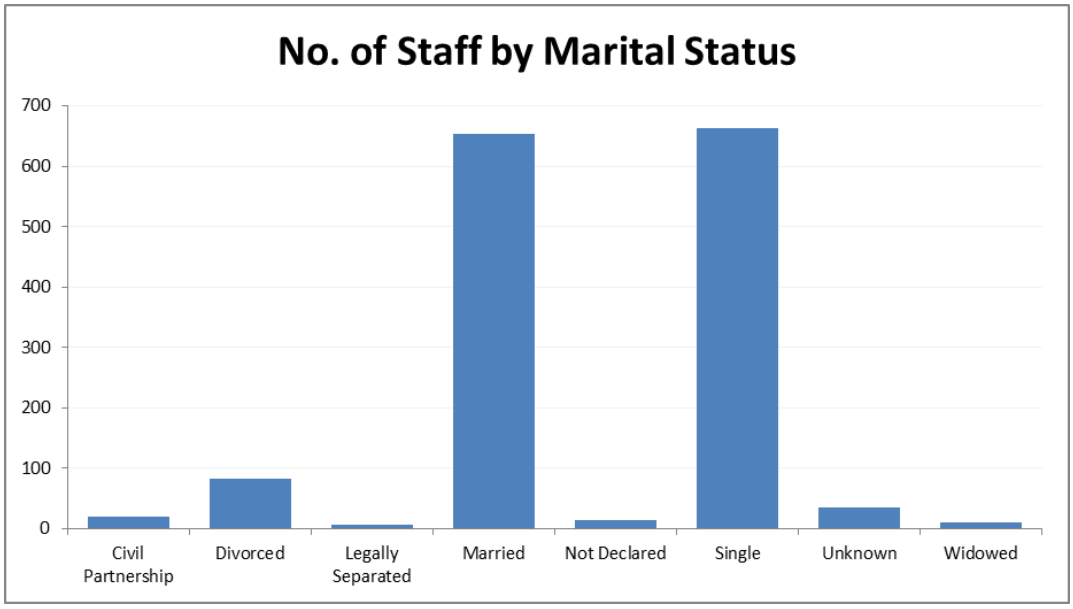
7.7.3



7.8 Workforce by Marital Status

Status	No. Of Staff
Civil Partnership	20
Divorced	83
Legally Separated	7
Married	653
Not Declared	14
Single	662
Unknown	35
Widowed	10
Grand Total	**1484**

7.8.1

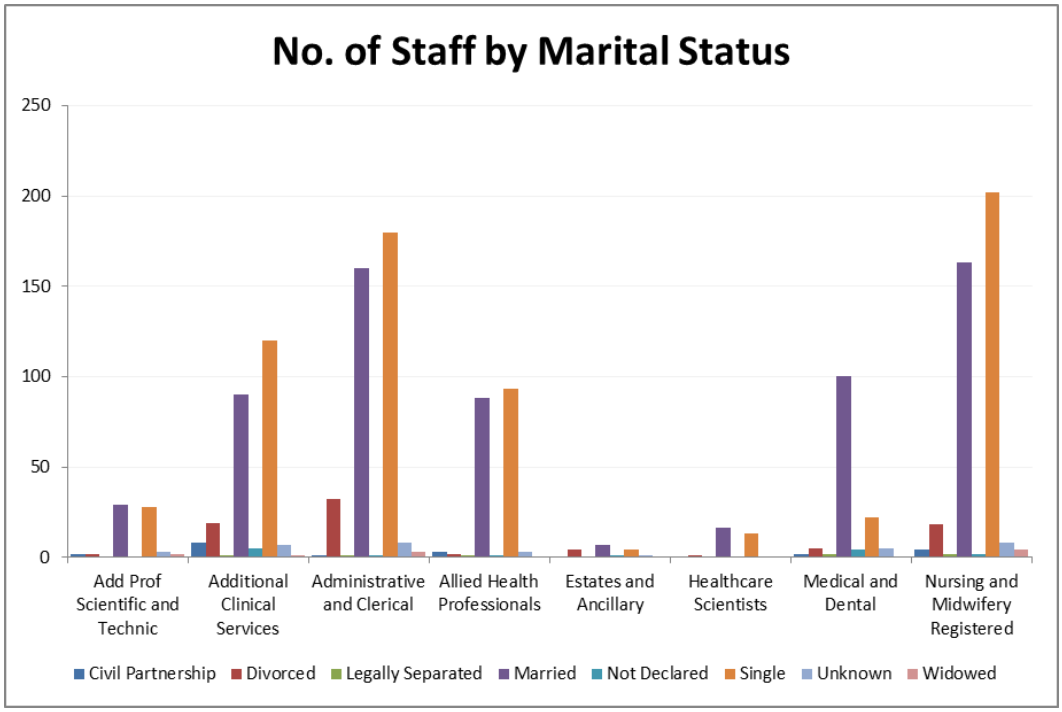


7.8.2 Staff Group by Marital Status

Staff Group	Civil Partnership	Divorced	Legally Separated	Married	Not Declared	Single	Unknown	Widowed	Grand Total
Add Prof Scientific and Technic	2	2		29		28	3	2	66
Additional Clinical Services	8	19	1	90	5	120	7	1	251

Administrative and Clerical	1	32	1	160	1	180	8	3	386
Allied Health Professionals	3	2	1	88	1	93	3		191
Estates and Ancillary		4		7	1	4	1		17
Healthcare Scientists		1		16		13			30
Medical and Dental	2	5	2	100	4	22	5		140
Nursing and Midwifery Registered	4	18	2	163	2	202	8	4	403
Grand Total	**20**	**83**	**7**	**653**	**14**	**662**	**35**	**10**	**1484**

7.8.2



8 New Starters 1ST April 2020 to 31st March 2021.

Disability	*No. of Staff*
No	211
Unspecified	3
Yes	7
Grand Total	**221**

8.1

Gender	*No. of Staff*
Female	*178*
Male	*43*
Grand Total	***221***

8.2

Marital Status	*No. of Staff*
Civil Partnership	*6*
Divorced	*7*
Legally Separated	*2*
Married	*74*
Single	*128*
Unknown	*4*
Grand Total	***221***

8.3

Age Band	*No. of Staff*
<=20 Years	5
21-25	53
26-30	32
31-35	33
36-40	34
41-45	24
46-50	10
51-55	12
56-60	14
61-65	4
Grand Total	**221**

8.4

Ethnic Origin	*No. of Staff*
A White - British	180
B White - Irish	5
C White - Any other White background	11
D Mixed - White & Black Caribbean	1
E Mixed - White & Black African	1
H Asian or Asian British - Indian	12
L Asian or Asian British - Any other Asian background	1
N Black or Black British - African	7
S Any Other Ethnic Group	2
Unspecified	1
Grand Total	**221**

8.5

Nationality	*No. of Staff*
American	1
Argentine	1
Australian	1
British	189
Dutch	1
Filipino	1
Indian	11
Irish	5
Italian	1
Japanese	1
Nigerian	1
Polish	4
Romanian	1
South African	1
Spanish	1
Tanzanian	1
Grand Total	**221**

8.6

Sexual Orientation	*No. of Staff*
Bisexual	3
Gay or Lesbian	11
Heterosexual or Straight	200
Not stated (person asked but declined to provide a response)	5
Other sexual orientation not listed	1
Unspecified	1
Grand Total	**221**

8.7

Religious Belief	*No. of Staff*
Atheism	45
Buddhism	1
Christianity	130
Hinduism	10
I do not wish to disclose my religion/belief	10
Islam	3
Judaism	1
Other	20
Unspecified	1
Grand Total	**221**

9 Recruitment Data 1st April 2020 to 31 March 2021

Category	Description	Number of applications	Constituting the following % of applications	Number of applications shortlisted	Constituting the following % of those shortlisted	% of applications shortlisted under each Description
Gender	Male	1,593	31.10%	282	20.50%	17.70%
	Female	3,504	68.30%	1080	78.40%	30.80%
	Undisclosed	30	0.60%	15	1.10%	50.00%
Disability	Yes	201	3.90%	66	4.80%	32.80%
	No	4,854	94.70%	1296	94.10%	26.70%
	Undisclosed	72	1.40%	15	1.10%	20.80%
Criminal Conviction	Yes	47	0.90%	13	0.90%	27.70%
	No	5,038	98.30%	1326	96.30%	26.30%
	Not asked	42	0.80%	38	2.80%	90.50%
Ethnicity	WHITE - British	3,247	63.30%	1061	77.10%	32.70%
	WHITE - Irish	62	1.20%	28	2.00%	45.20%
	WHITE - Any other white background	274	5.30%	51	3.70%	18.60%
	ASIAN or ASIAN BRITISH - Indian	385	7.50%	64	4.60%	16.60%
	ASIAN or ASIAN BRITISH - Pakistani	188	3.70%	12	0.90%	6.40%
	ASIAN or ASIAN BRITISH - Bangladeshi	45	0.90%	2	0.10%	4.40%
	ASIAN or ASIAN BRITISH - Any other Asian background	95	1.90%	16	1.20%	16.80%
	MIXED - White & Black Caribbean	21	0.40%	4	0.30%	19.00%
	MIXED - White & Black African	76	1.50%	11	0.80%	14.50%
	MIXED - White & Asian	20	0.40%	3	0.20%	15.00%
	MIXED - any other mixed background	56	1.10%	16	1.20%	28.60%
	BLACK or BLACK BRITISH - Caribbean	22	0.40%	6	0.40%	27.30%
	BLACK or BLACK BRITISH - African	351	6.80%	56	4.10%	16.00%
	BLACK or BLACK BRITISH - Any other black background	20	0.40%	5	0.40%	25.00%

	OTHER ETHNIC GROUP - Chinese	22	0.40%	4	0.30%	18.20%
	OTHER ETHNIC GROUP - Any other ethnic group	152	3.00%	9	0.70%	5.90%
	Undisclosed	91	1.80%	29	2.10%	31.90%
Age Band	Under 18	2	0.00%	0	0.00%	0.00%
	18 to 19	48	0.90%	7	0.50%	14.60%
	20 to 24	698	13.60%	133	9.70%	19.10%
	25 to 29	1,164	22.70%	250	18.20%	21.50%
	30 to 34	930	18.10%	201	14.60%	21.60%
	35 to 39	709	13.80%	214	15.50%	30.20%
	40 to 44	481	9.40%	182	13.20%	37.80%
	45 to 49	394	7.70%	137	9.90%	34.80%
	50 to 54	357	7.00%	123	8.90%	34.50%
	55 to 59	231	4.50%	88	6.40%	38.10%
	60 to 64	87	1.70%	36	2.60%	41.40%
	65 to 69	19	0.40%	5	0.40%	26.30%
	70 and over	6	0.10%	1	0.10%	16.70%
	Undisclosed	1	0.00%	0	0.00%	0.00%
Religion	Atheism	637	12.40%	211	15.30%	33.10%
	Buddhism	50	1.00%	11	0.80%	22.00%
	Christianity	2,775	54.10%	825	59.90%	29.70%
	Hinduism	235	4.60%	29	2.10%	12.30%
	Islam	516	10.10%	37	2.70%	7.20%
	Jainism	6	0.10%	0	0.00%	0.00%
	Judaism	11	0.20%	6	0.40%	54.50%
	Sikhism	9	0.20%	1	0.10%	11.10%
	Other	476	9.30%	125	9.10%	26.30%
	Undisclosed	412	8.00%	132	9.60%	32.00%
Sexual Orientation	Heterosexual	4,758	92.80%	1253	91.00%	26.30%
	Gay/Lesbian	122	2.40%	37	2.70%	30.30%
	Bisexual	84	1.60%	23	1.70%	27.40%
	Other	5	0.10%	1	0.10%	20.00%
	Undecided	14	0.30%	6	0.40%	42.90%
	Undisclosed	144	2.80%	57	4.10%	39.60%
Marital Status	Married	1,667	32.50%	498	36.20%	29.90%
	Single	2,971	57.90%	706	51.30%	23.80%
	Civil partnership	126	2.50%	30	2.20%	23.80%
	Legally separated	42	0.80%	9	0.70%	21.40%
	Divorced	158	3.10%	61	4.40%	38.60%
	Widowed	39	0.80%	12	0.90%	30.80%
	Undisclosed	124	2.40%	61	4.40%	49.20%
Impairment	Physical Impairment	24	10.70%	11	14.90%	45.80%
	Sensory Impairment	20	8.90%	10	13.50%	50.00%

	Mental Health Condition	53	23.70%	15	20.30%	28.30%
	Learning Disability/Difficulty	40	17.90%	19	25.70%	47.50%
	Long-Standing Illness	58	25.90%	16	21.60%	27.60%
	Other	29	12.90%	3	4.10%	10.30%
Total	Total	5,127	100.00%	1377	100.00%	26.90%

10 Patient ED&I Profile

WCFT Patient Diversity Breakdown: June 2019 to May 2020

10.1 Gender

Sex	Description	Inpatient	Outpatient	Grand Total	% of Total
F	Female	9095	64394	73489	58.59%
I	Indeterminate/Other		2	2	0.00%
M	Male	5838	46091	51929	41.40%
U	Unknown/Not Stated	3	5	8	0.01%
Grand Total		14936	110492	125428	100.00%

10.2 Age Band

Age Band	Inpatient	Outpatient	Grand Total	% of Total
Under 18	43	728	771	0.61%
18-24	697	5948	6645	5.30%
25-34	1589	12899	14488	11.55%
35-44	2394	15853	18247	14.55%
45-54	3533	22789	26322	20.99%
55-64	3232	22801	26033	20.76%
65-74	2341	17928	20269	16.16%
75+	1107	11546	12653	10.09%
Grand Total	14936	110492	125428	100.00%

10. 3 Religion

Religion	Religion Description	Inpatient	Outpatient	Grand Total	% of Total
AGN	AGNOSTIC	16	105	121	0.10%
ANG	ANGLICAN	22	102	124	0.10%
ATH	ATHEIST	91	513	604	0.48%
BAP	BAPTIST	16	198	214	0.17%
BUD	BUDDHIST	32	115	147	0.12%
CHR	CHRISTIAN	616	3067	3683	2.94%
COE	CHURCH OF ENGLAND	3766	25324	29090	23.19%
CON	CONGREGATIONAL	2	18	20	0.02%
COS	CHURCH OF SCOTLAND	37	85	122	0.10%
COW	CHURCH OF WALES	44	314	358	0.29%
GO	GREEK ORTHODOX	6	43	49	0.04%
HIN	HINDU	21	118	139	0.11%
JEW	JEWISH	22	150	172	0.14%
JW	JEHOVAH'S WITNESS	40	297	337	0.27%
MET	METHODIST	134	984	1118	0.89%
MOR	MORMON	3	20	23	0.02%
MUS	MUSLIM	72	484	556	0.44%
NRP	NO RELIGIOUS PREFERENCE	3345	18900	22245	17.74%
NULL	NULL	2606	36129	38735	30.88%
OC	OTHER CHRISTIAN	135	1068	1203	0.96%
ONC	OTHER NON CHRISTIAN	29	122	151	0.12%
PRE	PRESBYTERIAN	1	48	49	0.04%
QUA	QUAKER		5	5	0.00%
RAS	RASTAFARIAN	1	3	4	0.00%
RC	ROMAN CATHOLIC	2879	16868	19747	15.74%
REF	PATIENT REFUSED TO GIVE INFO	7	22	29	0.02%
RO	RUSSIAN ORTHODOX	7	9	16	0.01%
SAL	SALVATION ARMY	3	30	33	0.03%
SEI	SEIKH	12	36	48	0.04%
SPR	SPIRITUALIST	2	47	49	0.04%
UNK	UNKNOWN	968	5257	6225	4.96%
WES	WESLEYAN		4	4	0.00%
WW	WHITE WITCHCRAFT	1	7	8	0.01%
Grand Total		14936	110492	125428	100.00%

10.4 Ethnicity

Ethnic Group	Ethnic Group Desc	Inpatient	Outpatient	Grand Total	% of Total
A	WHITE - BRITISH	13382	84645	98027	78.15%
B	WHITE - IRISH	42	319	361	0.29%
C	WHITE - ANY OTHER BACKGROUND	152	940	1092	0.87%
D	MIXED - WHITE/BLACK CARIBBEAN	31	110	141	0.11%
E	MIXED - WHITE/BLACK AFRICAN	14	105	119	0.09%
F	MIXED - WHITE AND ASIAN	24	183	207	0.17%
G	MIXED - ANY OTHER	23	142	165	0.13%
H	ASIAN - INDIAN	35	244	279	0.22%
J	ASIAN - PAKISTANI	20	121	141	0.11%
K	ASIAN - BANGLADESHI	24	75	99	0.08%
L	ASIAN - ANY OTHER BACKGROUND	23	172	195	0.16%
M	BLACK - CARIBBEAN	25	66	91	0.07%
N	BLACK - AFRICAN	15	143	158	0.13%
NULL	NULL	117	12142	12259	9.77%
P	BLACK - ANY OTHER BACKGROUND	24	157	181	0.14%
R	OTHER - CHINESE	19	157	176	0.14%
S	OTHER - ANY OTHER	44	471	515	0.41%
Z	NOT STATED	922	10300	11222	8.95%
Grand Total		14936	110492	125428	100.00%

10.5 Disability

Disability Risk Flag Y/N	Total	% of Total
No	122142	97.38%
Yes	3286	2.62%
Grand Total	125428	100.00%

Please note that patient disability the figures are compiled from aggregating known medical conditions that are considered to be disabilities, as patient data is not collected specifically under the general category of disability.

11 The use of interpretations services

11.1

Number of interpreter appointments conducted per language spoken 1st April 2020 to 31st March 2021					
Polish	Arabic	Cantonese	Farsi	Romanian	Kurdish
242	153	42	91	73	26
Portuguese	Turkish	Russian	Mandarin	Tamil	Urdu
50	62	16	21	55	13
Hungarian	Lithuanian	Spanish	Bulgarian	Slovak	Bengali
30	9	8	22	40	6
Czech	Somali	Amharic	Latvian	French	Italian
11	9	5	7	4	1
Albanian	Pashtu	German	Dari	Punjabi	Thai
5	3	1	23	13	6
Sinhalese	Chinese	Macedonian	Hindi	Sorani	Tigrinya
4	3	1	0	0	5
Vietnamese					
0					
Total appointments made:1060					

11.2

Number of sign language interpreter appointments made 1st April 2020 to 31st March 2021.			
Total number of appointments	21	Number of cancellations by the provider	1

12 Conclusion

This annual Equality, Diversity and Inclusion Report has set out how the Walton Centre has been demonstrating 'due regard' to our Public Sector Equality Duty' under the Equality Act 2010 and the Specific Duties to publish equality information and set equality objectives.

13 Contact Details

For further information the Equality and Inclusion Lead can be contacted as follows:

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End of Report

Appendix

Equality Delivery System – *EDS2* Summary Report

The Equality Delivery System – EDS2 was made mandatory in the NHS standard contract from April 2015. NHS organisations are strongly encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf
This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. Once completed, this Summary Report should be published on the organisation's website.
NHS organisation name:

The Walton Centre NHS Foundation Trust

Organisation's Board lead for EDS2:

Lisa Salter (Director of Nursing & Governance)

Organisation's EDS2 lead (name/email):

Workforce – Andrew Lynch (Andrew.Lynch2@thewaltoncentre.nhs.uk)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

- Staff Partnership Committee
- Patient Experience Group
- Business Performance Committee
- Healthwatch Liverpool

Organisation's Equality Objectives (including duration period):

2017-2021

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

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

In November 2017 the Trust published its ED&I 5 Year Vision.

This vision sets out the way forward for The Walton Centre to improve ED&I for both its patients and staff. This vision has come from both staff and patients sharing what good practice looks like and how we will know when we have achieved it, supported by a detailed strategy action plan. This will be delivered by the Operational ED&I Group, who will be held to account by the ED&I Steering Group. It will be monitored through the Quality Committee with an annual review of the vision and action plans progress in the same manner the Quality & Patient Strategy is currently monitored. This vision will guide the Trust towards making systematic improvements around ED&I in this year and in coming years.

EDS2 Grades (Date: 18/06/2021)		
Goal	**Outcome**	**Grade and reasons for rating**
Better health outcomes		**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is in the process of adopting a new standard operating procedure to ensure that reasonable adjustments and made to make our service accessible to patients with disabilities.** **The Trust has analysed patient equality data and has identified lower numbers of Black Asian and minority ethnic staff using our services than we would expect given the local demographics in terms of racial diversity.** **The Trust has participated in the Steering Group of the Cheshire and Merseyside Health and Care Partnerships, community insight research "Getting Under the Skin" which though primarily aimed at measuring the impact of COVID- 19 on Black, Asian and Minority Ethnic communities, will lead to better mapping of and engagement with these communities in relation to a wide variety of health conditions including neurological conditions.**
	1.1	**The Trust believes that the highest quality services should be provided to all patients, which is reflected in the Trust's corporate objectives and mission statement. This belief is the key driver in the design and procurement of all its services. The Trust works in partnership with commissioners to shape their contract thus ensuring that services are commissioned to meet the needs of the local population and to reduce health inequalities. The Trust is currently engaged in a joint retendering process with local Trusts and CCGs to ensure that interpretation and translations services of the highest quality. Equality performance is routinely monitored in the quality contract with the Trust's commissioners.** **Any new services or existing services undergoing change are assessed for possible equality impact on patients, visitors and staff. In addition, services are designed to be compliant with the Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) standards and guidelines, and are fully accredited by awarding bodies.** **The Trust believes that the services offered by the Trust are available to all irrespective of their protected characteristics, and data from the patient data report, complaints monitoring, patient surveys and engagement supports this belief. Patients, carers, Foundation Trust members and other stakeholders and local organisations and community groups are consulted with and involved in the design and delivery of services, thus ensuring that the health needs of the local communities are considered. All tenders assess equality and diversity, with responses considered as part of the tender process. All contracts include equality clauses.** **For this outcome, the Trust has good evidence and data to demonstrate that services are equality impact assessed. The Trust can also demonstrate that the health and well-being of its staff and patients is taken seriously through strategic planning processes and policy making.**

		Patients from all protected characteristics are engaged with in the above processes, but the Trust currently does not capture all characteristics and therefore is unable to demonstrate a higher number of protected characteristics that fare well. Continuing actions will be implemented to address these issues in the next 12 months.
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust remains in a similar position for sub goal 1.2. Due to the limited data captured the Trust is unable to evidence further progression to show all protected characteristics fair well. However, processes are in place to ensure that all patients' health needs are assessed and met regardless of protected characteristics. The Trust is committed to provide individualised patient care and, where required, protected characteristics are taken into account during the health needs assessment and through the patient journey. For example, the Trust ensures that reasonable adjustments are made for disabled patients, patients with learning disabilities, and patients with dementia. In addition, the Trust has access to 24-hour interpretation services that cover the languages or dialects that are spoken within the organisations catchment area. Sign language is also catered for via our externally commissioned interpretation and translation service.** **Following an individual health needs assessment, either in an outpatient, inpatient or in a community setting, all patients are provided access to the services they require in an appropriate and effective manner. The Trust ensures effective assessments are undertaken and case note and nursing quality audits support this process.** **Risk assessments are undertaken on all patients and therefore from all protected characteristics in relation to falls, pressure ulcers, venous thromboembolism (VTE) and nutrition, in line with Commissioning and quality targets. The assessment includes review of patient's religious and cultural requirements, communication and care requirements, family support and carer needs. Individual care plans are developed for each patient and reviewed throughout their period of care. These plans are contributed to by all members of the Trust multidisciplinary team as and referrals made to subsequent services such as smoking cessation, dieticians, support groups or district nursing and rehabilitation services as appropriate.** **For this outcome, the Trust is satisfied that the processes in place across the organisation allow for all the patients who are referred to services or self-refer, where appropriate, are provided with individualised health needs assessments. Although quantitative data is not available for all protected characteristics, plans are in place to address this.**
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust has numerous examples to demonstrate effective and appropriate transitions from services to support individual needs. This happens during transfer of patients into the Trust from the Trauma Network, from District General Hospitals, from other specialist Trust, for example Alder Hey, and GP referrals. We also transfer patients onto various points of care, including services within the Rehab Network, repatriating hospitals and social care or specialist services. This includes patients from Wales and the Isle of Man.** **Individual care plans are developed for each patient and reviewed throughout their period of care. The patient's assessment includes a review of their religious and cultural requirements, communication and care requirements, family support and carer needs. These plans are contributed to by all members of the Trust's multidisciplinary teams with input from the patient and carers, alongside health and social care professionals. Any change in services provided is planned and communicated with all concerned and any referrals are made to subsequent services with full handover of information.** **The Trust has good links with local communities and social services across its footprint. Holding multi-disciplinary meetings with internal and external stakeholders, as well as family members, to ensure arrangements are agreed and planned in the best interests of individual patients.** **The Trust is currently working to ensure that the needs of people with learning disabilities are fully taken into account in accessing services and in transitions. Patients who have learning disabilities are encouraged to utilise the Traffic Light Assessment system the Trust has in place which gives consistent and current information about the patient and ensures continuity of care.** **The Trust actively signposts carers to appropriate support, includes them as partners in care and has developed a Carer's Strategy identifying how the Trust will continue to support and work with carers in the future. The Trust is currently allocating space for a carers resource where it will provide information and a quiet space for carers to access. This resource will be supported by the Brain Charity in partnership with the Trust.**

		For this outcome, despite good examples, the Trust cannot provide data to demonstrate that people from all protected groups are supported and have smooth transitions between services. However, complaints received by the organisation do not demonstrate that any protected characteristics are discriminated against during this process.
	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust believes that patient safety and quality must be at the heart of everything it does. The Quality Accounts Annual Report provides the back drop to demonstrate the organisations commitment to improving the quality of services and safety of care. The Trust must ensure that it listens to and acts on feedback received.** **The Trust takes patient safety very seriously and has reported on several current work streams within the Quality Accounts report, including medication errors, cancelled operations and healthcare acquired infections. Data is available for 4 protected characteristics at the present time however, as previously stated, work is being undertaken to extend the data collection systems to improve data capture.** **Patient Led Assessment of Cleanliness and Environment (PLACE) inspections are carried out annually. Teams are made up of patient representatives and members of staff. The visits are unannounced and intended to review the hospital for standards in cleanliness, hand hygiene, quality of accommodation and food** **The organisation has a system in place whereby incidents of abuse must be reported by staff whether the abuse is directed at staff by patients, patient to patient or patient to staff, patient to patient and staff to patient. Abuse includes behaviours such as violence, verbal abuse, gestures, sexual or racial abuse. Reporting is web based, and all incidents are investigated thoroughly and actions undertaken to address the behaviours. All incidents are reported through the appropriate governance committee structures. Some incidents, such as neglect, abuse of vulnerable adults or children, are reported directly to the Strategic Executive Information System (STEIS) as per NHS standard procedures for external reporting. The Trust also has an appointed Freedom to Speak Up Guardian to ensure that staff are encouraged and supported to report any mistakes, mistreatment and abuse.** **Reporting incidents by protected characteristic is difficult at the present time. Work is being undertaken to tie in together the three data systems required: the patient administration system, the electronic staffing record and the incident reporting system in order that data can be gathered for protected characteristics. The Trust seeks causes through incident reporting and whistle-blowing systems, which informs actions to be undertaken. Therefore, having a robust and safe complaints and whistle-blowing process is vital. Policies are in place to protect people making complaints and follow strict guidelines. Staff and patients are able to make complaints without fear of victimisation.** **The Trust has a Safeguarding Adults and Children team to ensure the Trust operates within national statutory and non-statutory guidance for on safeguarding vulnerable people. Policies have been introduced to provide guidance to staff on the management of allegations of abuse and deprivation of liberty safeguards. In addition, staffs have access to taught sessions and e-learning training packages on safeguarding issues.** **For this outcome, the Trust firmly believes that all people from all protected characteristics are given the same protection in accordance with its mission statement to provide the very best care for each patient on every occasion, which is at the core of everything it does. However, grading has been identified as developing. This is due to the good data and evidence to demonstrate patient safety across the protected characteristics available in comparison to the less adequate data available for incident reporting of bullying or harassing behaviours. Patients from all protected characteristics are engaged with in the above processes.**
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.**

		The Trust has an extensive range of health programmes and initiatives in place to support staff and patients alike in accessing public health, vaccination and screening programmes. The Trust is able to provide evidence to demonstrate that people are accessing services; however, due to the limitations of the patient administration system, this is only possible for 4 of the protected characteristics. Work is underway to enhance the current data collection systems to cover all protected characteristics. **Throughout the hospitals wards, outpatients and public areas there is an extensive range of public health information for staff and patients to access, examples being for infection control and smoking cessation. Audits are undertaken by volunteers to ensure sufficient coverage and appropriate placement of information is provided. All patient information is available on request in alternative formats. Interpreters are utilised to ensure communication is most effective.** **The Trust carried out an extensive COVID-19 vaccination programme on 2020 and took particular steps to ensure a high vaccination rate amongst Black, Asian and minority ethnic staff in response to national reports of their being a disproportionate impact of COVID-19 on these groups.** **Health, vaccination and screening programmes include: pre-natal advice for epilepsy patients, flu vaccination programmes and smoking and alcohol intake screenings. After a positive trial for epilepsy patients a number of Nurse advice lines have also been rolled out to enable patients to get disease specific advice and support between appointments.** **The Trust believes that a healthy workforce leads to safer and better patient care and is committed to improving the health and wellbeing of all staff. The Trust has also been re-accredited with the Workplace Wellbeing charter and continues to run regular schemes and initiatives including health checks, fitness classes, various mental well-being initiatives, and discounted weight loss programmes.** **For this outcome, the Trust is again able to present data for 4 of the protected characteristics for patients, and all but 1 protected characteristic for staff (although not all staff services are monitored for equality purposes).**
Improved patient access and experience	**2.1**	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust has undertaken an analysis of accessibility to our service regarding race and ethnicity via the Trust's Strategic BAME Advisory Committee, which indicated that fewer patients from Black, Asian and Minority Ethnic backgrounds are currently accessing our service when compared with their proportionate demographic percentage of the population we serve. The Trust has taken steps to ascertain the reasons for this disparity with relatively fewer numbers of Black, Asian and minority ethnic patients accessing the service.** **The following barriers have been identified by the Trust through networking with voluntary sector organisations such as the Neurological Alliance:** • **A lack of knowledge in some newer communities as to how the health system works and how to access health services e.g. refugees and asylums seekers.** • **Language can be a barrier for people who have English as a second language. Basic information as to how to navigate the health system can be more difficult to access, resulting in patients not being referred on from primary care in the numbers we might expect.** • **Different ways of understanding illness and describing symptoms in some communities leading to greater difficulties in diagnosis of some conditions e.g. in some languages there is no separate word for a neurological condition and a mental health condition.** • **Stigma and a reluctance to come forward for diagnosis because of fear of being stigmatised in some communities.** • **A greater emphasis in some communities on families taking care of their own family members rather than relying on health care services, leading to later presentation at health services and later diagnosis.** **The Trust is continuing to network with the Neurological Alliance and other organisations to find ways to address these barriers e.g. The Trust has participated in the Steering Group of the Cheshire and Merseyside Health and Care Partnerships, community insight research "Getting Under the Skin" which though primarily aimed at measuring the impact of COVID- 19 on Black, Asian and Minority Ethnic communities, will lead to better mapping of and engagement with these communities in relation to a wide variety of health conditions including neurological conditions.** **Due to the limitations of the current patient administration system (PAS), the Trust is only able to provide quantitative data for 4 of the protected characteristics: namely, age, ethnicity, religion and belief and sex. Plans are already in place to update PAS to collect additional information regarding disability, sexual orientation and carer status.** **The Trust recognises that accessing services can be more difficult for some people – such as people with a disability, people with learning difficulties or people whose first language is not English. The Trust is committed to ensuring that reasonable adjustments are made for disabled patients and patients with learning difficulties where required. For example, where a patient is distressed by waiting rooms and bright lighting, staff arrange for the patients appointment to be first on the list and the patient seated in a quiet area to wait for their appointment, thus reducing anxiety for the patient and carer or relatives. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities.** **Pictorial menus have also been developed to support patients to choose their meals and interpreters are in place to support patients who are**

		unable to read or comprehend English. The Trust has implemented the Accessible Information Standard and is working on ensuring this remains fully implemented. Since its implementation we have received requests from a number of patients to meet their needs and have been able to accommodate all of these. When patients telephone to make appointments, the access, booking and choice receptionists ask patients whether they have caring responsibilities or any disability in order to ensure that the best appointment possible is provided to suit their needs. Patients are also able to make appointments via email if preferred. Text messages are also sent to patients to remind them of their appointment, and the Trust has a self-check in kiosk, which has been reviewed regarding its accessibility. **The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings** **The Trust has an interpreting service that is readily available and covers languages and dialects required, there also a provision for British sign language. Language interpretation is available face to face and by telephone. The Trust has an interpreting policy to ensure that staff understand how to access the interpreting services.** **'Pathfinder' volunteers have been recruited to support patients to navigate around the hospital and the Trust is working with local communities and charities to ensure training is appropriate regarding peoples cultural and disability requirements, i.e. patients with vision impairment being guided appropriately.** **For this outcome, the Trust is able to demonstrate that patients, carers and communities from 4 of the protected characteristics readily access services and there are no obvious concerns as demonstrated in the patient data report.**
	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust is committed to ensure that all patients, irrespective of protected characteristics, are informed, supported and involved in their diagnosis and decisions about their care where appropriate.** **The National Inpatient Survey is the main source of reporting the perceptions of patients across the NHS and is used in comparative performance tables and quality indicators. Action plans have been developed and targeted work undertaken where patient perception has been less than anticipated. Improvements were made over the last few years, with the result that when asked, the majority of patients felt they had been involved in decisions about their care, had been kept informed about medication side effects and were provided with information in a way that was easy to understand. Local real-time surveys and the regular patient listening events undertaken across the Trust support the findings of the national survey.** **The Trust implemented a Ticket Home scheme on all wards. The aim of the scheme is to improve discharge planning through a focus on the predicted date of discharge, and recognizing as good practice to inform patients and their carers of their predicted discharge date and so improve patient experience by allowing patients to feel involved in decisions about their discharge. It also allows patients and their families to plan accordingly.** **All patients give consent to treatment in line with Trust and national consent policies. The Trust policy has recently been reviewed and reflects discussions with local communities.** **The Trust has an active Patient Experience Group which includes patients and Healthwatch representatives and supports patient information developed across the Trust. Standard, easy read and talking leaflets are being developed continually. The Trust strives to meet the communication needs of all patients with pictorial menus to support patients to make choices and the roll out of the Accessible Information Standard.** **Staff are able to access the interpreting services to ensure that patients whose first language is not English, or those patients who use British Sign Language, are fully able to understand their diagnoses and treatment. Indeed, where patients are to be given 'bad news' interpreting provision takes place face to face and not by telephone.** **For this outcome, the Trust is again able to demonstrate that patients from 4 of the protected characteristics are informed and supported to be as involved as they wish to be in decisions about their care. However, changes are underway to improve the data monitoring information collected at a local level. The national inpatient survey is limited to 6 protected characteristics at the present time.**
	2.3	**People report positive experiences of the NHS** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6**

		• **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust has been assessed as Outstanding by the CQC. As part of this assessment NHS England reviewed and assessed the delivery of care to patients and their experiences when accessing services. They also undertook a review of equality and diversity provision and compliance within the Trust and found the outcome to be good.** **Feedback through surveys and social media indicate a very good patient experience of services at the Walton Centre. In CQC National Surveys results do not indicate any discrimination due to a particular characteristic. Scheduled quarterly reports on all patient experience and dignity and respect activities are presented to the Trust Board and to the specialist CCG commissioners. In addition, the complaints department publishes a regular report to the Trust Board on the experiences of patients and how issues have been resolved. This information also goes to Patient Experience Group which has representatives from the Governing Body, Healthwatch and local charitable organisations.** **The usual numbers of patient surveys that are carried out on wards by our volunteers have been suspended in 2020/21 due to the COVID-19 pandemic. As soon as normal post- covid operations are resumed, these patient engagement activities will start up again.** **The Trust has Dignity Champions across the organisation with each ward having at least one Dignity Champion. The Champions act as role models, identifying breaches of dignity in care, addressing and challenging issues as they arise and promoting dignity in care for every patient.** **The Trust has already identified gaps in engagement with some seldom heard groups, such as gypsy, traveller and Roma communities and homeless people communities. Work will continue to forge better relationships with all community groups to ensure that their voices are heard through partnership working with local communities and interest groups, CCGs and Local Authorities and the Health watch.** **For this outcome, the Trust is firmly committed to listening to the views of patients, carers and other local interest groups and communities and ensuring positive patient experience. Evidence from all of the above leads us to suggest that we are Achieving with regards to this sub-goal.**
	2.4	**People's complaints about services are handled respectfully and efficiently** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **Complaints about our services are taken very seriously and all concerns and complaints are investigated by Patient Experience Team, which incorporate the Patient Advice and Liaison Service and are recorded on the Trust's electronic database. Statistical information and lessons learnt are reported to the Patient Experience Group and the Quality Committee and Trust Board on a quarterly basis. This report also highlights actions taken as a result of complaints.** **A patient experience and engagement strategy has been developed and ratified in partnership with patients, carers, staff and other local interest groups to ensure that the Trust engages, involves and informs people from all backgrounds in the best ways possible.** **The Trust Board continues to recognise the importance of hearing the patients' voice directly through a patient story which is provided to the Trust Board at the start of the meeting.** **The Trust records only 3 protected characteristics when patients complain. This is an area we have identified as needing further work and will be included in the Trust Equality Action Plan. This will enable further detailed analysis to ensure there are no patterns or themes.** **The Trust has set itself targets for responding to formal complaints, based on an initial assessment and in discussion with the complainant. In most cases this target is within 25 working days of receipt but can be extended in consultation with the complainant. This is monitored and reported quarterly to Trust Board members and monthly to the Chief Executive and Executive Directors. Trends over the last few years indicate an increased level of efficiency in the complaints process for patients of most groups.** **For this outcome, whilst the Trust feels it has strong processes in place to respond to all complaints, but due to the lack of data capture we are unable to evidence this for many of the individual protected characteristics.**
A representative and supported workforce	**3.1**	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.**

		The Trust uses NHS Jobs which collects data on 7 of the 9 protected characteristics (gender reassignment and pregnancy/maternity are currently not recorded). Recruiting managers are unable to see any of the monitoring information at any point and are also unable to see the applicants name or right to work status until after the shortlisting process has been completed either. All figures and demographics can be found in the E&D Workforce Annual Report 2019 however the following outlines a brief overview and some additional actions taken to support a fairer recruitment process. **The Trust is now a DWP Disability Confident Level 2 employer (previously referred to as Two Ticks), and therefore continues to guarantee an interview to all applicants who declare that they have a disability and would like to be considered under this scheme, providing they meet the essential criteria for the vacancy. The data shows that a higher percentage of applicants with a disability (4.80%) were shortlisted compared to those who applied (3.90%).** **Although NHS Jobs is a web-based system hard copy application forms are also available in other formats upon request.** **All candidates are also asked in their invite to interview if they require any reasonable adjustments to be made for their interview and these are always accommodated. Once appointed, and throughout an employee's employment, where necessary the Trust's occupational health department will be consulted to advise on any reasonable adjustments which need to be made.** **Although not recorded via NHS Jobs work has been done to support applicants from 'trans' individuals. Guidance is provided on all adverts advising that if any trans applicants require a DBS there is a process they can use to protect any previous identity being disclosed. A transgender staff support policy has also been developed for any employees who are considering undergoing, currently undergoing or have undergone gender reassignment. The Trust was reaccredited with the Navajo Chartermark recognising this and other initiatives to support LGBT applicants and staff.** **The Trust is aware that there is a notable difference in the disaggregated percentages of BME applicants shortlisted compared to White applicants. Changes to resident labour market test restrictions and changes to immigration rules may have in part affected this but this is an area we are investigating further in line with the WRES. The Trust now also advertises our job vacancies to potential BME applicants via a specialist website: bmejobs.co.uk**
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** • **Grade: Developing** • **Number of protected characteristics that fare well:** **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Gender Pay Gap** **The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and will be making use of the data to inform action planning for the coming year.**
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** • **Grade: Achieving** • **Number of protected characteristics that fare well: 7** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has done a lot of work around improving access to training and development; this has been to support all protected characteristics but in particular to support BME staff. The Trust has also reviewed all mandatory training and has made equality, diversity & human rights training mandatory on a 3 yearly basis, as opposed to a one off session. Furthermore, the Trust's OLM e-Learning allows employees to complete parts of their mandatory training at a time and place convenient to them. Adjustments have been accounted for to support individuals as needed including 1:1 support sessions.** **Following the findings from the WRES a BME Staff Network was established. Feedback from this group suggested BME staff were not always aware of opportunities available to them. In response to this targeted communications are sent to BME staff to increase awareness around certain courses and opportunities. This has included ensuring BME representation on an accredited Coaching Course, gaining representation for a regional BME group, circulating information about the Stepping Up Programme aimed at developing black, Asian and minority ethnic (BAME) colleagues in bands 5 – 7 and the Ready Now Programme for bands 8a and above.** **All training opportunities are well publicised, through weekly communications and the monthly team brief. Data is collected on 7 of the protected**

		characteristics (gender reassignment and pregnancy/maternity are not captured, although questions are asked around pregnancy where appropriate to ensure training can be adjusted where necessary). Analysis for all data can be found within the E&D Annual Report however the general findings show no concerning aspects. In comparison to last year there is no over-representation of females applying for training. There is however still an under-representation of BME staff, compared to the overall workforce demographics however the steps discussed above should hopefully address any differences observed. The percentages of applications by age group, sexual orientation and religion or belief are all comparable with the workforce demographics with the percentage by disability also being broadly in line.
	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** • **Grade: Developing** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Data in respect of all employee relation cases (grievances, disciplinaries, and dignity at work) is monitored against the 7 protected characteristics currently recorded in ESR. The E&D Annual Report includes analysis of this.** **In relation to race, monitoring is also conducted via the Workforce Race Equality Standard (WRES).** **In relation to Disability, monitoring is also conducted via the Workforce Disability Equality Standard (WDES).** **Due to the nature of the patients treated by the Walton Centre aggression is quite common and is often a symptom of their illness. Whilst any patient behaving inappropriately will be spoken to it is often the case that they are either unable to help their actions or they forget the warning given, this makes it very difficult to eradicate this behaviour completely, however, the Trust does try to offer staff additional support in these case.** **Initiatives undertaken to try and ensure staff feel able to raise any concerns and to enable the Trust to address these issues include:** ○ **Staff listening weeks** ○ **CQC internal visits** ○ **Friends and family tests** ○ **Dignity at Work Policy** ○ **Raising Concerns Policy** ○ **Violence and Aggression Training** ○ **A number of trained mediators who can support in resolving conflict without escalation where necessary** ○ **The use of exit questionnaires and interviews** ○ **The promotion of access to the Freedom to Speak Up Guardian**
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** • **Grade: Developing** • **Number of protected characteristics that fare well: 3** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading. The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust's Flexible Working Policy enables all employees from the point at which they join the Trust to request a flexible working arrangement. In addition to part-time working, flexible working options also include compressed or adjusted hours, job-sharing, flexi-time, term-time working, home working (where possible) and career breaks.** **The Trust also offers flexible retirement options, as detailed in the Trust's Flexible Retirement policy. This aims to support older employees in their retirement plans and therefore demonstrates our commitment, and appreciation of, a diversity workforce. Take up of flexible retirement has been at an all-time high over the last 12 months, more than doubling the previous year.**
	3.6	**Staff report positive experiences of their membership of the workforce** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.**

		Evidence can be taken from the National Staff Survey which reports against 4 of the protected characteristics, this can also be collaborated by local data collected from the Trust Friends and Family Tests and Staff Listening weeks although these do not currently capture any protected characteristics. **In 2020 there was only a marginal difference between the average and the best performing trusts, with The Walton Centre indicated at slightly above average. The trajectory across the five years measured is relatively flat for The Walton Centre, as is also indicated for all but the worst performing trust, which is on a downward trajectory.** **The Trust also monitors staff experience via Workplace Race Equality Standards (WRES) reporting and Workplace Disability Equality Standards (WDES) reporting and has corresponding action plans to improve staff experience. The Trust also has an extensive suite of wellbeing activities that a promoted to staff.**
Inclusive leadership	**4.1**	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **The Trust board review and approve the Equality and Diversity Annual Report; which covers all the protected characteristics. All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed.** **The Director of Nursing and Governance is the Executive Lead for Equality within the Trust. Examples of when Board members and senior leaders have demonstrated their commitment to equality include; clear statements of the Trusts commitment to ED&I by the Chief Executive both in policy documents and in personal statements and online blogs, the creation of a designated Executive Lead for ED&I on the Board, an ongoing commitment form Board members to participate in reciprocal mentoring for BME staff, as well as becoming involved in the BME Staff Network; promotion of services for people with disability through the Vanguard Programme and National Rehab Conference held at the Trust; and the Trust has maintained its Navajo Chartermark which is also supported by the Executive Team. The Trust has also set up a Strategic BAME Advisory Group Chaired by the Chief Executive and reporting directly to the Board in order to advance race equality objectives.**
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** • **Grade: Developing** • **Number of protected characteristics that fare well: 9 (however not always completed, see below)** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed, unfortunately however this is not always done robustly and only a small number fulfil this requirement. EIA's are also expected to be completed before all policies are ratified by the appropriate committee. To support this, the EIA screening tool has been added to the policy template.**
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** • **Grade: Developing** • **Number of protected characteristics that fare well: 3** • **Evidence drawn upon for rating:** **The Trust has chosen to maintain the previous year's grade on all EDS 2 Outcomes, as the evidence available has not changed significantly since the previous grading.** **In 2019/2020 the Trust introduced its Building Rapport training programme for managers, which has an equality section aimed at Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. This programme was halted during the COVID-19 pandemic but it will resume in 2021.**

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 01/07/21		**Report of:** Quality Committee
Date of last meeting: 17/06/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Quality Presentation by Human Resources • Patient Story • Medical Director's update • Integrated Performance Report • CQC Action Plan • CQC Strategy • Visibility & Walkabout Report • MIAA Recommendations for Annual Programme & MIAA updates • Safeguarding Annual Report • Trust Risk Register Report • Board Assurance Framework • Clinical Audit Plan • Sub-Committees Chairs' reports
2.	**Alert**	• The Director of Nursing & Governance highlighted that some of the data in the KPI report (pages 15 and 38 of the QC board pack) are not accurate. The Information Team are working with the Clinical Team to determine how the information needs to be processed. Page 15 relates to those patients moved to other wards are not being counted correctly and page 38 relates to sickness rates which are not accurate due to ward moves arising from the heating and pipework. More accurate data is expected next month. • Ms Oulton Lead Nurse for Infection, Prevention & Control also drew attention to the Sepsis report by SMART in which 35% of patients were not screened when NEWS scores indicated otherwise. SMART have been undertaking work so improvements should be reflected in the next audit. • The Director of Nursing & Governance provided on overview of the new CQC Strategy noting that the strategy is high level. Ms Salter is awaiting a meeting with another new CQC relationship partner next month to understand how future reviews will be undertaken. • Ms Oulton advised that the National Cleaning Standards have been published and need to be implemented within six months. It is envisaged that the new standards will have an impact on the cost of domestic cleaning services.

	Assurance	• Ms J Mullin, Deputy Director of Human Resources (HR) gave a comprehensive presentation which demonstrated the scope and quality service delivered by the HR Dept. Much work has been undertaken to support the medical workforce, ensuring effective outcomes both in terms of quality and finance. The HR team are passionate about the health & well-being of staff and several elements supporting this were described. Equality Diversity and Inclusion is part of every aspect the team offer and they strive to achieve this to enhance WDES, WRES and gender pay gap results. .The Innovation strategy is key to ensuring innovation occurs and the impact benefit patients, staff, the Trust and the wider community. • The Medical Director discussed the report received from the NHS Blood and Transplant service. The report noted that despite the Covid-19 pandemic, the WCFT continued with the organ donation programme achieving a total of 38 transplants in total from 24 consented donors. • When reviewing the Integrated Performance Report, the Director of Nursing & Governance gave assurances that no lapses in care were found for the patient who suffered a fractured humerus following a fall. There were also deficits in care noted regarding a staff fall in which the staff member sustained a broken arm. Attention was drawn to the number of C. Difficile cases to date which total 3 cases against a trajectory of 5 and to the number of cases of MSSA which currently total 3 to date against a trajectory of 8. Divisions are working to address both of these issues. With regards to patient flow benchmarking, Ms Vlasman advised that length of stay is part of the transformation work out the Trust are outliers for length stay duration. Mr. Carter advised that due to being a Tertiary centre, the Trust accommodate patients with significant need and also encounter issues with repatriation. • The Committee received positive assurances from Ms Kane, Quality Manager & Freedom to Speak Up Guardian with regards to progress on the CQC action plan. • The Committee were assured that Visibility and Walkabouts will re-commence this month following a long pause due to the covid pandemic. It is hoped that the new process will encourage discussion with staff. • Mr. J Haury from MIAA joined the meeting to provide an update with regards to MIAA recommendations for the annual programme and on progress to date. It was noted that 25 actions remain outstanding, however work is underway to bring this up to date. It was noted that a review of Covid-19 will be undertaken in quarter 4. Questions were raised as to whether this would still go ahead in view of the National Enquiry. Further discussion is needed with the Director of Finance with regards to this audit. • Ms D. Lee joined the meeting to present the Safeguarding Annual Report. Whilst the number of safeguarding activity continues to increase, this was seen as a positive as staff are recognising the need to raise a safeguarding concern. The number of DoLS applications has also increased which also indicates that

		staff are understanding the Mental Capacity Act/DoLs requirement so that the correct legal processes are put in place. Ms Lee advised that the Liberty Protection Safeguards Act has been postponed to April 2022. This Act will move responsibility of the assessment of DoLS away from local authorities to within trusts. Specialist assessors will be required to support LPS requirements.		
	Advise	• Mr Buckingham, Corporate Secretary presented the Board Assurance Framework. The Committee agreed that BAF risk 004 with regards to the Quality Strategy could be reduced from a risk rating of 16 to risk rating 12 as significant amount of work had been achieved on the Quality Strategy despite the Covid-19 pandemic. A request was made to consider raising BAF risk 005 (which relates to harm to staff) due to the number of staff suffering fractures. Following discussion the Committee agreed to review in 3 months' time in order to monitor and evaluate the work that has been put in place to reduce incident. The Committee seek Board approval for these risks.		
2.	Risks Identified	• Risk 669 was identified as a new risk added to the Trust Risk Register which relates to the international shortage of immunoglobulin. This risk has been upgraded from a rating of 9 to a rating of 20.		
3.	Report Compiled by	Seth Crofts Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 1/7/21		**Report of:** Business Performance Committee
Date of last meeting: 22/6/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report (IPR) • BPC Priorities • Response to the National NHS People Plan 2021/22 and Trust Annual Staff Survey 2020 • Sustainability Plan • Board Assurance Framework • Feedback from BPC Task Group Meeting • 2021-22 Cycle of Business • Trust Waste Services Update • Sub Committee Chair's Report from 4 Committees/Groups • AOB – Update on Transformation and QIP
2.	**Alert**	• None
3.	**Assurance**	• In reviewing the Integrated Performance Report (IPR) the Committee noted positive assurance in relation to a) operational performance in May 2021 with a reduction in 52 week waiters at month end of 191 waiters against a trajectory of 221. Overall performance against the Recovery Plan was positive with target levels achieved in all areas; b) vacancy levels, staff turnover and sickness; c) I&E YTD surplus of £185k was on plan, with both income and expenditure c. £330k above plan corresponding to higher than planned activity. Capital spend YTD is behind plan largely because the trajectory of Digital Aspirant spend is now later than planned. • The Committee received the consolidated action plan which is the Trust's response to both the annual staff survey undertaken last year and the updated national interim People Plan for 2021/22. The four key groups of commitments supported both nationally and regionally by NHSE/I were outlined and noted by the Committee. An Operational Workforce Group led by the Director of Workforce and Innovation is being established with the main focus to oversee the action plan. The Terms of Reference for the group will be presented at the next BPC meeting for approval and it was agreed the group would report to

		BPC.
4.	**Advise**	• The Committee noted plans in relation to the presentation of the IPR at future meetings. Over the next couple of months the old style report would be presented in line with a new style of reporting with focus on leading and lagging indicators. The new streamlined report is still to be signed off from a governance perspective. • The Committee Chair presented a paper to propose that the Committee defined a few critical issues as its current priorities. It was further proposed that the shortlist is reviewed and updated as deemed appropriate at each meeting. Short term priorities were agreed to be: i) Implementation of the Recovery Plan. ii) Adapting to changes in the financial regime; break-even in 2021/22. Medium term priorities were agreed to be: iii) Transformation and efficiency improvement (QIP) programmes. iv) Further advancing implementation of the People Plan. v) Updating and implementing the Digital Strategy. • The Deputy Director of Operations presented the Sustainability Plan with the purpose to provide assurance to the Committee that the Trust had a plan to reduce its carbon footprint and to help deliver a Net Zero NHS. The Trust needs to have a plan in place that will need to have been signed off by the Board of Directors by March 2022 and a draft plan would be presented to Board in December 2021. In preparation a Task and Finish group is being established and a Sustainability Plan update would be brought to BPC on a quarterly basis. • The Committee were provided with feedback from the second meeting of the BPC Task Group established to progress development areas identified through the Committee Effectiveness Review. Definitive outcomes from the second meeting were: o Terms of Reference for the Operational Workforce Group would be presented to the Committee for consideration. o Mr Buckingham to schedule a 'Report Writing Clinic'. o The development of a more effective presentation of the Risk Register to the Committee. Already implemented had been the completion of a 4A's report to replace the Chair's Report and this had been presented at last month's Trust Board meeting. • The Committee received the Board Assurance Framework (BAF) that contained 8 principal risks identified in the BAF where BPC is identified as the Assurance Committee. There had been no significant movement in risk scores with the exception of Risk ID 007 relating to the delivery of benefits associated with the Trust's Digital Strategy which had been reduced to reflect the Trust's successful application for Digital Aspirant funding and progress in delivery of the Digital Strategy. The Committee discussed Risk ID 002 Operational Performance which had a risk rating of 20. The Interim Director of Operations challenged this score considering it to be too high as the landscape pre-Covid was very different to now and operational performance was good with the Trust reaching its recovery objectives. A revised score of 16 was agreed and the Committee would

		propose this change to Trust Board. Conversely, the Committee suggested increasing the risk score of Risk ID 013 Financial Plan from 8 to 12 to reflect the current increased uncertainty of achieving break-even in 2021/22, partly because of flux in the finance regime. • The Committee approved the Estates, Facilities and Medical Devices Group revised Terms of Reference subject to the inclusion that the Group would monitor plans for capital management ideas and support the divisions in this.		
5.	Risks Identified	• None.		
6.	Report Compiled by	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary