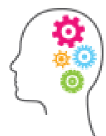
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 1st June 2023

Agenda and Papers

Excellence in Neuroscience



The Walton Centre NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
Thursday 1 June 2023
Boardroom
09:30 – 13.25

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Patient Story (v)	Chief Nurse	N/A
2	09.50	Welcome and Apologies (v)	Chair	N/A
3	09.55	Declaration of Interests (v)	Chair	Note
4	10.00	Minutes and actions of meetings held on: • 4 May 2023 (d)	Chair	Approve
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive	Note
6	10.20	Charity Substrategy Update (d)	Chief People Officer	Assurance
FINANCE AND PLANNING				
7	10.40	Financial Planning Update 2023/24 (d)	Chief Finance Officer	Approve
PERFORMANCE				
8	11.00	Integrated Performance Report (d)	Chief Executive Officer	Assurance
9	11.05	Business Performance Committee (d) • Chair's Assurance Report – 23 May 2023	Committee Chair	Assurance
10	11.20	Quality Committee (d) • Chair's Assurance Report – 18 May 2023	Committee Chair	Assurance
11.35 BREAK				
GOVERNANCE				
11	11.45	Board Effectiveness Review 2022/23 (d)	Chief Executive Officer	Assurance
12	11.55	Board and Committee Reporting Schedule (d)	Corporate Secretary	Approval
13	12.10	Update to the Trust Constitution and Standing Orders (d)	Corporate Secretary	Approval
QUALITY & SAFETY				
14	12.20	Guardian of Safe Working Quarterly Report to April 2023 (d) *Dr Chrissie Burness, Guardian of Safe Working*	Chief Medical Officer	Assurance
15	12.30	Quality Account 2022/23 (d)	Interim Chief Nurse	Assurance
16	12.45	Freedom to Speak Up Annual Report 2022/23(d) *Julie Kane, Freedom to Speak up Guardian*	Interim Chief Nurse	Assurance
COMMITTEE CHAIR'S ASSURANCE REPORTS/ TERMS OF REFERENCE				

Item	Time	Item	Owner	Purpose
17	12.55	Audit Committee – 16 May 2023 (d)	Committee Chair	Assurance
18	13.00	Neuroscience Programme Board – 11 May 2023 • Terms of Reference (ToR) and Effectiveness Review (d)	Committee Chair	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Mortality and Morbidity Q4 Report (d) • Patient Experience Q4 & Annual Report 2022/23 (d)				
CONCLUDING BUSINESS				
19	13.20	Any Other Business (v)	Chair	
20	13.25	Review of Meeting (v)	Chair	Note

Date and Time of Next Meeting: 9.30am, 6 July 2023, Boardroom, The Walton Centre

UNCONFIRMED
Minutes of the Public Trust Board Meeting
Board Room
4 May 2023

Present:

Max Steinberg (MS)	Chair
Mike Burns (MB)	Chief Financial Officer
Mike Gibney (MG)	Chief People Officer
Karen Heslop (KH)	Non-Executive Director
Paul May (PM)	Non-Executive Director
Andy Nicolson (AN)	Medical Director
Morag Olsen (MO)	Interim Chief Nurse
Su Rai (SR)	Deputy Chair and Senior Independent Director
David Topliffe (DT)	Non-Executive Director
Lindsey Vlasman (LV)	Chief Operating Officer
Ray Walker (RW)	Non-Executive Director

In attendance:

Katharine Dowson (KD)	Corporate Secretary
Jennifer Ezeogu (JE)	Deputy Corporate Secretary
Justin Griffiths (JG)	Chief Digital Information Officer (*item 8 only*)
Julie Kane (JK)	Freedom to Speak Up Guardian (*item 17 only*)
Nicola Martin (NM)	Deputy Chief Nurse *(item 6 only)*
Rachael Saunderson (RS)	Innovation Manager *(item 9 only)*
Elaine Vaile (EV)	Communications and Marketing Manager (*item 7 and observer*)

Observers

Barbara Strong	Public Governor: Merseyside

Apologies:

Irene Afful	Non-Executive Director
Jan Ross	Chief Executive Officer
Lisa Salter	Chief Nurse

1 Staff Story

1.1 An Advanced Nurse Practitioner (ANP) from the Neuropsychiatry Team presented a staff story regarding the work undertaken by the Team in tackling Violence and Aggression (V&A) and improving patient experience and staff safety. This was a team that had been invested in which had greatly improved the response time and handling of V&A against staff and support of staff following V&A.

1.2 The Neuropsychiatry Team work closely with the Risk and Governance Team, Head Injury Practitioner, Neuropsychology, and the Occupational Therapists to reduce and manage incidences of V&A. The ANP highlighted that training is also offered to the security and support staff in regard to the Mental Health Act, Deprivation of Liberty Safeguards orders (DoLS), restraining/restriction interventions and de-escalating techniques.

1.3 The ANP noted that staff awareness had improved about the Neuropsychiatry team and the support available to them, but this work continued to increase awareness further, raise staff confidence in de-escalating aggression and highlighting the role of Neuropsychiatry and security to intervene when incidents escalate. It was highlighted by the ANP that weekly meetings were held with the Safeguarding Lead to review restrict interventions and alternatives to this to ensure the safety of both patients and staff.

1.4 PM asked how staff were supported after incidents of V&A. The ANP responded that Team reflections and risk assessments were held frequently, there was a culture of speaking up and asking for support amongst staff and staff were encouraged to escalate concerns to more senior colleagues. The newly opened Staff Wellbeing Hub would also allow staff to seek support, reflect and debrief. Regular training would continue to be held for staff and a standardised risk assessment developed to help minimise incidents of aggression.

The Board recorded its thanks to the Staff for sharing their story.

2 Welcome and apologies

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

3 Declarations of interest

3.1 No declarations of interest in relation to the agenda were made, no new declarations were recorded.

4 Minutes of the meeting held on 6 April 2023

4.1 Paragraph 2.2 – the first sentence was amended from “MG highlighted that the Trust was the only one in the region with gold accreditation.” to read “MG highlighted that the Trust was the only one in the *country* with gold accreditation *for both the full Investors in People and the Health and Wellbeing award*”.

4.2 Paragraph 4.1 – Company Secretary to be corrected to Associate Director of Corporate Governance.

4.3 Paragraph 8.2 - Minor typo was corrected by MB.

4.4 Paragraph 13.3 – the sentence was amended from “DT highlighted that the Committee had recommended to the Board that Audit Committee and BPC put more productivity improvement programmes and processes in place to help deliver on the required QIP given the forecasted challenges in next year’s finance and operation plan.” to read “ *DT highlighted that the Committee had recommended to the Board that Audit Committee and BPC heighten their scrutiny of QIP processes and programmes (respectively) given the challenges in the next year’s finance and operational plan.”*

4.5 Paragraph 16.3 – “was certified and” in the second sentence to be deleted.

4.6 Paragraph 17.3 – the first and second sentence was amended from “DT agreed to the proposed review but disagreed with paragraph 17 that stated that the BPC agenda was stretched. He stated that it was unnecessary to suggest the total removal of the issues around people from the ambit of BPC and move to a new committee.” to read “*DT supported the proposal but suggested that the longer-term goal expressed in paragraph 20 (to later move workforce entirely from BPC to the new committee) should be reviewed sometime*

down the line: whilst it would certainly help unload BPC, it could introduce other unintended risks."

4.7 Following the completion of these amendments, the minutes of the meeting held on 2 March 2023 were approved as an accurate record of the meeting.

Action tracker

4.8 There were no outstanding actions.

5 Chair & Chief Executive's Report

5.1 MS informed that Saffron Cordery, Deputy CEO of NHS Providers, visited the Trust on 25 April 2023 and officially opened the Staff Wellbeing Hub dedicated to the memory of staff member Jean Blevin who passed away in 2020. MS advised that Councillor Liam Robinson, from Liverpool City Council, was scheduled to visit the Trust on 18 May 2023, and the Vice-Chancellor of UoL had also been invited to visit the Trust.

5.2 The second Joint Site Aintree Committee meeting was held in shadow form, on 26 April 2023, and the draft Committee Terms of Reference (ToR) would be presented to the Board for approval at today's meeting.

5.3 MS had attended an introductory meeting with the new Vice-Chancellor of the University of Liverpool (UoL), the Liverpool Hospitals Review meeting, the Combined North-West System meeting for leaders and chairs and the Annual Sutcliffe Kerr Lecture

5.4 AN presented the CEO's report and updated that the industrial action called by the Royal College of Nursing (RCN) only lasted until midnight on 1 May 2023 due to a successful legal challenge from the Secretary of State on the length of the strike. The Trust had put in place mitigations to keep patients safe as there were initially no derogations for the Intensive Care Unit and Critical Care. AN commended the effort of the Senior Nursing Team (SNT) and the Medical Team during the strike period who worked tirelessly to ensure patient and staff safety was not compromised; no safety concerns had yet been raised.

5.5 AN informed the Board that JR had been appointed as the new Chair of the Cheshire and Merseyside Integrated Stroke Delivery Network.

5.6 AN advised that the proposed documentary for the Trust had been commissioned and would be aired on Channel 5 in September 2023. Filming of the documentary would commence in June 2023.

The Board noted the Chair and Chief Executive reports.

6 Quality Substrategy 2023-2026

6.1 NM presented the Quality Substrategy and advised that it had been developed in line with the strategic ambitions outlined in the Trust Strategy 2022-25. The Quality Substrategy identified four priority areas, including a focus on patient and family-centred care and incorporated the Trust 6i's approach to quality improvement. Following the Board's approval, the final version of the Quality Substrategy would be transferred to the agreed format by the Communications Team, and workplans would be developed by divisions to implement the Substrategy.

6.2 SR asked what plans the Team had to increase patient's voice and representation at Trust groups. NM responded that the Team had focused more on listening to patients and families to increase direct involvement, and there was ongoing work to recruit two Patient and Safety Advocates (PSA) who would attend patient focus groups. NM highlighted that working groups would be created to achieve each step in the Quality Substrategy.

6.3 KH questioned if plans were in place for patients to provide feedback digitally. NM answered that Lisa Judge, the Head of Patient and Family Experience, had developed a business case for a digital feedback platform. The platform would provide an opportunity for more feedback to be received digitally.

6.4 LV stated that the Trust had purchased the license for the DrDoctor platform and suggested that the forum could also be used to gather more patient voices and digital feedback.

The Board approved the Quality Substrategy.

7 Trust Brand Narrative

7.1 EV presented the Trust Brand narrative and highlighted that it was developed from the collective feedback of the board members and internal stakeholders; it formed part of the building blocks of the Trust's rebranding project and would be used to communicate to the public the work undertaken at the Walton Centre. A long, medium and short brand narrative had been developed and this would be used in the Trust's internal and external communications.

7.2 EV highlighted that the next steps following the approval of the brand narrative by the Board included developing a messaging framework, promoting the visual representation of the brand narrative and producing a short brand film for the Trust. The next phase of the Trust rebranding project would be the Naming project.

7.3 MS questioned if the Trust brand narrative had been tested externally. EV responded that the brand narrative had not been tested externally. However, it would be tested externally together with the naming project, as the naming project was due to be completed by the end of due June 2023. It was hoped that the Trust's new name would be reflected in the documentary by Channel 5 in September 2023.

The Board approved the Trust Brand Narrative.

8 NHS Digital Maturity Assessment

8.1 JG presented the NHS Digital Maturity Assessment and reported that the Trust underwent a peer review with Alder Hey Children's Hospital NHS Foundation Trust and Liverpool Heart and Chest NHS Foundation Trust and a further peer session with NHS England (NHSE), McKinsey and-, the Integrated Care Board (ICB). JG highlighted that Cheshire and Merseyside's overall capabilities score for "What Good Looks Like" were the highest in the NHS and best in the Northwest region. The final data would be submitted to NHSE on 14 May 2023 and would be available for the public in July 2023 once approved by the NHSE Board.

The Board approved the NHS Digital Maturity Assessment data for submission to NHSE.

9 NHS Prevention Pledge

9.1 RS presented the NHS Prevention Pledge update report and highlighted that of the fourteen commitments made by the Trust in 2022/23, four had been completed, nine were in progress, and the Trust were unable to progress on two commitments; *Commitment 11b*- increased public access to fresh drinking water on NHS sites and *Commitment 13*- sign up to the Prevention Concordat for Better Mental Health for all. The inability to progress on the two commitments was due to infection control concerns and awaiting the launch of a national framework respectively; therefore, no NHS trusts had advanced on the two commitments to date.

9.2 PM questioned how the commitment in Pledge 12 had been achieved and if the bicycle scheme would be extended. RS responded that the bicycle scheme was carried out in partnership with the Liverpool University Hospitals Foundation Trust (LUHFT) Aintree site, and discussions were ongoing to extend this as part of the bike-to-work scheme.

9.3 KH suggested that the Trusts 6i's of improvement methodology be used as the chosen approach to review and transform services. RS confirmed that the quality impact assessments were to be used for evaluating the impact of proposed improvements.

The Board endorsed the NHS Prevention Pledge update report and noted the progress made.

10 External Well Led Review Report

10.1 AN informed that the External Well Led Review Report had been discussed extensively at the Board Development Session in April 2023. The report highlighted areas of good practices and areas of improvement.

Action: KD to develop an action plan in line with the recommendations from the report and report back to the Board in six months.

The Board noted the External Well Led Review Report.

11 Aintree Site Joint Committee Key Issues Report and Draft Terms of Reference

11.1 MS presented the key issues report for the Aintree Site Joint Committee meeting held on 26 April 2023 and stated that the Committee had endorsed its draft Terms of Reference to be presented to the respective Boards for approval. Work was ongoing between colleagues across both sites to develop a workplan, and the next Joint Site Committee meeting would be held in June. The workplan would include areas of existing collaboration and highlight the clinical areas and recommendations from the Carnall Farrar review.

11.2 KD advised that there was further work in progress to agree across Liverpool how the three joint site committees would report into the ICB.

Action: A further update on the governance structure for the Joint Committees would be brought back to Board in July.

The Board noted the Key Issues report and approved the Joint Site Committee Terms of Reference.

12 Integrated Performance Report

12.1 AN introduced the Integrated Performance Report (IPR) and noted that check and challenge of the IPR had been undertaken at Board Committees, and the Chairs of the relevant Committee would present this as part of their assurance reports. AN informed that the Quality Committee had been advised of the occurrence of a potential never event, and this had now been confirmed, declared with the appropriate body and would go through the prescribed process.

The Board noted the Integrated Performance Report.

13 Business Performance Committee

13.1 DT, as Chair of the Business Performance Quality (BPC) highlighted that the Follow up outpatients waiting list remained high and the Committee had received an update on efforts to improve this which had led to an overall reduction of 30% where clinical review had taken place.

13.2 There had been significant improvement in appraisal compliance in April which would be reflected in subsequent reports. The Better Payment Practice Code (BPPC) performance was below plan, but there was continued focus and the Audit Committee carried out a deep dive of this in April.

13.3 The Strategic Project Management Office (SPMO) had started work to oversee priorities focused on transforming elective patient pathways and outpatients and monitoring the improvement projects arising from all the substrategies.

13.4 RW questioned why the Trust was taking such a long time to achieve full appraisal compliance and what could be done to improve and sustain it once it had been completed. MG responded that the Executive Team had begun monthly monitoring of appraisal compliance, and the appraisal process had been streamlined to make the process easier for staff.

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

14 Quality Committee

14.1 RW, as Chair of the Quality Committee, highlighted that the Trust had breached its annual target for healthcare-associated infections and noted that a comprehensive integrated review was ongoing within the Intensive Treatment Unit (ITU) and infection, prevention and control measures would form part of the review. Planned deep cleaning and decanting of wards would commence soon.

14.2 RW noted that work was underway by the new Chief Pharmacists to understand the governance of the Trust's pharmacy, which may lead to a change in reporting. Good progress had been made on the Clinical Audit Progress Report, and only two outstanding projects had passed their anticipated completion date, but a clear rationale had been provided to the Committee for the delays. Excellent progress had been made towards clearing the backlog of outstanding NICE compliance assessments, with only three remaining out of sixty assessments.

14.3 SR queried about the spike in mortality and if these were monitored. AN responded that all deaths were reviewed and monitored through the Mortality Surveillance Group (MSG), and

there were high levels of scrutiny to monitor the numbers. The Team were conscious of the numbers and kept a focus on this and the Board received a quarterly report of all inpatient deaths.

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

15 Annual Plan 2023/24 Update

15.1 MB gave a verbal update on the 2023/24 Annual Plan and stated that the plan would be submitted to the ICB at 12pm on 4 May 2023 and reported to the next Board meeting.

The Board noted the Annual Plan 2023/2024 Update.

16 Guardian of Safe Working Report to January 2023

16.1 AN presented the Guardian of Safe Working Hours report (GoSW) which covered the period to January 2023 and highlighted that there had been six exception reports for breach of minimum rest period from Neurology registrars during the reporting period. The breach of the minimum rest requirement led to six guardian levied fines during the reporting period. Discussions were underway to scrutinise Neurology Registrars' working hours which was largely due to the impact of 24-hour thrombectomy and alter roles and responsibilities for out-of-hours working to improve compliance with safe working.

The Board noted the Guardian of Safe Working Report.

17 Freedom to Speak Up Guardian Report Quarter 4 2022/23

17.1 JK presented the 2022/23 Quarter 4 Freedom to Speak Up Guardian (FTSUG) Report and highlighted that the Trust's Freedom to Speak Up Policy had been revised in line with the national update and the revised Policy had been approved by the Staff Partnership Committee and made available on the Trust intranet. A meeting would be held with the FTSUG, Deputy Chief Nurse, Executive Lead for Raising Concerns, and the Deputy Chief People Officer in June 2023 to review the Freedom to Speak Up (FTSU) reflection tool in greater detail.

17.2 JK stated that five FTSU cases were raised during quarter 4; some issues had been resolved and others were open pending further investigation. The FTSUG and the Executive Lead would review the 2022 Staff survey results for issues regarding raising concerns and an update of the findings would be included in the FTSUG annual report.

17.3 KH, as the Non-Executive Lead for Raising Concerns and FTSU champion gave an update on the FTSU webinar for Non-Executive Directors she attended in April 2023. KH suggested that the Team publish case studies to encourage staff to speak up and reassure them that their complaints would be followed up.

The Board noted the 2022/23 Q4 Freedom To Speak Up Guardian Report.

18 Audit Committee Key Issues Report and Terms of Reference

18.1 SR presented the Audit Committee key issues report and highlighted that the Committee received the Data Quality Review Report and the Sickness Absence Report from the internal auditors which provided Moderate and Limited assurance respectively. The respective Executive Leads informed the Committee that several actions had been implemented in line with the recommendations raised. The Committee raised concerns

about the timeliness of the implementation actions to some of the internal audit recommendations.

18.2 The Committee received the Internal Audit Charter and approved the 2023/2024 Internal Audit Plan. A verbal update on the 2022/23 Head of Internal Audit Opinion had been received by the Committee, and the draft report would be presented at the Committee meeting in May. The Committee approved the 2022/23 Counter Fraud Annual Report and received the 2023/24 Counter Fraud Annual Plan. The External Audit Plan for the year ending 31 March 2023 was presented to the Committee, and it was noted that the Trust's materiality level had increased.

18.3 SR noted that the Committee received the Financial Compliance Report and that the Trust was behind target for the BPPC national compliance percentage. The Finance Team had continued communication with LUHFT to recover the aged debt owed by LUHFT. The Committee also received the Draft Annual Governance Statement for inclusion in the Annual Report which would be signed off by the Board in June 2023. The Audit Committee ToR was recommended to the Board for approval with no significant changes to the ToR.

The Board noted the Audit Committee Key Issues Report and approved the Audit Committee's Terms of Reference.

19 The Walton Centre Charity Committee Key Issues Report

19.1 SR presented the Charity Committee key issues report and highlighted that the Committee had received the finance report which showed a reduction in the funds balance which was indicative that the funds were being utilised. The 2022/23 Walton Centre Charity Committee outturn position was received with a decrease of £64k in the fund balance as at 31 March 2023, and the estimated budget deficit in the plan for 2023/24 was £91K.

19.2 Three committee members would present on charitable funds and the importance of fund utilisation at the Clinical Senate in May, and the Committee would receive quarterly update reports on the top five funds. The Committee formally approved funding for a collaborative study on "Differentiating Multiple Sclerosis and MOG Antibody Diseases Using Quantitative MRI Measures" between the Walton Centre and the Liverpool BRAIN Lab.

The Board noted the Walton Centre Charity Committee Key Issues Report.

20 Remuneration Committee Key Issues report and Terms of Reference

20.1 MS presented the Renumeration's Committee key issues report and advised that the Committee received an update report of the recently concluded Mutually Agreed Resignation Scheme (MARS). The Committee recommended its ToR to the Board for approval.

The Board noted the Remuneration Committee Key Issues Report and approved the Committee's Terms of Reference.

21 Business Performance Committee Terms of Reference

21.1 DT presented the BPC ToR and highlighted that the committee had carried out its annual effectiveness review and there were no significant changes to the Committee's ToR.

The Board approved the Business Performance Committee Terms of Reference.

22 **Quality Committee Terms of Reference**

22.1 RW presented the Quality Committee Terms of Reference and highlighted that the Chief Operating Officer had been incorporated as a member of the Committee and there were otherwise no significant changes to the Committee's ToR.

The Board approved the Quality Committee Terms of Reference.

23 **Consent Agenda**

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

- **Nursing Revalidation Annual Report 2022/23 –** noted.
- **ED&I Annual report 2022/23 –** noted.

24 **Any Other Business**

24.1 There was no other business to be discussed.

26 **Review of Meeting**

26.1 Those present agreed that the Board debate was robust and well challenged.

There being no further business the meeting closed at 12.55

Date and time of next meeting – Thursday, 1 June 2023 at 09:30 Boardroom

Trust Board Attendance 2023-24										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Max Steinberg	A	✓								
Irene Afful	✓	A								
Mike Burns	✓	✓								
Mike Gibney	✓	✓								
Karen Heslop	✓	✓								
Paul May	✓	✓								
Andy Nicolson	✓	✓								
Morag Olsen	✓	✓								
Su Rai	✓	✓								
Jan Ross	✓	A								
Lisa Salter	A	A								
David Topliffe	✓	✓								
Lindsey Vlasman	✓	✓								
Ray Walker	✓	✓								

PUBLIC TRUST BOARD
Matters Arising Action Log
June 2023

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

ACTIONS FOR FUTURE MEETINGS

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
04/05/2023	Item 11	**Aintree Site Joint Committee Key Issues Report** A further update on the governance structure for the Joint Committees would be brought back to Board.	MS/KD		6 July 2023	
04/05/2023	Item 10	**External Well Led Review Report** KD to develop an action plan in line with the recommendations from the report and report back to the Board.	KD		2 November 2023	

NHS The Walton Centre NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Chief Executive's Report		
Executive Lead	Jan Ross, Chief Executive		
Author (s)	Jan Ross, Chief Executive		
Action Required	To note		
Level of Assurance Provided			
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls	

Key Messages

The purpose of this report is to highlight to the Board the activities for the month, nationally, regionally and within the Trust:

- Industrial action remains a key issue nationally and within the Trust. Urgent care pressures remain a concern regionally and nationally; KPI's have been established and winter planning commenced.
- NHS England (NHSE) response to COVID-19 is stepping down from a level 3 incident. The implications are described in the paper.
- The Trust is delivering against key performance and financial targets.

Next Steps

N/A

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks		
All Risks	Choose an item.	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Chief Executive's Report
June 2023

National Updates

1. The Royal College of Nursing (RCN) are opening a new ballot on Tuesday 23rd May which will close Friday 23rd June. The Ballot will include all members in England on Agenda for Change contracts.

2. Industrial action has been called by the British Medical Association (BMA) for Junior Doctor's across England. The 72-hour stoppage will run from 7am on Wednesday 14 June to 7am on Saturday 17 June. As previously, industrial action meetings will take place across the Trust to manage services for the duration.

3. NHS England (NHSE) released guidance that sets out integrated urgent care services Key Performance Indicators (KPIs) for 2023/24, and the NHSE guidance confirms the expectations from individual organisations including reporting against the KPIs. There are currently no expectations for The Walton Centre (TWC).

Cheshire & Merseyside Integrated Care System (ICS)

4. Earlier this year, NHSE set out its Urgent and Emergency care plan. Two of the main targets for 2023/24 relate to accident and emergency performance and ambulance performance. NHSE this week confirmed that local NHS systems and ambulance trusts would be placed into one of three tiers, each receiving a different level of improvement support.

5. Cheshire and Merseyside (C&M) has been named one of seven Integrated Care Boards in Tier 1, which means we will be in receipt of the highest level of national support and scrutiny.

6. This will include support to diagnose problems and develop an improvement plan, hands-on implementation support and direct access to national Urgent and Emergency Care and Improvement Teams.

7. The proposed governance around the Joint Site Committees has now been established with a 'Liverpool Trusts Joint Committee' reporting into the Integrated Care Board (ICB) and sitting below this Committee are the site sub committees. A paper will come to Board in July. The TWC and Liverpool University Hospital Foundation Trust (LUHFT) Joint Committee has met, and Terms of Reference (TORs) have been agreed, next steps are to agree priorities and a work plan.

Cheshire and Merseyside Acute and Specialist Trusts provider Collaborative (CMAST)

8. The Board started its meeting by reflecting on the latest position in respect of industrial actions. Hearing from Chris Douglas MBE, Director of Nursing and Care at the ICB, the Board explored the system impact and ICB and regional arrangements for oversight and coordinated response. Linked to this discussion, the Board shared intelligence on wider union activity and contact with Boards. The Board agreed to follow up on this outside of the meeting, sharing intelligence and approaches, follow up will take place with individual trusts to understand potential impact.

9. The Board received an update on the work taking place within the CMAST programme for Elective Recovery and Transformation focused on outpatients. A significant number of Cheshire and Merseyside (C&M) patients waiting for treatment are outpatients and this area has rightly attracted an amount of national planning focus for 2023/4 delivery. A number of planned initiatives and relative performance were discussed.

10. The Board then went on to discuss options for, and development of, a business case for a North Mersey Elective Hub. This programme relates to a multi-year investment from national monies that was signed off by NHSE in the spring of 2022.

11. Parameters including geographies were set at that time, however, detailed plans to release already committed investments needed to be developed this year. A discussion on the need for enhanced capacity and treatment in gynaecology and ophthalmology were discussed and supported in principle.

12. The Board also received a final draft copy of the CMAST Annual Work Plan, which has been requested by the ICB for consideration it its Board meeting in May. The plan sets out CMAST's operating environment, approach and priorities and goes on to describe the scope, delivery priorities and any applicable targets for each of CMAST programmes through 2023/24. The Board provided their endorsement to this document and reflected on the need to include CMAST's contribution to the ICB's Financial Recovery Plan as had recently been committed to.

13. In April the Board had received an update on the progress made in respect of clearing patients waiting over 78 weeks for treatment. Significant progress was noted in reducing the numbers waiting. 558 patients were treated between 20th and 29th of March with the progress made over the preceding 29 weeks meaning 39,576 less patients are waiting in this cohort. At the time of the meeting, it was not possible to say whether the target of having no patients waiting above this threshold would be met but the impact of industrial action across the NHS was also recognised.

14. At the same meeting, the Board received updates on the shaping of its critical work on Efficiency at Scale and recognised that the identification of a Programme Director was critical to the required and expected delivery from this programme. The Board also received an update on the work of its Directors of Strategy and Medical Director Networks and a number of joint initiatives that they had cultivated. This work and associated collaboration was commended.

15. The Deputy Chief Nurse of The Walton Centre (TWC) is the project lead for the CMAST workforce programme for Developing the ward nurse and department nurse band 6 project. The project is ongoing until March 2024.

16. The CEO attended a NHSE provider collaborative innovators scheme launch event. The event was hosted by NHSE and described expectations as well as sharing good practice from across the country.

Covid-19

17. NHSE wrote to all CEOs on 18 May to inform them that the NHSE response to COVID-19 is stepping down from a level 3 incident. The implications of this are:

- **COVID-19 Patient Notification System (CPNS):** As of 30 June 2023, NHSE will no longer be collecting data where an individual has died from COVID-19 via the CPNS system. Instead,

data on individuals who have died with COVID-19 will be recorded using the death certification process which is the same as other infectious diseases.

- **Other COVID-19 data reporting:** NHSE have been working with colleagues in the UK Health Security Agency to ensure there are no unintended consequences by changing the way we collect data on COVID-19. The acute COVID-19 data collection process will be stood down with a subset of data incorporated into the existing Urgent & Emergency Care data collection from June. It is hoped this will ease the burden on NHS trusts.
- **Outbreak reporting:** NHSE are currently reviewing the outbreak reporting process and will be contacting organisations about this separately.
- **Communications**: NHSE have recognised the value of having a permanent operations structure to support Trusts, disseminate information and collect data during declared incidents and/or other periods of heightened risk or disruption, e.g. industrial action and winter pressures. Our National and Regional Operations Centres will continue to operate, but we will review the hours of operation.

18. TWC currently has no issues in relation to COVID-19, wards have reverted to individual specialities, but plans remain in place on Chavasse ward should we require them. Lipton ward did have a COVID outbreak in April which is all now resolved and stood down.

Trust Update

19. Liverpool Citizens

Members of the Trust's Liverpool Citizens Core Group attended two days of Community Leadership training at the Al Rahma Mosque, Liverpool on the 17 to 18 May 2023. Other attendees included members from housing associations, charity, community, voluntary and faith groups from across the city. The training will support the work being undertaken to progress the Alliance from pre-founding to founding stage, with the formal launch and listening campaign taking place in September 2023.

20. ADASS Masterclass

On 10 May 2023, Mike Gibney delivered a Masterclass on Employee Engagement to the Directors of Adult Social Services in the North-West (ADASS). This was a collaboration that also included some Health Partners – North-West Employers, Leadership Academy, AQUA, Innovation Agency and MIAA.

21. Channel 5 Documentary

Pre-production has started on the eight-part documentary series to be filmed solely at The Walton Centre, due to air on Channel 5 in September 2023. Filming will commence the week starting 29 May 2023, for eight weeks. The production team have met with a number of senior clinical staff, including leading consultants who will feature prominently in the series as well as ward managers and department heads across the Trust. All staff and patients who are likely to be involved will be consented, either to say they are happy to be featured or to decline involvement.

22. Patient stories have started to be collated and fed through to the Production Team who will be the main contact for key staff and the patients to be featured. We are in liaison with Aintree Hospital regarding any potential filming there in connection with the Trauma Network and have also informed NHS England and NHS Cheshire and Merseyside. An access agreement and code of conduct has been approved by our legal team to be adhered to by both the Trust and the Production Team.

23. As mentioned in a pervious CEO update the Trust was awarded a silver award under the Ministry of Defence Employer Recognition Scheme for their support to Defence and the wider Armed Forces community. There will be an associated press release for this next month.

Business as Usual

24. Performance
Performance remains on track for cancers and diagnostics, long waits have now been completed for 104 weeks and 78 weeks. The Trust is now focusing on patients who have waited 52 weeks; at this current moment in time, we have 18 patients who have waited 52 weeks. The Trust continues to deliver cancer and diagnostic performance.

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

26. Estates and Facilities
The Trust received the results from the PLACE inspection that was undertaken in October 2022, several areas did see a decline and an action plan is now in place. A mini-PLACE inspection is due to take place in July 2023.

27. The Air Handling Unit work has now gone out to tender and the initial business case for the scoping exercise has been approved by the executive with the plan for next steps and approval to move forward with further plans.

28. Sustainability
The Walton Centre Bees have arrived … as part of our sustainability plan, we have utilised our roof space to accommodate beehives and we plan to hopefully produce our own WCFT honey.

29. Finance
Financial performance in April is in line with plan. The Trust reported a £350k surplus. The full year plan is a £4.1m surplus and has been submitted to NHSE and the C&M ICS. The Trust is seeing some upward pressure on costs across high-cost drugs (matched by income) and utilities in April which it will keep under review. Costs were overall slightly above plan. Income has been estimated as underperforming on the main Aligned Payment and Incentive (API) contract but has over-performed across other contracts and the Health Education England (HEE) contract which resulted in a small over-performance. Capital was overspent by £192k in month which related to the Ponta system (which had been profiled in at a later date). As noted during planning, the recurrent Quality Improvement Programme (QIP) target of 5% will be a challenge to deliver across the year.

30. The ICS has started work on a draft financial strategy and an initial document was presented to Chief Executives and Director of Finance meetings in May.

Recommendation

31. To note

Author: Jan Ross, Chief Executive Officer
Date: May 2023

NHS
The Walton Centre
NHS Foundation Trust

Report to The Trust Board
1 June 2023

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

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

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

Key Messages *(2/3 headlines only)*

- This is an 8-month update on the Charity substrategy.
- Highlights achievements against delivery plan

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

N/A

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

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Charity Substrategy Update

Introduction and Background

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

Analysis

2.

1. INCOME GENERATION

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

Digital Fundraising

a) The Facebook donation function is now fully operational, enabling the Charity to access individual donor information previously not available. The Digital Fundraising Manager monitors and manages this data to ensure supporters are thanked and included, where appropriate, in communications about impact, new fundraising initiatives and events.

b) A review of the website content and functionality has been undertaken by the Digital Fundraising Manager, and several changes have been implemented. This includes the development of a dedicated 'In-memory' tab to enable supporters to create Tribute pages and collect donations in memory of loved ones. It also includes a live leader board function to be used to encourage supporter engagement and encouragement during the Walk for Walton event in May. The website navigation has also been improved using insights from analytics.

c) Opportunities to set up dedicated charity Instagram and TikTok accounts to aid digital fundraising initiatives have been explored by the Digital Fundraising Manager and discussions are underway with the Communications Team to consider viable options or alternate solutions to increase donor supporter engagement.

d) An online raffle was held in February using a 'prize draw' platform called Raffall. It was a successful trial, raising over £500, so another raffle is planned in the run-up to the NHS 75th birthday, increasing the time scale and thereby maximising number of participants.

e) A review is on-going of the automated emails sent from the website platform when a user completes an action (i.e. signs up to an event, gives a donation) to make these more personable, have clear call to actions and consistent messaging, to aid with positive donor journeys.

f) Creation of process to share potential 'good' fundraisers stories more easily with Communications Team, from digital fundraising platforms. To promote the benefit and the impact of the charity and the hospital.

Individual / Committed Giving

g) The Lottery scheme is actively promoted on the Trust/Charity's social media platforms as well as the website. By the end of March the membership was 106 which equates to a regular monthly income of approximately £300. The

aim is to at least double the membership by the end of 2024. Plans have been put in place to undertake some face-to-face marketing to promote the lottery and sign-up new players both on site, and with partners off-site.

Events

h) The Charity's events calendar is this year back to pre-covid status, with one new event planned by the Community Fundraiser for September. Snowdon Hike. Promotion of the event and 'recruitment' of participants is underway.

Grants

i) An application was made to NHS Charities Together for a Development Grant. This was approved at the end of March and the Charity was awarded £28,883. This will be used to improve systems; upskill fundraising team and tools; and engage support to develop learning, monitoring and evaluation within the charity.

2. GRANT MAKING

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

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

b) Meetings are arranged with colleagues in the clinical and corporate divisions, as well as finance and procurement during April - June to consult on proposed policy and process.

3. IMPACT

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

Learning, Monitoring and Evaluation

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

Staff Awareness and Engagement

b) A draft communications plan for charity staff engagement and awareness has been developed by Head of Comms & Marketing, and a planning day between the two teams is arranged for mid June to develop the plan further.

4. PROJECT PIPELINE

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

a) An open-call for potential charitable funding needs across the Trust was sent out in January. The request was sent to divisional managers who were asked to share with all colleagues and teams; it was also advertised weekly in Walton Weekly for 6 weeks and in Team Brief.

b) Information requested included a brief outline of the project; approximate capital/revenue cost; explanation of the benefit to patients; and any information which might strengthen the case for support to attract funders/donors (i.e. first of its kind etc). The projects must also of course be 'over and above' what should be provided by the NHS.

c) The aim of the open-call was to get a flavour of the charitable funding opportunities that are out there, in areas such as:

- Innovation & New Technology
- Patient & Family Experiences
- Research & Development
- Staff enhanced training and Health & Wellbeing

d) The initial expressions of interest/potential projects were considered by the Charity Committee in April, and subsequently, if appropriate, applicants have been invited to submit full applications to be considered at future Charity Committee meetings during 2023/2024 (April/July/October/January).

5. FUNDRAISING TEAM

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

Expand Team

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

b) The Fundraising Team had a strategic away day in February to discuss and plan for 2023/2024 events, initiatives and appeals.

Conclusion

3 The first 8 months have seen some achievements and progress against the strategy.

Recommendation

4. To note

Author: **Madeleine Fletcher**
Head of Fundraising

Date: **23 May 2023**

NHS
The Walton Centre
NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Financial Planning Update 2023/24
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Andrew Green, Deputy Chief Finance Officer
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Integrated Care System (ICS) financial plans submitted to NHS England and NHS Improvement (NHSEI) in February 2023 were rejected due to the outstanding deficit that remained, meaning that all organisational financial plans were rejected, and that revised plans were submitted 4th May.
- 2023/24 financial plan reported to NHSEI in February was a £2.420m surplus. This increased to £4.079m in the May submission.
- Capital funding has been allocated by the ICS to the Trust, meaning the overall 2023/24 allocation is £4.845m, leaving a gap of £1.540m between funding and capital demand.

Next Steps

- Further prioritisation work on the capital plan.
- Continued identification and development of QIP plans for 2023/24.
- Monitoring of financial risks identified within the paper.

Related Trust Strategic Ambitions and Themes	**Impact**		
Value for Money	Finance	Not Applicable	Not Applicable

Strategic Risks

003 System Finance	007 Captial Investment	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

2023/24 Business Planning

Executive Summary

1. Operational and financial planning guidance was issued in late December 2022. This laid out the principles for 23/24 planning which included the requirement to submit 12-month plans (consistent with 22/23 planning guidance). There was also a requirement to continue to work at a system level (Cheshire & Merseyside Integrated Care System (C&M ICS)). There was also a national expectation that the ICS, and partners within the ICS, will deliver a breakeven plan for the 2023/24 financial year.

2. Financial planning has been an iterative process with a number of submissions required to be made to the Integrated Care System (ICS) (shown in the paper). The Trust has also had to submit a number of plans to NSHEI with the final submission being made on 4th May 2023, in which the Trust posted a planned year end surplus of £4.079m.

3. The paper provides a breakdown of the key assumptions applied in the 2023/24 business plan, main movements between the reported 2022/23 year-end position and plan, analysis of the balance sheet and cashflow, main financial risks and associated mitigations, efficiency requirements and capital update.

Background and Analysis

4. Systems are asked to develop fully triangulated plans across activity, workforce, and finances for the 2023/24 financial year.

5. The 2023/24 financial plan is based on a number of assumptions (national, system and internal)

6. 5% recurrent system QIP applied (1.1% national efficiency target, 0.7% ICS nationally mandated convergence target to move towards fair share allocations, 1.3% to align with C&M Integrated Care System target, and 1.9% to cover internal Trust developments and non-recurrent QIP from prior years).

7. The financial plan shown includes a 5% (operating expenditure excluding the impact of high-cost drugs and devices) efficiency requirement (QIP), equating to £7.5m.

8. The plan submitted on 23rd February showed a surplus of £2.420m.

9. At the end of February 2023, Cheshire & Mersey ICS reported a 2023/24 planned deficit of £120m. There is an expectation from the national NHSE team that the system delivers a breakeven position by the end of the financial year. The Trust (along with all other providers) were asked to review their existing plans with a view to improving positions and the overall system position. Revised plans were then submitted to NHSE on 4th May 2023.

10. Following discussions, with the ICS, there have been some improvements to organisational plans to reduce the overall system deficit, and this was submitted on 4th May. There is still a £51m deficit position in the Cheshire & Merseyside ICS.

11. Final Walton Centre Plan Submission: £4.079m surplus position.

12. Trust's cash balance is planned to be £50.9m at the end of March 2024.

13. Trust's current capital submission for the year 2023/24, compared to the ICS allocation of £4.8m Current capital submissions from departments total £6.4m for 2023/24, which is significantly more than the Trust's allocated capital funding.

Conclusion

14. The financial plan submitted to NHSEI on 4th May shows a planned year end surplus of £4.079m. This plan is based on a number of assumptions and there are risks associated with the delivery of this plan.

Recommendation

15. To approve the financial plan for 2023/24.

16. To note the associated risks and mitigations within the financial plan.

Author: Andrew Green – Deputy Chief Finance Officer
Date: 25th May 2023

2023/24 Financial Planning

Purpose of the report
The purpose of the report is to provide an update on financial plans for the 2023/24 financial year. The paper will describe the financial planning process, key assumptions that have been applied and risks within the plan, alongside potential mitigations, and opportunities.

Background
Operational and financial planning guidance was issued in late December 2022. This laid out the principles for 23/24 planning which included the requirement to submit 12-month plans (consistent with 22/23 planning guidance). There was also a requirement to continue to work at a system level (Cheshire & Merseyside Integrated Care System (C&M ICS)). There was also a national expectation that the ICS, and partners within the ICS, will deliver a breakeven plan for the 2023/24 financial year.

Systems are asked to develop fully triangulated plans across activity, workforce, and finances for the 2023/24 financial year.

There have been several submissions made to both the ICS and NHSEI during the planning process, with the financial plan position changing as further clarification was received around national and system wide assumptions as well as internal validation of financial plans. Appendix 1 provides a summary of the submission timetable as well as the Trust financial positions that were submitted (all of which have been shared with BPC and Board).

System and organisational financial plans submitted on 23rd February were rejected nationally by NHSE with a further submission requested for 4th May, with a requirement for the system to deliver breakeven. Following discussions, with the ICS, there have been some improvements to organisational plans to reduce the overall system deficit, and this was submitted on 4th May. There is still a £51m deficit position (including £42m for the new LUHFT hospital transition) in the C&M ICS which needs addressing to deliver the required system breakeven requirement. The national team is still concerned that the £51m deficit plan has not been met through non-recurrent measures to achieve a break-even position. Medium term financial plans are now expected to be produced by September to show improvements in underlying positions and recurrent financial balance within 3 years.

Key assumptions applied.
The 2023/24 financial plan is based on a number of assumptions (national, system and internal):

Income

- Block contract values carried forward from 2022/23, adjusted for inflation, growth and capacity support plus non recurrent allocations for COVID and elective recovery funding;
- 1.8% net inflation applied to income partially offset by the 0.71% convergence target that has also been applied;
- 0.9% capacity support has been supplied in addition to 1.5% growth;
- Elective Recovery funding to be paid as part of block payments in 2023/24 based upon achieving activity targets of 109% of 19/20 levels;
- Contracts will be set on a basis of aligned payment and incentive (API) meaning there will be a fixed and variable element of each contract;

- The fixed element will be set based upon achieving an agreed amount of activity (109% of 19/20 activity);
- The variable element will then be used to adjust this payment depending upon elective performance. Where activity is delivered above the target additional funding for this activity will be received whereas if activity is below the level agreed, funding will be withdrawn; and

Expenditure

- Pay budgets calculated to reflect agreed WTE establishments;
- Bank for Nursing and HCA based at M6 extrapolated less the increase in enhancements for the wards;
- CEA budget for expected 2023/24 payments;
- 2023/24 pay award set at 2.1%;
- WLI was set based at M9 extrapolated for the full financial year;
- Additional pay costs assumed for the additional activity delivery requirement in 2023/24;
- Non-pay based at M6 extrapolated for the full year;
- Additional non-pay costs assumed for 2023/24 activity plan;
- Additional Theatre capacity to replace lost capacity during the replacement of the Theatre Air Handling Units;
- Inflation included based on national assumptions; and
- The expenditure plan includes a small non-recurrent contingency reserve to cover unplanned expenditure that will be incurred during the year.

Efficiency

- Non recurrent QIP has been built back into plan;
- QIP has been increased to reflect the system wide deficit for Cheshire and Merseyside;
- QIP is in as full recurrent value rather than split between recurrent and non-recurrent; and
- 5% recurrent system QIP applied (1.1% national efficiency target, 0.7% ICS nationally mandated convergence target to move towards fair share allocations, 1.3% to align with C&M Integrated Care System target, and 1.9% to cover internal Trust developments and non-recurrent QIP from prior years).

Finance

- Finance costs increased to reflect increased capital spend;
- Interest receivable increased to reflect higher payments due to increased interest rates.

Plan submissions

The plan submitted on 23rd February showed a surplus of £2.420m, as shown below:

	Plan £'000 v5 NHSE 23rd Feb
Income	
Patient Care Income	136,687
Exclusions	31,512
Private Patients	84
Other Operating Income	7,741
Total Operating Income	**176,024**
Expenditure	
Pay	(89,412)
Non-Pay	(52,275)
Exclusions	(31,512)
Total Operating Expenditure	**(173,199)**
Total Operating Surplus/(Deficit)	**2,825**
Finance Income	1,680
Finance Expense	(578)
PDC Dividends Payable	(1,764)
I & E Surplus / (Deficit)	**2,163**
Impact Donations Depreciation	257
Adjusted I & E Surplus / (Deficit)	**2,420**

System position and changes to organisational plans

At the end of February 2023, Cheshire & Mersey ICS reported a 2023/24 planned deficit of £120m. There is an expectation from the national NHSE team that the system delivers a breakeven position by the end of the financial year. The Trust (along with all other providers) were asked to review their existing plans with a view to improving positions and the overall system position. Revised plans were then submitted to NHSE on 4th May 2023.

Following discussions, with the ICS, there have been some improvements to organisational plans to reduce the overall system deficit, and this was submitted on 4th May. There is still a £51m deficit position in the Cheshire & Merseyside ICS.

The national team is still concerned that the £51m deficit plan has not been met through non-recurrent measures to achieve a break-even position. Medium term financial plans are now expected to be produced by providers for September to demonstrate improvements in underlying positions and recurrent financial balance within 3 years. This requirement is due to C&M being allowed to post a deficit plan in 2023/24.

Initial Walton Centre Planned Submission: £2.420m surplus position further changes:

- Removal of excess inflation on utility costs to be consistent with national assumptions as requested by the C&M ICS;
- Non-recurrent balance sheet reduction (balance sheet review required); and
- Walton Centre fair share adjustment for contribution to improve the system deficit plan.

Final Walton Centre Plan Submission: £4.079m surplus position.

	Plan £'000 v6 NHSE 4th May
Income	
Patient Care Income	136,709
Exclusions	31,512
Private Patients	84
Other Operating Income	7,741
Total Operating Income	**176,046**
Expenditure	
Pay	(89,783)
Non-Pay	(50,266)
Exclusions	(31,513)
Total Operating Expenditure	**(171,562)**
Total Operating Surplus/(Deficit)	**4,484**
Finance Income	1,680
Finance Expense	(578)
PDC Dividends Payable	(1,764)
I & E Surplus / (Deficit)	**3,822**
Impact Donations Depreciation	257
Adjusted I & E Surplus / (Deficit)	**4,079**

Explanation of key movements between forecast and plans

The table below shows the movement between the 2022/23 out-turn position (subject to audit) and the 2023/24 financial plan (submitted on 4th May).

	Out-turn position £'000 31st Mar	Plan £'000 v6 NHSE 4th May	£'000 Movement
Income			
Patient Care Income	138,657	136,709	(1,948)
Exclusions	34,355	31,512	(2,843)
Private Patients	131	84	(47)
Other Operating Income	8,341	7,741	(600)
Donated Income	78		(78)
Total Operating Income	**181,562**	**176,046**	**(5,516)**
Expenditure			
Pay	(92,477)	(89,783)	2,694
Non-Pay	(47,257)	(50,266)	(3,009)
Exclusions	(36,775)	(31,513)	5,262
Total Operating Expenditure	**(176,509)**	**(171,562)**	**4,947**
Total Operating Surplus/(Deficit)	**5,053**	**4,484**	**(569)**
Finance Income	857	1,680	823
Finance Expense	(550)	(578)	(28)
PDC Dividends Payable	(1,714)	(1,764)	(50)
I & E Surplus / (Deficit)	**3,646**	**3,822**	**176**
Impact Donations Depreciation	179	257	78
Adjusted I & E Surplus / (Deficit)	**3,825**	**4,079**	**254**

The table above shows that there is a planned reduction in income of £5.5m primarily due to:

- Reduction - centralised pension cost outside of plan which is paid directly by NHSE (£3.3m);
- Reduction - agenda for change one off payment for pay award in relation to 2022/23 (£2.8m);
- Reduction - exclusions income plan based at M9 extrapolated for full year against actual out-turn position;
- Reduction - non-recurrent, non-patient related income; offset by
    - Increase - ESRF income in addition to 2022/23 out-turn;
    - Increase - tariff inflation net of efficiency requirement (excluding additional inflationary allocation for pay award); and
    - Increase - top-up, growth, and capacity funding from commissioners.

There is also a planned decrease of £4.9m in operating costs from 2022/23 primarily due to:

- Reduction - centralised pension cost outside of plan which is paid directly by NHSE £3.3m;
- Reduction - agenda for change one off payment for pay award in relation to 2022/23 £2.8m;
- Reduction - exclusions expenditure plan based at M9 extrapolated for full year against actual out-turn position;
- Increase - vacancies back to establishment bringing planning principles back in line with pre-Covid assumptions (rather than run rates);

- Increase - pay award costs;
- Increase – expenditure inflation based on national assumptions;
- Increase - costs assumed for anticipated activity increase; and
- Quality improvement requirements.

Efficiency requirements
The financial plan shown includes a 5% (operating expenditure excluding the impact of high-cost drugs and devices) efficiency requirement (QIP), equating to £7.5m.

The Trusts assumed QIP target of 5% consists of:

- 1.1% national efficiency assumption;
- 0.7% ICS convergence adjustment (replaces pre-COVID Financial Improvement Trajectory regime to being organisations and system underlying deficits back to balance);
- 1.9% to cover internal Trust developments and non-recurrent QIP from prior years;
- 1.3% to align with C&M Integrated Care System Target.

2023/24 draft outline QIP schemes in development are:

	Recurrent £'000
QIP Scheme	
Neurosurgery Opportunities	1,086
Vacancy Rate/Turnover	832
Ongoing Budget Review	768
Theatre Utilisation	699
Premises Review	600
eRoster	400
Product Savings	370
Offsite Outpatient Review	221
Robotic Process Automation (RPA)	200
Business Rates	110
Staffing	100
Outpatient Review	100
Mail and Communication Review	75
Blood Tests	30
Radiology Contracts	20
EBME Contracts	20
Funeral Expenses Review	10
Total QIP Schemes - identified	**5,641**
Total QIP Schemes - unidentified	**1,879**
	7,520

All schemes identified will require a quality impact assessment to be undertaken and approved by the Chief Nurse and Medical Director before budgets are adjusted.

To support the delivery of the QIP programme, the Trust will utilise the Service Transformation team. Reporting of QIP delivery and progress will take place through Strategic Project Management Office (SPMO), and Business Performance Committee (BPC) on a monthly basis (through the Integrated Performance Report).

Statement of Financial Position (SOFP/ Balance sheet) and cashflow
Appendix 2 shows the planned balance sheet and cashflow for 2023/24. Based on the current financial plan, the Trust's cash balance is planned to be £50.9m at the end of March 2024. This is an increase of nearly £3.1m from the cash balance at the end of March 2023. This is primarily due to increased surplus position and capital allocation from the ICS being lower than the planned level of depreciation in 2023/24.

The impact of the new lease standard (International Financial Reporting Standard – IFRS16) is included within the 2023/24 plan.

Interest, tax, depreciation, and amortisation
Planned interest receivable has increased by £823k, reflecting the full year impact of the rise in interest rates.

Planned depreciation (including IFRS 16 leased assets) has increased by £450k, reflecting the increase in capital spend over the last two years.

PDC Dividend payments have increased by £50k, reflecting the increased average net relevant assets of the Trust offset by an increase in the average daily cash balance in the Government Accounting System (GBS) account, which impacts directly on the calculation.

Capital
The national system allocation for capital for 2023/24 is £4.1 billion, of which the C&M ICS share is £174.1m. The ICS continue to be responsible for the allocation of capital funding to organisations for 2023/24, following the principles set in 2021/22. This principle for planning has removed autonomy that Foundation Trusts have previously had to utilise cash reserves for capital items.

The allocation of capital allocations from the ICS is based on 80% of 2021/22 provider depreciation. The total allocation for 2023/24 is as follows:

- ICS allocations 80% of 21/22 depreciation (£4.4m); and
- Additional ICS allocation based on 2022/23 financial performance (£0.4m).

Appendix 3 shows the Trust's current capital submission for the years 2023/24, compared to the ICS allocation of £4.8m Current capital submissions from departments total £6.4m for 2023/24, which is significantly more than the Trust's allocated capital funding.

Initial prioritisation work has taken place which has reduced capital submissions to £6.4m (for 2023/24) and further work is required on this given there remains a gap in funding. As such, a prioritisation process will be undertaken using a risk-based approach. The Trusts risk register will be reviewed to ensure the capital plan addresses the most pressing risks utilising specific criteria for prioritisation. A prioritisation panel has been established and comprises the Chief Finance Officer, Chief Operating Officer, Deputy Medical Director, and Deputy Chief Finance Officer.

The Trust's capital budget must be agreed within the C&M ICS, and the overall ICS capital plan must be deemed affordable and approved by NHSE.

The approach to capital planning will be managed by the Trust's Capital Management Group (chaired by the Chief Finance Officer) with updates and progress against the capital plan provided to Business Performance Committee on a regular basis.

Risks and Mitigations

The most significant risks to delivery of the draft Financial Plan for 2023/24 are as follows:

- Actual elective activity below levels required to deliver elective recovery targets, resulting in lower than anticipated income through commissioner aligned incentive payment contracts that monitor and pay elective activity on a cost per case basis.

Mitigation: Performance monitoring through weekly performance meetings with corrective action taken as needed. Providing mutual aid in relation to spinal activity will help mitigate against under-performance. Monitoring of activity performance will be undertaken by Business Performance Committee.

- Potential capacity limitations around delivery of 2023/24 activity, including the potential impact of replacing the theatre air handling units which will result in a reduction in available theatre capacity (currently this impact is not assumed within plan)'

Mitigation: Review overall Trust capacity utilising national capacity modelling tools to determine any deficits in plan delivery, with corrective action taken as needed. Mutual aid discussions to potentially replace the lost theatre capacity. Commissioner discussions to adjust activity target requirements due to the lost capacity.

- Delivery of QIP programme – The delivery of a recurrent 5% QIP which is at a level the Trust has never delivered before.

Mitigation: weekly: Finance and transformation teams working in collaboration with Divisions on scheme identification and delivery. Reporting of QIP delivery and progress will take place through Strategic Project Management Office (SPMO), and Business Performance Committee (BPC) on a monthly basis (through the Integrated Performance Report). The Trust is also participating in site joint committee and C&M collaboration of scale meetings.

- Additional costs pressures arising during the year for emerging issues.

Mitigation: Small contingency fund held in reserves. Budget monitoring, forecasting, and reporting in place.

- Delegated ICS Capital Resource Limit insufficient to meet investment requirements.

Mitigation: Risk based approach to capital prioritisation to take place. Work with ICS to identify potential slippage for diversion where possible. Identification of potential capital schemes that could be mobilised at short notice if additional ICS capital funding made available. Pursue alternative funding sources from outside the system envelope where opportunities exist (e.g. PDC).

- Levels of inflation incurred are greater than assumed within plan. Due to national and international events inflationary increases have been greater than levels assumed within national planning guidance.

Mitigation: Monitoring of costs with budget monitoring, forecasting, and reporting. Procurement controls on contract renewals that include high levels of inflation funding into the bottom line being renegotiated as inflation levels decrease.

- NICE, funded drugs may not be funded by Commissioners creating cost pressures.

Mitigation: Monitoring of spend (including forecasting) and raising potential issues with commissioners through regular contract meetings. Also raise cost pressures with ICS.

- ICS partners performance – may put pressure on organisations that can deliver to improve positions to help towards those that can't.

Mitigation: Regular meetings with senior ICS leaders. Discussion at a CEO and Chair level to discuss potential impact of this on Trust performance.

- Limits on workforce availability may impact on ability to deliver planned levels of activity and productivity.

Mitigation: Recruitment, retention, turnover and sickness monitoring through Business Performance Committee.

- Outpatient Follow Up targets – if reductions cannot be made in line with funding, costs will be incurred for which funding will not be received (as no funding will be received for any follow-up activity over 75% of 2019/20 levels).

Mitigation: Weekly monitoring of activity performance. Discussion with commissioners and ICS about the nature of some long-term conditions that will require a higher level of follow-up appointments.

- Potential further industrial action – Medical and Nursing unions are currently out to ballot for further industrial action on pay awards. Junior medical unions have already announced the next phase of action. This will impact on the Trust due to the increased costs to deliver services during strike days and on its ability to deliver activity target levels.

Mitigation: Operational planning to ensure that the impact on activity is minimised as much as possible in the most cost-effective way. Weekly monitoring of activity performance. Providing mutual aid in relation to spinal activity will help mitigate against under-performance. Monitoring of activity performance will be undertaken by Business Performance Committee. Discussions with commissioners outlining the impact of any strike action on delivering national activity targets.

- Potential escalation of pay rates for additional activity in other ICS Trusts impacting on WCFT.

Mitigation: Benchmarking of rates across providers. Negotiation with HR and consultant groups in relation to payments and productivity of the sessions. Monitoring of costs with budget monitoring, forecasting, and reporting.

<u>**Next steps**</u>

As has been stated, the national team is still concerned that the £51m deficit plan has not been met through non-recurrent measures to achieve a break-even position.

The ICS is currently developing its financial strategy ('Working as one to maximise value for every pound we spend') which will include a number of workstreams comprising of the Finance Directors from providers in C&M. This work will include areas such as reviewing cost and control measures, efficiency analysis and monitoring and further review of provider balance sheets.

In addition to this, medium term financial plans are now expected to be produced by September to show improvements in underlying positions and recurrent financial balance within 3 years.

The impact of the above on the Trust is not known at the present time but will be discussed with the Executive Team once the information is available.

Recommendations

The Board is asked to note the 'final' Financial Plan for 2023/24 that was submitted to C&M ICS and NHSE on 4th May including the associated risks and mitigations.

Appendix 1: Summary of financial positions and dates submitted.

	Plan £'000 v1 BPC 24th Jan	Plan £'000 v2 ICS 15th Feb	Plan £'000 v3 BPC 21st Feb	Plan £'000 v4 ICS 21st Feb	Plan £'000 v5 NHSE 23rd Feb	Plan £'000 v6 NHSE 4th May
Income						
Patient Care Income	126,600	135,372	135,189	137,419	136,687	136,709
Exclusions	31,704	31,512	31,512	31,512	31,512	31,512
Private Patients	84	84	84	84	84	84
Other Operating Income	7,676	7,737	7,737	7,741	7,741	7,741
Total Operating Income	**166,064**	**174,705**	**174,522**	**176,756**	**176,024**	**176,046**
Expenditure						
Pay	(92,760)	(90,746)	(90,746)	(90,746)	(89,412)	(89,783)
Non-Pay	(49,160)	(52,984)	(52,818)	(53,036)	(52,275)	(50,266)
Exclusions	(31,704)	(31,512)	(31,512)	(31,512)	(31,512)	(31,513)
Total Operating Expenditure	**(173,624)**	**(175,242)**	**(175,076)**	**(175,294)**	**(173,199)**	**(171,562)**
Total Operating Surplus/(Deficit)	**(7,560)**	**(537)**	**(554)**	**1,462**	**2,825**	**4,484**
Finance Income	1,254	1,680	1,680	1,680	1,680	1,680
Finance Expense	(578)	(578)	(578)	(578)	(578)	(578)
PDC Dividends Payable	(1,914)	(1,764)	(1,764)	(1,764)	(1,764)	(1,764)
I & E Surplus / (Deficit)	**(8,798)**	**(1,199)**	**(1,216)**	**800**	**2,163**	**3,822**
Impact Donations Depreciation	257	257	257	257	257	257
Adjusted I & E Surplus / (Deficit)	**(8,541)**	**(942)**	**(959)**	**1,057**	**2,420**	**4,079**

Appendix 2 – Balance sheet and cash flow

STATEMENT OF FINANCIAL POSITION - 2023/24	Mar-24
	£'000
Non-current assets	
Intangible Assets	751
Other property, plant and equipment	101,324
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	2,076
Receivables: due from non-NHS/DHSC Group bodies - non current	324
Total non-current assets	**104,475**
Current assets	
Inventories	1,042
Receivables: due from NHS and DHSC group bodies - current	4,787
Receivables: due from non-NHS/DHSC Group bodies - current	2,614
Cash and cash equivalents: GBS/NLF	**50,808**
Cash and cash equivalents: commercial/in hand/other	58
Total current assets	**59,309**
Current liabilities	
Trade and other payables: capital	(1,000)
Trade and other payables: non-capital	(33,013)
Borrowings - current	(1,960)
Provisions - current	(80)
Other liabilities: deferred income including contract liabilities	(500)
Total current liabilities	**(36,553)**
Total assets less current liabilities	**127,231**
Non-current liabilities	
Borrowings - non current	(21,127)
Provisions - non current	(527)
Total non-current liabilities	**(21,654)**
Total net assets employed	**105,577**
Financed by	
Public dividend capital	38,028
Revaluation reserve	14,412
Income and expenditure reserve	53,137
	105,577

STATEMENT OF CASH FLOW - 2023/24 PLAN	MAR - 24
	£'000
Cash flows from operating activities	
Operating surplus/(deficit)	**4,484**
Non-cash income and expense:	
Depreciation and amortisation	7,844
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
(Increase)/decrease in receivables	0
(Increase)/decrease in inventories	0
Increase/(decrease) in trade and other payables	0
Increase/(decrease) in other liabilities	(564)
Increase/(decrease) in provisions	0
All other movements in operating cash flows (including working capital movements)	1
Net cash generated from/(used in) operations	**11,765**
Cash flows from investing activities	
Interest received	1,680
Purchase of property, plant and equipment and investment property	(6,336)
Proceeds from sales of property, plant and equipment and investment property	0
Initial direct costs, up-front payments and (lease incentives) in respect of new right of use assets	0
Receipt of cash donations to purchase capital assets	0
Net cash generated from/(used in) investing activities	**(4,656)**
Cash flows from financing activities	
Public dividend capital received	0
Loans from Department of Health and Social Care - repaid	(1,396)
Capital element of lease payments	(191)
Interest paid	(501)
Interest element of lease payments	(62)
PDC dividend (paid)/refunded	(1,811)
Net cash generated from/(used in) financing activities	**(3,961)**
Increase/(decrease) in cash and cash equivalents	**3,148**
Cash and cash equivalents at start of period	**47,718**
Cash and cash equivalents at end of period	**50,866**
Cash balance per SOFP	**50,866**

Appendix 3: Trust capital requests compared to ICS funding.

2023/24 Capital Plan	Plan
Division	
Heating & Pipework	507
Estates	2,650
IM&T	300
Neurology	1,370
Neurosurgery	658
Corporate	900
TOTAL	**6,385**
ICS ALLOCATION	**4,845**
OVER-COMMITMENT	**1,540**

NHS
The Walton Centre
NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Integrated Performance Report	
Executive Lead	Lindsey Vlasman - Chief Operating Officer	
Author (s)	Rebecca Sillitoe – Senior Information Analyst	
Action Required	To note	
Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*		
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls
Key Messages *(2/3 headlines only)*		
• See summary for performance overview		
Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*		
• Ongoing		

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

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*		
001 Quality Patient Care	004 Operational Performance	003 System Finance
Equality Impact Assessment Completed *(must accompany the following submissions)*		
Strategy ☐	Policy ☐	Service Change ☐

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

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

Integrated Performance Report

Executive Summary

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

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
28 Day Emergency Readmissions
% of Patients on a PIFU
Theatres

Opportunity for improvement
Activity Restoration
Referral to Treatment
Outpatient Waiting List

Underperforming
% of beds occupied by 14 day stranded patients

Workforce Indicators

High Performing
Vacancies

Opportunity for improvement
Mandatory Training
Turnover
Sickness Absence

Underperforming
Appraisal Compliance

Quality Indicators

High Performing
VTE
CAUTI
Mortality
Friends and Family Test (% Recommended)
Surgical Site Infections

Opportunity for improvement
Hospital Acquired Pseudomonas
Hospital Acquired Pressure Ulcers
Serious Incidents
Never Events

Underperforming
Moderate Harm Falls

Finance Indicators

Key Performance Indicators	February	March	April
% variance from plan - Year to date	50.3%	33.4%	0.3%
% variance from plan - Forecast	59.4%	33.4%	0.0%
% variance from efficiency plan - Year to date	0.6%	0.0%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	33.8%	1.8%	-181.1%
Capital % variance from plan - Forecast	0.0%	1.8%	0.0%
Capital Service Cover *	3.5	4.6	6.1
Liquidity **	43.4	36.0	36.5
Cash days operating expenditure ***	106.3	102.2	106.0
BPPC - Number	83.8%	83.0%	84.8%
BPPC - Value	82.4%	82.8%	90.9%

* Capital service cover - the level of income available to fund the Trust's capital commitments
** Liquidity - the level of cash available to fund the Trust's activities
*** Number of days cash available to cover operating expenditure

Conclusion

As listed just under half of indicators are high performing either against a set target, local improvement or external benchmarking. Unfortunately, there has been one serious incident and one never event reported in month.

Recommendation

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

Author: Rebecca Sillitoe – Senior Information Analyst
Date: 17/05/2023

The Walton Centre NHS
NHS Foundation Trust

Board Report
June 2023

Data for April 2023 unless indicated

The Walton Centre NHS
NHS Foundation Trust

Notes

Explanation of SPC Charts and Assurance Icons

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

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

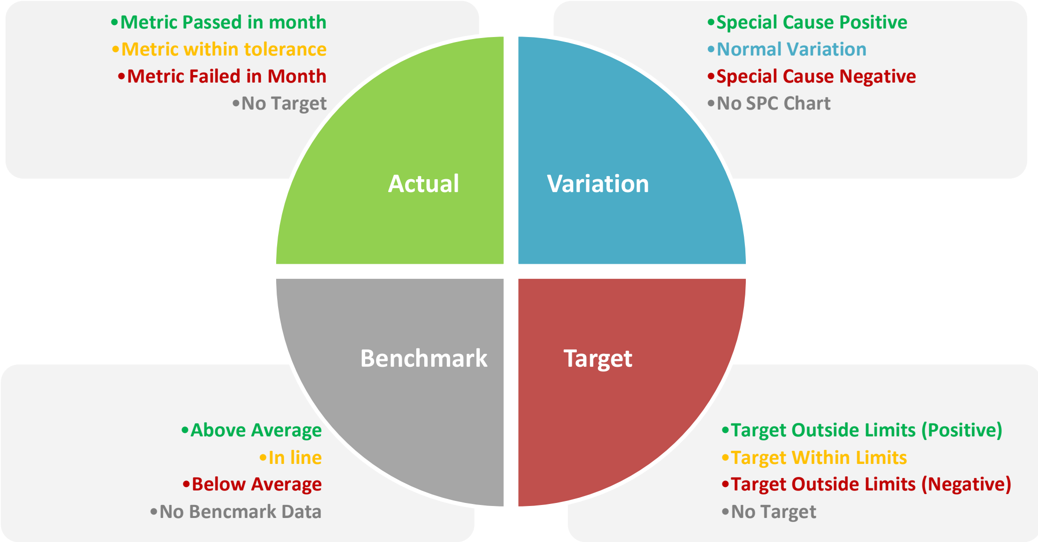
All SPC charts will follow the below key unless indicated

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

= Part of Single Oversight Framework ☆ = Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

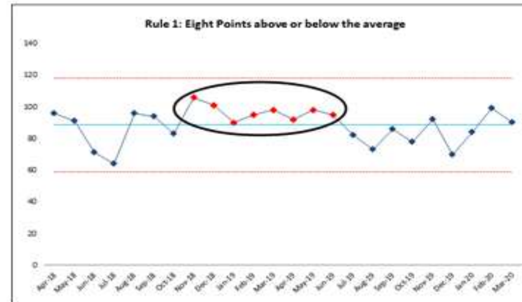
All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.

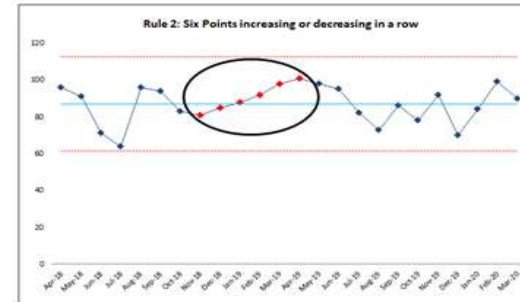


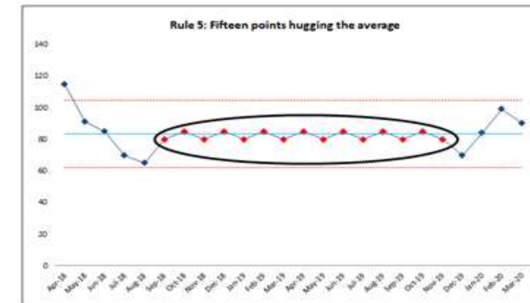
Notes

Statistical Process Control Chart Rules

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







Operations & Performance Indicators

The Walton Centre NHS
NHS Foundation Trust

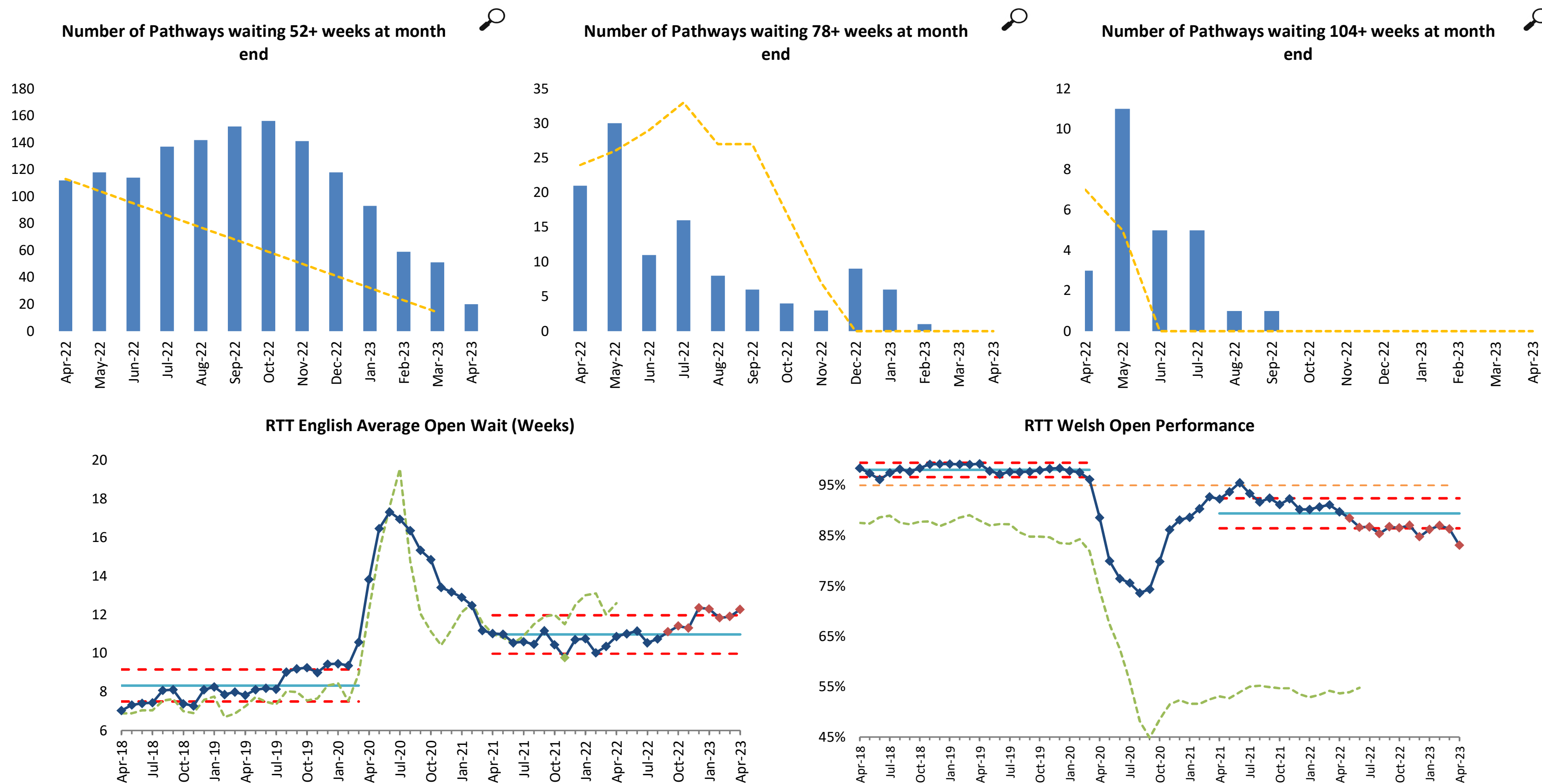
Operational - Responsive

Referral to Treatment

The number of patients waiting more than 52 weeks for treatment has decreased for the sixth consecutive month to only 20, the position at end April is there are no patients waiting more than 78 weeks.

Unfortunately the waiting times in Wales remains in special cause negative variation with a run of 12 months below mean, and English average wait has increase above the control limit again this month, this is now the eighth month that the English average wait has been above the mean.

As part of plans to restore services to pre-COVID levels, each Trust was required to submit a trajectory along with timescales for reducing long waits. The Walton Centre have achieved this trajectory but may see fluctuations with mutual aid requests.



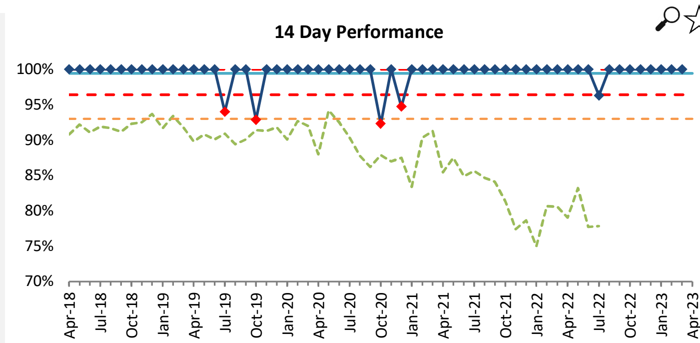
The Walton Centre NHS
NHS Foundation Trust

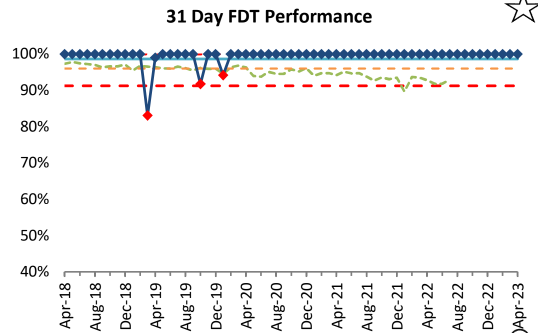
Operational - Responsive

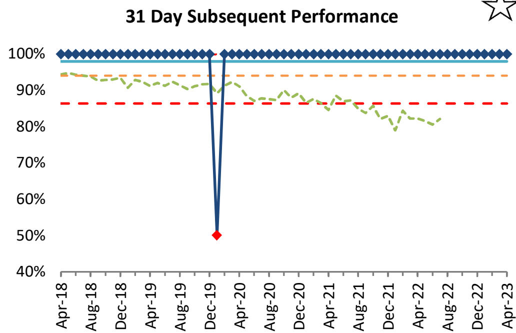
Cancer Standards

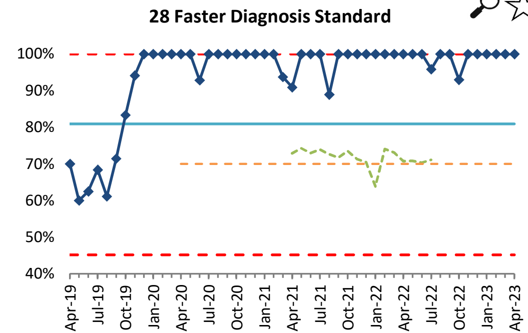
Access Standards	Target	Actual	
Cancer TWW	93%	100%	A V B T
Cancer 31 Day FDT	96%	100%	A V B T
Cancer 31 Day Sub	94%	100%	A V B T
Cancer 62 Day Standard	85%	NA	A V B T
28 Day Faster Diagnosis Standard	70%	100%	A V B T

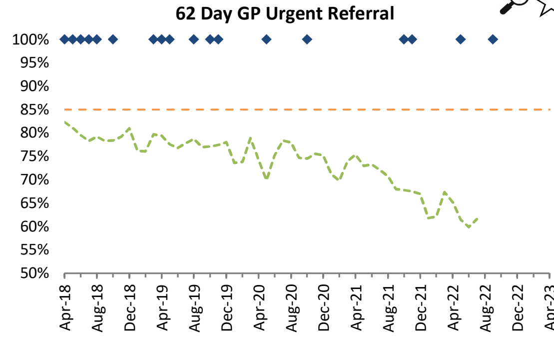
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, this is in line with NHSE requirements.

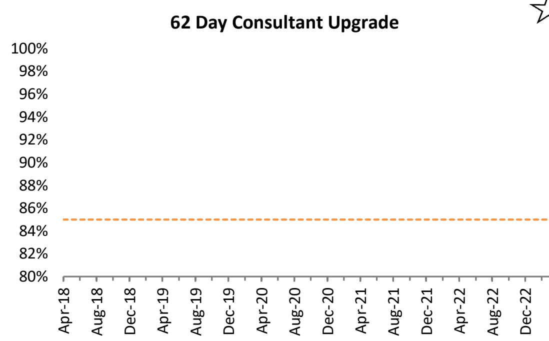












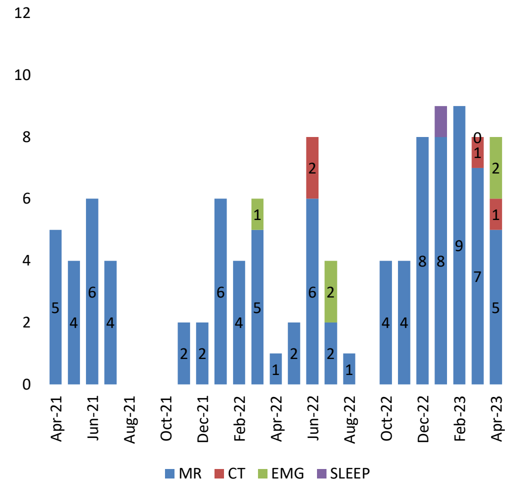
The Walton Centre NHS Foundation Trust

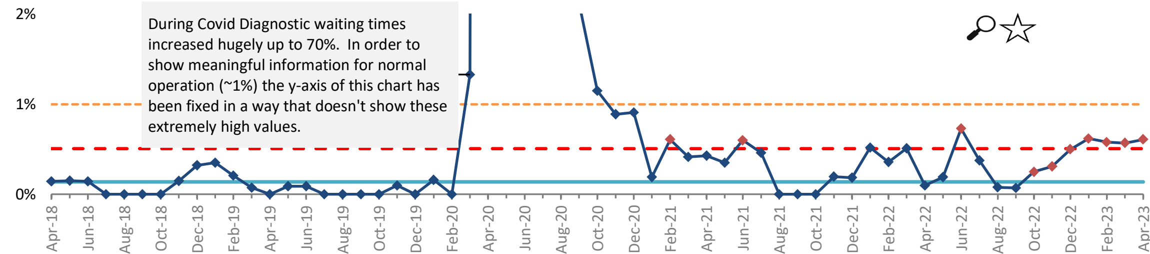
Operational - Responsive

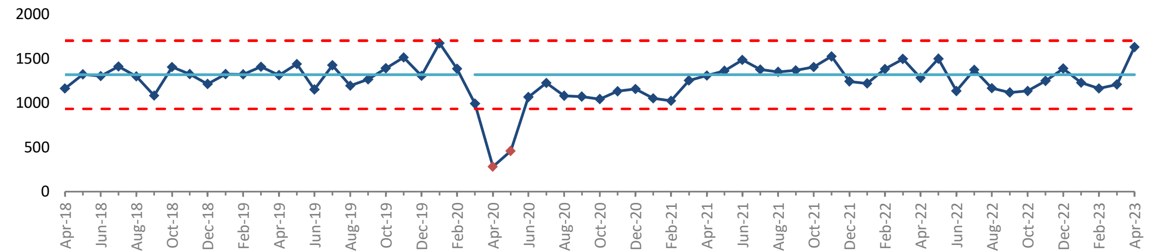
Diagnostics

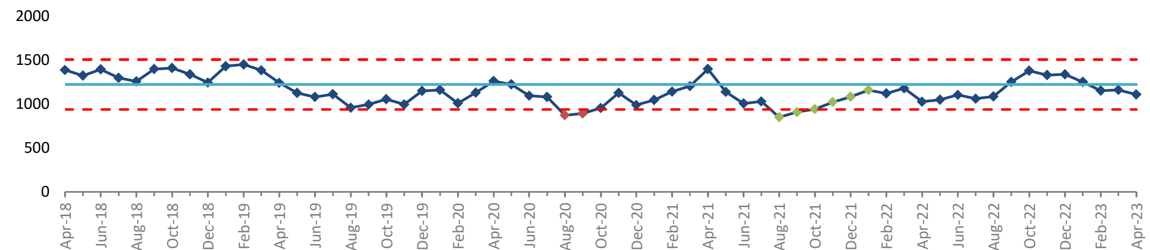
Access Standards	Target	Actual
Diagnostic 6 Week Performance	1%	0.61%

Achievement against the Diagnostic 6 week standard has been met in month. There were eight six week breaches in month. Although still well below target the diagnostic performance has been above the upper control limit for the last four months and above mean for the last seven.









The Walton Centre NHS
NHS Foundation Trust

Operational - Effective

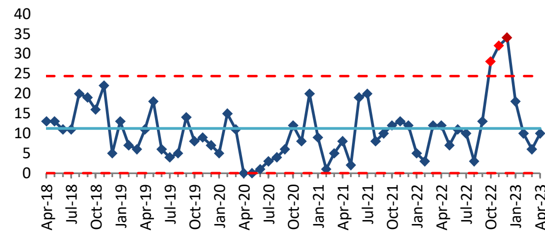
Theatres

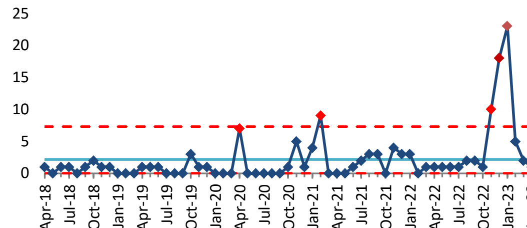
	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	10	
% Cancelled operations non clinical on day	0.80%	0.90%	
28 Day Breaches in month	0	1	

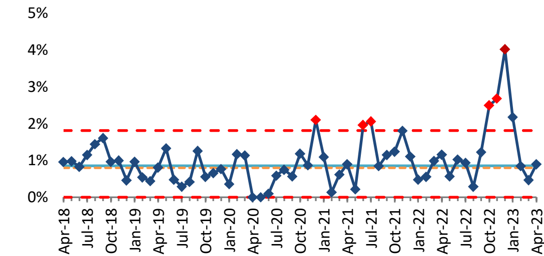
There were a lower number of possible sessions in April due to the bank holidays reducing the total working days in month. The majority (35 from 46) of unutilised sessions in April were due to the junior doctors industrial action with the remainder largely due to a shortage of staff across various staff groups. The trust is working with product partners as part of the theatre utilisation transformation work to ensure theatre capacity is utilised appropriately.

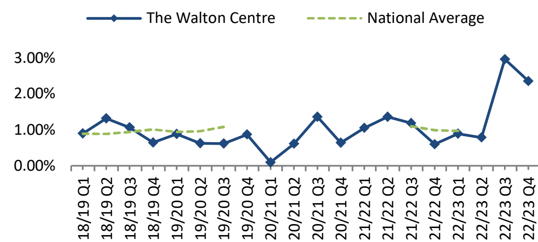
There were ten non-clinical cancellations in month of which: 8 related to unavailability opf beds in ITU/HDU, one due to an emergency and 1 to unavailability of surgeons.

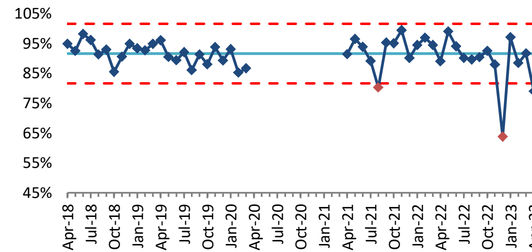
The single patient who breached was rescheduled within 28 days but unfortunately had to be cancelled again due bed pressures in ITU.

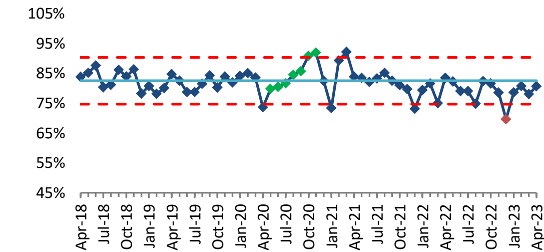












The Walton Centre NHS
NHS Foundation Trust

Operational - Effective

Elective Recovery Fund

Legend for all charts on page

19/20 Act — 23/24 Act — 23/24 Plan

March 2023 Overall Activity Performance

% of 19/20

POD	Actual 23/24	Plan 23/24	Actual % of 19/20	Target*	YTD
Daycase	873	1112	116.2%	104%	78.51%
Elective	224	260	73.2%	104%	86.15%
Elective & Daycase Total	**1097**	**1372**	103.8%	**104%**	79.96%
Non Elective	147	-	93.6%	-	97.35%
New Outpatients	3842	4006	48.7%	104%	95.91%
Follow Up Outpatients	6996	6172	93.7%	100%	113.35%
English Admitted Stops	217	310	72.6%	110%	72.58%
English Non Admitted Stops	1615	1788	93.9%	110%	93.95%
Total English Stops	**1832**	**2098**	**90.8%**	**110%**	**90.78%**

*Target a guide for ERF purposes

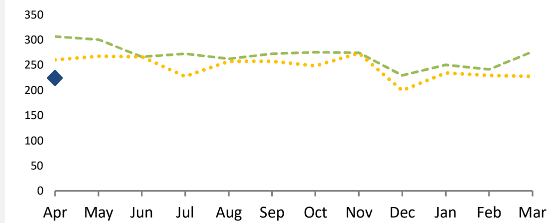
Operational planning for 2022/23 set Trusts the ambition to increase new outpatient appointments, Elective and Daycase activity to 110% of 19/20 level by March 2023 which is measured using RTT Stops.

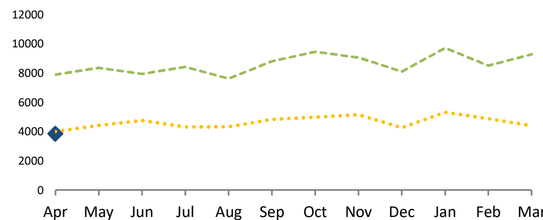
ERF is calculated using Value Weighted Activity and is set to 104% of 2019/20 levels.

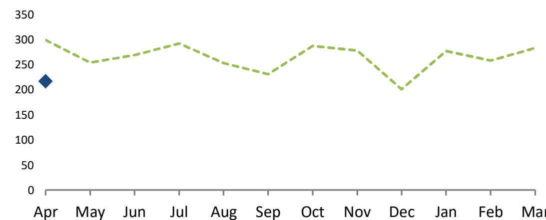
Trusts are also asked to achieve the ambition of reducing follow up outpatient appointments compared to 2019/20.

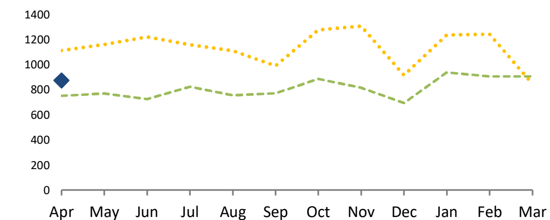
There is no target set against Non Elective activty.

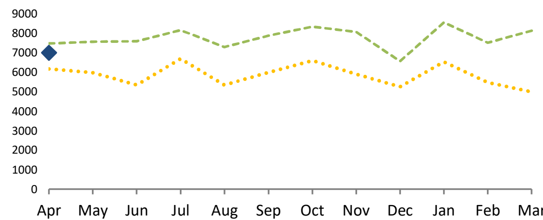
The information on this slide is raw activity for all Walton Centre patients and is unweighted.

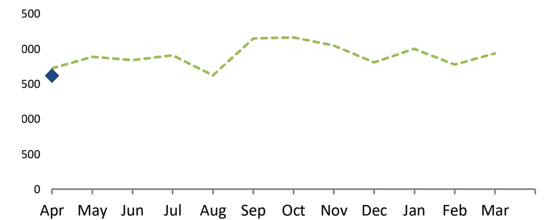


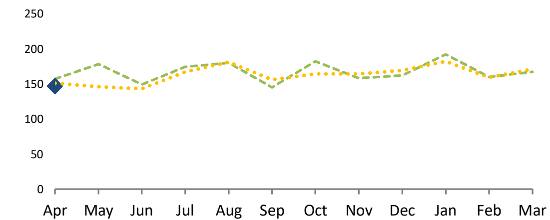










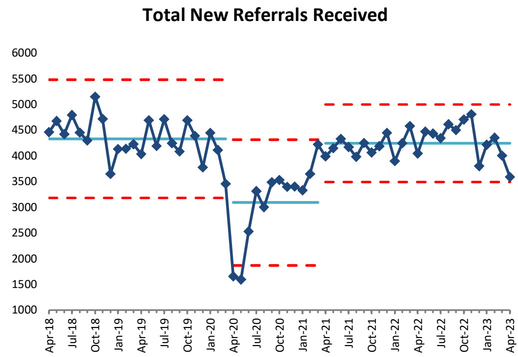


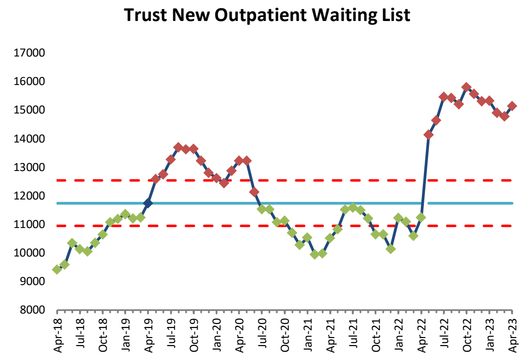
Operational - Effective

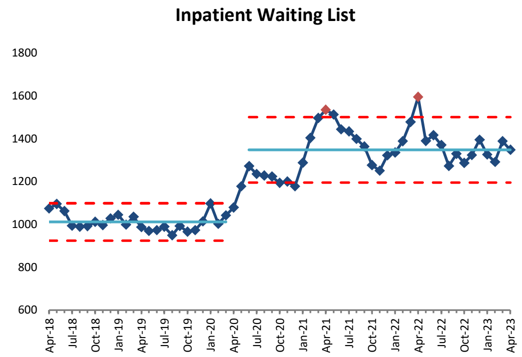
Activity

Most activity metrics remain within normal variation although referrals in April we low, possibly due to the Easter holidays. New Outpatient Waiting List remains high, it is now twelve months since the significant increase in waiting list last May. The initial jump was due to Spinal patients being brought over from LUHFT in May of 2022 but the Spinal and Surgery list has consistently decreased in each subsequent month. The trust OPWL has remained high due to staffing pressures in NEU division.

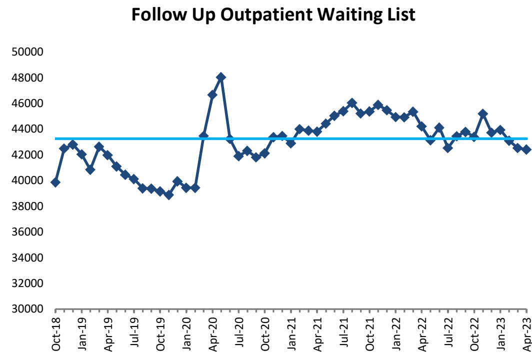
Overdue Follow Up Outpatient waiting list has been climbing slightly over the past two years but the small hump we saw at the beginning of 2023 has started to reduce over the last two months.

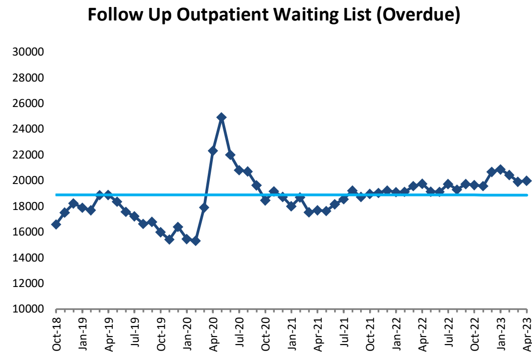






*Spinal transfer patients added to OPWL





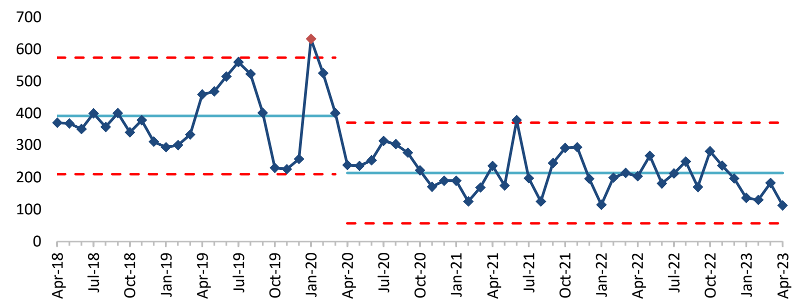
The Walton Centre NHS
NHS Foundation Trust

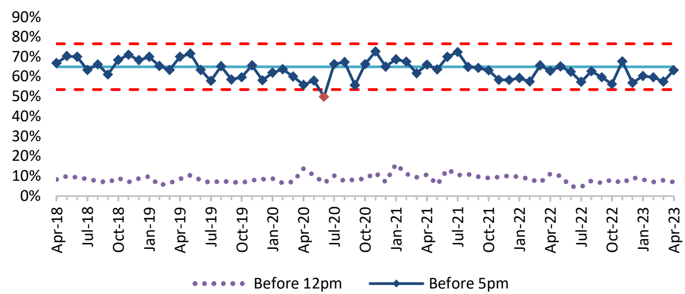
Operational - Effective

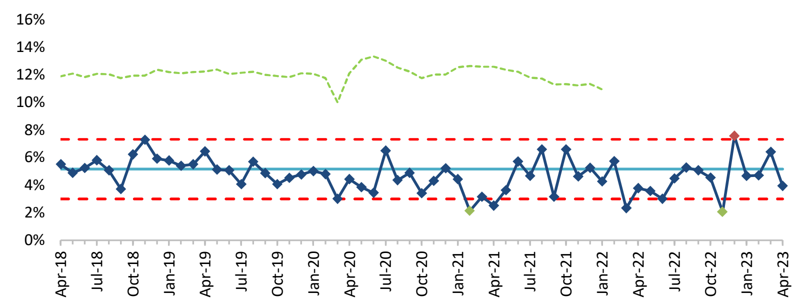
Flow

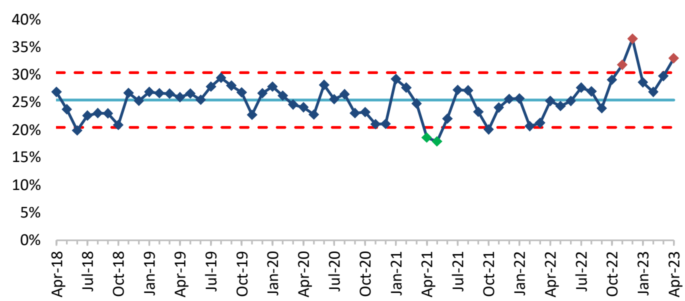
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	3.94%	A V B T
Total Delayed Discharge Days	-	113	A V B T
% Discharges by 5pm	-	63.38%	A V B T
% 14 Day Stranded Patients	-	33.02%	A V B T

Delayed transfers of care, earlier than 5pm discharges and emergency readmissions are in normal variation this month. Unfortnuately the percentage of stranded patients has increase again above the upper control limit in April. This may be driven by delays in transferring the care of patients to other acute trusts.









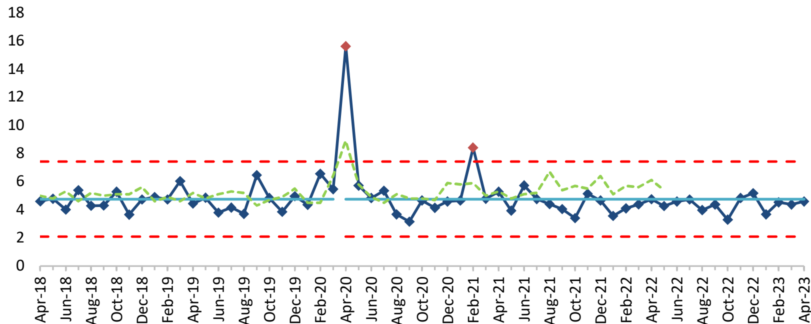
The Walton Centre NHS
NHS Foundation Trust

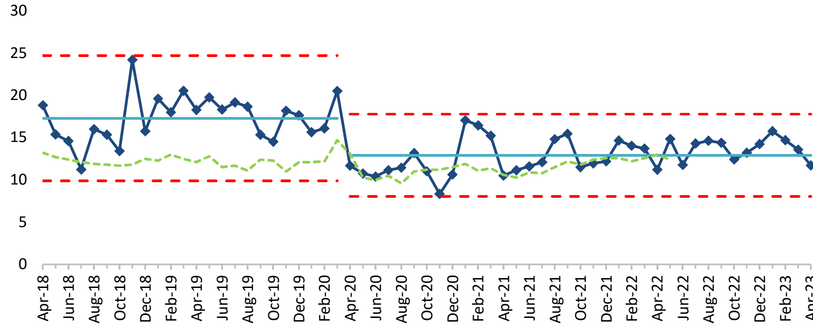
Operational - Effective

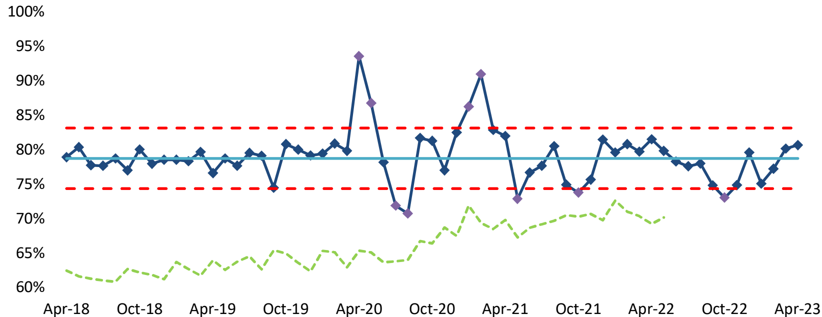
Flow (Leading Indicators)

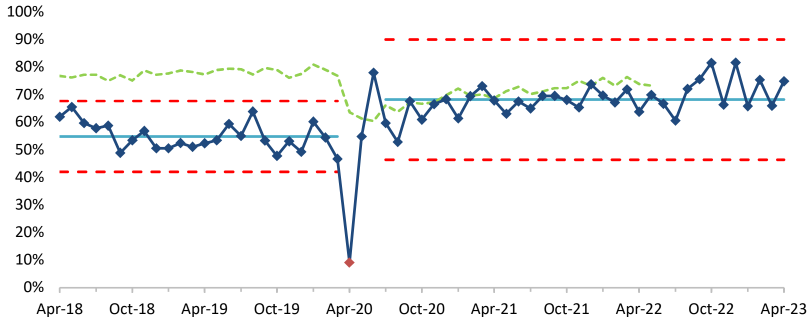
Effective - Flow	Target	Actual	Assurance
Elective LOS	-	4.58	A V B T
Non Elective LOS	-	11.72	A V B T
Day of Surgery Admission %	-	74.85%	A V B T
Daycase Rate	-	80.68%	A V B T

Non elective length of stay has decreased again this month. All metrics are within normal variation which is positive as this is an area of focus for patient flow transformation work. Day of surgery admission is within normal limits, we do recognise that not all patients can be admitted on the day of procedure due to complexities. Day case admissions are also moving in the right direction.









The Walton Centre NHS
NHS Foundation Trust

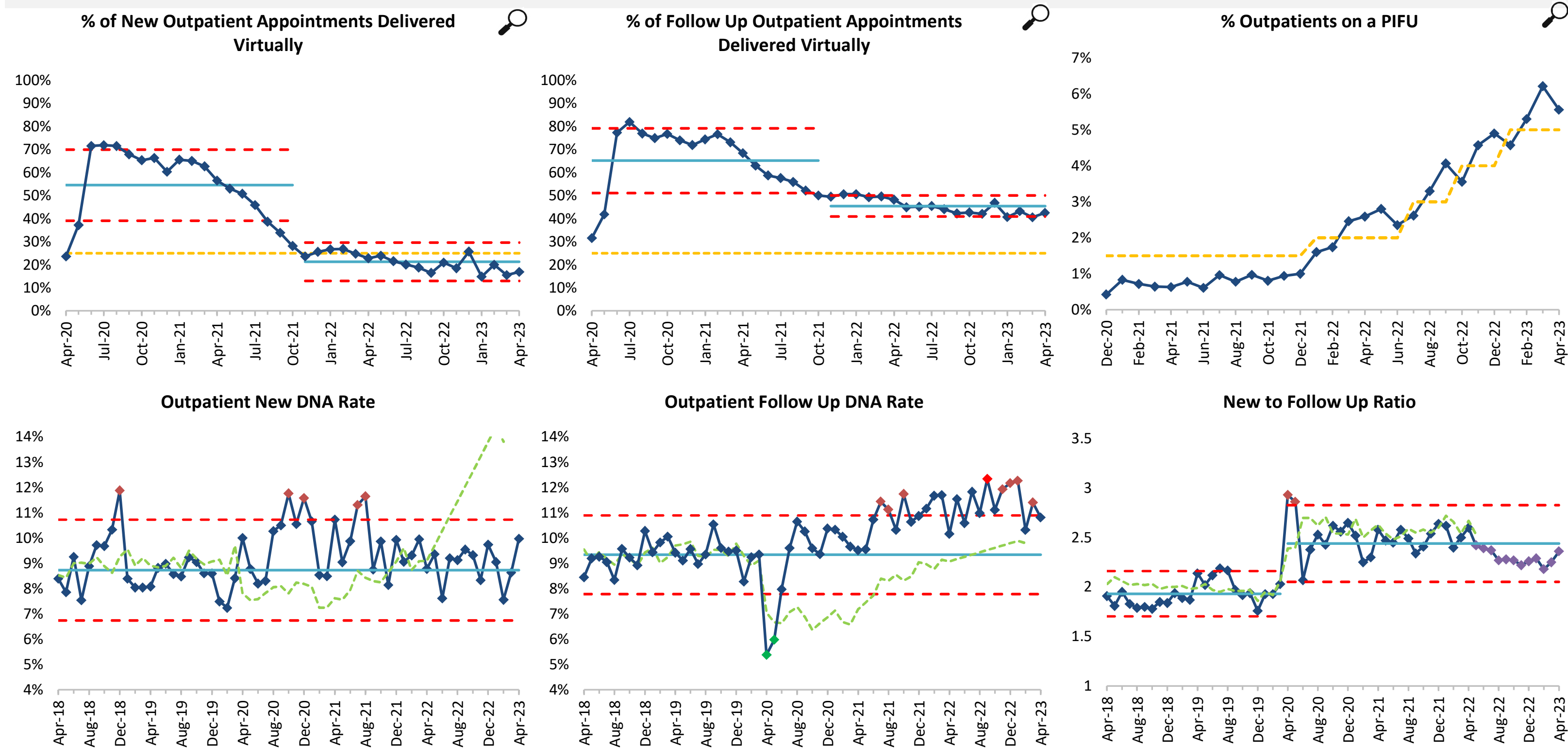
Operational - Effective

Outpatient Transformation

Virtual Appointments: The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. Although new appointments have dipped below this threshold in the last two months the trust as a whole remains above the target at 34%. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

DNA Rate: The New DNA rate has increased again this month but remains within normal variation, as it has been for the last 20 months. Follow Up DNA rate has decreased back within the control limits this month and the last three months data represent a slight drop from the peak of an increasing trend between summer 2021 and winter 2023. This will be a focus of work in outpatient transformation.

Patient Initiated Follow Up (PIFU): As part of national Outpatient Transformation schemes the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In April 2023 we achieved 5.56% and although this is a decrease on last month it is excellent.



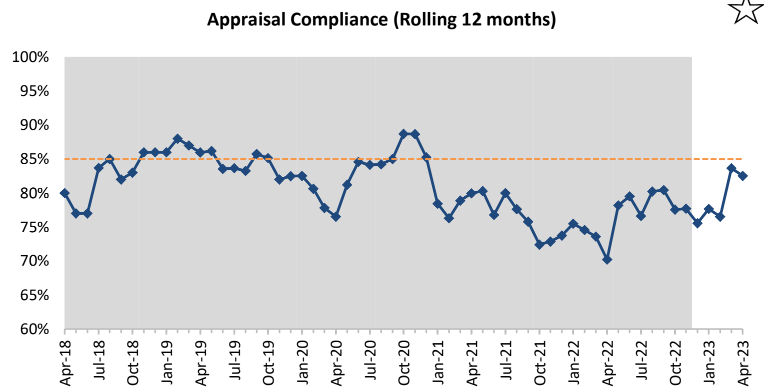
The Walton Centre NHS
NHS Foundation Trust

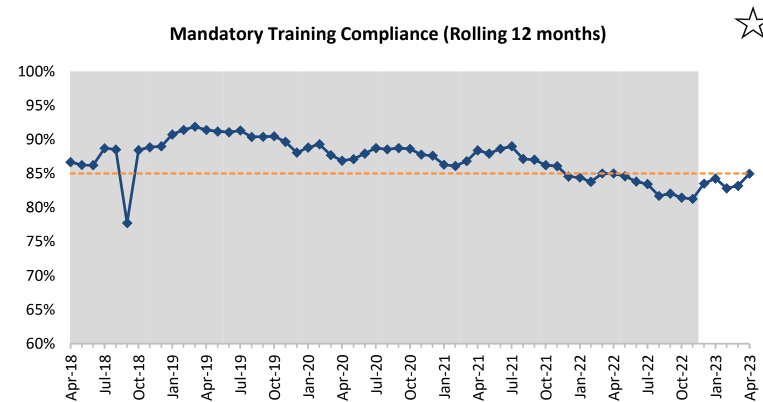
Well Led - Work force

Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	82.53%	A V B T
Mandatory Training Compliance	85%	84.97%	A V B T

Appraisal compliance has decreased slightly in month but is still higher than the previous three.
The grey shading represents data inclusive of junior doctors and the white background represents months with junior doctors removed.

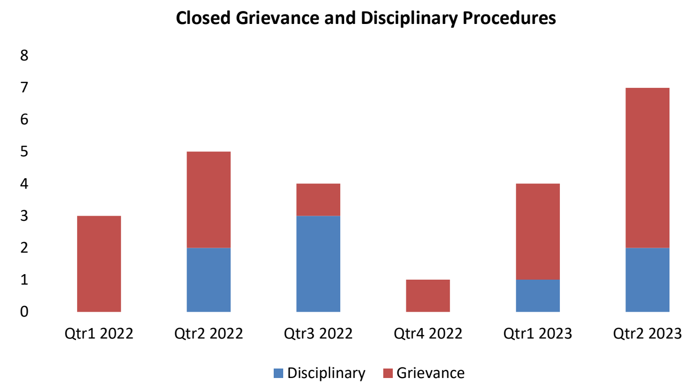




Grievance and Disciplinary Procedures
Included this month are the number of closed grievance and disciplinary procedures. In the interests of anonymity these have been rolled up to quarter level because several months had only one closed process in month.

It is also important to note that these numbers are for closed procedures only and do not include any currently open procedures.

From Q2 2023 live Grievance and Disciplinary procedures have been reported rather than closed procedures as in previous quarters.



Well Led - Work force

Workforce KPIs

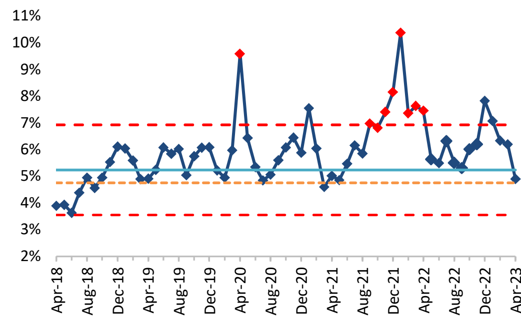
Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	4.90%	A V B T
Trust Turnover	-	16.76%	A V B T
Nursing Turnover	-	11.64%	A V B T
Other Staff Turnover	-	18.76%	A V B T

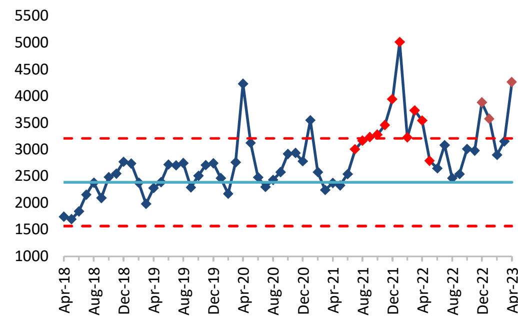
Sickness/Absence

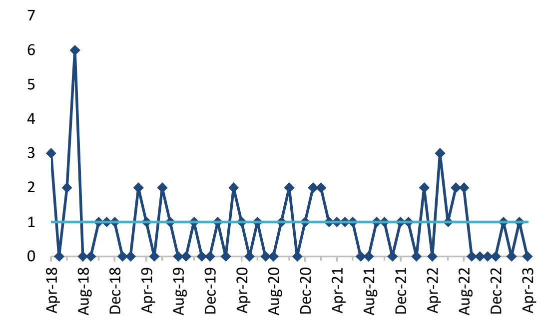
Sickness absence has decreased over the last three months, but remains above target. The percentage of Covid related absenses has continued to decline.

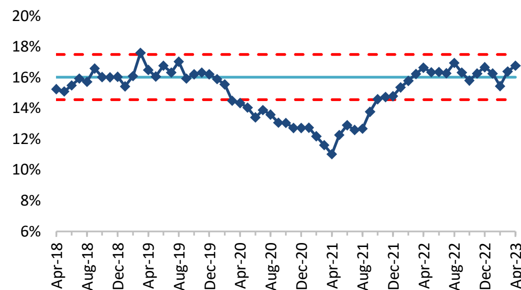
Turnover

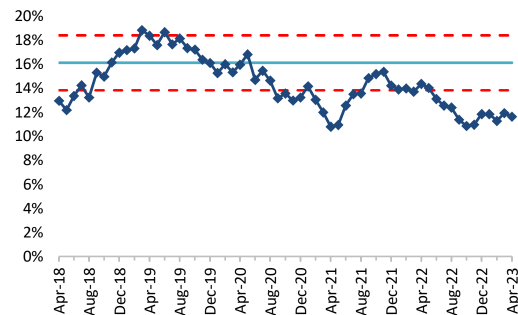
Turnover for the trust has remained at a significant level, largely driven by Corporate Services and Non Nursing Staff within Divisions. Nursing turnover is within normal variation and the trust is fully established in this area.
Other staff turnover has increased steadily and reflects the pressures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

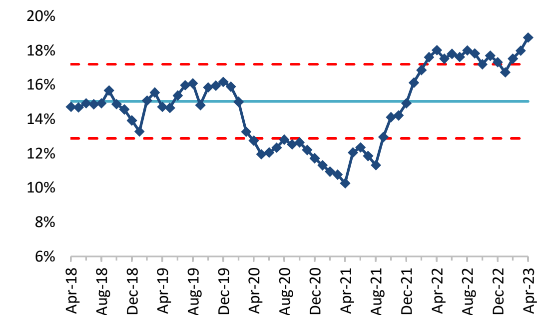








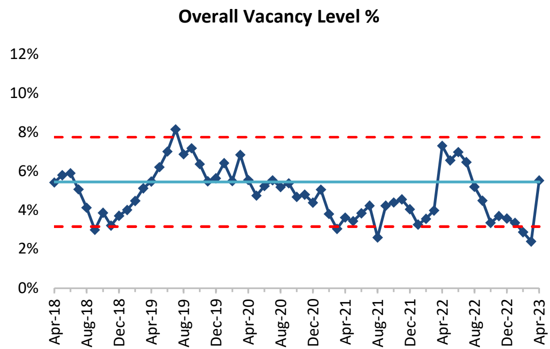


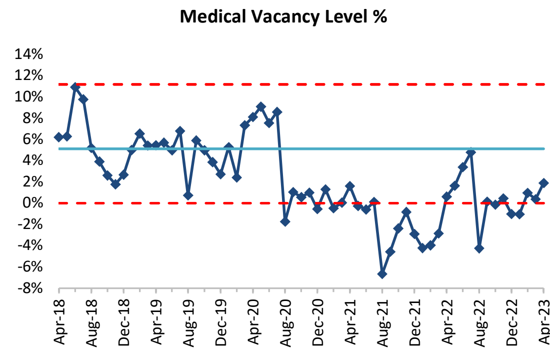


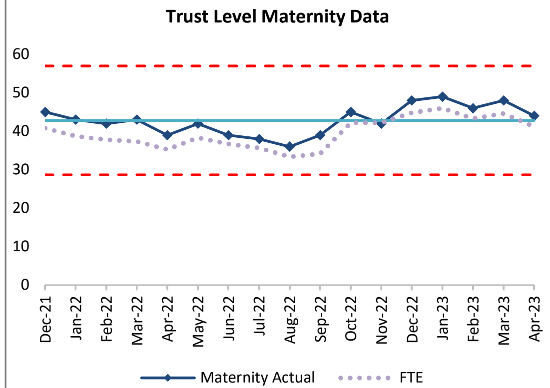
The Walton Centre NHS
NHS Foundation Trust

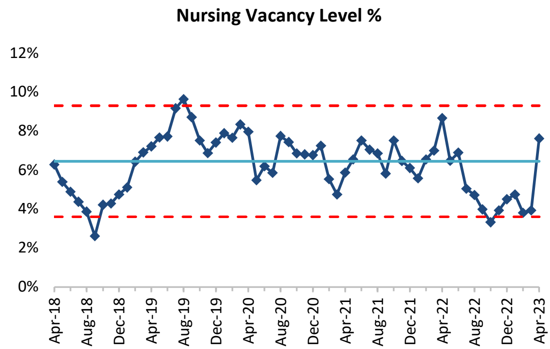
Well Led - Work force

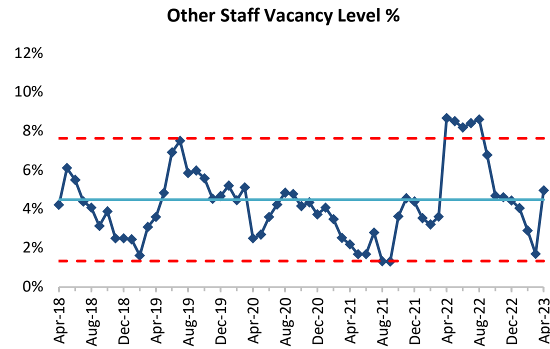
Workforce KPIs











Current month maternity figures

Directorate	Headcount	FTE
Corporate Services Directorate	4	3.8
Neurology & Long Term Care	23	21.37
Surgery & Critical Care	17	16.05
Grand Total	**44**	**41.22**

Vacancy Rates

New budgets have been set for 2022/23 which reflect several ongoing restructures across the organisation, this has impacted the vacancy rate this month.

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

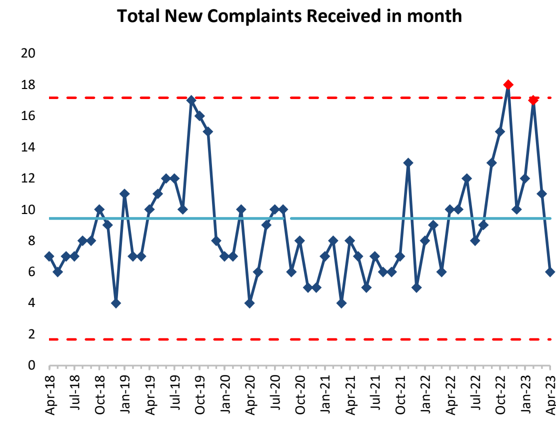
Quality Indicators

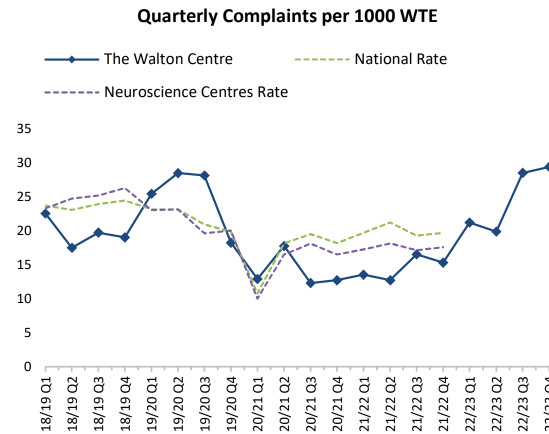
The Walton Centre NHS
NHS Foundation Trust

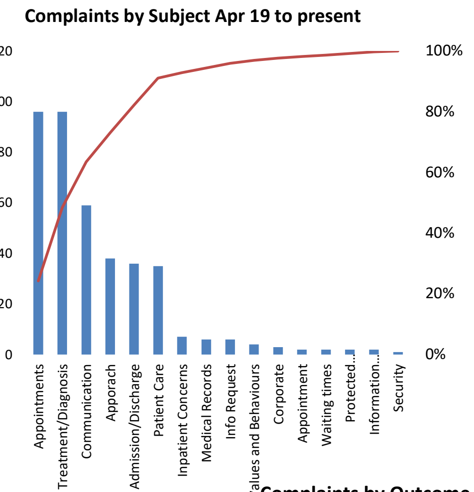
Quality of Care

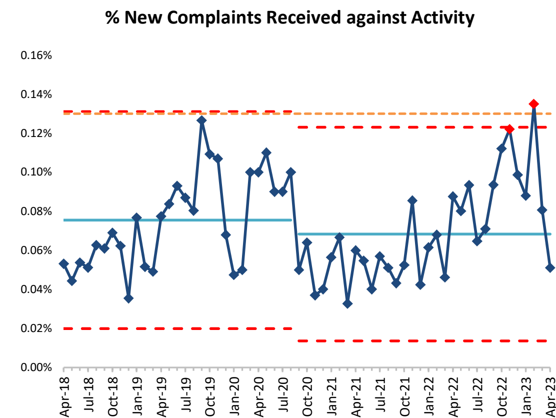
Complaints

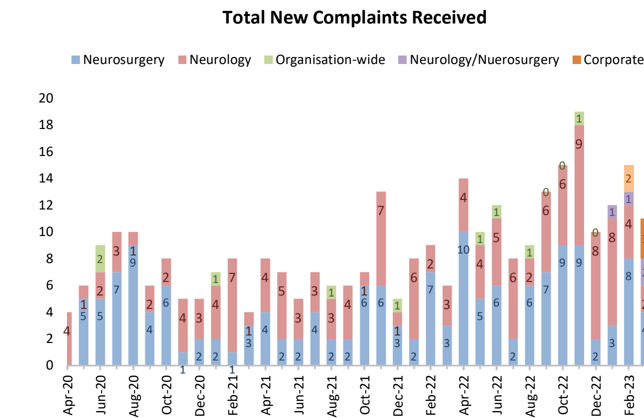
In April 2023 the trust receieved six new complaints, two in surgery and four in neurology. Three of these complaints related to Communication and one each to each of Information Governance, Diagnosis/Treatment and Inpatient Concerns. Six complaints in month is a reduction back below the mean but remains within normal variation.











Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	45	19	11
22/23	51	31	33
22/24*	1	0	0

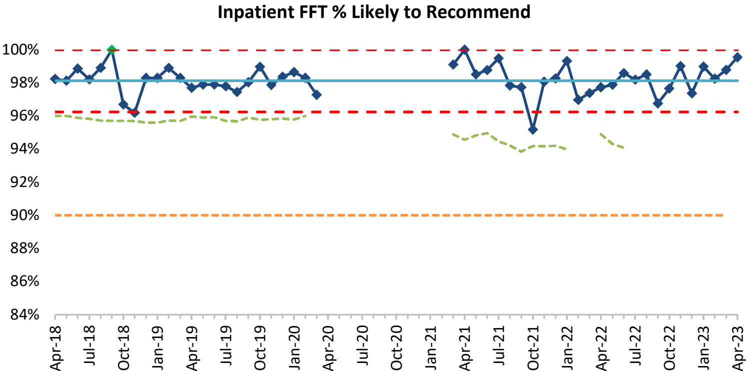
*from January 2023 there is now the option to attribute complaints to both divisions where this is necessary.

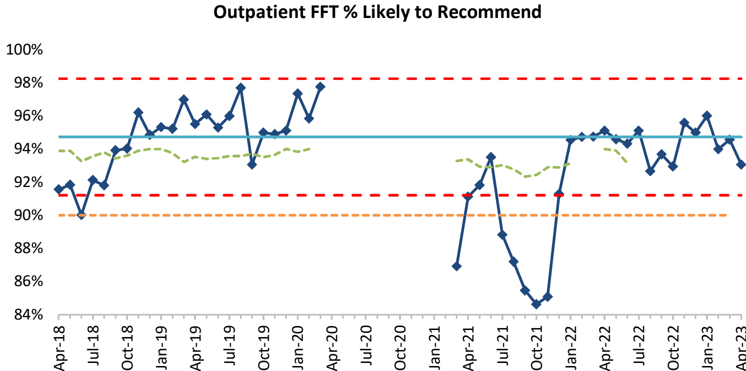
The Walton Centre NHS
NHS Foundation Trust

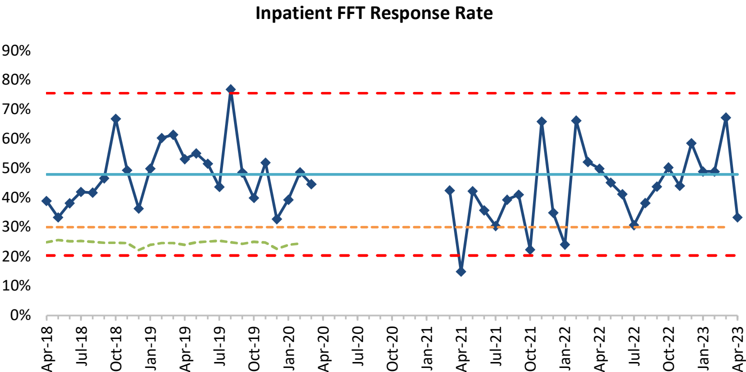
Quality of Care

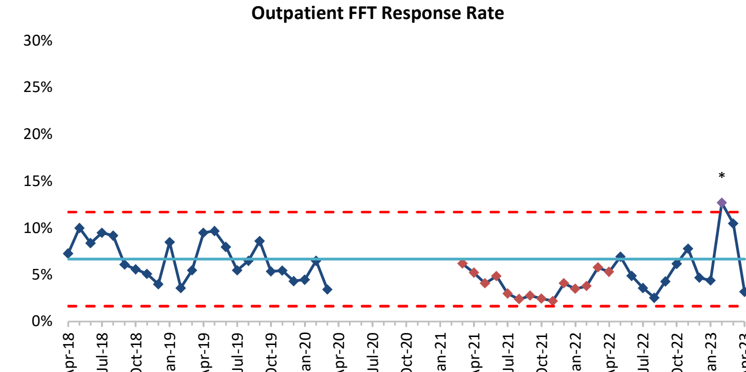
Family and Friends Test

Due to some sickness and one staff member leaving the process of FFT collection has been interrupted and uncertain in the last couple of months. The collection may also have been affected by the impact of strike action on staffing priorities. The nursing teams have been working with older processes to cover this where the discharging nurse is supplying and ensuring the FFT card. Surgery are currently tasking their students with the FFT cards with the oversight of an HCA to see if this helps generate an increase in the response rate.







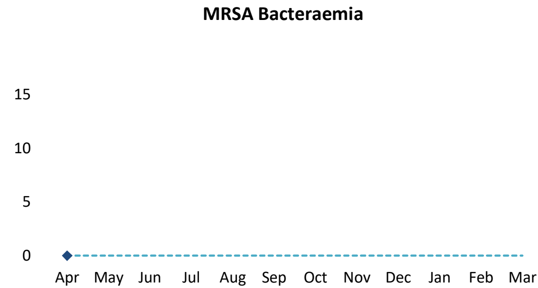


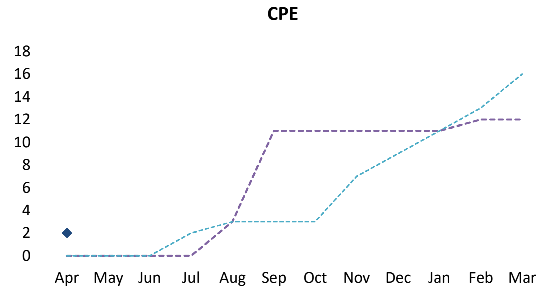
*The increase in OP response rate, though genuine, may be slightly inflated by a data collection issue at the end of January which meant that some January responses have been counted in February.

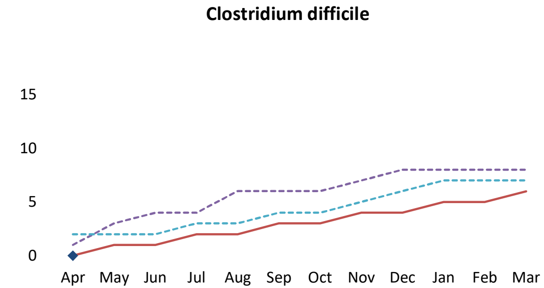
The Walton Centre NHS
NHS Foundation Trust

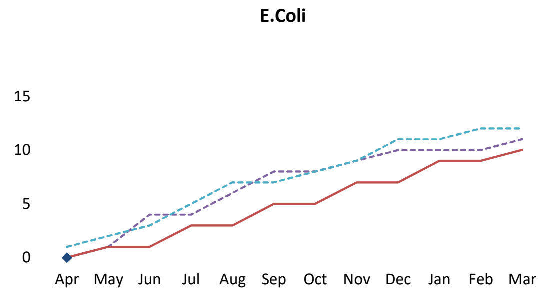
Quality of Care

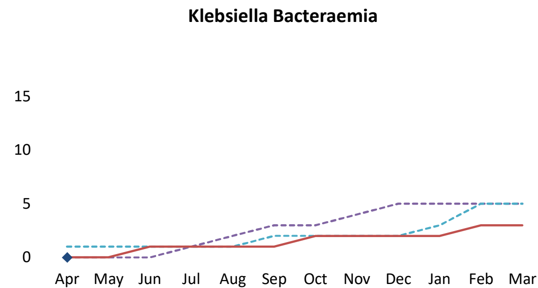
Infection Control

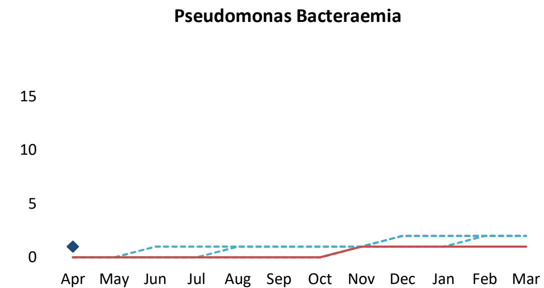


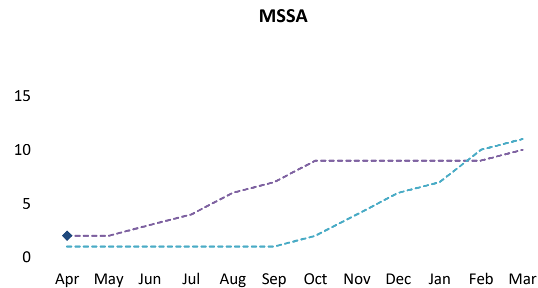












Total Healthcare Acquired Infections 2023/24

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

April Breakdown by Ward

2x MSSA on Chavasse
1x CPE on each of Horsley and Cairns
1x PB on Horsley

Pseudomonas is already at trajectory for the year as the total trajectory for 23/24 is 1.

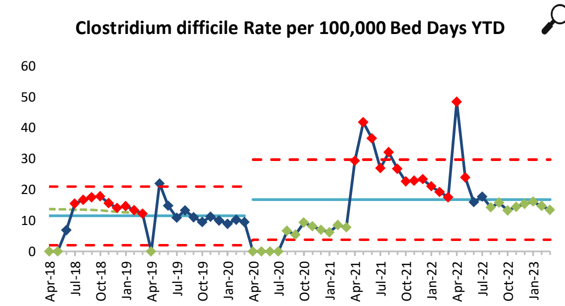
Legend for all charts

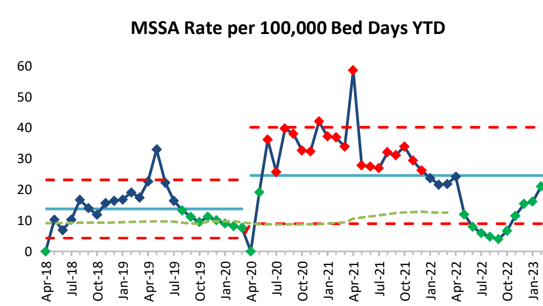
20/21 Actual YTD
21/22 Actual YTD
22/23 Actual YTD
23/24 Trajectory YTD
23/24 Actual YTD

The Walton Centre NHS
NHS Foundation Trust

Quality of Care

Infection Control

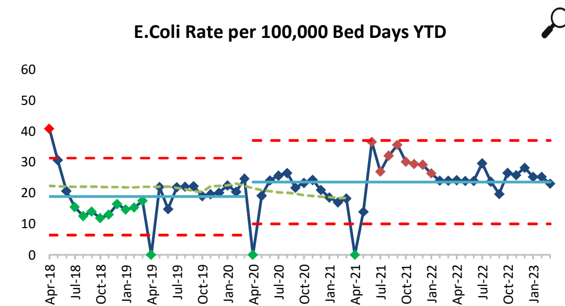


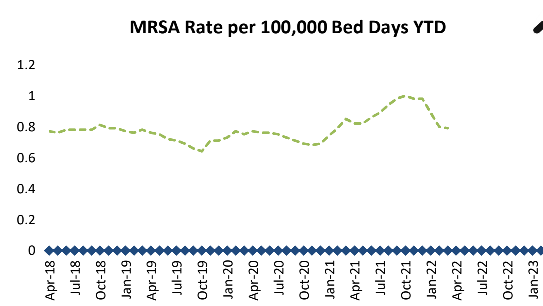


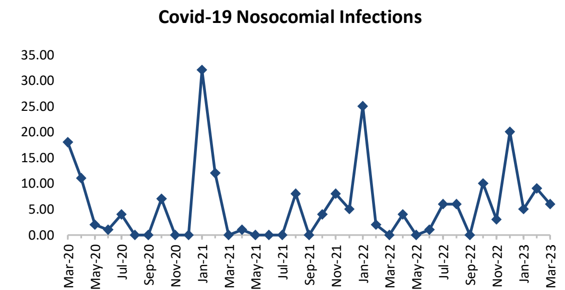
All infection rates are within the control limits this month and Clostridium difficile, MSSA and Klebsiella all continue special cause runs below the mean.

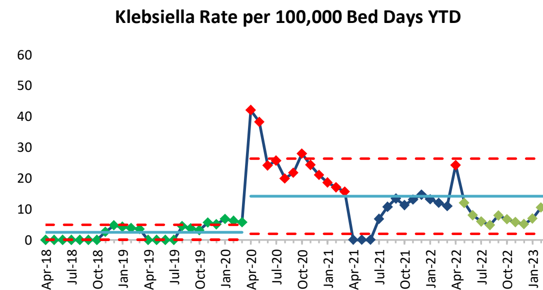
2022/23 to date

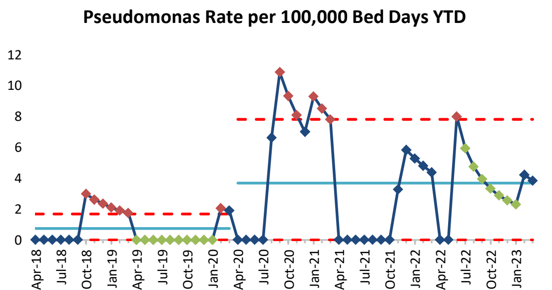
Infection	Number	Rate
C. Diff	0	
MSSA	2	
E. Coli	0	
MRSA	0	
Klebsiella Bacteriama	0	
Pseudomonas Baterian	1	
Covid -19	4 (in month)	











The Walton Centre NHS
NHS Foundation Trust

Quality of Care

Harm Free Care

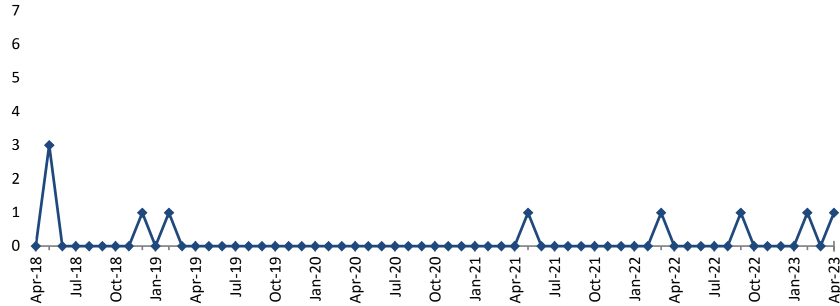
Pressure Ulcers: There were 4 hospital acquired pressure ulcers in April all category 2, 1 x DTI and 1 x Mucosal; 50% of all the pressure ulcers in April were device related. This puts the trust in special cause variation in April. The education programme continues and our next TV study day is on the 24th May. TV have also completed bedside training for Caton, however, capacity within the service meant that only one session was accomplished.
TVN has organised ward based training from pressure ulcer prevention companies, they are visiting wards and providing bite size training sessions in relation to the products that we currently use within the Trust (Repose, Dermis Plus, Flamigel/Flaminal and QV skin integrity products).

CAUTI: There were no CAUTI incidents this month.

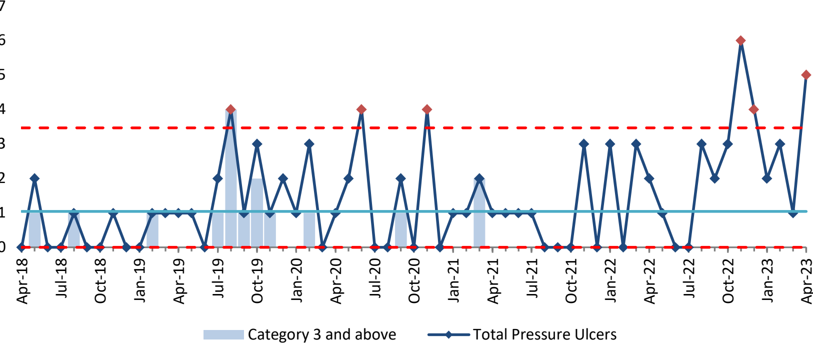
VTE: There were no VTE incident in month.

Falls: There was one fall with major harm in April.

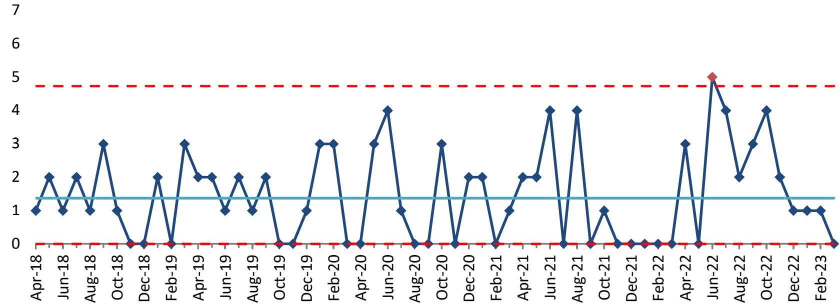
Total Moderate or Above Harm Inpatient Falls



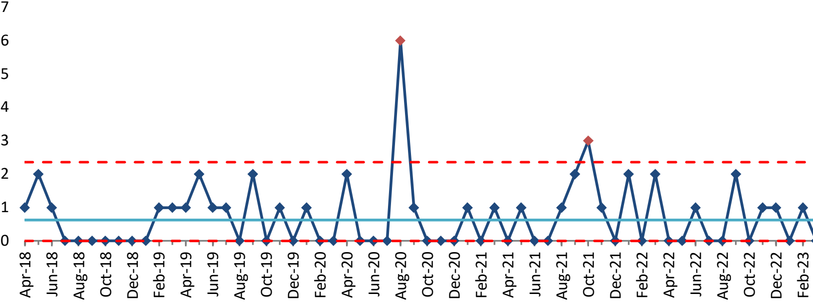
Total Hospital Acquired Pressure Ulcers



CAUTI Incidences



VTE Incidences

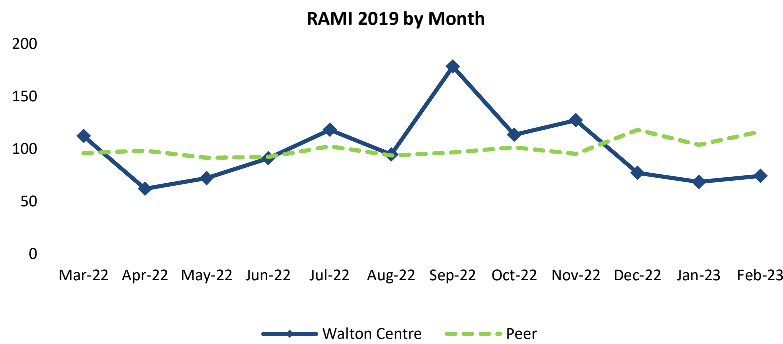


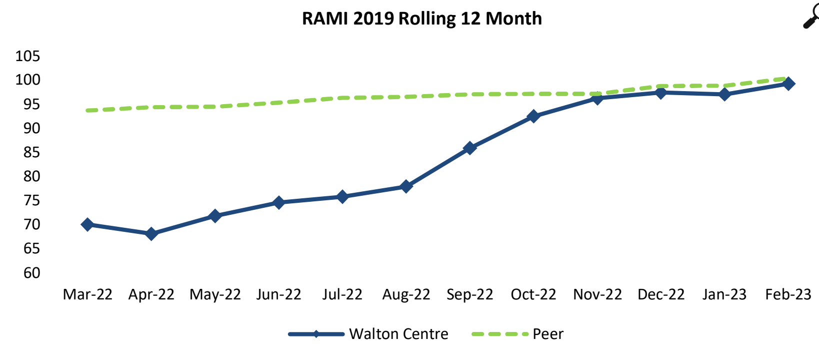
Quality of Care

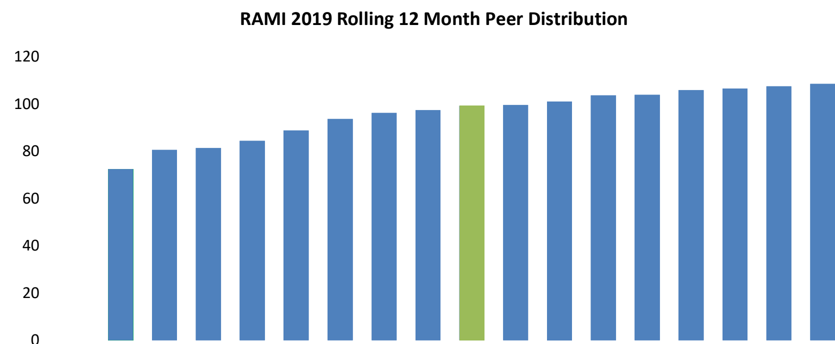
Mortality

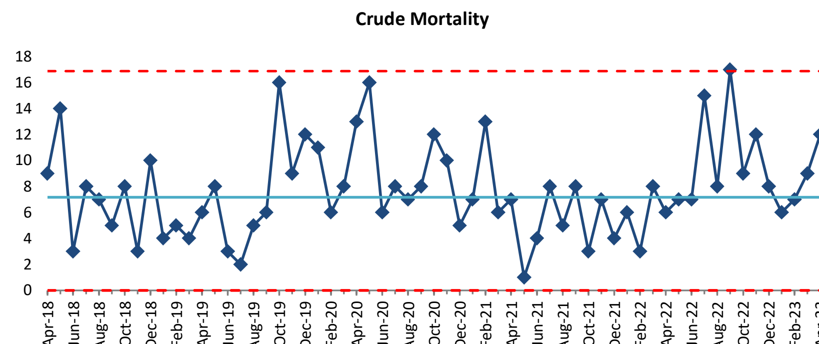
As at February 2023 the rolling 12 month RAMI19 figure is 99.24. During the period there were a total of 99 observed deaths against 100 expected deaths. When viewed against peers the Walton Centre is in 9th position. In month RAMI figures for WCFT in January have decreased again compared to December, and remains below peers. The increase in rolling twelve month RAMI figures has levelled off this month. When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 99.33.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 8 deaths following a positive covid-19 result, of which 2 were in December, 0 in January, 1 in February and 0 in March and 0 in April.



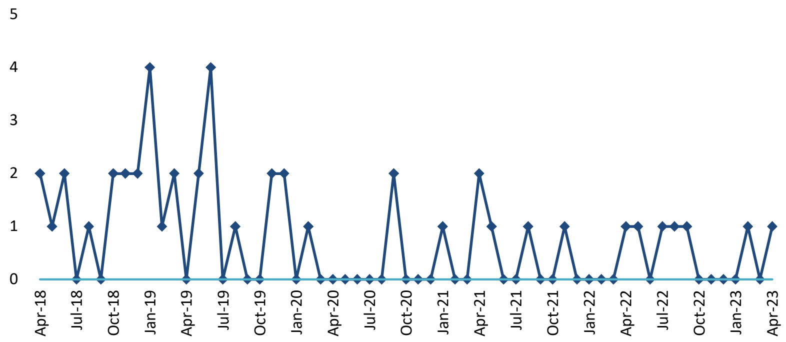


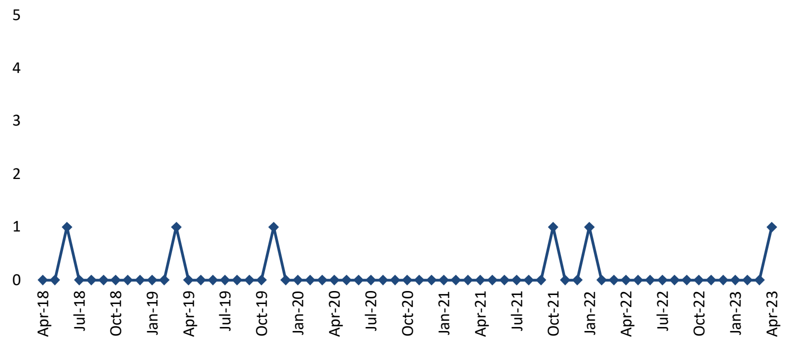




Quality of Care - Safe

Governance





Quality of Care

Ward Scorecard

Number of shifts judged in each of the four categories and number flagged overall	Safe Staffing						Harms				Infection Control			
	Green	Grey	Amber	Red	Flagged	Walton Cares	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	18	43	28	0		Gold	0	0	0	0	0	0	0	0
Caton	27	57	6	6		Silver	3	1	0	0	0	0	0	0
Chavasse	14	46	29	1		Gold	0	0	0	0	0	2	0	0
CRU	2	55	33	0		Gold	0	0	0	0	0	0	0	0
Dott	22	38	30	0		Gold	0	0	0	0	0	0	0	0
Horsley ITU	48	40	1	1			0	0	0	0	0	0	0	0
Lipton	27	55	8	0		Silver	0	0	0	0	0	0	0	0

There is one additional category 2 pressure ulcer in April which has yet to be attributed to a ward. The patient pathway was complicated and a review is underway.

Safe staffing now reflects the utilisation statuses which are managed through SafeCare. Green shifts are those where staff were underutilised, Grey are fully utilised and Amber and Red indicate where staff have been utilised at more than their capacity. These values are initially calculated based on the staff assigned to a shift and the acuity of inpatients. This initial calculation can be overridden by the professional judgement of the nursing team. The figures here incorporate those professional judgements.

Utilisation Key

- Green: Less than 90%
- Grey: 90% to 110%
- Amber: 110% to 150%
- Red: 150% and above

WELL LED

Finance

Key Performance Indicators	February	March	April
% variance from plan - Year to date	50.3%	33.4%	0.3%
% variance from plan - Forecast	59.4%	33.4%	0.0%
% variance from efficiency plan - Year to date	0.6%	0.0%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	33.8%	1.8%	-181.1%
Capital % variance from plan - Forecast	0.0%	1.8%	0.0%
Capital Service Cover *	3.5	4.6	6.1
Liquidity **	43.4	36.0	36.5
Cash days operating expenditure ***	106.3	102.2	106.0
BPPC - Number	83.8%	83.0%	84.8%
BPPC - Value	82.4%	82.8%	90.9%

* Capital service cover - the level of income available to fund the Trust's capital commitments
** Liquidity - the level of cash available to fund the Trust's activities
*** Number of days cash available to cover operating expenditure

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

Trust I&E	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	14,025	14,017	(8)	14,025	14,017	(8)	168,305	168,305	0
Other operating income	645	689	44	645	689	44	7,741	7,741	0
Donated Income	0	0	0	0	0	0	0	0	0
Total Operating Income	**14,670**	**14,706**	**36**	**14,670**	**14,706**	**36**	**176,046**	**176,046**	**0**
Employee expenses	(7,479)	(7,373)	106	(7,479)	(7,373)	106	(89,783)	(89,783)	0
Operating expenses excluding employee expenses	(6,809)	(6,976)	(167)	(6,809)	(6,976)	(167)	(81,779)	(81,779)	0
Total Operating Expenditure	**(14,288)**	**(14,349)**	**(61)**	**(14,288)**	**(14,349)**	**(61)**	**(171,562)**	**(171,562)**	**0**
EBIT	**382**	**357**	**(25)**	**382**	**357**	**(25)**	**4,484**	**4,484**	**0**
Finance income	140	167	27	140	167	27	1,680	1,680	0
Finance expense	(47)	(48)	(1)	(47)	(48)	(1)	(578)	(578)	0
PDC dividends payable/refundable	(147)	(147)	0	(147)	(147)	0	(1,764)	(1,764)	0
Other gains/(losses) including disposal of assets	0	0	0	0	0	0	0	0	0
Financial performance surplus/(deficit)	**328**	**329**	**1**	**328**	**329**	**1**	**3,822**	**3,822**	**0**
I&E impact capital donations and profit on asset disposals	21	21	0	21	21	0	257	257	0
Adjusted financial performance surplus/(deficit)	**349**	**350**	**1**	**349**	**350**	**1**	**4,079**	**4,079**	**0**

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

The current plan includes:

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

Month 1 – in month the trust posted a £350k surplus position against a plan of £349k, £1k ahead of plan.

Income – In month overperformance of £36k, due to:

- Increased Overseas, Welsh, Northern Ireland, Isle of Man, and private patient income; and
- Income received in month for training from Health Education England; offset by
- Estimated under-performance on elective activity on API contracts.

Expenditure (inc. Financing Costs) – In month over-spend of £35k due to:

- Increased spend on High-Cost Drugs (Homecare Drugs).

BPPC

- BPPC is measured on a 12-month cumulative basis, March being 12 months of data and April being the first month and 1 month cumulative.

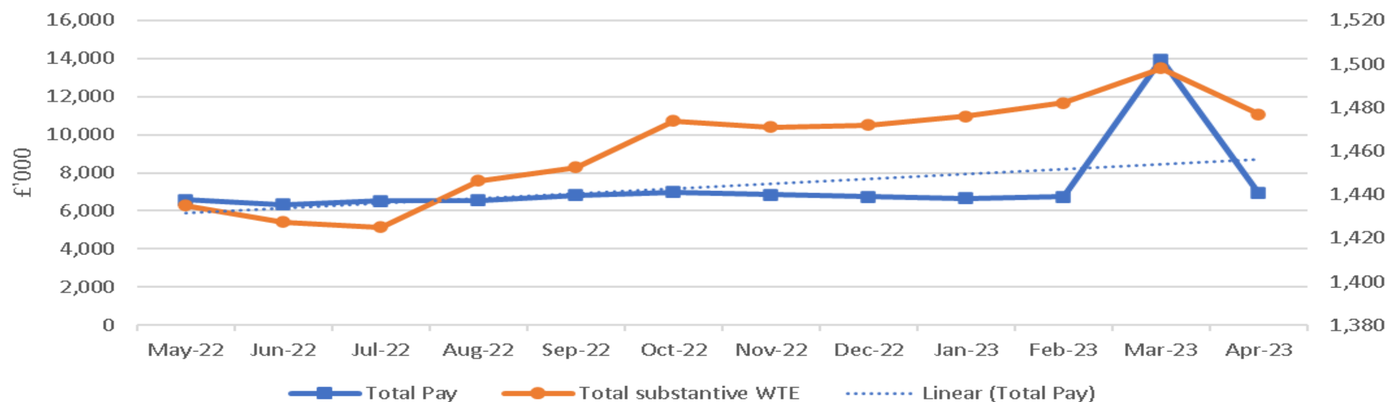
STATEMENT OF FINANCIAL POSITION - 2023/24	Plan Apr-23	Actual Apr-23	Variance
	£'000	£'000	£'000
Intangible Assets	916	908	(8)
Tangible Assets	103,390	103,529	139
Least Assets - Right of use assets	897	897	0
Receivables	324	324	0
TOTAL NON CURRENT ASSETS	**105,527**	**105,658**	**131**
Inventories	1,042	935	(107)
Receivables	7,401	7,777	376
Cash at bank and in hand	48,266	48,669	403
TOTAL CURRENT ASSETS	**56,709**	**57,381**	**672**
Payables	(36,207)	(37,043)	(836)
Borrowings	(1,892)	(1,882)	10
Provisions	(80)	(80)	0
TOTAL CURRENT LIABILITIES	**(38,179)**	**(39,005)**	**(826)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**124,057**	**124,034**	**(23)**
Borrowings	(21,455)	(21,425)	30
Provisions	(520)	(526)	(6)
TOTAL ASSETS EMPLOYED	**102,082**	**102,083**	**1**
Public Dividend Capital	38,028	38,028	0
Revaluation Reserve	14,412	14,412	0
Income and Expenditure Reserve	49,642	49,643	1
TOTAL TAXPAYERS EQUITY AND RESERVES	**102,082**	**102,083**	**1**

Leased assets is now split in line with acccounting requirements due to IFRS 16.

STATEMENT OF CASH FLOW - 2023/24	Plan Apr-23	Actual Apr-23	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**382**	**359**	**(23)**
Non-cash income and expense:	653	654	1
Working Capital	(1)	212	213
Net cash generated from/(used in) operations	**1,034**	**1,225**	**191**
Cash flows from investing activities	(457)	(275)	182
Cash flows from financing activities	(30)	0	30
Increase/(decrease) in cash and cash equivalents	**547**	**950**	**403**
OPENING CASH	**47,718**	**47,719**	**1**
CLOSING CASH	**48,265**	**48,669**	**404**

At the end April - £48,669k cash balance compared to £48,265k plan, a favourable variance of £404k:

- Movement in inventories: £107k
- Movement in payables/receivables: (£260k)
- Movement in deferred income: £372k
- Capital programme: £156k
- Other £29k
- **Total** **£404k**



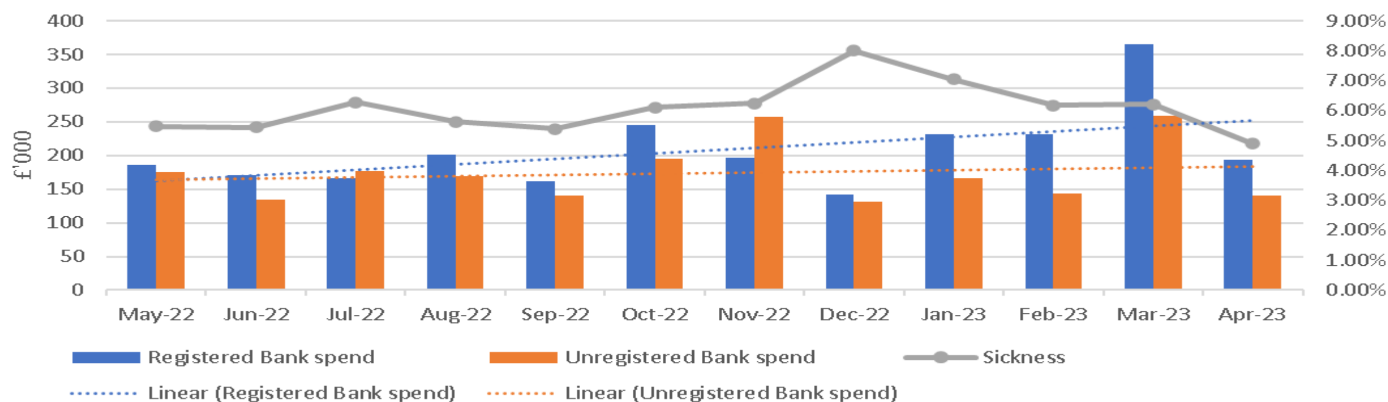
March 2023 increase is due to additional pay award and additional pension contribution, both offset in income.

Pay costs:

- Feb: £6,734k
- Mar: £13,213k
- Apr: £6,932k

WTE:

- Feb: 1,482 WTE
- Mar: 1,498 WTE
- Apr: 1,477 WTE



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

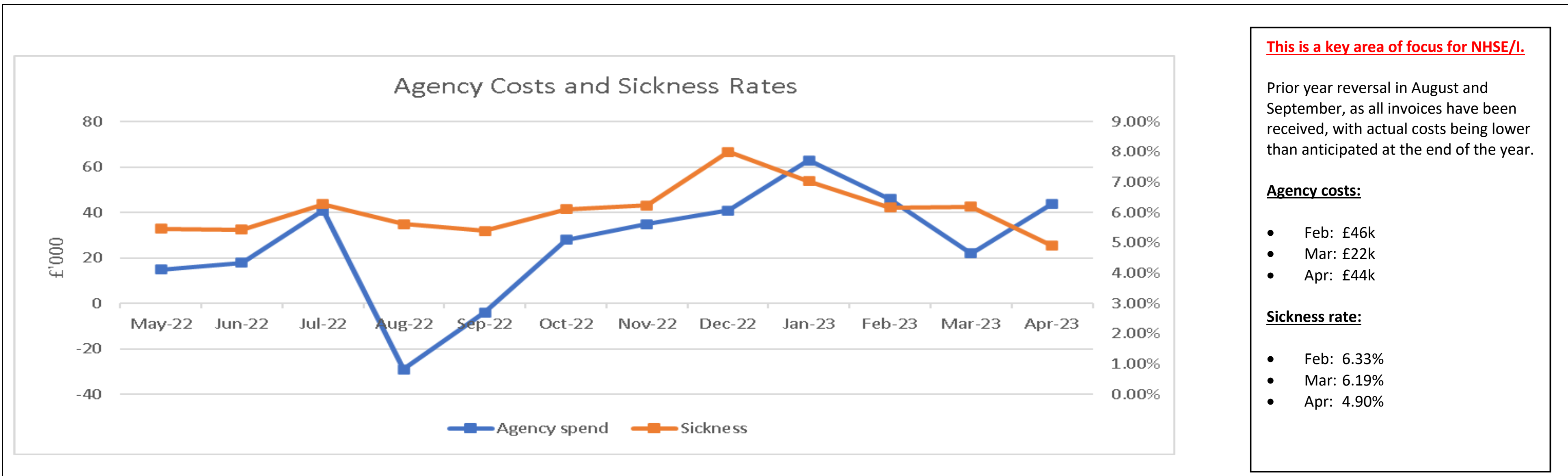
Increase in Registered Bank costs in October 2022, January 2023, and February 2023 across all wards. Increase in November 2022 due to pay award for all bank staff backdated to April 2022. Increase in March 23 is due to pay award for bank staff.

Nursing Bank costs:

- Feb: £375k
- Mar: £624k
- Apr: £334k

Sickness rate:

- Feb: 6.33%
- Mar: 6.19%
- Apr: 4.90%



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

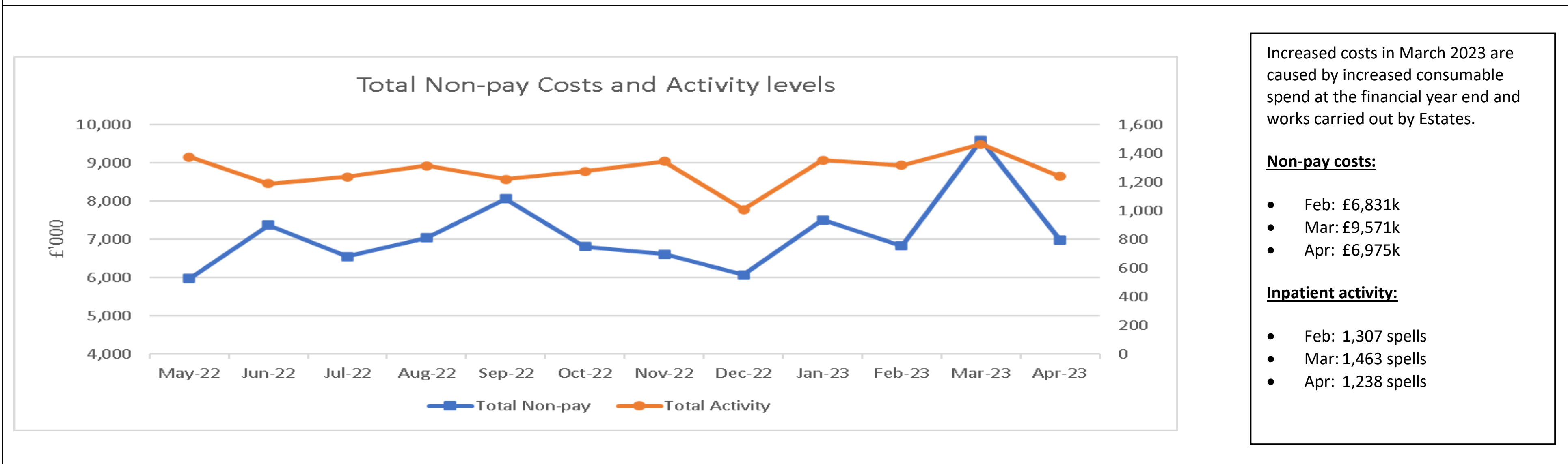
Prior year reversal in August and September, as all invoices have been received, with actual costs being lower than anticipated at the end of the year.

Agency costs:

- Feb: £46k
- Mar: £22k
- Apr: £44k

Sickness rate:

- Feb: 6.33%
- Mar: 6.19%
- Apr: 4.90%



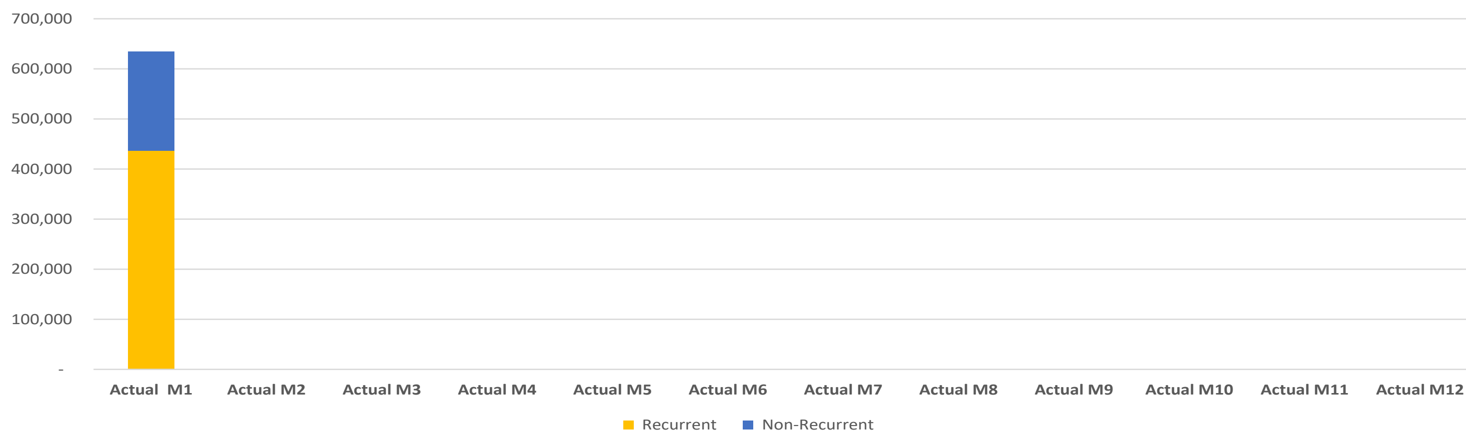
Increased costs in March 2023 are caused by increased consumable spend at the financial year end and works carried out by Estates.

Non-pay costs:

- Feb: £6,831k
- Mar: £9,571k
- Apr: £6,975k

Inpatient activity:

- Feb: 1,307 spells
- Mar: 1,463 spells
- Apr: 1,238 spells



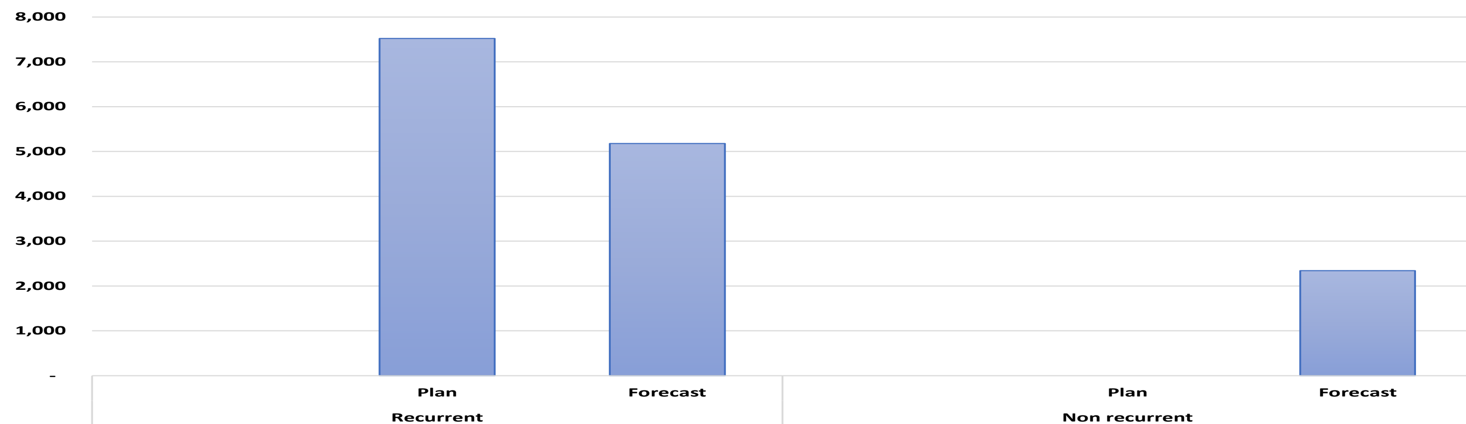
The Trust has a QIP target if £7,520k for the 2023/24 financial year. In M1 the CIP target was achieved via £437k recurrently and £198k non recurrently.

Recurrent CIP:

- Apr: £437k

Non-recurrent CIP:

- Apr: £198k



All QIP has been set to be achieved recurrently this financial year with a total plan £7,520k.

In M1 69% of the target was achieved recurrently, with 31% achieved non recurrently.

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

PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
NHS England	9,927	9,826	(101)	9,927	9,826	(101)	119,128	119,128	0
Clinical Commissioning Groups	2,099	2,082	(17)	2,099	2,082	(17)	25,191	25,191	0
Wales	1,748	1,721	(27)	1,748	1,721	(27)	20,972	20,972	0
Isle of Man	177	203	26	177	203	26	2,130	2,130	0
Other Patient Related Income	74	185	111	74	185	111	884	884	0
Total Patient Related Income	**14,025**	**14,017**	**(8)**	**14,025**	**14,017**	**(8)**	**168,305**	**168,305**	**0**

To note that patient related income includes ERF income.

NON-PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Non-patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
Research & Development Income	91	91	0	91	91	0	1,097	1,097	0
Education And Training	273	308	35	273	308	35	3,277	3,277	0
Employee Benefits Income	187	200	13	187	200	13	2,242	2,242	0
Other Non-patient Related Income	94	90	(4)	94	90	(4)	1,125	1,125	0
Total Patient Related Income	**645**	**689**	**44**	**645**	**689**	**44**	**7,741**	**7,741**	**0**

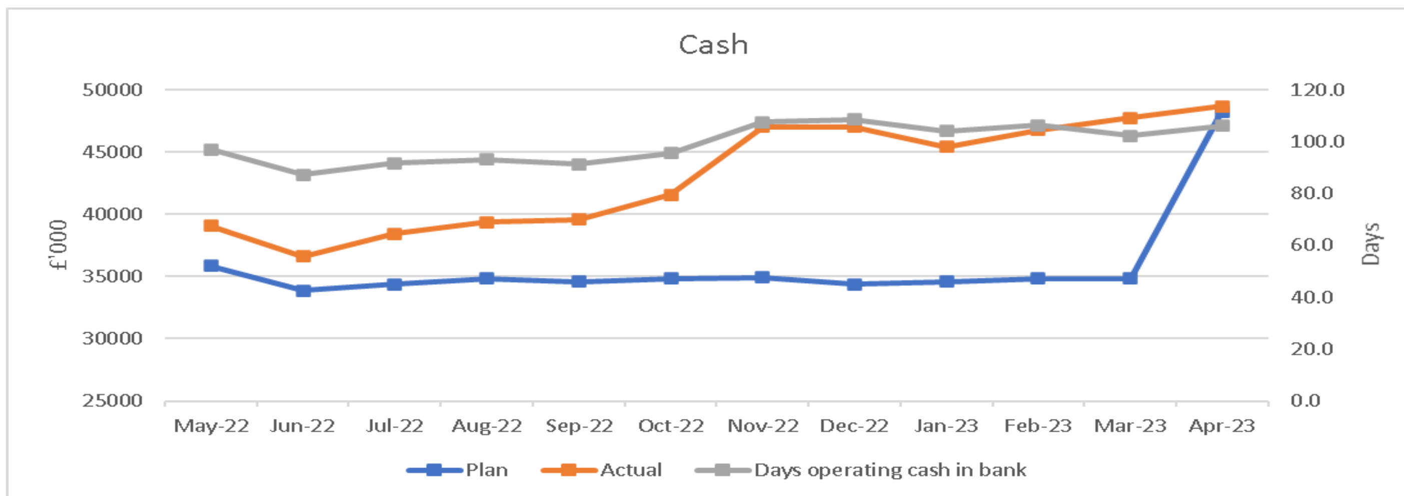
ERF

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Elective Recovery Funding	402	402	0	402	402	0	4,821	4,821	0

CAPITAL

Division	In month Plan £'000	In month Actual £'000	In month Var £'000	Year to date Plan £'000	Year to date Actual £'000	Year to date Var £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Var £'000
Heating & Pipework	70	0	70	70	0	70	890	890	0
Estates-Ponta systems	0	262	(262)	0	262	(262)	450	441	9
Estates-Theatres air handling units	0	0	0	0	0	0	2,010	2,010	0
Estates-General	0	9	(9)	0	9	(9)	0	9	(9)
IM&T	18	27	(9)	18	27	(9)	220	220	0
Neurology-Ultramax Flouro machine	0	0	0	0	0	0	1,050	1,050	0
Neurosurgery-Other clinical equipment	18	0	18	18	0	18	225	225	0
Corporate	0	0	0	0	0	0	0	0	0
TOTAL (excl. external funding)	**106**	**298**	**(192)**	**106**	**298**	**(192)**	**4,845**	**4,845**	**0**

- Capital expenditure in month of £298k, against a plan of £106k.
- Current year spend on divisional schemes includes:
  - Ponta Systems ITU – initially planned for June and July.
  - IT Staffing.
- Meetings will take to prioritise the Capital scheme for 2023/24 and to establish timelines of when projects will start within the 2023/24 financial year.
- Full year plan is set at £4,825k (excluding the impact of IFRS 16 for leased assets).

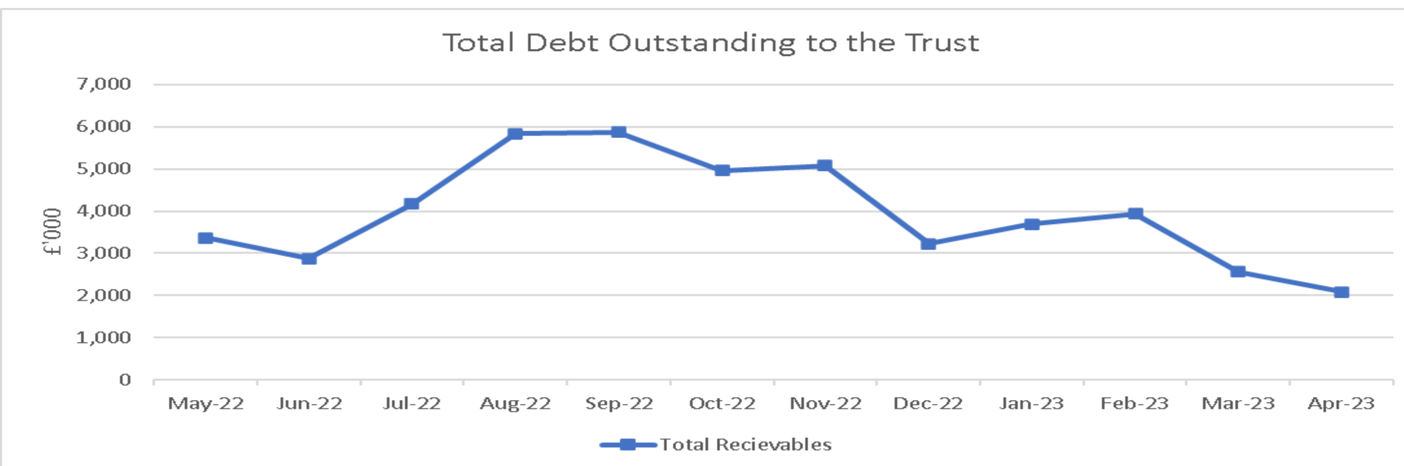


Cash:

- Feb: £46,755k
- Mar: £47,718k
- Apr: £48,669k

Operating expenditure days cover:

- Feb: 106.3 days
- Mar: 102.6 days
- Apr: 106.0 days



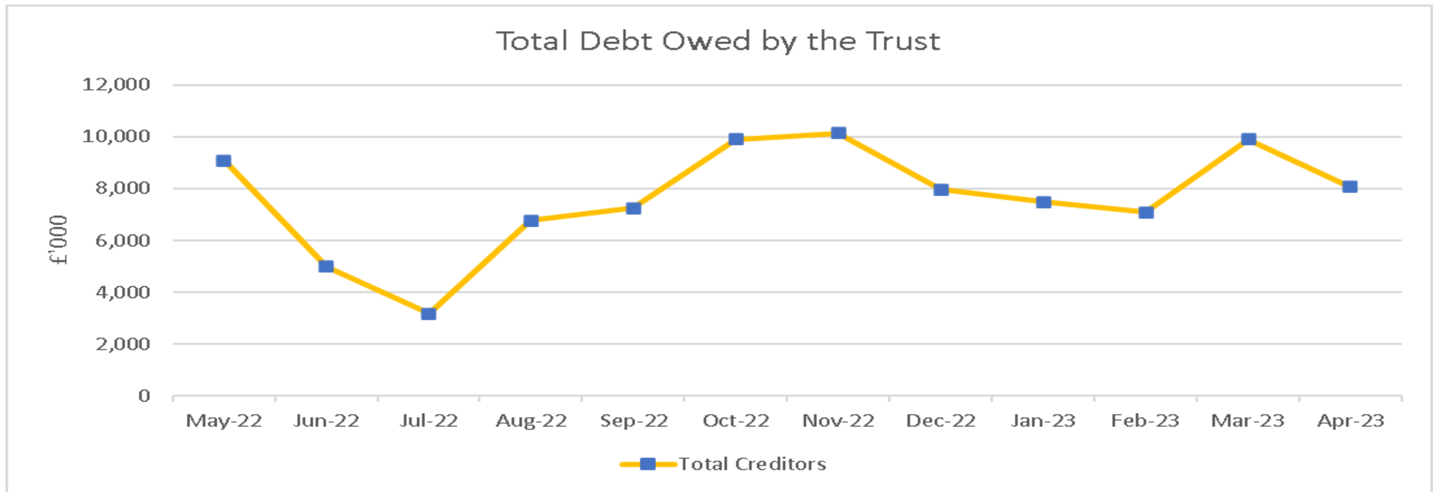
August and September 2022 increase, due to WHSSC year-end settlement invoice, Isle of Man M1-4 invoice, and Health Education England M4-6 invoice.

November 2022, due to Health Education England M7-10 invoice and Q3 invoices raised to other NHS organisations.

Isle of Man M1-4 invoice settled in January.

Debt outstanding to Trust:

- Feb: £3,938k
- Mar: £2,567k
- Apr: £2,089k

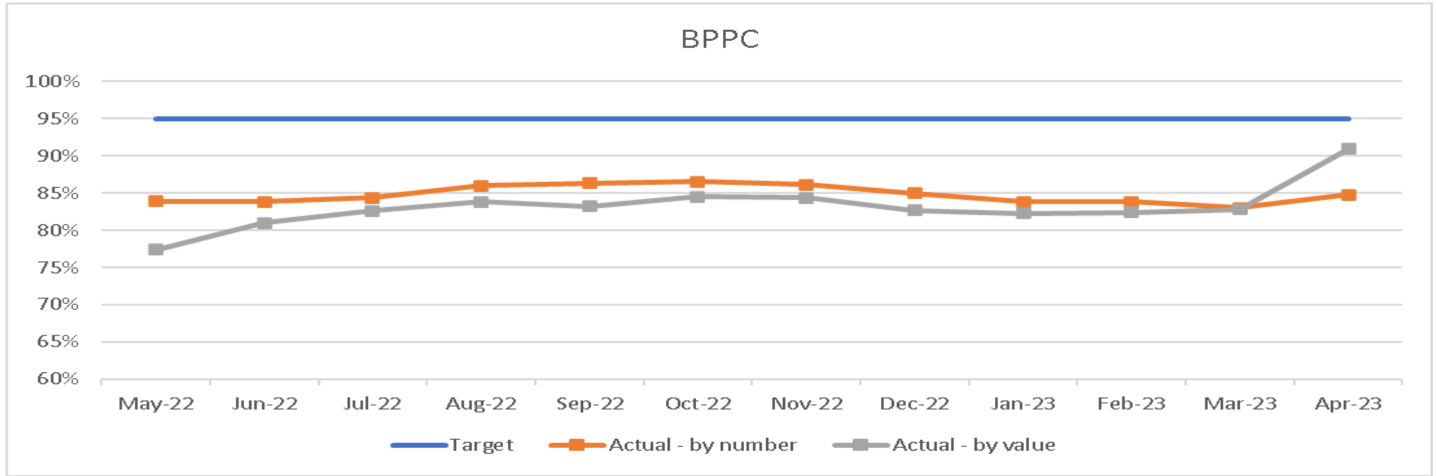


Debt owed by the Trust:

November 2022 due to £1.0m Liverpool University Hospital NHS FT invoices for drugs and service level agreement received at the end of the month, which have since been paid.

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

- Feb: £7,088k
- Mar: £9,905k
- Apr: £8,071k



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

- The Trust BPPC percentage (by number of invoices paid) at the end of April is 84.8%. This has increased from 83.0% at the end of March.
- The Trust BPPC percentage (by value of invoices paid) at the end of April is 90.9%. This has improved from 82.8% at the end of March.
- The Trust has been contacted by NHS England requesting an Action plan to improve BPPC performance. This involves collaborative working across the finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner prior to breaching the 30-day limit.
- BPPC is also being closely monitored by Audit Committee.

EXPENDITURE - NEUROLOGY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(492)	(432)	60	(492)	(432)	60	(5,897)	(5,897)	0
Allied health professionals	(513)	(477)	36	(513)	(477)	36	(6,162)	(6,162)	0
Other scientific, therapeutic and technical staff	(107)	(81)	26	(107)	(81)	26	(1,282)	(1,282)	0
Health care scientists	(63)	(63)	0	(63)	(63)	0	(760)	(760)	0
Support to nursing staff	(310)	(256)	54	(310)	(256)	54	(3,724)	(3,724)	0
Support to allied health professionals	(78)	(84)	(6)	(78)	(84)	(6)	(930)	(930)	0
Support to other clinical staff	(1)	(1)	0	(1)	(1)	0	(8)	(8)	0
Medical - Consultants	(838)	(833)	5	(838)	(833)	5	(9,990)	(9,990)	0
Medical - Junior	(248)	(232)	16	(248)	(232)	16	(2,971)	(2,971)	0
NHS infrastructure support	(218)	(195)	23	(218)	(195)	23	(2,619)	(2,619)	0
Bank/Agency	(28)	(188)	(160)	(28)	(188)	(160)	(28)	(28)	0
Total Pay Expenditure	**(2,896)**	**(2,842)**	**54**	**(2,896)**	**(2,842)**	**54**	**(34,371)**	**(34,371)**	**0**
Supplies and services – clinical (excluding drugs costs)	(709)	(733)	(24)	(709)	(733)	(24)	(8,510)	(8,510)	0
Supplies and services - general	(17)	(23)	(6)	(17)	(23)	(6)	(207)	(207)	0
Drugs costs	(2,004)	(2,268)	(264)	(2,004)	(2,268)	(264)	(24,044)	(24,044)	0
Establishment	(3)	(7)	(4)	(3)	(7)	(4)	(32)	(32)	0
Premises - other	(101)	(105)	(4)	(101)	(105)	(4)	(1,209)	(1,209)	0
Transport	(5)	(3)	2	(5)	(3)	2	(65)	(65)	0
Education and training - non-staff	(2)	(1)	1	(2)	(1)	1	(22)	(22)	0
Lease expenditure	(6)	(6)	0	(6)	(6)	0	(68)	(68)	0
Other	(8)	2	10	(8)	2	10	(96)	(96)	0
Total Non-pay Expenditure	**(2,855)**	**(3,144)**	**(289)**	**(2,855)**	**(3,144)**	**(289)**	**(34,253)**	**(34,253)**	**0**
Total Divisional Operating Expenditure	**(5,751)**	**(5,986)**	**(235)**	**(5,751)**	**(5,986)**	**(235)**	**(68,624)**	**(68,624)**	**0**

EXPENDITURE - NEUROSURGERY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,282)	(1,105)	177	(1,282)	(1,105)	177	(15,316)	(15,316)	0
Allied health professionals	(187)	(201)	(14)	(187)	(201)	(14)	(2,226)	(2,226)	0
Other scientific, therapeutic and technical staff	(52)	(52)	0	(52)	(52)	0	(621)	(621)	0
Health care scientists	(78)	(76)	2	(78)	(76)	2	(934)	(934)	0
Support to nursing staff	(284)	(258)	26	(284)	(258)	26	(3,391)	(3,391)	0
Support to allied health professionals	(12)	(15)	(3)	(12)	(15)	(3)	(150)	(150)	0
Support to other clinical staff	(2)	(2)	0	(2)	(2)	0	(21)	(21)	0
Medical - Consultants	(795)	(777)	18	(795)	(777)	18	(9,197)	(9,197)	0
Medical - Junior	(383)	(420)	(37)	(383)	(420)	(37)	(4,533)	(4,533)	0
NHS infrastructure support	(231)	(210)	21	(231)	(210)	21	(2,771)	(2,771)	0
Bank/Agency	(22)	(208)	(186)	(22)	(208)	(186)	(22)	(22)	0
Total Pay Expenditure	**(3,328)**	**(3,324)**	**4**	**(3,328)**	**(3,324)**	**4**	**(39,182)**	**(39,182)**	**0**
Non-executive directors	0	0	0	0	0	0	0	0	0
Supplies and services – clinical (excluding drugs costs)	(1,293)	(1,356)	(63)	(1,293)	(1,356)	(63)	(15,513)	(15,513)	0
Supplies and services - general	(23)	(25)	(2)	(23)	(25)	(2)	(277)	(277)	0
Drugs costs	(85)	(83)	2	(85)	(83)	2	(1,024)	(1,024)	0
Establishment	(11)	(8)	3	(11)	(8)	3	(126)	(126)	0
Premises - other	(46)	(57)	(11)	(46)	(57)	(11)	(550)	(550)	0
Transport	(6)	(6)	0	(6)	(6)	0	(69)	(69)	0
Education and training - non-staff	(3)	(5)	(2)	(3)	(5)	(2)	(42)	(42)	0
Lease expenditure	(6)	(7)	(1)	(6)	(7)	(1)	(76)	(76)	0
Other	(17)	(24)	(7)	(17)	(24)	(7)	(205)	(205)	0
Total Non-pay Expenditure	**(1,490)**	**(1,571)**	**(81)**	**(1,490)**	**(1,571)**	**(81)**	**(17,882)**	**(17,882)**	**0**
Total Divisional Operating Expenditure	**(4,818)**	**(4,895)**	**(77)**	**(4,818)**	**(4,895)**	**(77)**	**(57,064)**	**(57,064)**	**0**

EXPENDITURE - CORPORATE

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(112)	(74)	38	(112)	(74)	38	(1,340)	(1,340)	0
Support to nursing staff	(1)	0	1	(1)	0	1	(11)	(11)	0
Medical - Consultants	(5)	(5)	0	(5)	(5)	0	(63)	(63)	0
NHS infrastructure support	(946)	(848)	98	(946)	(848)	98	(11,357)	(11,357)	0
Apprenticeship Levy	(25)	(25)	0	(25)	(25)	0	(306)	(306)	0
Bank/Agency	0	(36)	(36)	0	(36)	(36)	0	0	0
Total Pay Expenditure	**(1,089)**	**(988)**	**101**	**(1,089)**	**(988)**	**101**	**(13,077)**	**(13,077)**	**0**
Non-executive directors	(11)	(9)	2	(11)	(9)	2	(136)	(136)	0
Supplies and services – clinical (excluding drugs costs)	(27)	(15)	12	(27)	(15)	12	(329)	(329)	0
Supplies and services - general	(280)	(296)	(16)	(280)	(296)	(16)	(3,355)	(3,355)	0
Consultancy	(2)	(3)	(1)	(2)	(3)	(1)	(28)	(28)	0
Establishment	(82)	(87)	(5)	(82)	(87)	(5)	(982)	(982)	0
Premises - business rates payable to local authorities	(69)	(69)	0	(69)	(69)	0	(824)	(824)	0
Premises - other	(424)	(526)	(102)	(424)	(526)	(102)	(5,084)	(5,084)	0
Transport	(9)	(26)	(17)	(9)	(26)	(17)	(105)	(105)	0
Audit fees and other auditor remuneration	(9)	(9)	0	(9)	(9)	0	(103)	(103)	0
Clinical negligence	(528)	(528)	0	(528)	(528)	0	(6,337)	(6,337)	0
Education and training - non-staff	(11)	0	11	(11)	0	11	(128)	(128)	0
Lease expenditure	0	4	4	0	4	4	0	0	0
Other	(119)	(165)	(46)	(119)	(165)	(46)	(1,424)	(1,424)	0
Total Non-pay Expenditure	**(1,571)**	**(1,729)**	**(158)**	**(1,571)**	**(1,729)**	**(158)**	**(18,835)**	**(18,835)**	**0**
Total Divisional Operating Expenditure	**(2,660)**	**(2,717)**	**(57)**	**(2,660)**	**(2,717)**	**(57)**	**(31,912)**	**(31,912)**	**0**

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

Board of Directors Key Issues Report

NHS
The Walton Centre
NHS Foundation Trust

Report Date: 01/06/2023		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 23/05/23		**Membership Numbers: 6 (Quorate)**
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report • Year End Spend of Digital Aspirant – deferred • Digital Transformation Monthly Update • Information Governance Bi-Annual Update • Occupational Health Annual Report • Learning and Development Annual Report • Capital Planning Update • Consolidated Estates Report Update • 2023/24 Financial Plan Update
2	**Alert**	• None noted
3	**Assurance**	*Integrated Performance Report* ***Operations and Performance*** • All cancer wait/treatment and diagnostic standards continue to be achieved • The number of long waiters (52+ weeks) continued to reduce (there are no 78+week waits); but this may change due to the number of mutual aid requests. Focus is now shifting to restore improvement in average waits (Referral To Treatment), especially for Welsh patients. • Elective Recovery Fund (ERF) activity was slightly under for elective and day cases at 103.8% in April but overall ERF was achieved. • Outpatient waiting lists remain high but are starting to reduce in line with the impact of the comprehensive revalidation project; the recruitment of clinical fellows within neurology should also aid reduction of waiting lists. • All flow indicators remain within normal variation. Patient Initiated Follow Up (PIFU) continues to increase. Further work is being undertaken on Did Not Attends (DNA) especially within the area of pain. ***Workforce*** • Sickness reduced to 4.9% (target 4.75%) from 6.2% in the previous month. • Nursing turnover decreased slightly to 11.64% and vacancies are low. • Appraisal compliance was 82.53% and mandatory training compliance 84.79%, below the target of 85%; both continue to receive leadership focus. • Quarterly Pulse Survey noted overall positivity at 61.9% which is anticipated to increase next quarter ***Finance*** • The 2023/24 plan is a £4.1m surplus position. Month 1 is in line with plan; £0.35m surplus delivered against a £0.35m plan. The Quality Improvement Programme

		(QIP) target for the month was delivered, however there was a lower proportion of recurrent QIP compared to a planned delivery of a 100% recurrent QIP. • Better Payment Practice Code stands at 84% of invoices paid and 90% of value against target of 95%. • Capital spend in month is £0.3m in month. Full year is £4.8m – prioritisation reviews are underway due to an excess capital requirement of £1.5m *Other matters* • All digital programmes are progressing as planned. Stakeholder reviews are being undertaken to prioritise future focus and reporting against the digital sub-strategy. • Internal Audit report on Data Security & Protection Toolkit – all evidence has been uploaded and the report is awaited. There were 542 Freedom of Information requests in 2022/23 (returning to pre covid levels). The Trust has never breached FOI timescales. There were five externally reportable information governance incidents mainly due to human error. New post system Synertec should help to prevent this. The ICO is satisfied with the actions taken. • The Trust achieved re-accreditation of ISO 27001 (Information Security) • The first Occupational Health Annual report was received which included information on the uptake of services although there was only verbal assurance regarding the timeliness of services provided and no qualitative data. • The first Training & Development annual report was received and highlighted the various initiatives developed to support the workforce at all levels. The team have aided managers in increasing mandatory training and appraisal compliance. Focus going forward will include greater utilisation of the apprenticeship levy. • The Estates Q4 report noted good performance with regards to water safety testing and improvements in the laundry service. Further options appraisal papers are to be submitted to the Executive Team with regards to meal service for patients and the transportation of deceased patients contract. Updates were provided for key capital works in 2023/24 • Key Issues reports from five subgroups were received and noted; no alerts presented. Work on subgroup annual effectiveness reviews is on-going but none were received at the meeting.
4.	**Advise**	• The final iteration of the financial plan was presented. There was an increase in surplus from the previous submission, driven by changes such as increased CIP requirements and removal of excess inflation to be consistent with national assumptions. • Initial capital plan prepared by the Trust was £6.3m of which £4.8m would be funded during the year which means that capital requirement for 2023/24 is overcommitted by £1.5m. Re-prioritisation of capital projects is to be undertaken by the Executive Team to bring the capital plan into line with the ICS allocation which will consider the impact on quality and safety for patients and staff. Key projects include theatre air handling units (£2m) Ultamax Fluoroscopy (£1.1m) Pipework (£0.5m) Ponta system ITU (0.5m)
5.	**Risks Identified**	• Achievement of the financial plan due to the CIP levels and possible reduced activity arising from industrial action and delivery of mutual aid.

6.	**Report Compiled**	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

NHS
The Walton Centre
NHS Foundation Trust

Trust Board Key Issues Report

Report Date: 18/05/2023		**Report of: Quality Committee**
Date of last meeting: 18/05/2023		**Membership Numbers: 7 (Quorate)**
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report and Joint Divisional Report • Infection Prevention and Control Q4 Report • Mortality and Morbidity Q4 Report • Clinical Audit Annual Report • Visibility and Walkabout Q4 Report • Trust Wide Risk Register • Safeguarding Statutory Responsibilities Q4 Report • Risk and Governance Q4 and Annual Report • Draft Quality Accounts 2022/23 • Patient Experience Q4 and Annual Report • Clinical Effectiveness and Services Group Annual Effectiveness and Terms of Reference Review • Quality Impact Assessments
2.	**Alert**	**Patient Experience Q4 and Annual Report** Safeguarding alert raised by the adult safeguarding board regarding a discharge, this is being investigated and Quality Committee will be updated when completed.
	Assurance	**Infection Prevention and Control Q4 Report** An action plan and detailed approach was in place relating to issues identified on the Intensive Therapy Unit (ITU) and a review of previously identified actions was planned to ensure that they were fully embedded. A meeting had been held with Specialist Commissioners regarding action plans for C.Difficile and positive feedback received. The IPC Board Assurance Framework would be presented in June when fully updated. **Clinical Audit Annual Report** No significant issues were identified; extensive work noted to reduce the backlog of outstanding audits. **Risk and Governance Q4 and Annual Report** It was noted that the themes and trends of incidents recorded correlated with the themes and trends of complaints received.

		Patient Experience Q4 and Annual Report There had been an increase in the number of concerns recorded however the Patient Support Assistant had been resolving a number of issues locally and these were recorded as a concern. This work had in turn led to a reduction in the number of formal complaints recorded. The report would be redacted to remove appendices containing anonymised patient information prior to submission to Board. **Mortality and Morbidity Q4 Report** The number of deaths recorded had increased from 64 in 2021/22 to 112 in 2022/23 however it was recognised that the figure of 2021/22 had been impacted by low activity. Those recorded were mostly attributable to trauma and vascular cases. **Integrated Performance Report** The majority of indicators recorded on the IPR were within normal variation and high performing.		
	Advise	**Risks** The Committee scrutinised the risks scoring twelve or above within the remit of Quality Committee and were satisfied with the processes in place to manage the risks. **Integrated Performance Report and Joint Divisional Report** The Committee focussed on indicators with special cause variation and agreed that a review of the Ward Scorecard would be undertaken to provide more clarity and assurance in these areas. The indicators relating to Caton ward would be checked to ensure they are separated between the main ward and Caton Short Stay as they are managed as two different wards. **Quality Accounts** The Committee noted the report and agreed that the substance of the accounts was very good however they required a plain English proofread before submission to Board. **Visibility and Walkabout Q4 Report** A summary of the report would be presented to Council of Governors and further requests for Governor involvement would be made. It was agreed that future reports would include information regarding closure of any actions identified going forward. **Clinical Effectiveness and Services Group Effectiveness Review and Terms of Reference** The Committee approved the terms of reference for the Clinical Effectiveness and Services Group.		
2.	Risks Identified	No new risks were identified.		
3.	Report Compiled by	Ray Walker – Non-Executive Director	Minutes available from:	Katharine Dowson – Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Board of Directors
1 June 2023

Report Title	Board Effectiveness Review 2022-23	
Executive Lead	Jan Ross, Chief Executive	
Author (s)	Katharine Dowson, Corporate Secretary	
Action Required	To note	
Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*		
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- Self-assessment annual review completed with feedback received from Board Members, Governors and staff
- Generally positive responses from the Board, with a collective recognition of areas for improvement and the actions being taken to address these
- More mixed responses received from Governors and staff

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

- Build on findings from External Well Led self-assessment to develop a Board Development Programme
- Paper to be shared with Governors and results to be shared with staff through internal communications alongside well led review

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

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*		
Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*		
Strategy ☐	Policy ☐	Service Change ☐

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

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

Board Effectiveness Review 2022-23

Executive Summary

1. The responses to the survey were overall positive about the effectiveness of the Board from Board Members. There were some areas of disagreement with the statements, but the comments illustrated that these were areas where work had been carried out but further work was required.

2. This year for the first time Governors and staff were also asked to respond to a series of statements about the Board and its effectiveness. The Governor responses were balanced although disappointingly there were no comments provided where disagreement was raised. There were 92 responses from staff members which were more mixed but given the number of responses there are some helpful high-level themes that have emerged.

3. A summary of the results has been provided in the appendices with a selection of some of the comments received.

Background

4. A formal self-evaluation of performance of the Board is recognised good practice and there is an explicit requirement for this in the NHS Foundation Trust Code of Governance. This links closely to the duty of directors to promote the success of the Trust to maximise the benefits for the members as a whole and for the public, as laid out in the NHS Act 2006. Self-evaluation is also a core principle of the NHS England Well Led Framework by which Board's should evaluate their overall performance and leadership.

5. An annual evaluation allows the Board to benchmark itself, assess its performance, set action plans and identify development gaps. The effectiveness review should be considered alongside individual appraisals of the performance of directors (as Board Members) and the performance of the Board's Committees to develop an overall view of the Board's performance. It is also an opportunity for the Board to reflect on its recent achievements and the work of the past year

6. The Board were asked to assess and rate their agreement or disagreement with 19 statements across five themes: Support, Structure, Leadership, Effectiveness and Engagement. Respondents also had the option to state that they were unable to answer, for example if they were new in post and had not yet been able to sufficiently assess a particular aspect of the Board.

7. In addition this year the Governors and wider staff body were also asked for their views. This provides evidence of how the Board is effectively linking and communicating with the Council of Governors and how the Board is perceived by its key internal stakeholders: Governors and staff. The staff responses provide an insight into the culture of the Trust and together with staff surveys and engagement with staff provide a picture of the satisfaction of the staff workforce and areas where focus by the Board would have the most impact.

Analysis – Board Self-Evaluation

8. The responses to this survey (Appendix 1) were sought in March from Board Members which was before the Well Led Review Report was received and therefore before some changes

and Board members may consider that some behaviours raised may have already been addressed such as ensuring all Board Members have the opportunity to comment.

9. Responses were generally positive and were received from all of the substantive Board members currently in post. The most positive response areas were in regard to the modelling of organisational values and culture, the time allowed for items on the agenda, the strategy and identification of strategic risks, the Board Assurance Framework and an appropriate agenda balance towards strategy.

10. The work undertaken in the last 18 months to improve the quality of Board papers and the information being presented to the Board was recognised and the improvements made were noted, although it was still considered that there was some further work required, for example regular reports require updating to avoid repetition.

11. Visibility in the organisation was felt to have improved and this was also reflected in the staff and Governor feedback. A programme of visits was re-established in 2022/23 following the lifting of Covid-19 restrictions. Some Board Members felt that the Board had a good focus on organisational culture, but there were two disagrees and comments reflect that more work is required, particularly in regard to equality, diversity and inclusion issues.

12. Succession planning was an area that generated the most uncertainty, with almost half disagreeing that there was a succession plan in place for all Board roles. This is despite a review of Board succession planning being discussed at Remuneration Committee in year and therefore this will be reviewed again in more detail and reported back to Board .

Analysis – Council of Governors Feedback

13. There were twelve responses to the Governor survey from 20 Governors. The Governor statements were different to those for Board Members and staff members.

14. The responses were generally positive, with the majority of Governors responding positively to the statements. There were a smaller number of disagrees or strongly disagrees across a a number of areas but there were no related comments making it very difficult to understand the drivers behind these responses. The results will be shared with Governors and further information requested to understand the results.

15. There were three responses from Governors who felt that they had not been able to shape the future direction of the organisation and this reflects feedback given by Governors as part of the Well Led review. This is disappointing as the emerging strategy was shared with Governors at two meetings early in 2022 as well as at the advisory group where input and feedback was sought. There appears to be a disconnect between the opportunities offered by the Trust and what the Governors wanted in order to give their views which could be explored further.

16. There was disagreement from Governors that they were being kept informed about progress towards delivering the strategy and strategic ambitions and this will be added to the Council of Governors agenda on a regular basis.

17. Five Governors felt unable to comment on that what they were told by Directors matches what they are told by staff and patients. Engaging with members including staff and patients is a key part of the Governor role and these responses suggest that this triangulation of

evidence is not happening for some Governors despite opportunities for walkabouts and invitations to membership events. Therefore work needs to be done to ensure all Governors are able to access these opportunities.

Analysis – Staff Feedback

Image 1 – Wordle of Staff Comments

18. This year for the first time a series of statements was sent out to all staff via Walton Weekly to obtain feedback on the Trust and the staff perception of the effectiveness of the Board. There were 92 responses which was very positive and the full results are attached at Appendix 3.

19. Unsurprisingly the results from staff were more mixed, the responses provide some insight into the culture and views of the Trust's workforce and the Board's role in leadership of this. As with all surveys of this kind there are responses from those that feel particularly strongly about wider healthcare issues, politics and funding and have commented on this and some who are disengaged in their role. There were a large number of comments which have been shared in full with the Board but the focus here is on the trends that can be established from the responses of all 92 staff members. Key themes identified were:

    - Board visibility is as expected and there is room for improvement, Executive Director recognition was about two-thirds. Understandably, given their time commitment in the Trust, Non-Executive Directors are less recognisable, with the majority stating that they would not recognise them. New display boards were installed recently which may help and an ongoing programme of walkrounds and visits is planned for 2023/24
    - About half of respondents felt that the Trust had actively engaged staff in the development of the Trust Strategy but there was a theme which was reflected in the Well Led Review Report that more work needed to be done to 'socialise' the strategy and substrategies with staff which would help staff understand their role in delivering the strategic ambitions and understand the key risks to the organisation

      "I feel strategy is explained in a more of a whistle stop tour at high level and doesn't explain what impact that has at departmental level."
    - There was a positive response to line managers with two-thirds of respondents stating that their line manager got the best out of them
    - There was less agreement about innovation and support available to find and adopt new ways of working although just over half agreed with the statement
    - Most staff felt that the Trust did not tolerate bad behaviours by patients and visitors which was positive and similar to those that felt there was a safe and supportive work

environment in place which reflects the value and behaviours reflected in the Walton Way

"I feel the executive team are very visible and supportive. Recently the CEO attended our team meeting and find both the Executive Team and Non-Executives Directors have always been very open, friendly, honest and supportive."

- There was a much more negative response to the statement that the Trust does not tolerate bad behaviour by staff with more staff disagreeing than agreeing to this statement and some strongly-worded comments relating to this issue

  "The executives in this Trust know the behaviour of senior management and how they operate but do absolutely nothing to challenge this".

  "Finally there has been action on toxic behaviour of a [senior staff member] after years of inaction"

Conclusion

20. The responses from the three groups create a broad picture of the effectiveness of the Board and reflect the findings of the external Well Led assessment. There are areas for improvement and focus for the Board to consider.

Recommendation

To note

Author: Katharine Dowson
Date: May 2023

Appendix 1 – Board of Directors Self-Assessment Results
Appendix 2 – Council of Governors Survey Results
Appendix 3 – Staff Survey Results

Appendix 1

Board Effectiveness Review March 2023

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to Answer	Comments/Actions
Theme 1 Support and Infrastructure						
The Board receives timely information.		11	1			This has improved. Still some items that come late, but an improvement overall. Papers often late
The papers received are of an appropriate quality.		12				Most of the time, seen significant improvement Whilst there is still room for improvement, much progress has been made in this area, which is very welcome The Chair and CEO updates are stronger than ever and keep us well updated on the system issues People follow the templates which helps with a consistent approach.
The papers received are concise and focused.		11	1			Papers have improved, especially Executive Summaries, the full papers often seem overly long and key messages are not clear There is a tendency for some 'routine papers' to carry the same text from month-to-month without being refreshed/updated and sometimes what's there is no longer true or relevant Much progress has been made in this area Some that are not, but this is an exception A more focused summary and better use of appendices would help
The information received is in an appropriate form to enable the Board to make sound decisions.		11	1			Whilst the vast majority are fit for purpose there are still some papers received which are merely reporting data and lack concrete metrics, assurance or actions Not always In the main this is true – unfortunately, given some of the finance / performance deadlines not fitting in with board schedules, these can sometimes be difficult to present in a more formal format.

Theme 2 –Structure						
The Committee has the right balance of experience, knowledge and skills to deal with current and anticipated challenges.	2	8	2			Generally agree but still a gap in IT expertise at board Given the size of the Trust we are a smaller board and therefore have some gaps however these are recognised and mitigated. Still lacking a focus on the challenges and opportunities that the digital agenda presents; we could benefit from stronger focus on this Board members have a good grasp of the key areas of their portfolios and are able to discuss other areas.
There is a succession plan in place for all Board roles.		6	5		2	Executive directors have identified deputies for interim business continuity, but not necessarily succession. There are some roles that are easier to succession plan, for others we would want to test the market Not all deputy directors will want to be directors. The Board strikes the right balance between succession planning and equality of opportunity to increase the diversity of Board members.
Theme 3 - Leadership						
The Board periodically review organisational culture and plans to maintain a positive culture.	2	7	2			Via feedback from staff surveys, external reviews and ad hoc perceptions Some of the less than favourable data/reports on ED&I issues have been hampered by the vacant ED&I post. This is an area where the board has a clear focus, especially following the pandemic and the elective recovery. The staff survey is usually reviewed in detail by a Committee and improvement plans are developed and reviewed regularly.
The Board collectively and individually models behaviours consistent with organisational values and culture.	5	6				
Members of the Board are visible in the organisation.	1	7	1		2	Staff opinion on this varies. Non-Executive Directors are probably visible to a minority of the organisation and whilst trying to 'go see' this is necessarily rather infrequent Always an area to improve on. This has improved following Covid. Objectively I don't know if all members are

Theme 4 – Effectiveness						
The Board has set a strategy for the Trust and regularly monitors progress against this at Board meetings.	8	4				The strategy has been set and his is being monitored on a quarterly basis We are still in the process of identifying the KPIs for the strategy. Clearly, the further away the strategic ambition the harder it is to be specific
The Board has identified the strategic risks facing the organisation and that it has the controls to manage them.	6	6				These are monitored through the BAF which is regularly reviewed by executives, at the Board Committees and at the Board
The Board Assurance Framework is effective.	7	5				This is updated on a regular basis to reflect changes in the environment
The agenda is sufficient to allow the Board to carry out its functions	4	8				The agenda is sufficient for the board to carry out its functions although it could be more strategic at times. Not enough focus on cyber (apart from the annual training) and digital
The agenda prioritises the right issues.		12				Generally true – apart from Digital Need to include a greater system focus
Sufficient time is spent on each agenda item.	1	11				The meeting is well managed
The time spent on strategy results in defined proposals to be incorporated into the forward plan of the Trust.	2	10				Apart from Digital This is a driver for discussions and the link back to strategic goals
The chair ensures that there is sufficient challenge on each issue on the agenda.	3	8	1			Challenge needs to be sought from all Board Members. The challenge that takes place at Committee needs to be pulled through Agree that this is true for Non-Executive Directors, although not always the case for Executives The quality of the challenge could be augmented if There was more Executive (Exec) to Non-Executive Director and Exec to Exec challenge

Theme 5 – Engagement						
The decisions and policies adopted by the Board reflect the views of the Board members.	6	4	1			The board works as a unitary board and this is reflected in the view and decisions of the board
The Board informs and involves key stakeholders in its work.	1	8	1		1	It is reviewing its list of stakeholders which should strengthen this. This is subject to some variation

General Comments on Board Effectiveness

- Recent discussions suggested re-aligning the frequency and focus of Board meetings. Less in some respects could result in more
- More focussed papers and/or delegating more to Committees
- The Board works very well and has improved significantly over the past year. The quality of papers has improved and the focus of discussion is more relevant and strategic than previously
- At times the discussions could be more 'unitary' rather than focusing on Non-Executive Director views.
- Board acts as a unitary board
- The quality of the Board papers has improved.
- Time management has improved
- A time to reflect on the external environment and strategies to navigate the complexities as we move forward
- The meetings are well chaired and there are very few surprises. The only issue that can sometimes emerge is from Non-Executive Directors concerning the activities of Board Committees of which they are not a member. This seems unavoidable
- As we progress as a unitary board in our challenge , mutual respect and engagement , I feel that we need to re-establish /reconfirm the differences between operational , executive and accountability responsibilities that can become blurred as Committee Chairs develop deeper and closer engagement and understanding of all trust activity , relationships and responsibilities , often fed by walkrounds
- The Board has matured over the last 12 months and become more strategic in its outlook. There is a good level of debate and challenge. The Chairship of the Board is strong which means discussion are focussed and all Board members contribute.

Appendix 2 – Governors responses to the Board of Directors Effectiveness Survey

Statement No of responses received - **12**	**Strongly Agree**	**Agree**	**Slightly Agree**	**Slightly Disagree**	**Disagree**	**Strongly Disagree**	**Cannot Say**
The quality of patient care drives the work of the Board of Directors.	4	6	2				
The organisation's performance against key targets and key risks are reported to Governors on at least a quarterly basis.	4	8					
There is not a history of nasty surprises and only being told half the story by the Board of Directors – I am told the truth in a timely way.	3	6	2				1
What I'm told by Directors matches what I'm told by staff and patients.		4	2			1	5
If performance slips, I understand the reasons why it has slipped and the key actions that are being undertaken to rectify the situation.	3	6	1				2
The Board of Directors has a history of quickly getting performance back on track.	1	5				1	5
The Board of Directors take the Council seriously and treat Governors with respect – Directors genuinely listen to what we have to say and deliver on their promises.	3	4	4	1			
When the Board of Directors does not agree with the view of the Council, the reasons are effectively explained and communicated on a timely basis.	1	5	2			1	3
Issues I have raised with the Board of Directors have been dealt with promptly and to my satisfaction.	1	4	2				5
Governors and the wider membership have been able to shape the future direction of the organisation.		5	2			3	2
I am kept appropriately informed about progress towards delivering the organisational visions, Trust Strategy, and the strategic ambitions.	3	5	2		1	1	

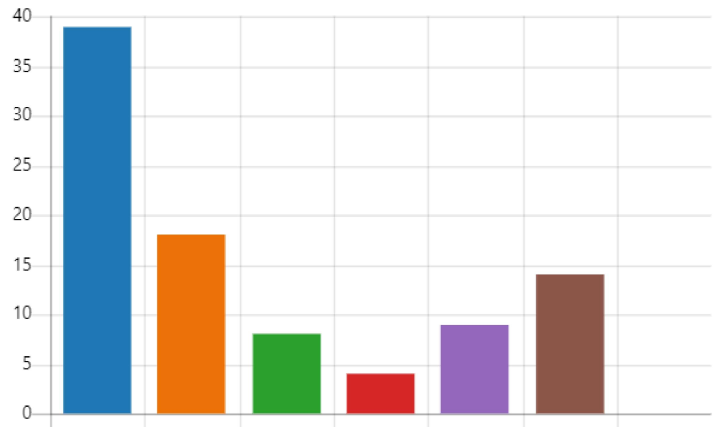
The Board of Directors has an appraisal process in place for its members that is consistent with best practice, is undertaken on at least an annual basis and reported to Governors.	2	5				1	4
From what I observe, Directors seem to work well together.	5	6					1
Individual Executive and Non-Executive Directors on the Board of Directors appear to be highly capable.	4	6	1			1	
As Governors, we are regularly briefed on major service developments and issues impacting on the FT.	1	7	2			1	1

Board Effectiveness Staff Survey

92	13:45	Active
Responses	Average time to complete	Status

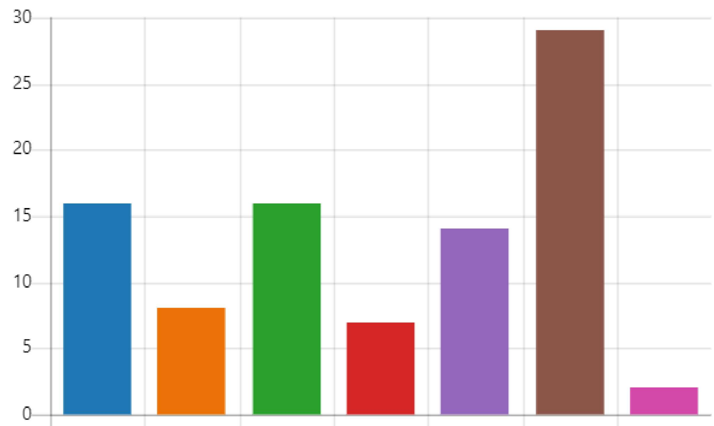
1. I would recognise a member of the Trust Executive if they visited my work environment.

Strongly Agree	39
Agree	18
Slightly Agree	8
Slightly Disagree	4
Disagree	9
Strongly Disagree	14
Cannot Say	0

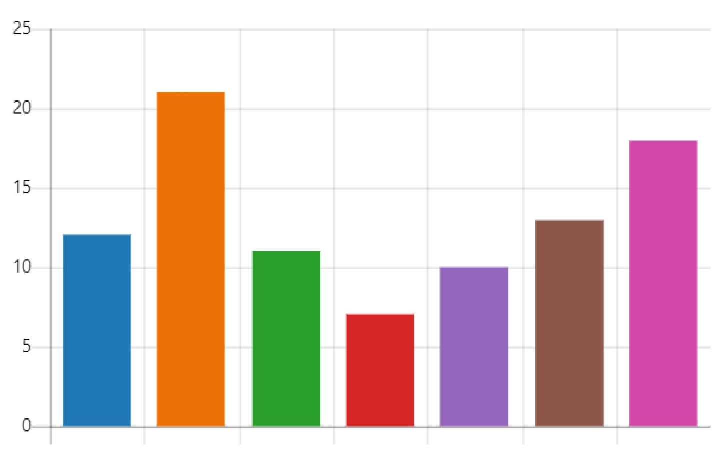


2. I would recognise a Non-executive Director if they visited my work environment.

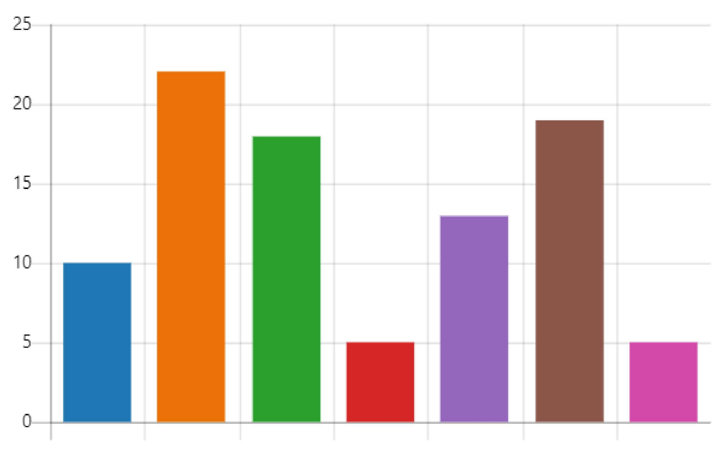
Strongly Agree	16
Agree	8
Slightly Agree	16
Slightly Disagree	7
Disagree	14
Strongly Disagree	29
Cannot say	2



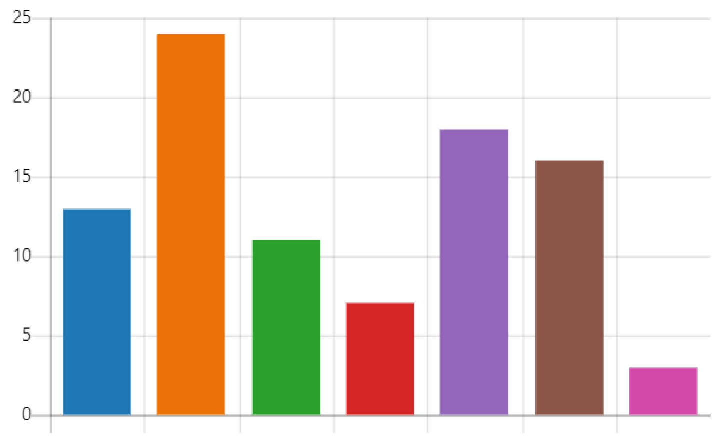
3. The Board of Directors has actively engaged staff in the development of the Trust Strategy and strategic ambitions.



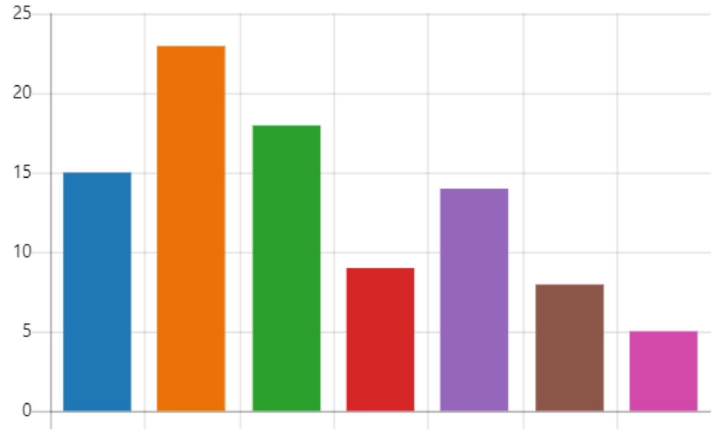
4. I understand the future direction of this organisation and my role in helping to deliver the Trust Strategy



5. I am aware of the key risks faced by this organisation and my responsibilities in minimising these risks.

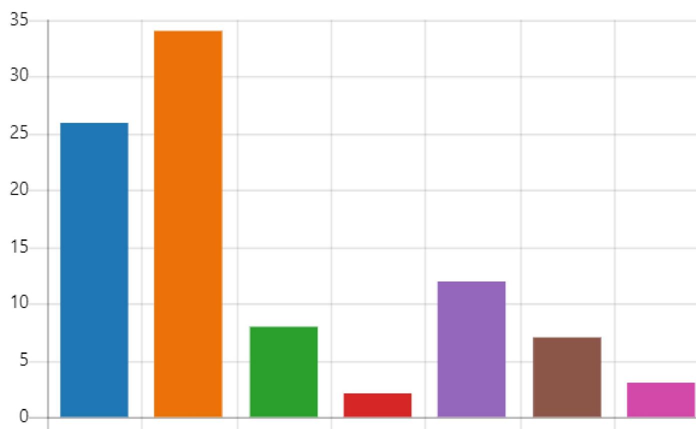


6. There is a safe and supportive work environment at work which reflects the values and behaviours described in the Walton Way.



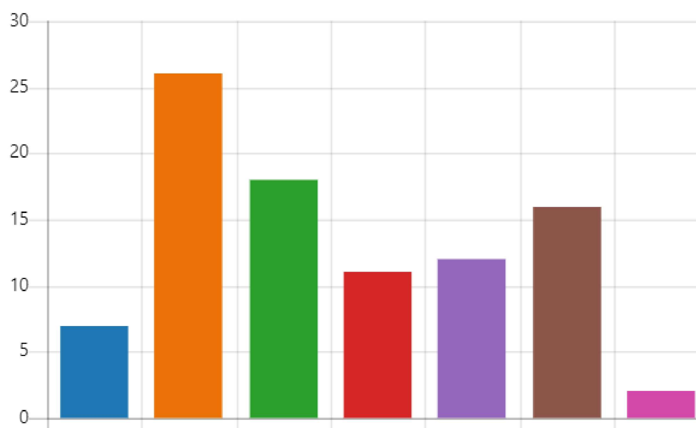
7. My line manager behaves in a way that gets the best out of me.

Strongly Agree	26
Agree	34
Slightly Agree	8
Slightly Disagree	2
Disagree	12
Strongly Disagree	7
Cannot Say	3



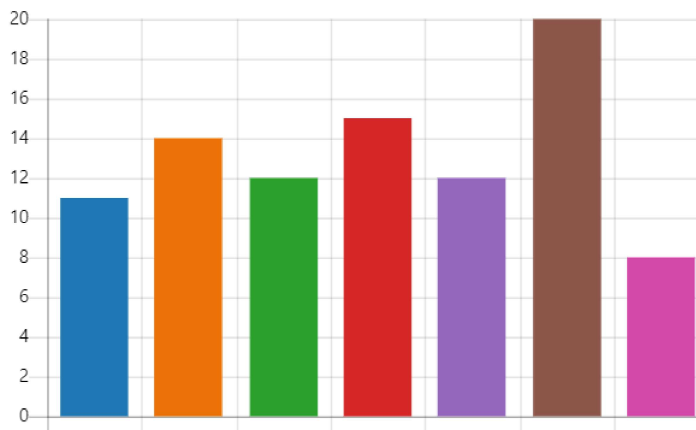
8. Staff are encouraged to find and adopt new ways of doing things.

Strongly Agree	7
Agree	26
Slightly Agree	18
Slightly Disagree	11
Disagree	12
Strongly Disagree	16
Cannot Say	2



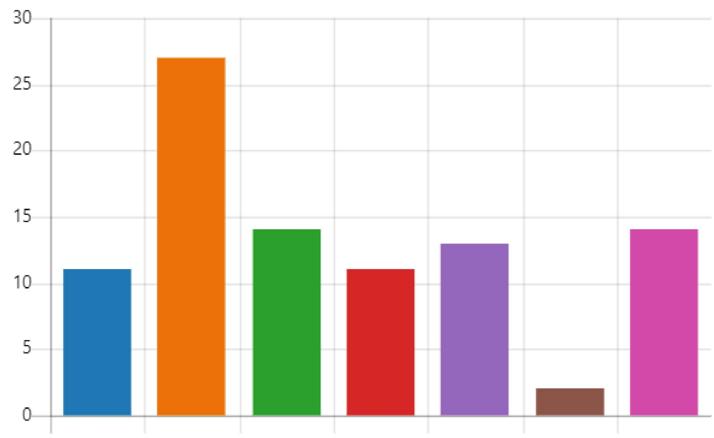
9. The Trust does not tolerate bad behaviour by staff.

Strongly Agree	11
Agree	14
Slightly Agree	12
Slightly Disagree	15
Disagree	12
Strongly Disagree	20
Cannot Say	8



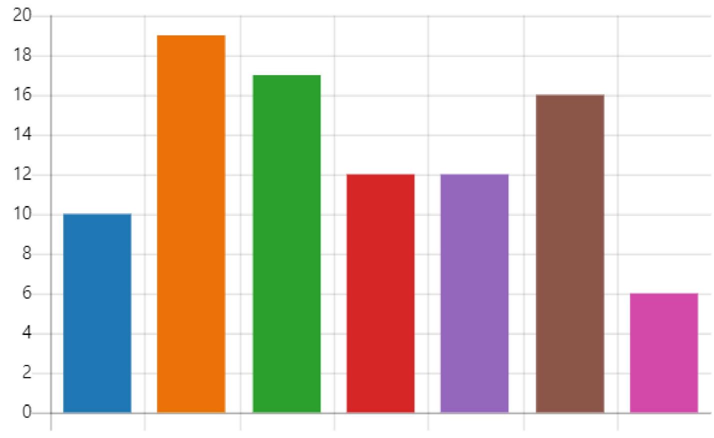
10. The Trust does not tolerate bad behaviour by patients and visitors.

Strongly Agree	11
Agree	27
Slightly Agree	14
Slightly Disagree	11
Disagree	13
Strongly Disagree	2
Cannot Say	14



11. The Trust routinely seeks the views of staff and communicates what actions have been taken as a result of this feedback.

Strongly Agree	10
Agree	19
Slightly Agree	17
Slightly Disagree	12
Disagree	12
Strongly Disagree	16
Cannot Say	6



12. Any general comments:

20

Responses

Latest Responses

10 respondents (**50**%) answered **staff** for this question.

The Walton Centre NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Revised Board and Committee Schedule
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- A new schedule for Board and Committee Meetings is proposed to reduce the frequency of meetings, this would be effective from September 2023
- Cycle of Business of Board and monthly Board Committees has been revised to reflect this; with a move away from quarterly reporting
- Board Development Days would slot into the vacated Board dates
- Hospital Management Group to be moved to bi-monthly as well

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

- Board Committees to update their Cycle of Business
- All contributors to be advised of changed dates and confirm new reporting schedules

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Revised Board and Committee Schedule

Case for Change

1. The Board is reviewing the structure and frequency of Board and subcommittee meetings for the following reasons:
   - The Trust has historically invested a large proportion of time on Board and subcommittee meetings/structure and has not reviewed the frequency for many years
   - The nature of the Trusts' portfolio means that performance, finance, quality and workforce metrics are relatively static, predictable and do not oscillate much on a monthly basis. Particularly for Board Committees there is monthly repetition of items with little change in between due to the nature of the metrics being considered.
   - Any time spent in Board and Committee meetings is both costly in terms of attendees and those that support the production of papers and reports. The demand for Non-Executive Director (NED) time for system and Liverpool Place meetings is increasing and the Trust needs to consider the best use of this time which should only be up to four days per month (two days per week for the Chair).
   - The Board has expressed its wish to review the frequency through discussions at Board and through the annual effectiveness review of Board to allow more time to focus on strategic and challenging issues in detail outside of Board meetings.

Requirement for NHS Public Board Meetings

2. There is no set number of meetings that must take place in statute or guidance, but the following principles apply:
   - Frequency of meetings must support the decision-making processes and submission deadlines of the Trust so that business is not delayed because there is no Board meeting
   - There must be sufficient opportunity for debate and discussion in public Board to provide assurance to stakeholders including Governors that the Board is discharging its duties effectively
   - The level of information provided to Board members in order for them to fulfil their duties should not reduce.

3. Many Trusts have already taken the decision to move to less frequent public meetings for the reasons outlined in paragraph 1, with some even moving to quarterly Board Committees.

Proposal for Change

4. It is proposed that the number of public meetings should be reduced from 10 per year to six, each to be followed by a closed meeting to discuss business that cannot be discussed in public. A cycle showing the revised schedule of Board meetings, Board Committee and key internal and external meetings is on the following page.

Revised Meeting Schedule

	Apr				May				Jun				Jul				Aug				Sep				Oct				Nov				Dec				Jan				Feb				Mar			
Week	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Meeting																																																
Board Meetings																																																
Board of Directors	Th								Th			Ex					Th								Th								Th								Th							
Board Development Day					Th								Th								Th								Th																Th			
Board Committees																																																
Audit			Tu				Tu					Ex		Tu													Tu																Tu					
Business Performance								Tu								Tu								Tu								Tu								Tu								Tu
Health Inequalities											Mo												Mo											Mo													Mo	
Quality							Th								Th								Th							Th									Th								Th	
Research, Innovation and Med Ed										Tu												Tu												Tu												Tu		
Walton Centre Charity			Fr												Fr												Fr												Fr									
Remuneration (as required)																																																
Other Meetings (no change)																																																
Hospital Management Group							Mo								Mo								Mo								Mo								Mo								Mo	
Other Meetings (no change)																																																
Council of Governors																																																
Annual Members Meeting																																																
Aintree Site Joint Sub-Committee												We							We								We								We								We					
Organ Donation Committee								Th												Th											Th												Th					
Neurosciences Programme Board						Th								Th								Th								Th								Th								Th		

When a five week month falls these will be dealt with on a case by case basis with Quality and Business Performance Committee potentially moved a week later.

5. A revised Cycle of Business for the Board is attached at Appendix 1 and the following considerations have been made in creating this:
   - There were a number of quarterly reports coming to Board and these have been amended to come three times per year
   - Any submission dates for NHS England and other bodies have been taken into account
   - Alignment with Board Committee reporting and frequency of meetings

6. The vacated Board dates would be replaced with Board Strategy Days (with the exception of January) which would incorporate Board development and which could also incorporate a formal private Board meeting if required to approve any urgent business.

7. There are two Board Committees that currently meet monthly, Business Performance Committee (BPC) and Quality Committee. It is proposed to also reduce the number of meetings of these two Board Committees to six per year as, meeting 2-3 weeks before the Board to review delegated responsibilities such as the Integrated Performance Report.

8. New cycles of business for the Quality and Board Performance Committees (currently monthly) have been modelled and will be shared with those committees at their June meetings.

9. There would be no impact on the timings or cycle of business for Board Committee's that currently meet less than once a month i.e. Audit, Health Inequalities and Business Performance Committee.

10. Hospital Management Group (HMG) currently also meets monthly and has the same issues with duplication of review of the IPR and it is proposed to move this six times a year meeting from the current ten meetings. The vacated meetings would be replaced with development sessions for the current attendees for 2023-24. The meeting would still be scheduled to take place the Monday before the Quality Committee meetings.

Engagement Between Meetings

11. There are already established informal communications between Board members which would continue. Each NED has an assigned Executive Director that they can meet with as required.

12. The Board Strategy Days would ensure that there was a monthly meeting between Board members (with the exception of January).

13. If required, the NED meeting which currently takes place before the public board meeting could also take place before Board Strategy Days.

Conclusion

14. It is recommended that the cycle of business and frequency of meetings is reduced to reduce the time burden on Board members and reduce the regularity of reporting required from senior managers.

Recommendation

To approve.

Author: K Dowson, Corporate Secretary
Date: May 2023

Appendix 1 – Board Cycle of Business

	Purpose	Lead	Assurance Committee	External deadline	April	June	June (Extra Ordinary)	August	October	December	February
Standing Items											
Welcome and apologies	Note	Chair			✓	✓		✓	✓	✓	✓
Minutes of previous meeting	Approve	Chair			✓	✓		✓	✓	✓	✓
Matters Arising Action Log	Decision	Chair		N/A	✓	✓		✓	✓	✓	✓
Chair and CEO Report	Note	Chair/CEO			✓	✓		✓	✓	✓	✓
Patient Story	Note	CN			✓	✓		✓	✓	✓	✓
Strategy (Updates provided by bi-annual review and relevant annual reports)											
Trust Strategy Update	Note	MD			✓				✓		
Charity Substrategy	Approve	CFO	Charity		✓				✓		
Digital Substrategy	Approve	CPO	BPC			✓				✓	
Estates, Facilities and Sustainability Substrategy	Approve	COO	BPC					✓			✓
Finance and Commercial Development Substrategy	Approve	CFO	BPC		✓				✓		
Marketing and Communications Substrategy	Approve	CEO						✓			✓
People Substrategy	Approve	CPO	BPC		✓				✓		
Quality Substrategy	Approve	CN	Quality					✓			✓
Strategic Risk											
Board Assurance Framework	Approve	CEO	All		✓			✓		✓	
Principal Risks	Approve	CEO			✓						
Risk Appetite Statement	Approve	CEO			✓						
Performance											
Integrated Performance Report	Note	CEO	BPC/QC		✓	✓		✓	✓	✓	✓
EPRR Core Assurance Self-Assessment	Approve	COO	BPC	31-Oct					✓		
Major Incident Plan	Approve	COO	BPC					✓			
ERIC Return	Note	COO	BPC						✓		

Quality & Safety											
Quality Account Priorities	Approve	CN	Quality								✓
Quality Account	Approve	CN	Quality			✓	✓				
Mortality and Morbidity Report	Note	MD	Quality		✓			✓		✓	
Nurse Staffing - Bi-Annual Acuity Review	Note	CN	Quality			✓				✓	
Safeguarding Annual Report	Note	CN	Quality			✓					
Infection Prevention & Control Annual Report	Note	MD	Quality			✓					
Complaints and Patient Experience Annual Report	Note	CN	Quality			✓					
Medicines Management (including AO for Controlled Drugs) Annual Report	Note	MD	Quality					✓			
Nursing Revalidation Report (Annual)	Approve	CN				✓					
Medical Revalidation Report (Annual)	Approve	MD				✓					
Freedom to Speak Up Guardian Report	Note	CN	Quality		✓				✓		✓
Freedom to Speak Up Guardian Annual Report	Note	CN	QC/ Audit			✓					
Mixed Sex Accommodation: Annual Statement of Compliance	Approve	CN	Quality		✓						
Workforce											
Staff Survey Results	Note	CPO	BPC		✓						
Equality Diversity & Inclusion Annual Report	Note	CPO	HIC				✓				
Gender Pay Gap Annual Report	Approve	CPO	HIC								✓
Workforce Race Equality Standard	Approve	CPO	HIC						✓		
Workforce Disability Equality Standard	Approve	CPO	HIC						✓		
Medical Education Annual Report	Note	MD	RIME			✓					
Violence and Aggression Strategy Update	Note	CN	Quality		✓				✓		
Guardian of Safe Working Report	Note	MD			✓			✓		✓	
Guardian of Safe Working Annual Report	Note	MD							✓		
Modern Slavery Act Statement	Approve	CN	N/A						✓		
Finance and Governance											
Annual Plan	Approve	COO	BPC	NHSE	✓						
Annual Audit Letter	Approve	CFO	Audt	30-Jun			✓				

Annual Report and Accounts inc. Annual Governance Statement	Approve	CFO	Audit	30-Jun			✓				
Provider Licence Self Certification (G6, FT4,)	Approve	CEO	Audit			✓					
Use of the Trust Seal	Approve	CEO			✓						
Board Effectiveness Review	Note	CEO				✓					
Research & Innovation											
Research & Development Annual Report	Note	CPO	RIME					✓			
Innovation Annual Report	Note	CPO	RIME					✓			
Corporate Trustees											
Charitable Funds Annual Report & Accounts	Approve	CFO	Charity						✓		
Ad-hoc Items in Year											

The Walton Centre NHS Foundation Trust

Report to Board of Directors
1 June 2023

Report Title	Update to the Trust Constitution		
Executive Lead	Jan Ross, Chief Executive		
Author (s)	Katharine Dowson, Corporate Secretary		
Action Required	To approve		
Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*			
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls	

Key Messages

- A full review, with legal advice, of the Constitution has taken place with three key areas of change:
  - Updates following Health and Care Act
  - Changes to the Standing Orders of Council of Governors
  - Changes proposed to the composition of the Council of Governors

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

- To be further approved by Council of Governors
- Agreed changes to be ratified at the Annual Members Meeting in September

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

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
CoG Advisory Committee	9 May 2023	K Dowson, Corporate Secretary	Broad agreement to proposals. Minor changes to be made to tidy up document

Update to the Trust Constitution

Executive Summary

1. Following the new Health and Social Care Act the Company Secretaries in Cheshire and Merseyside, acting through Cheshire and Merseyside Acute and Specialist Trusts (CMAST), asked Hill Dickinson to conduct a review of the model Constitution and bring it up to date and in line with statutory requirements. In particular this updated terminology, for example replacing Monitor with NHS England and making explicit the new powers to collaborate and form statutory bodies with other organisations.

2. At the same time an internal review of the Constitution has been conducted to ensure it is in line with current practice and remains fit for purpose. There is some duplication that has been removed and there are some elements proposed for removal to streamline processes or remove detail of operational processes.

3. It is proposed that the composition of the Council of Governors is reviewed to improve its effectiveness as it is currently comparatively large (33 posts) and many of these posts are not filled.

4. Changes proposed to the text of the Constitution are summarised in Appendix 1 and Appendix 2 includes the full revised text.

Changes to Standing Orders of the Council of Governors

5. There was one proposed change to the standing orders of the Council of Governors that was taken to the Advisory Group in May now that the quorum has been reduced. This relates to the number of Governors who may call a meeting. The proposal is to change this to one third of current Governors as per the quorum rather than eleven Governors

6. A new change has since been proposed regarding changing the Standing Orders in paragraph 4.14. The current process is that any motion to amend the Standing Orders must be signed by seven Governors and submitted at least 21 days before the meeting is proposed. It is proposed to add ‘or gain approval from the Advisory Committee’. This will reduce the administrative burden but still ensure that Governors have early sight of any proposed changes.

Composition of the Council of Governors

7. The composition of the Council of Governors was established when the Trust became a Foundation Trust is 2009. The structure reflected the wide reach of the Trust and the number of key stakeholders in the Liverpool and wider areas.

8. The statutory requirements are as follows:

   The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

   1.1 *the interests of the community to whom the Foundation Trust provides services are appropriately represented;*

1.2 *the level of representation of the Public Constituency, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs;*

and to this end, the Council of Governors:

1.3 *shall from time to time and not less than every two years review the policy for the composition of the Council of Governors, and when appropriate shall propose amendments to this Constitution*

9. To meet the requirements of the 2006 Act the following conditions must be met:
    a. More than half of the members of the Council of Governors are to be elected by members of the trust other than those who come within the Staff Constituency. Therefore, there must be a majority of public governors.
    b. At least three members of the Council of Governors are to be elected by the Staff Constituency
    c. The 2012 Act abolishes the requirement for a primary care trust (PCT) governor. There is no requirement for a commissioner governor to be appointed in place of former PCT governor/s though Trusts may wish to nominate a commissioner/s as an organisation specified for the purposes of appointing a governor.
    d. At least one member of the Council of Governors is to be appointed by one or more qualifying local authorities. A qualifying local authority is a local authority for an area which includes the whole or part of an area specified in the constitution as a public constituency
    e. If any of the trust's hospitals includes a medical or dental school provided by a university, at least one member of the Council of governors is to be appointed by that university

10. It is proposed to cut the number of governors posts from 33 to 24 or 25 as per Table 1.

Type of Governor	Current	Proposed	Number currently filled
Appointed	12	8	5
Public	**17**	**13**	**10**
Merseyside	8	5	4
Cheshire	4	3	3
North Wales	3	3	2
Rest of England	2	2	1
Staff	4	4	3
Total	**33**	**25**	**18**

11. This would have no impact on any Governors currently in post as the seats removed are currently empty or at the end of term. There would remain 13 public governors and 11 (12) staff/appointed governors.

12. The impact on elections for 2023, taking into account the end of term for some Governors, would be:
    - Merseyside – going out for two Governors rather than five
    - Cheshire – not going to election this time
    - North Wales – no change, would still need to recruit to one vacant post
    - Rest of England – no change, would still need to recruit to one vacant post
    - Staff – no change, would still need to recruit to one vacant post

13. This would also result in some saving of costs as the trust would not need to hold an election from the Cheshire constituency.

14. The greatest change would be to appointed Governors, there are currently only five posts filled out of twelve and this has been the position for some time. It is proposed to drop the following posts:

    - Healthwatch – no nominations have been provided. There is a potential conflict of interest as Healthwatch is an organisation which advocates on behalf of patients and is an independent voice which may be difficult to balance with being part of the Trust structures. Healthwatch remain actively involved with officers of the Trust and on the Patient Experience Group.
    - Isle of Man Society for MS – this is a very small organisation with limited resource who have not been able to provide a nomination. They are part of the wider Neurological Alliance and it is proposed that their views would be covered this way (see note below)
    - North Wales Neurological Conditions Partnership – no longer in place, this is now the Wales Neurological Alliance which is closely aligned to the Neurological Alliance (see paragraph 17)
    - North Wales Community Health Council – has previously provided a Governor but has now ceased to operate. It has now been replaced with LLAIS which is a Citizens Voice body along similar lines to Healthwatch and therefore the same concerns would exist.
    - Clinical Commissioning Groups (See note 7c above) – no longer in place, replaced with Integrated Care Board). There is no appetite from the ICS to nominate to every Council of Governors in Cheshire & Merseyside and many Trusts dropped the requirement for a Commissioner Governor when the PCT requirement was removed.

15. The Trust must have a Governor from a local authority and further endeavours will be made to secure a nomination from both Liverpool and Sefton Councils.

16. The Trust has two incumbent University governors and with the Trust securing University Hospitals status this link remains important and therefore no change is proposed. It is also not proposed to change the post for the North West Coast Clinical Network.

17. Links to third sector groups remain very important as these provide feedback directly from patients. The Neurological Alliance is an umbrella organisation representing many smaller charities and patient groups. Currently there is a Cheshire and Merseyside representative, and it is proposed to widen this post to the Neurological Alliance and not limit it to Cheshire and Merseyside in the future if the post became vacant.

18. The Brain Charity is a local organisation which provides ongoing support to many of the Trusts patients. The Group are asked to consider whether a governor for the Neurotherapy Centre based in Chester should also be explored as this centre provides similar services in Cheshire and North Wales. There has been an expression of interest from the CEO of the Neurotherapy Centre who is also a representative on Neurological Alliance Wales.

19. The proposal is that there should be 8 appointed Governors in the future a set out in Annex 3 of the Constitution:

    - Liverpool City Council

- Sefton Metropolitan Borough Council
- Edge Hill University
- University of Liverpool
- Cheshire and Merseyside Clinical Network
- Neurological Alliance
- Neurotherapy Centre, Chester
- The Brain Charity

Conclusion

20. The Constitution has not been fully reviewed since 2018 and the changes in legislation have provided an opportunity to review the whole document and whether it still meets the needs of the Trust.

21. The composition of the Council of Governors has not been amended since it was established. Changes proposed would refresh the Council and enable it to become fully established without multiple vacancies. This would include reducing the number of appointed governors to 8 from the current 12.

Recommendation

- To review the changes proposed ahead of consideration at the Council of Governors
- To consider the proposal to review the composition of the Council of Governors.

Author: Katharine Dowson
Date: 2 May 2023

Appendix 1 – Summary of Changes to Constitution
Appendix 2 – Full Text of Constitution

Appendix 1 – Summary of Changes (also marked as tracked changes in the full text at Appendix 2)

Page No.	Reference	Summary of Changes
1	Cover	Reference to Health and Care Act 2022 (HCA 2022) added and new revision date
2	Interpretation	Additional Paragraph Added in
2	Contents	Updated to reflect changes in document
4	Interpretation and Definitions	Reference to HCA 2022 added Definitions added in
5-6	4. Powers	Items 4.3 to 4.12 added as defined in the HCA 2022
10	14.1 Council of Governors Tenure	Removal of reference to term commencing immediately after the Annual Members Meeting as it limiting and approval of Governors appointment at AMM is not required.
9	14.4 Council of Governors Tenure	Max term of office remains at nine years, but language simplified in line with model constitution
10	14.5 Council of Governors Tenure	'Terminates the appointment' replaced with 'withdraws its sponsorship' in line with model constitution

10	14.7 Council of Governors Tenure	Removal of clarification clause about terms of office being linked to AMM.
10-11	15.4 Council of Governors – disqualification and removal	Addition of 15.1 and 15.4 regarding disqualification and removal of Governors. Previously absent from Constitution but is required
13	19 Council of Governors – referral to the panel	The NHSE panel does not formally exist as there were no referrals made, however this would be convened if required. Additional clause at 19.3 added in which requires the trust to provide advice and guidance to enable Governors to fulfil their duties as per legal advice.
14	26. Appointment/ Removal of Chair and NEDs	26.3 removed as refers to initial appointments paragraph and had previously been removeas no longer relevant.
15	27 Appointment of Deputy Chair	The current clause and process is additional to the model Constitution. It is proposed to remove the process and replace with clause 29 which requires ratification of the appointment by the Council of Governors rather than a mandated process. Wording of aligned to clause 27 re appointment of Senior Independent Director. Reference to appointment also removed from paragraph 3.2 of Annex 6.
16	30. Board of Directors – disqualification	Additional clauses added at 30.2 as per legal advice
19	32. Board of Directors – Conflicts of Interest	32.10 Addition of provisions to agree when a conflict of interest would be deemed as authorised as per legal advice. Previously not included in trust's constitution.
21	39.2 Auditor	Addition of clause 39.2, as set out in the new Code of Governance (D2.3), that external auditors must be retendered at least every ten years and changed at least every twenty years.
21	41. Accounts	Note - There are a number of requirements in the NHS Act 2006 Schedule 7 as to annual reports prior to the 2022 Act which are not set out within the Model Core. Therefore, the new changes to these annual reporting requirements (such as the extent to which the Trust has exercised its functions in accordance with the joint forward plans and joint capital resource plans published for the ICB and its partners) are not included in the Model Core either.
42	Annual report, forward plans	Removal of clause 42.1 with requirements of annual report as the detail of what must be in the annual report is in the NHS Annual Reporting Manual which is published each year and it is a statutory obligation to comply with this. Current clause is not comprehensive and not required. (see note in row above).
Annexes to the Constitution		
25	Annex 1 – The Public Constituencies	Change to the minimum number of members in any public constituency to three to reflect number in North Wales constituency.
27	Annex 2 – Composition of Council of Governors	3.1 To reflect changes proposed in Appendix 2 of this paper to numbers of governors in public constituencies. 3.2 Removal of information duplicated in Annex 2. 3.3 To reflect changes proposed in Appendix 2 of this paper to appointed governors.

78	Annex 5 3. Lead Governor	Remove reference to the Lead Governor as also being Vice Chair of the Council of Governors as this is not in line with the Lead Governor Role specification most recently agreed by the Council which states that the Lead Governor will only "Undertake the role of Deputy Chairman of the Council of Governors in exceptional circumstances when it is not appropriate for the Chairman or another Non-Executive Director to do so". The Deputy Chair would normally deputise for the Chair
80	Annex 5 4. Further provisions as to eligibility to be a Governor	4.10 to 4.14 removed as duplicate provisions already exist in 15.4 and there was some discrepancy between the two ie number of consecutive meetings missed by Governors before ceasing to hold office was two in 15.4 and three in Annex 5. 4.11 Paragraph 5.5 of Annex 5 To be removed as duplicates clause 15.4.8 in the Constitution and states a different majority required to remove a governor, here three-quarters rather than the majority stated in 15.4.8
82	Annex 5 5.1 Vacancies	Title changes to Mid Term Vacancies among Governors. New wording added at paragraph 5.1 which enables the Trust to only hold elections once a year even if there is a vacancy, this reflects current practice 5.2 Rewording of previous paragraph 5.1 to simplify process
82	Annex 5 6. Expenses	Removal of clause with requirements of annual report as the detail of what must be in the annual report is in the NHS Annual Reporting Manual which is published each year and it is a statutory obligation to comply with this, current clause is not comprehensive as there are a number of requirements regarding Governors that need to be included in the annual report.
93	Annex 6 Standing Orders Council of Governors 4.14 Changes to Standing Orders	Additional sub section added which allows changes to the Standing Orders to be approved at the Advisory Group as an alternative to the process outlined in 4.14.2 *Change to Standing Order therefore requires three-quarters of Governors in attendance to agree and must be signed by 7 governors at least 21 days before the meeting.*
85	Annex 6 Standing Orders Council of Governors 4.2 Calling Meetings	Requirement for there to be 11 Governors to call a meeting changed to one-third of current Governors to duplicate the quorum requirement.
122	Annex 8 – Further Provisions – Members 4.1.2	4.1.2 removed text as duplicates 3.6.2.1-3 of Annex 8

Appendix 2

Constitution of
The Walton Centre NHS Foundation Trust

(A Public Benefit Corporation)

(updated as per the Health and Social Care Act 2012 and the Health and Care Act 2022)

Revised June 2023

Interpretation

Unless otherwise stated, all references are to paragraph numbers in Schedule 7 of the 2006 Act as amended by the 2012 Act and 2022 Act.

Unless otherwise stated, the Model Core Constitution reflects the relevant provisions of the 2006 Act as amended by the 2012 Act and 2022 Act.

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1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and Health and Care Act 2022.

A reference to legislation or to a legislative provision shall be to that legislation or legislative provision as it is in force, amended or re-enacted from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

the 2022 Act is the Health and Care Act 2022.

Annual Members Meeting is defined in paragraph 13 of the constitution

constitution means this constitution and all annexes to it.

NHSE is the body corporate known as NHS England, as provided by Section 1H of the 2006 Act.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. Name

2.1 The name of the trust is The Walton Centre NHS Foundation Trust (the trust).

2.2 The trust's head office is at Lower Lane, Fazakerley, Liverpool.

3. Principal purpose

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other

purposes.

3.3 The trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4.4 The trust may enter into arrangements for the carrying out, on such terms as the trust considers appropriate, of any of its functions jointly with any other person.

4.5 The trust may arrange for any of the functions exercisable by the trust to be exercised by or jointly with any one or more of the following:

4.5.1 A relevant body;

4.5.2 A local authority within the meaning of section 2B of the 2006 Act;

4.5.3 A combined authority.

4.6 The trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

4.7 Where a function is exercisable by the trust jointly with one or more of the other organisations mentioned at paragraph 4.5, those organisations and the trust may:

4.7.1 Arrange for the function to be exercised by a joint committee

of theirs;

4.7.2 Arrange for the trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund in accordance with section 65Z6 of the 2006 Act.

4.8 The trust must exercise its functions effectively, efficiency and economically.

4.9 In making a decision about the exercise of its functions, the trust must have regard to all likely effects of the decision in relation to:

4.9.1 The health and well-being of (including inequalities between) the people of England

4.9.2 The quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England

4.9.3 Efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

4.10 In the exercise of its functions, the trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate change in the most recent report under section 56 of the Climate Change Act 2008).

4.11 For the purposes of this section, “relevant body” means NHSE, an integrated care board, an NHS trust, a NHS foundation trust (including the trust) or such other body as may be prescribed under section 65Z5(2). “Relevant bodies” means two or more of these organisations as the context requires.

4.12 The arrangements under this paragraph 4 shall be in accordance with:

4.12.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act

4.12.2 any applicable statutory guidance that has been issued and

4.12.3 otherwise on such terms as the trust sees fit.

5. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 a staff constituency

6. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified as a public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.3 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within

Annex 2 and being referred to as a class within the Staff Constituency.

8.4 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.5 The Secretary shall make the final decision about the class of which an individual is eligible to be a member.

9. Automatic membership by default - staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency] without an application being made, unless he informs the trust that he does not wish to do so.

10. Restriction on membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 16 years old to become a member of the trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 8 – Further Provisions - Members.

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual

Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 8 – Further Provisions – Members.

12. Council of Governors – composition

12.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 3.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

13. Council of Governors – election of governors

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by NHS Providers form part of this constitution. The Model Election Rules current are attached at Annex 4.

13.3 A subsequent variation of the Model Election Rules by NHS Providers shall not constitute a variation of the terms of this constitution for the purposes of paragraph 44 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors - tenure

14.1 An elected governor may hold office for a period of up to three years. ~~commencing immediately after the Annual Members' Meeting at which his/her election or appointment, whichever the case may be, is announced.~~

14.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

14.3 An elected governor shall be eligible for re-election at the end of his term.

14.4 An appointed governor may hold office for a period of up to nine consecutive years. ~~A Governor (whether elected or appointed) may not hold office for more than nine consecutive years, and shall not be eligible for re-election or appointment, whichever the case may be, if he has already held office for more than six consecutive years.~~

14.5 An appointed governor shall cease to hold office if the appointing organisation ~~terminates the appointment.~~ withdraws its sponsorship of him.

14.6 An appointed governor shall be eligible for re-appointment at the end of his term.

14.7 ~~For the purposes of the provisions concerning terms of office for Governors, 'year' means a period commencing immediately after the conclusion of one Annual Members' Meeting, and ending at the conclusion of the next Annual Members' Meeting, save that a Governor may not hold a term of office for more than three calendar years.~~

15. Council of Governors – disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

- **15.1.1** a person who has been bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
- **15.1.2** a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
- **15.1.3** a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;
- **15.1.4** a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Board of Governors are set out in Annex 5.

15.4 A person holding office as a governor shall immediately cease to do so if:

15.4.1 he resigns by notice in writing to the Secretary;

15.4.2 it otherwise comes to the notice of the Secretary at the time that the governor takes office or later that the governor is disqualified,

15.4.3 he fails to attend two Council of Governor meetings in any financial year, unless the other governors are satisfied that the absences were due to reasonable causes and he will be able to start attending meetings of the Trust again within such a period as they consider reasonable;

15.4.4 in the case of an elected governor, he ceases to be a member of the Trust;

15.4.5 in the case of an appointed governor, the appointing organisation withdraws it sponsorship;

15.4.6 he has failed to undertake any induction/ training which the Council of Governors requires all governors to undertake

15.4.7 he has failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct for Governors;

15.4.8 he is removed from the Council of Governors by a resolution approved by a majority of the remaining governors present and voting at a General Meeting on the grounds that:

15.4.8.1 he has committed a serious breach of the Trust's Code of Conduct, or

15.4.8.2 he has acted in a manner detrimental to the interests of the Trust, or

15.4.8.3 he has failed to discharge his responsibilities as a governor.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chair of the trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 23.2 and 26) or, in his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 28 below), shall preside at meetings of the Council of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for reasons of commercial confidentiality or special reasons.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by NHSE to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

19.3 Without prejudice to the ability of a governor to make a referral to the Panel, the trust must take steps to secure that governors are able to access support and / or advice, as and where necessary, to enable them to fulfil their duties.

20. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors (Annex 6) shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust in accordance with the Trust's Expenses Policy for Governors.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

- **23.2.1** a non-executive Chair
- **23.2.2** not less than four but not more than seven other non-executive directors; and
- **23.2.3** not less than four but not more than seven executive directors.

provided that at least half of the Board of Directors, excluding the Chair, shall at all times compromise non-executive directors

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer

23.5 One of the executive directors shall be the finance director

23.6 One of the executive directors is to be a registered medical practitioner.

23.7 One of the executive directors is to be a registered nurse.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if:

25.1 he is a member of a Public Constituency, or

25.2 he is not disqualified by virtue of paragraph 30 below.

26. Board of Directors – appointment and removal of chair and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chair of the trust and the other non-executive directors.

26.2 Removal of the chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

27. Board of Directors – appointment of Senior Independent Director

27.1 The Board of Directors may appoint a non-executive director as a Senior Independent Director.

27.2 Any appointment of a Senior Independent Director shall require the approval of the Council of Governors.

28. Board of Directors – appointment of Deputy Chair

28.1 The Board of Directors shall appoint a non-executive director as a Deputy Chair.

28.2 Any appointment of a Deputy Chair shall require the approval of the Council of Governors.

29. Board of Directors - appointment and removal of the Chief Executive and other executive directors

29.1 The non-executive directors shall appoint or remove the Chief Executive.

29.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

29.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

29.4 The Chief Executive may appoint one of the executive directors as Deputy Chief Executive.

30. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

30.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

30.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986).

30.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

30.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three

months (without the option of a fine) was imposed on him.

31. Board of Directors – meetings

31.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

31.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

32. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

33. Board of Directors - conflicts of interest of directors

33.1 The duties that a director of the trust has by virtue of being a director include in particular –

33.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.

33.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

33.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

33.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

33.2.2 The matter has been authorised in accordance with the constitution.

33.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

33.4 In sub-paragraph 32.1.2, “third party” means a person other than –

33.4.1 The trust, or

33.4.2 A person acting on its behalf.

33.5 If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.

33.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

33.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

33.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

33.9 A director need not declare an interest –

33.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

33.9.2 If, or to the extent that, the directors are already aware of it;

33.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

33.9.3.1 By a meeting of the Board of Directors, or

33.9.3.2 By a committee of the directors appointed for the purpose under the constitution.

33.10 A matter shall have been authorised for the purposes of paragraph 33.2.2 if:

33.10.1.1 It has been approved by the Board of Directors (excluding any director whose interest is the subject of authorisation) on the basis that to do so would be in the best interests of the trust.

33.10.1.2 The Board of Directors may grant any such authorisation in paragraph 32.2.2 subject to such terms and conditions as the Board of Directors thinks fit.

33.10.1.3 The Board of Directors may decide to revoke or vary any authorisation granted pursuant to paragraph 32.2.2 at any time, but such a decision will not affect anything done by the director(s) whose interest is the subject of authorisation prior to such revocation or variation

34. Board of Directors – remuneration and terms of office

34.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

34.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

35. Registers

The trust shall have:

35.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

35.2 a register of members of the Council of Governors;

35.3 a register of interests of governors;

35.4 a register of directors; and

35.5 a register of interests of the directors.

36. Admission to and removal from the registers

36.1 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this Constitution.

37. Registers – inspection and copies

37.1 The trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, if the member so requests.

37.3 So far as the registers are required to be made available:

37.3.1 they are to be available for inspection free of charge at all reasonable times; and
37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

38. Documents available for public inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current constitution,
38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and
38.1.3 a copy of the latest annual report.

38.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.
38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.
38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHSE's decision), 65KB (Secretary

of State's response to NHSE's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The trust shall have an auditor

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.The External Audit Service should be re-tendered at least every ten years and changed at least every twenty years.

40. Audit committee

The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the trust's auditor.

41.4 The trust shall prepare in respect of each financial year annual accounts in such form as NHSE may with the approval of the Secretary of State direct.

41.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The trust shall prepare an Annual Report and send it to NHSE.

42.2 The trust shall give information as to its forward planning in respect of each financial year to NHSE.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

42.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about –

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 41.7 the Council of Governors must –

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the directors of the trust of its determination.

42.7 If the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, the trust may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members

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

43.1.1 the annual accounts

43.1.2 any report of the auditor on them

43.1.3 the annual report.

43.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

44. Instruments

44.1 The trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the constitution

45.1 The trust may make amendments of its constitution only if:

45.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

45.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

45.2 Amendments made under paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

45.3.1 At least one member of the Council of Governors must

attend the next Annual Members' Meeting and present the amendment, and

45.3.2 The trust must give the members an opportunity to vote on whether they approve the amendment.

45.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

45.5 Amendments by the trust of its constitution are to be notified to NHSE. For the avoidance of doubt, NHSE's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the council of governors.

46.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

46.3 "Significant transaction" may be either an investment or divestment means

A "transaction".

44.2.2 A transaction is "significant" if its value equates to 25% of either the trust's:

44.2.2.1 gross assets;

44.2.2.2 income; or

44.2.2.3 gross capital (following completion of the transaction) calculated with reference to the trust's opening Balance Sheet for the Financial Year in which approval is being sought.

45.4 If more than half of the members of the Council of Governors voting decline to approve a significant transaction or any part of it, the

Council of Governors must approve a written Statement of Reasons for its rejection to be provided to the Board of Directors.

45.5 For the avoidance of doubt, paragraph 45 does not prevent the Board of Directors from appropriate engagement with the Council of Governors, as it sees fit, to provide information on any other transaction that the trust may enter, which does not constitute a significant transaction.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

The Public Constituencies are:

Merseyside	(Districts of Knowsley, Liverpool, Sefton, St Helens and Wirral, including all electoral wards in those Districts)
Cheshire	~~(Districts of Chester, Congleton, Crewe and Nantwich, Ellesmere Port and Neston, Macclesfield, Vale Royal, Warrington and Halton~~, (Unitary authorities of Cheshire East and Cheshire West including all electoral wards in those Districts)
North Wales	(Districts of Conwy, Denbighshire, Flintshire, Gwynedd, Isle of Anglesey and Wrexham, including all electoral wards in those Districts)
Rest of England	Those areas not included in the above.

The minimum number of members of each of the areas of the Public Constituency is to be three.

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

The classes within the Staff Constituency are:

1 Registered nurses and non-registered nurses (being health care assistants or their equivalent and student nurses)

2 Non-clinical staff

3 Clinical staff other than those in 1 and 2 above (allied healthcare professionals, technical and scientific staff)

4 Registered medical practitioners

The minimum number of members of each class of the Staff Constituency is to be four.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 12.1 to 12.3)

1 The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

2 The Council of Governors, subject to the 2006 Act, shall seek to ensure that through the composition of the Council of Governors:

2.1 the interests of the community to whom the trust provides services are appropriately represented;

2.2 the level of representation of the Public Constituency, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the trust's affairs.

2.3 The Council of Governors shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy; and

2.4 shall from time to time and not less than every two years review the policy for the composition of the Council of Governors, and

2.5 when appropriate shall propose amendments to this Constitution.

3 The Council of Governors of the trust is to comprise:

3.1 17 Public Governors from the following areas of the Public Constituency:

3.1.1 Merseyside: five Public Governors

3.1.2 Cheshire: three Public Governors

3.1.3 North Wales: three Public Governors

3.1.4 the Rest of England: two Public Governors

Four Staff Governors as described in Annex 2 3.

3.3 Eight Appointed Governors, one from each of the following organisations3.3.1

3.3.2 Liverpool City Council;

3.3.3 Sefton Metropolitan Borough Council;

3.3.4 University of Liverpool;

3.3.5 Neurological Alliance;

3.3.6

3.3.7

3.3.8

3.3.9 Edge Hill University;

3.3.10 The Brain Charity;

3.3.11 Cheshire and Merseyside Clinical Network;

3.3.12 Neurotherapy Centre, Chester

ANNEX 4 –THE MODEL ELECTION RULES

(Paragraph 15.2)

Model Election Rules 2014
For use in elections to FT councils of governors

The trust has adopted the Model Election Rules contained in this Annex. It will determine the result of the election using the Single Transferable Vote (STV) method.

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PART 1: INTERPRETATION

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1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution; "*council of governors*" means the council of governors of the corporation; "*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message; "*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be

by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section

61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b) "*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

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4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the corporation,
(d) the address and times at which nomination forms may be obtained;
(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and
(b) is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,
(b) contact address in full (which should be a postal address although an e- mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:
- (a) any financial interest that the candidate has in the corporation, and
- (b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:
- (a) that he is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
- (b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
- (a) they wish to stand as a candidate,
- (b) their declaration of interests as required under rule 11, is true and correct, and
- (c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
- (a) decides that the candidate is not eligible to stand,
- (b) decides that the nomination form is invalid,
- (c) receives satisfactory proof that the candidate has died, or
- (d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
(b) that the paper does not contain the candidate's particulars, as required by rule 10;
(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:
(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
(b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
  (i) configured in accordance with these rules; and
  (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e- voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,
(b) that he has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:
(a) a postal address; and,
(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:
(a) the name of the corporation,
(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
(g) the address for return of the ballot papers,
(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
(k) the date and time of the close of the poll,
(l) the address and final dates for applications for replacement voting information, and
(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:
(a) a ballot paper and ballot paper envelope,
(b) the ID declaration form (if required),
(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
(d) a covering envelope;

(“postal voting information”).

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e- voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),
(b) the voter's voter ID number,
(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:
(a) only be sent postal voting information; or
(b) only be sent e-voting information; or
(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make declarations of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;

(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to:
(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:
(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) instructions on how to vote and how to make a declaration of identity,
(v) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he is entitled to at the election;
(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:
  (i) provide his or her voter ID number; and
  (ii) where the election is for a public or patient constituency, make a declaration of identity;

  in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

  (i) the voter's voter ID number;
  (ii) the voter's declaration of identity (where required);
  (ii) the candidate or candidates for whom the voter has voted; and
  (iii) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he:

(a) is satisfied as to the voter's identity; and
(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it);
and
(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter; and
(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it); and
(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he:

(a) is satisfied as to the voter's identity,
(b) has no reason to doubt that the voter did not receive the original voting information,
(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter
(b) the details of the unique identifier of the replacement ballot paper, if applicable, and
(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the information unless, in addition to the requirements imposed by rule 29.3 or

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,
(b) the unique identifier of any replacement ballot paper issued under this rule;
(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:
- (a) a covering envelope, or
- (b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

- (a) the candidate for whom a voter has voted, or
- (b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he is to:

(a) put the ID declaration form if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he is to:

(a) mark the ballot paper “disqualified”,
(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and
(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",
(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
(d) place the document or documents in a separate packet; and
(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,
(b) the ID declaration forms, if required,
(c) the list of spoilt ballot papers and the list of spoilt text message votes, (d) the list of lost ballot documents,
(e) the list of eligible voters, and
(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates, "*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X", "*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred

votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,
"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and
"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted. STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which votes are given for more candidates than the voter is entitled to vote,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted. FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,
(b) otherwise than by means of a clear mark, (c) by more than one mark, is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,
(b) voting for more candidates than the voter is entitled to,
(c) writing or mark by which voter could be identified, and
(d) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,
(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the

candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and (c) unmarked or rejected because of uncertainty,
and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes

sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the

sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred, whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,
(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the

returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
(b) subject to rule STV50, one or more vacancies remain to be filled, the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and
(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate

excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

- (a) record:
  - (i) the total value of votes, or
  - (ii) the total transfer value of votes transferred to each candidate,
- (b) add that total to the previous total of votes recorded for each candidate and record the new total,
- (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
- (d) compare:
  - (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  - (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he has declared elected:
(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or
(ii) in any other case, to the chair of the corporation; and
(c) give public notice of the name of each candidate whom he or has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and
(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who he has declared elected –
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or
    (ii) in any other case, to the chair of the corporation, and
(c) give public notice of the name of each candidate who he has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule STV44.1,
(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he has declared elected to the chair of the corporation, and
(c) give public notice of the name of each candidate who he has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
(b) the ballot papers and text voting records endorsed with "rejected in part",
(c) the rejected ballot papers and text voting records, and
(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the list of spoilt ballot papers and the list of spoilt text message votes,
(c) the list of lost ballot documents, and
(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:
    (i) any rejected ballot papers, including ballot papers rejected in part,
    (ii) any rejected text voting records, including text voting records rejected in part,
    (iii) any disqualified documents, or the list of disqualified documents,
    (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
    (v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:
(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and
(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) that his or her vote was given, and
(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

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66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or
(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and
(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

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67. Secrecy

67.1 The following persons:

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
(ii) the unique identifier on any ballot paper, (iii) the voter ID number allocated to any voter,
(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph 22)

Elected Governors

1 A member of the Public Constituency may not vote at an election for a Public Governor unless they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant area of the Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2 Appointed governors are to be appointed by the appointing organisations, in accordance with a process agreed with the Secretary.

Appointment of Lead Governor

3 The Council of Governors shall elect a Public Governor to be Lead Governor of the Council of Governors. The term of office for the Lead Governor shall be two years. At the end his term of office the Lead Governor shall be eligible for re-election by the Council of Governors. The maximum term of office as Lead Governor shall be no more than four years.

Further provisions as to eligibility to be a Governor

4 A person may not become a governor of the trust, and if already holding such office will immediately cease to do so, if:

4.1 they are a director of the trust or a governor or director of an NHS body (unless they are appointed by an appointing organisation which is an NHS body);

4.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the trust;

4.3 they are a member of a committee which has any role on behalf of a local authority to scrutinise health matters;

4.4 they have been previously removed as a Governor;

4.5 being a member of the Public Constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the trust, and that they are not prevented from being a governor of the Council of Governors;

4.6 they are subject to a sex offender order, sexual risk order, sexual harm prevention order or equivalent;

4.7 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or medical incapacity, from any paid employment with an NHS body;

4.8 They are, or are eligible to be, a member of the Staff Constituency and have received a final written warning from the trust which has not yet expired.

4.9 they are a person whose tenure of office as the Chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

4.10 A person holding office as a Governor shall immediately cease to do so if:

4.10.1 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the trust's Conflict of Interests policy.

4.10.2 they are removed from the Council of Governors under the provisions of clause 15.4.

Mid Term Vacancies amongst Governors

5.1 Elections for elected members of the Council of Governors will normally be held annually within a financial year, at a time most appropriate, giving due regard to Governor vacancies.

5.2 A vacancy that arises amongst the elected governors for any reason other than expiry of term of office will be offered to the candidate who received the next highest number of votes in the same class and constituency in the most recent election, or, should that candidate decline, offered to each of the remaining next highest polling candidates in order until the seat is filled. If the election was uncontested, or if none of the previous candidates is willing to serve as a governor, a further election will be held.

5.3 Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

~~**Expenses**~~

~~6 Expenses for Governors are to be disclosed in the annual report.~~

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 18 and 20)

1 INTERPRETATION

1.1 Save as permitted by law, the Chair of the trust shall be the final authority on the interpretation of Standing Orders (on which he shall be advised by the Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

"Board of Directors"	shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the Nominations, Remuneration and Succession (Executive Directors) Committee of the Board of Directors.
"Chair"	is the person appointed by the Council of Governors in accordance with paragraph 24 of this Constitution. The expression "the Chair" shall be deemed to include the Deputy Chair or otherwise a Non-Executive Director appointed by the Board of Directors to preside for the time being over its meetings.
"Chief Executive"	shall mean the chief officer of the trust.
"Constitution"	means the constitution of the trust and all annexes to it, as may be amended from time to time.
"Council of Governors"	means the Council of Governors of the trust from time to time;
"Director"	shall mean a person appointed to the Board of Directors in accordance with the trust's Constitution and includes the Chair.
"Governor"	means a Governor on the Council of Governors

“Meeting”	means a duly convened meeting of the Council of Governors;
“Motion”	Means a formal proposition to be discussed and voted on during the course of a meeting.
“Nominated Officer”	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.
“Officer”	means an employee of the trust.
“Question on Notice”	means a question from a Governor (notice of which has been given pursuant to Standing Order 4.7.2) about a matter over which the Council has powers or duties or which affects the services provided by the trust;
“Remuneration and Appointments Committee “	shall be a committee appointed by the Board of Directors in accordance with paragraph 28.3 of this Constitution.
“Secretary”	means the Secretary of the trust or any other person appointed to perform the duties of the Secretary, including a joint assistant or deputy secretary.

2. GENERAL INFORMATION

2.1 These Standing Orders for the practice and procedure of the Council of Governors are the standing orders referred to in paragraph 16 of the Constitution. They may be amended in accordance with the procedure set out in Standing Order 4.14 below. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

2.2 The purpose of the Council of Governors’ Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all meetings of the Council of Governors and associated deliberations. The Council shall at all times seek to comply with the trust's Code of Conduct for the Council of Governors.

2.3 All business shall be conducted in the name of the trust.

2.4 The Board of Directors shall appoint trustees to administer, separately, charitable funds received by the trust and for which they are accountable to the Charity Commission.

2.5 A Governor who has acted honestly and in good faith will not have to meet, out of his or her own personal resources, any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Governor save where the Governor has acted recklessly. On behalf of the Council of Governors, and as part of the trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3. Composition of the Council of Governors

3.1. The composition of the Council of Governors shall be in accordance with paragraph 10 and Annex 3 of the trust's Constitution.

3.2. **Appointment and Removal of the Chair of the Council of Governors -** This appointment shall be made by the Council of Governors in accordance with paragraph 24 of the trust's Constitution.

3.3. **Duties of Deputy Chair** - Where the Chair of the trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair or the Non-Executive Director nominated by the Council of Governors to take on the duties of the Chair or Deputy Chair should both be absent from a meeting or otherwise unavailable or unable to perform his duties.

4. Meetings of the Council of Governors

4.1. Admission to meetings

4.1.1 Meetings of the Council of Governors must be open to the public (which, for the avoidance of doubt, includes representatives of the press), subject to 4.1.2 and 4.1.3 below.

4.1.2 The Council of Governors may resolve to exclude members of the public or a representative from the press from any

meeting or part of a meeting for reasons of commercial confidentiality or for other special reasons.

4.1.3 The Chair may exclude any member of the public or representative from the press from the meeting of the Council of Governors if he considers that he is interfering with or preventing the proper conduct of the meeting.

4.1.4 Meetings of the Council of Governors shall be held at least four times each year at such times and places that the Chair may determine.

4.1.5 Without prejudice to the power of the Council of Governors to require one or more of the Directors to attend a meeting of the Council of Governors for the purposes of obtaining information about the trust's performance of its functions or the Directors' performance of their duties (and decide whether to propose a vote on the trust's or Directors' performance) at paragraph 15.3 of the Constitution, the Council of Governors may invite the Chief Executive, one or more Directors or a representative of the auditor or other advisors, as appropriate, to attend any meeting of the Council of Governors to enable Governors to raise questions about the trust's affairs.

4.2 **Calling Meetings**

4.2.1 Meetings of the Council of Governors may be called by the Secretary or the Chair or one third of current Governors (including at least two elected Governors and one appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. If upon receipt of such a request, the Secretary fails to call such a meeting, the Chair or the one-third of Governors, whichever is the case, shall call the meeting.

4.2.2 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting.

4.3 **Notice of Meetings**

4.3.1 The Secretary shall deliver a schedule of the dates, times and venues of meetings of the Council of Governors for each calendar year, six months in advance of the first meeting of the Council of Governors to be called, duly signed by the Chair or by an Officer of the trust authorised by the Chair to sign on his behalf, to every Governor, or send such schedule by post to the usual place of residence of such Governor. Lack of service of the notice on any Governor shall not affect the validity of a meeting, subject to 4.3.4 below.

4.3.2 Notwithstanding 4.3.1, and subject to 4.3.3, should an additional meeting of the Council of Governors be called pursuant to 4.2, the Secretary shall, as soon as possible, deliver written notice of the date, time and venue of the meeting to every Governor, or send by post to the usual place of residence of such Governor, so as to be available to him/her at least fourteen days and not more than twenty eight days before the meeting. Such notice will also be published on the trust's website.

4.3.3 The Chair may waive the notice required pursuant to 4.3.2 in the case of emergencies or in the case of the need to conduct urgent business.

4.3.4 Subject to 4.3.3, failure to serve notice on more than three quarters of Council of Governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.5 Before each meeting of the Council of Governors, the Secretary shall ensure that every Governor is provided with reasonable notice of the details of the business to be transacted in it. In the case of a meeting called by Governors in default of the Chair, no business shall be transacted at the meeting other than that specified in the notice.

4.4 **Setting the Agenda**

4.4.1 The Secretary shall ensure an agenda, minutes of the previous meeting of the Council of Governors, copies of any Questions on Notice and/or motions on notice to be considered at the relevant meeting of the Council of

Governors and any supporting papers are delivered to every Governor, either electronically, or sent by post to the usual place of residence of such Governor, so as to be available to him/her normally at least seven days in advance of the meeting.

4.4.2 Approval of the minutes of the previous meeting of the Council of Governors will be a specific item on each agenda.

4.4.3 In the case of a meeting called by the Chair, a Governor desiring a matter to be included on an agenda shall make his request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.5 **Chair of Meeting**

At any meeting of the Council of Governors, the person presiding shall be determined in accordance with paragraph 17.1 of the Constitution.

4.6 **Notices of Motions**

4.6.1 For the avoidance of doubt, motions by the Council of Governors may only concern matters for which the Council of Governors has a responsibility or which affect the services provided by the trust.

4.6.2 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governor who gave it and the signature of four other Governors. When any such motion has been disposed of by the Council of Governors it shall not be competent for any Governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

4.6.3 Subject to paragraph 4.6.5 and except in the circumstances covered by paragraph 4.8, Governors desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting at which it is proposed to be considered to the Secretary, such written notice to be

signed or transmitted by at least two Governors. For the purposes of this paragraph 4.6, receipt of such motions by electronic means is acceptable.

4.6.4 Upon receipt of a motion, the Secretary shall:

4.6.4.1 acknowledge receipt in writing to each of the Governors who signed or transmitted it; and

4.6.4.2 insert this in the agenda for that meeting, together with any relevant papers.

4.6.5 The following motions may be moved at any meeting without notice:

4.6.5.1 To amend the minutes of the previous meeting of the Council of Governors in order to ensure accuracy;

4.6.5.2 To change the order of business in the agenda for the meeting;

4.6.5.3 To refer a matter discussed at a meeting to an appropriate body or individual;

4.6.5.4 To appoint a working group arising from an item on the agenda for the meeting;

4.6.5.5 To receive reports or adopt recommendations made by the Board of Directors;

4.6.5.6 To withdraw a motion;

4.6.5.7 To amend a motion;

4.6.5.8 To proceed to the next business on the agenda;

4.6.5.9 That the question be now put;

4.6.5.10 To adjourn a debate;

4.6.5.11 To adjourn a meeting;

4.6.5.12 To exclude the public and press from the meeting in question pursuant to 4.1.2 (in which case, the motion shall state on what grounds such exclusion is appropriate).

4.6.5.13 To not hear further from a Governor, or to exclude them from the meeting in question (if a member persistently disregards the ruling of the Chair or behaves improperly or offensively or deliberately obstructs business, the Chair, in his absolute discretion, may move that the Governor in question will not be heard further at that meeting and, if seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a

motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specific period. If seconded, that motion will be voted on without discussion.)

4.6.5.14 To give the consent of the Council of Governors to any matter on which its consent is required pursuant to the Constitution.

4.6.6 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.7 **Questions on Notice at Meetings**

4.7.1 Subject to 4.7.2, a Governor may ask a Question on Notice of:

4.7.1.1 the Chair;
4.7.1.2 another Governor;
4.7.1.3 an Executive Director; or
4.7.1.4 the chair of any sub-committee or working group of the Council.

4.7.2 Except in the circumstances covered by 4.8, notice of a Question on Notice must be given in writing to the Secretary at least ten days prior to the relevant meeting. For the purposes of this Standing Order 4.7, receipt of any such Questions on Notice via electronic means is acceptable.

4.7.3 A response to a Question on Notice may take the form of:

4.7.3.1 A direct oral answer at the relevant meeting (which may, where the desired information is in a publication of the trust or other published work, take the form of a reference to that publication);

4.7.3.2 Where a direct oral answer cannot be given, a written answer which will be circulated as soon as reasonably practicable to the questioner and circulated to the remaining Governors with the agenda for the next meeting.

4.7.4 Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Chair.

4.8 **Urgent motions or questions**

4.8.1 The Chair may, in his opinion, table an urgent motion or question.

4.8.2 A Governor may submit an urgent motion or question in writing to the Secretary before the commencement of the meeting at which it is proposed it should be considered.

4.9 **Reports from the Executive Directors**

4.9.1 At any meeting, a Governor may ask any question on any report by an Executive Director or another Officer through the Chair without notice, after that report has been received by or while such report is under consideration by the Council of Governors at the meeting.

4.9.2 Unless the Chair decides otherwise, no statements will be made by a Governor other than those which are strictly necessary to define or clarify any questions posed pursuant to 4.9.1 and, in any event, no such statement may last longer than three minutes each.

4.9.3 A Governor who has asked a question pursuant to 4.9.1 may ask a supplementary question if the supplementary question arises directly out of the reply given to the initial question.

4.9.4 The Chair may, in his/ absolute discretion, reject any question from any Governor if, in the opinion of the Chair, the question is substantially the same and relates to the same topic as a question which has already been put to the meeting or a previous meeting.

4.9.5 At the absolute discretion of the Chair, questions may, at any meeting which is held in public, be asked of the Executive Directors present by members of the trust or any other members of the public present at the meeting.

4.10 **Speaking**

This Standing Order applies to all forms of speech/debate by Governors or members of the trust and public in relation to a motion or question under discussion at a meeting of the Council of Governors.

4.10.1 Any approval to speak must be given by the Chair.

4.10.2 All speakers must state their name and role before starting to speak to ensure the accuracy of the meeting minutes.

4.10.3 Speeches must be directed to the matter, motion or question under discussion or to a point of order.

4.10.4 Unless in the opinion of the Chair it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech nor any reply may exceed three minutes.

4.10.5 The Chair may, in his absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

4.10.6 A person who has already spoken on a matter at a meeting may not speak again at that same meeting in respect of that matter unless exercising a right of reply or speaking on a point of order.

4.11 **Chair's Ruling**

Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.12 **Voting**

4.12.1 Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

4.12.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

4.12.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.12.4 If a Governor so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.12.5 In no circumstances may an absent Governor vote by proxy. Subject to paragraph 4.17.3, absence is defined as being absent at the time of the vote.

4.12.6 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the trust and that they are not prevented from being a Governor on the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors and every agenda for meetings of the Council of Governors shall draw this to the attention of the elected Governors.

4.13 **Suspension of Standing Orders (SOs)**

4.13.1 Except where this would contravene any statutory provision or a direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present and that a majority of those present vote in favour of suspension.

4.13.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.13.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.13.4 No formal business may be transacted while SOs are suspended.

4.13.5 The Trust's Audit Committee shall review every decision to suspend SOs.

4.14 **Variation and Amendment of Standing Orders**

Notwithstanding paragraph 44 of this Constitution, these Standing Orders shall be amended only if:

4.14.1 the variation proposed does not contravene a statutory provision;

4.14.2 a motion to amend the Standing Orders is signed by seven Governors (including at least two elected Governors and one appointed Governors) and submitted to the Secretary in writing at least 21 days before the meeting at which the motion is intended to be proposed

4.14.3 or approved at the Council of Governors Advisory Committee ; and

4.14.4 no fewer than three quarters of the Governors present and voting vote in favour of the amendment.

4.15 **Record of Attendance**

4.15.1 The names of the Governors present at the meeting (including when present pursuant to paragraph 4.17.3) shall be recorded in the minutes.

4.15.2 Governors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question in order that their apologies are submitted.

4.16 **Minutes**

4.16.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.16.3 The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public and press are excluded pursuant to 4.1.2 unless otherwise required by law.

4.17 **Quorum**

4.17.1 One third of current Governors shall form a quorum.

4.17.2 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.17.3 The Council of Governors may agree that its members can participate in its meetings by telephone, video or video media link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

5. Arrangements for the Exercise of Functions by Delegation

The Council of Governors may not delegate any of its powers to a committee or sub-committee, although it may appoint committees consisting of its members, Directors and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

6. Confidentiality

6.1 A Governor on the Council of Governors shall not disclose a matter dealt with by, or brought before, the Council of Governors without its permission.

6.2 Members of the Nominations Committee shall not disclose any matter dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the Committee resolves that it is confidential.

7. Declaration of Interests and Register of Interests

7.1 Governors are required to comply with the trust's Conflict of Interests policy and declare interests that are material to the Council. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.2 Subject to the exceptions in 7.3, a "material interest" is:

7.2.1 any directorship of a company;

7.2.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the trust;

7.2.3 any interest in an organisation providing health and social care services to the National Health Service;

7.2.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.2.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the trust including but not limited to lenders or banks.

7.3 The exceptions which shall not be treated as material interests for the purposes of these provisions are as follows:

7.3.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

7.3.2 an employment contract with the trust held by a Staff Governor;

7.3.3 an employment contract with a local authority held by a Local Authority Governor;

7.3.4 an employment contract with or other position of authority within an appointing organisation held by an Appointed Governor.

7.4 Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business or organisation in which the Governor or his spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:

7.4.1 shall withdraw from the meeting and play no part in the relevant discussion or decision; and

7.4.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

7.5 Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

7.6 If a Governor has any doubt about the relevance of an interest, he should discuss it with the Chair who shall advise him/her whether or not to disclose the interest.

7.7 At the time that a Governor’s interests are declared, they should be recorded in the Council of Governors’ minutes and entered on a Register of Interests of Governors to be maintained by the Secretary. Any changes in interests should be declared at the next meeting of the Council of Governors following the change occurring.

7.8 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust’s annual report.

8. Register of Interests

8.1 The Secretary, will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

8.2 Details of the Register will be kept up to date and reviewed annually.

8.3 The Register will be available to the public.

9. Compliance - Other Matters

9.1 All Governors shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the trust.

9.2 All Governors of the trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the trust.

9.3 All Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the trust's Code of Conduct for Governors as amended from time to time):

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty, and
- Leadership.

10. Resolution of Disputes with Board of Directors

10.1. Should a dispute arise between the Council of Governors and the Board of Directors, then the disputes resolution procedure set out below shall be followed.

10.2. The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3. Failing resolution under 10.2 above, then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4. The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5. The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.2 above shall be repeated.

10.6. If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then he shall advise the Council of Governors and Board of Directors accordingly.

10.7. On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8. On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

10.9. Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing Monitor that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the trust is not acting in accordance with the terms of its Constitution or not complying with the terms of the 2006 Act.

11. Council Performance

11.1. The Chair shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council of Governors to review its roles, structure and composition, and procedures, taking into account emerging best practice.

11.2. The performance assessment process in 11.1 shall include a review of the input into the Council of Governors of each appointing organisation.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 31)

1. Interpretation

1.1. Save as permitted by law, the Chair of the trust shall be the final authority on the interpretation of Standing Orders (on which he shall be advised by the Secretary).

1.2. Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

Board of Directors	shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the Nominations and Remuneration (Executive Directors) Committee.
Chair	is the person appointed by the Council of Governors in accordance with paragraph 26 of this Constitution. The expression “the Chair” shall be deemed to include the Deputy Chair or otherwise a Non-Executive Director appointed by the Board of Directors to preside for the time being over its meetings.
Chief Executive	shall mean the chief officer of the trust.
Committee	shall mean a committee appointed by the Board of Directors.
Committee Members	shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.
Constitution	shall mean the constitution of the trust and all annexes to it, as may be amended from time to time.

Director	shall mean a member of the Board of Directors appointed in accordance with the trust's Constitution and includes the Chair.
Motion	means a formal proposition to be discussed and voted on during the course of a meeting.
Nominated Officer	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders
Officer	means an employee of the trust.
Nominations and Remuneration Committee	shall be a committee appointed in accordance with paragraph 28.3 of this Constitution.
Secretary	means the Secretary of the trust or any other person appointed to perform the duties of the Secretary, including a joint assistant or deputy secretary.
SOs	Standing Orders
Trust	Means The Walton Centre NHS Foundation Trust

2. General Information

2.1. The purpose of the Board of Directors Standing Orders is to ensure that the highest standards of Corporate Governance are achieved in the Board of Directors and throughout the organisation. The Board of Directors shall at all times seek to comply with the trust's Code of Conduct for Directors.

2.2. All business shall be conducted in the name of the trust.

2.3. The Directors shall appoint trustees to administer, separately, charitable funds received by the trust and for which they are accountable to the Charity Commission.

2.4. A Director, or Officer of the trust, who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director save where the Director has acted recklessly. On behalf of the Directors, and as part of the trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3. Composition of the Board of Directors

3.1. The composition of the Board of Directors shall be as set out in paragraph 23 of the trust's Constitution. Subject to paragraph 23.2 of the Constitution, the number of Directors may be increased or reduced by the Board of Directors.

3.2. **Appointment and Removal of the Chair and Non-Executive Directors** - The Chair and Non-Executive Directors are appointed/removed by the Council of Governors in accordance with paragraph 24 of the trust's Constitution.

3.3. **Appointment and Removal of the Executive Directors** – The Nominations and Remuneration Committee of the Board of Directors (excluding the Chief Executive) shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors). The Nominations and Remuneration Committee of the Board of Directors (inclusive of the Chief Executive) shall appoint or remove the other Executive Directors.

3.4. **Appointment and Removal of Deputy Chair** – For the purpose of enabling the proceedings of the trust to be conducted in the absence of the Chair, a Deputy Chair shall be appointed in accordance with paragraph 27 of the trust's Constitution.

3.5. **Powers of Deputy Chair** - Where the Chair of the trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his duties, be taken to include references to the Deputy Chair or otherwise to the Non-Executive Director appointed by the Board of Directors to preside for the time being over its meetings.

3.6. **Joint Directors** - Where more than one person is appointed jointly to a post in the trust which qualifies the holder for executive directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count as one person.

3.7. Non-Executive Directors may seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective one by the majority of Non-Executive Directors.

4. Meetings of the Board of Directors

4.1. Admission to meetings

4.1.1. Meetings of the Board of Directors must be open to the public, unless the Board in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial sensitivity or for other special reasons.

4.1.2. The Board of Directors may resolve to invite an individual to any meeting or part of a meeting on the grounds that it considers that:

(a) their attendance at the meeting is relevant and beneficial to the nature of the business under consideration or is otherwise in the public interest; and

(b) that the individual understands any requirements for confidentiality that will be required of them by attending that meeting or part of a meeting.

4.1.3. Meetings of the Board of Directors shall be held at least three times each year at times and places that the Board of Directors may determine.

4.1.4. The Board of Directors shall arrange for an annual public meeting to be held within nine months of the end of each financial year. The registers and documents set out in paragraphs 34 and 37 of this Constitution shall be available for inspection at the meeting subject to the provisions of paragraph 36 of this Constitution.

4.2. Calling Meetings

Meetings of the Board of Directors may be called by the Secretary, or by the Secretary on the request of the Chair or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. If the Secretary fails to call such a meeting, the Chair or four Directors, whichever is the case, shall call the meeting.

4.3. Notice of Meetings

4.3.1 The Secretary shall deliver a schedule giving notice of the date, time and venue of all meetings of the Board of Directors planned for the next calendar year, signed by the Chair or by an Officer of the trust authorised by the Chair to sign on his behalf to every Director, or send such schedule by post to the usual place of residence of such Director, so as to be available to him/her at least fourteen days before the first meeting and, in any event, before 1 January of the next calendar year. Lack of service of the notice on any Director shall not affect the validity of a meeting, subject to 4.3.4 below.

4.3.2. Notwithstanding the above requirement for a schedule of meeting dates each calendar year, and subject to 4.3.3, should an additional meeting of the Board of Directors be called pursuant to 4.2, the Secretary shall, as soon as possible, deliver written notice of the date, time and venue of the meeting to every Director, or send by post to the usual place of residence of such Director, so as to be available to him/her at least fourteen days before the meeting and not more than twenty eight days before the meeting.

4.3.3. The Chair may waive the notice required pursuant to 4.3.2 in the case of emergencies or in the case of the need to conduct urgent business.

4.3.4. Subject to 4.3.3, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.5. Before each meeting of the Board, the Secretary shall ensure that every Director is provided with reasonable notice of the details of the business proposed to be transacted at it. In the case of a meeting called by Directors in default of the Chair, no business shall be transacted at the meeting other than that specified in the notice.

4.4. **Setting the Agenda**

4.4.1. The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

4.4.2. In the case of a meeting called by the Chair or Secretary, a Director desiring a matter to be included on an agenda shall make his request in writing to the Secretary at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.4.3. The Secretary shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2 above, are delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least seven clear days before the meeting. Copies of the final agenda must be sent to the Council of Governors at the same time.

4.5. **Chair of Meeting**

At any meeting of the Board of Directors the Chair shall preside, if present. If the Chair is absent from the meeting, the Deputy Chair appointed by the Council of Governors to take on the Chair's duties shall preside. Otherwise, such Non-Executive Director as the Directors present shall choose and shall preside.

4.6. **Notices of Motions**

4.6.1. A Director of the trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Secretary, who shall insert in the agenda for the meeting all notices so received subject to the

notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to 4.3.5 above.

4.6.2. A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3. Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Directors who gave it and also the signature of four other Directors. When any such motion has been disposed of by the Board of Directors it shall not be competent for any Director, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

4.6.4. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5. When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(a) An amendment to the motion.
(b) The adjournment of the discussion or the meeting.
(c) The appointment of an ad hoc committee to deal with a specific item of business.
(d) That the meeting proceeds to the next business.
(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate.

4.7. **Chair's Ruling**

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.8. **Voting**

4.8.1. Decisions at meetings shall be determined by a majority of the votes of the Directors present and voting.

(a) In the case of any equality of votes, the Chair, or, in his absence, the person appointed to preside in accordance with 4.5 shall have a second and casting vote.

(b) No resolution of the Board of Directors shall be passed if it is opposed by all of the Non Executive Directors present or by all of the Executive Directors present.

4.8.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.8.3. If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.8.4. If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.5. In no circumstances may an absent Director vote by proxy. Subject to paragraph 4.14.4, absence is defined as being absent at the time of the vote.

4.8.6. An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity

or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.9. **Joint Directors**

Where an Executive Director post is shared by more than one person:

(a) each person shall be entitled to attend meetings of the Board of Directors;
(b) in the case of agreement between them, they shall be eligible to have one vote between them;
(c) in the case of disagreement between them, no vote should be cast;
(d) the presence of those persons shall count as one person.

4.10. **Suspension of Standing Orders (SOs)**

4.10.1. Except where this would contravene any statutory provision or direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

4.10.2. A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.10.3. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.10.4. No formal business may be transacted while SOs are suspended.

4.10.5. The Audit Committee shall review every decision to suspend SOs.

4.11. **Variation and Amendment of Standing Orders**

Notwithstanding paragraph 43 of this Constitution, these Standing Orders shall be amended only if:

4.11.1. the variation proposed does not contravene a statutory provision; and

4.11.2. at least two thirds of the Directors are present; and

4.11.3. no fewer than half the total number of Non Executive Directors vote in favour of the amendment.

4.12. **Record of Attendance**

The names of the Directors present at the meeting (including when deemed present pursuant to paragraph 4.14.4) shall be recorded in the minutes.

4.13. **Minutes**

4.13.1. The minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.13.3. Approved minutes shall be sent to the Council of Governors as soon as practicable after each meeting of the Board and shall be otherwise circulated in accordance with the Directors' wishes.

4.14. **Quorum**

4.14.1. No business shall be transacted at a meeting of the Board of Directors unless at least five Directors including not less than two Executive Directors (one of whom must be the Chief Executive or Deputy Chief Executive or another Executive Director nominated by the Chief Executive), and not less than two Non-Executive Directors (one of whom

must be the Chair or the Deputy Chair of the Board of Directors) are present.

4.14.2. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.14.3. If a Director has been disqualified from participating in the discussion on any
matter and from voting on any resolution by reason of the declaration of a conflict of interest he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.14.4. The Board of Directors may agree that its members can participate in its meetings by telephone, video or video media link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

5. Arrangements for the Exercise of Functions by Delegation

5.1. Subject to the requirements of the 2006 Act, the Board of Directors may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, or by a Director or an Officer of the trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

5.2. **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

5.3. **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

5.4. **Delegation to Officers** - Those functions of the trust which have not been retained as reserved by the Board of Directors or delegated to one of its Committees shall be exercised on behalf of the Board of Directors by the Chief Executive. He shall determine which functions he will perform personally and shall nominate Officers to undertake remaining functions but still retain an accountability for these to the Board of Directors.

5.5. The Chief Executive shall prepare a Scheme of Delegation identifying his proposals that shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

5.6. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements.

5.7. The arrangements made by the Board of Directors as set out in the "Scheme of Delegation" shall have effect as if incorporated into these Standing Orders.

6. Committees

6.1. Appointment of Committees

6.1.1. The Board of Directors may appoint committees of the Board of Directors, consisting wholly or partly of Directors of the trust or wholly of persons who are not Directors of the trust.

6.1.2. A committee so appointed may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the trust) or wholly of persons who are not members of the committee (whether or not they include Directors of the trust).

6.1.3. The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board of Directors.

6.1.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors) as the Board of Directors shall decide from time to time following reviews of the terms of reference, powers and conditions. Such terms of reference shall be read in conjunction with these Standing Orders.

6.1.5. The Board of Directors may not delegate their executive powers to a committee, and a committee may not delegate any executive power it may have to a sub-committee, unless the committee or subcommittee consists wholly of Directors and such delegation is expressly authorised by the Board of Directors.

6.1.6. The Board of Directors shall approve the appointments to each of the committees that it has formally constituted. Where the Board of Directors determines that persons, who are neither Directors nor Officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors.

6.1.7. Where the trust is required to appoint persons to a committee, which is to operate independently of the trust, such appointment shall be approved by the Board of Directors.

6.2. Confidentiality

6.2.1. A member of the Board of Directors shall not disclose a matter dealt with by, or brought before, the Board of Directors without its permission.

6.2.2. A member of a committee of the Board of Directors shall not disclose any matter dealt with by, or brought before, the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

7. Declaration of Interests and Register of Interests

7.1. Declaration of Interests

7.1.1. Directors are required to comply with the trust's Standards of Business Conduct, to declare interests that are required to be declared by the Constitution and to declare any other interests that are material to the Board of Directors. All Directors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.2. Interests regarded as " material" include any of the following, held by a Director, or the spouse or partner of a Director:

a) Any interest (excluding a holding of shares in a company whose shares are listed on any public exchange where the holding is less than 2% of the total shares in issue) or position held by a Director in any firm, company or business which has or is likely to have a trading or commercial relationship with the trust.
b) Any interest in a voluntary or other organisation providing health and social care services to the National Health Service.
c) A position of authority in a charity or voluntary organisation in the field of health and social care.
d) Any connection with any organisation, entity or company considering entering into a financial arrangement with the trust including but not limited to lenders or banks.

7.1.3. If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

7.1.4. At the time that Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

7.1.5. Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board of Director's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6. During the course of a Board meeting, if a conflict of interest is established in accordance with this Standing Order, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2. Register of Interests

7.2.1. The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other relevant and material interests that have been declared by both Executive and Non- Executive Directors.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3. The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

8. Compliance - Other Matters

8.1. All Directors of the trust shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the trust.

8.2. All Directors of the trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors.

8.3. All Directors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the trust's Code of Conduct for Directors as amended from time to time):

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty; and
- Leadership.

9. Resolution of Disputes with Council of Governors

9.1. Should a dispute arise between the Board of Directors and the Council of Governors, then the disputes resolution procedure set out below shall be followed.

9.2. The Chair, or Deputy Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

9.3. Failing resolution under 9.2 above, then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

9.4. The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

9.5. The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 9.2 above shall be repeated.

9.6. If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair) and following the further discussions prescribed in 9.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then he shall advise the Council of Governors and Board of Directors accordingly.

9.7. On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

9.8. On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

9.9. Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the trust is not acting in accordance with the terms of its Constitution or not complying with the terms of the 2006 Act as amended by the 2022 Act.

10. Notification to Council of Governors

The Board of Directors shall notify the Council of Governors of any major changes in the circumstances of the trust, which have made or could lead to a substantial change to its financial well-being, healthcare delivery performance, or reputation and standing or which might otherwise affect the trust's compliance with the terms of its Constitution or the 2006 or 2022 Act.

11. Board of Directors' Performance

The Chair shall, at least annually, lead a performance assessment process for the Board of Directors. This process should act as the basis for determining individual and collective professional development programmes for Directors.

ANNEX 8 – FURTHER PROVISIONS - MEMBERS

(Paragraph 10.4 and 11.2)

1. **DISQUALIFICATION FROM MEMBERSHIP**

1.1 An individual may not become a member of the trust if:

1.1.1 they are under 16 years of age;

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the trust's hospitals or facilities or against any of the trust's employees or other persons who exercise functions for the purposes of the trust, or against any registered volunteer.

2. **TERMINATION OF MEMBERSHIP**

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;
2.1.2 they die;
2.1.3 they are expelled from membership under this Constitution;
2.1.4 they cease to be entitled under this Constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency; or
2.1.5 it appears to the Secretary that they no longer wish to be a member of the trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the trust.

2.2 A member may be expelled by a resolution approved by not less than three quarters of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this Constitution; or

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting, the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause, the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of three quarters of the Council of Governors present and voting at a General Meeting.

3. MEMBERS' MEETINGS

3.1 The Trust is to hold a members' meeting (called the Annual Members' meeting) within nine months of the end of each financial year.

3.2 All members' meetings other than annual meetings are called special members meetings.

3.3 Members' meetings are open to all members of the trust, Governors and Directors, representatives of the auditor and to members of the public. The Board of Directors may invite any experts or advisors whose attendance they consider to be in the best interests of the trust to attend a members meeting.

3.4 All members' meetings are to be convened by the Secretary by order of the Board of Directors.

3.5 The Board of Directors may decide where a members meeting is to be held and may also for the benefit of members:

3.5.1 arrange for the Annual Members' Meeting to be held in different venues each year:

3.5.2 make provisions for a members' meeting to be held at different venues.

3.6 At the Annual Members' Meeting:

3.6.1 the Board of Directors shall present to the members:

3.6.1.1 the annual report and accounts;
3.6.1.2 any report of the auditor;
3.6.1.3 any report of any other external auditor of the trust's affairs; and
3.6.1.4 forward planning information for the next Financial Year

3.6.2 the Council of Governors shall present to the members a report on:

3.6.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;
3.6.2.2 the progress of the membership strategy;
3.6.2.3 and any changes made to it; and
3.6.2.4 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

3.6.3 the results of the election and appointment of Governors and the appointment of non executive Directors will be announced.

3.7 Notice of a members' meeting is to be given:

3.7.1 by notice to all members;

3.7.2 by notice prominently displayed at the head office and at all of the trust's places of business; and

3.7.3 by notice on the trust's website at least 14 clear days before the date of the meeting. The notice must:

3.7.4 be given to the Council of Governors and the Board of Directors, and to the auditor;

3.7.5 state whether the meeting is an annual or special members' meeting;

3.7.6 give the time, date and place of the meeting; and

3.7.7 indicate the business to be dealt with at the meeting.

3.8 Before a members meeting can do business, there must be a quorum present. Except where this Constitution says otherwise, a quorum is eleven members present including at least one Governor.

3.9 The trust may make arrangements for members to vote by post or electronic communications.

3.10 It is the responsibility of the Board of Directors, the Chair of the meeting and the Secretary to ensure that at any members meeting:

3.10.1 the issues to be decided are clearly explained;
3.10.2 sufficient information is provided to members to enable rational discussion to take place.

3.11 The Chair of the trust, or in their absence the Deputy Chair of the Board of Directors, shall act as Chair at all members meetings of the trust. If neither the Chair nor the Deputy Chair of the Board of Directors is present, the members of the Council of Governors present shall elect one of their number to be Chair and if there is only one Governor present and willing to act, they shall be Chair.

3.12 If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.13 A resolution put to the vote at a members meeting shall be decided upon by a show of hands unless a poll is requested by the Chair of the meeting.

3.14 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes, the Chair of the meeting is to have a second and casting vote.

3.15 The result of any vote will be declared by the Chair and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

4. **REPRESENTATIVE MEMBERSHIP**

4.1 The trust shall at all times strive to ensure that, taken as a whole, its actual membership is representative of those eligible for membership. To this end:

4.1.1 the trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every two years,

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Report to Trust Board
1 June 2023

Report Title	Guardian of Safe Working Annual Report		
Executive Lead	Dr Andrew Nicolson, Medical Director		
Author (s)	Dr Chrissie Burness, Guardian of Safe Working		
Action Required	To note		

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

Key Messages

- Thrombectomy has significantly impacted Neurology Registrars out of hours working pattern
- During this report period there have been four exception reports from the neurology Registrars.
- Neurology Registrars continue to breach the minimum safety rule for rest during a 24 hour shift.

Next Steps

- Neurology Registrar working hours and rest remain under scrutiny.
- Further alterations to roles and responsibilities out of hours are underway.

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Workforce	Finance	Not Applicable

Strategic Risks		
008 Medical Education Strategy	001 Quality Patient Care	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Guardian of Junior Doctor's Safe Working Annual Report

Executive Summary

1. This report provides the Trust Board with information around contractually defined safe working hours for junior doctors in training February to April 2023.

2. There have been four exception reports during this period. All were from Neurology Registrars related to breaches in safe working as defined by the 2016 Junior Doctors Contract with associated fines.

3. Thrombectomy continues to be the main causal factor leading the exception reports.

Background

4. The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February, and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors placed in the Trust on the new 2016 terms and conditions of service.

5. In June 2019, amendments to the 2016 contract were agreed as follows:
   - Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am)
   - Maximum of 72 hours to be worked within any 7 day period.
   - Increased pay for weekend a night shifts (shifts ending between midnight and 4am)
   - £1000 per year extra for LTFT trainees
   - A fifth nodal point on the payscale when doctors reach ST6
   - Transitional pay protection extended until 2015
   - Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive)
   - Exception reporting for all ARCP/ portfolio requirements
   - Guaranteed annual pay uplift of 2% per year for the next 4 years
   - Fines to be levied by the GoSW for any breach of safe working hours

6. The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue.

7. Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be;
   - Differences in the total hours of work (including opportunities for rest breaks)
   - Differences in the pattern of hours worked
   - Differences in the educational opportunities and support available to the doctor
   - Differences in the support available to the doctor during service commitments

8. The Trust use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner.

9. Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust.

10. Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian.

11. The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum alternating with to the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract.

Analysis

High Level Data (requested by NHS Employers)

Number of doctors in training (total) 52

Number of doctors on 2016 T&C (total) 52

Amount of time in job plan for guardian to fulfil the role 1PA

Admin support provided to the guardian 0
(Support provided by Heather Doyle)

Amount of job-planned time for educational supervisors 0.25
(For education and training)

Expenditure to cover junior doctor rota gaps

	February	March	April	**TOTAL**
Neurorehabilitation	£9,735	£1,010	£ 1,010	£11,755
Neurosurgery	£13,888	£42,506	£7,074	£63,468
Total	**£23,623**	**£43,516**	**£8,084**	**£75,223**

Expenditure to cover junior doctors industrial action March 2023

Neurology	£32,641
Neurosurgery	£50,759
Total	**£83,400**

a) Exception reports

There have been 4 exception reports during this period. All were due to breaches in the minimum rest requirements for doctors working a 24 hour on call shift (the doctor did not achieve 5 hours of continuous rest between 10pm and 7am). In three of the four cases, thrombectomy calls or admissions were a causal factor.

b) Work schedule reviews
We have not had to undertake any work schedule reviews. The neurology registrars working hours were monitored in October 2021 and this exercise was repeated in September to December 2022.

Trainees are aware that they can request a work schedule review or hours monitoring exercise at any time of they have concerned. Potential rota changes to resolve any issues are reviewed in anticipation.

c) Vacancies
The Trust has 52 established training posts. During the report period we had 1 vacant IMT2 post, one IMT3 post and 2 at ST3 or above in neurosurgery. One neurosurgical post was covered by a locum doctor for 7 weeks and the other shifts were covered by Trust Grade and Trainee doctors at the Trust.

d) Fines
Payments for a total of 5 hours have been required from the neurology division due to breeches to the regulation regarding minimum rest during an on call shift for neurology registrars.

Qualitative Information

12. Four exception reports have been submitted by a registrar in Neurology and all have been resolved with compensatory rest the following day plus payment when minimum rest requirements have not been met.

13. The most recent National Education and Training survey was positive for the Walton Centre for all groups except for the neurology trainees. This group of doctors reported experiences of bullying, concerns about support and worryingly several said that they would not recommend training at the Walton Centre to colleagues. The neurology registrars cite the impact of 24/7 thrombectomy as the main factor causing their concern. The change in thrombectomy guidelines to include patients up to 24 hours after stroke onset will significantly increase referral numbers. Significant change to neurology registrars roles and responsibilities within the thrombectomy pathway are required in order to preserve their training and safe working hours.

14. Payments for additional hours during this report period have totalled £755.70 (5 hours).

15. The total payments until this reporting period have totalled £8312.70 (55 hours).

16. The senior neurosurgical registrar rota is also to be monitored if exception reports are received.

Conclusion

17. There have been four exception reports this quarter. All were due to a breach in safe working and minimum rest requirements. Three were related to thrombectomy.

18. The majority of the exception reports received are consistently due to thrombectomy referrals overnight causing neurology registrars to breech the minimum rest requirement.

19. The role of the neurology registrars pertaining to thrombectomy is under review as part of the wider review of the Thrombectomy service.

20. No concerns regarding safe working have been raised from any other groups of junior doctors during the report period.

Recommendation

21. The Annual Board report from the Guardian will be considered by the Care Quality Commission, General Medical Council and NHS Employers during any review.

22. The Board is asked to receive, review and comment upon the Guardian's annual report.

Author: Dr Chrissie Burness
Date: 22 May 2023

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Report to Trust Board
1 June 2023

Report Title	Quality Account 2022-2023	
Executive Lead	Morag Olsen, Interim Chief Nurse	
Author (s)	Julie Kane, Quality Manager & Freedom to Speak Up Guardian	
Action Required	To note	
Level of Assurance Provided		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- The purpose of this report is to provide the Trust Board with the 22/23 Quality Account
- The Quality Account provides information relating to the work, collaborations and outcomes achieved throughout 22/23
- The Quality Account has been presented to Commissioners during the Quality Account Presentation and Feedback Day on 18th May 2023
- The Quality Account has been presented to the Quality Committee

Next Steps

- Healthwatch, Governors and Commissioners are preparing their commentaries which will be included in the final Quality Account
- The Quality Account will be published on the internet by the 30th June 2023 as required

Related Trust Strategic Ambitions and Themes	**Impact**		
Leadership	Quality	Equality	Workforce

Strategic Risks		
001 Quality Patient Care	004 Leadership Development	004 Operational Performance

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Circulated to Executive Team	3rd May 2023		N/A
Quality Committee	18th May 2023		

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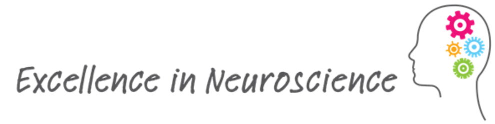


Quality Account

2022 – 2023

Part 1 Statement on quality from the Chief Executive

Part 2 Priorities for improvement and Statements of Assurance from the Board

Improvement priorities

2.1 Update on improvement priorities for 2022/23

2.1.1 Patient safety
2.1.2 Clinical effectiveness
2.1.3 Patient experience

2.2 What are our priorities for 2023/24?

2.2.1 Patient safety
2.2.2 Clinical effectiveness
2.2.3 Patient experience

2.3 Statements of Assurance from the Board

2.3.1 Data quality
2.3.2 Participation in Clinical Audit and National Confidential Enquiries
2.3.3 National audits
2.3.4 National Confidential Enquiries
2.3.5 Participation in local clinical audits
2.3.6 Participation in clinical research and development
2.3.7 CQUIN framework and performance
2.3.8 Care Quality Commission (CQC) registration
2.3.9 Trust data quality
2.3.10 Learning from Deaths
2.3.11 Progress in implementing clinical standards for seven day hospital services
2.3.12 Speaking up
2.3.13 NHS Doctors in Training

Part 3 Trust overview of quality 2022/23

3.1 Complaints
3.2 Local engagement – Quality Account
3.3 Quality governance
3.4 First Walton Centre patient receives groundbreaking treatment for Essential Tremor
3.5 New guidelines launched for fibromyalgia syndrome
3.6 Specialist spinal service receives Centre of Excellence award
3.7 The Walton Centre launches its new Trust Strategy
3.8 Specialist neurosciences trust achieves University status
3.9 The Walton Centre operates on first patients using cutting-edge navigation in complex spinal surgery
3.10 New clinic making a difference for MND patients
3.11 Tracheostomy Ted helps young visitors understand rehabilitation
3.12 Lighting innovators Circada launch first pilot at Trust to improve staff and patient wellbeing
3.13 Saving the day with the HALO Service
3.15 Neurologist appointed to leading research programme
3.15 Professor of Pain Medicine at the Institute of Life Course and Medical Sciences
3.16 Overview of performance in 2022/23 against National Priorities from the Department of Health's Operating Framework
3.17 Overview of performance in 2022/23 against NHS Outcomes Framework
3.18 Indicators

Annex 1 Statements from Commissioners and Local Healthwatch Organisations

Annex 2 Statement of Directors' responsibilities for the Quality Report

Glossary of terms

Part 1 Statement on quality from the Chief Executive

It gives me great pleasure to share the Quality Account for 2022/23 which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families.

As Chief Executive, I see examples of fantastic work on a daily basis, from the big to the small, impacting the lives of our patients and our staff across every area of the hospital.

The past year has seen some great developments, demonstrating our innovation and leadership both within The Walton Centre, and with our partners.

Our new Trust Strategy was launched in September 2022, setting out how we will continue to develop excellent clinical outcomes and patient experience with our teams of dedicated, specialist staff. The strategy reflects the pace of change in the NHS to move to a more collaborative approach and the ambition of the Trust to deliver services that meet the needs of our patients and communities.

The Quality Account details our performance over the last year whilst also highlighting our key priorities for 2023/24.

Our mission is to provide high quality treatment, care and patient experience in the most appropriate place for the needs of our patients. Some of our achievements within year include:

- Our spinal service became the regional centre and received a Centre of Excellence award for its fully endoscopic spinal surgery
- The Trust became a member of the University Hospitals Association recognising its specialist research and education status
- Our new brain tumour pathway was implemented, in collaboration with neighbouring Trusts
- The establishment of our purpose built Rapid Access to Neurology Assessment (RANA) service for fast referral from regional A&E departments

I feel incredibly privileged and proud of our Walton Centre family and everything we have achieved this year for the benefit of our patients, their families and friends. By working together and supporting each other, we are stronger and I would like to thank every single member of staff for their tireless efforts over the past year, which mean so much to our patients, and each other.

In detailing our achievements and forthcoming priorities, I confirm that the information provided in this quality account is accurate and to the best of my knowledge.

Jan Ross, Chief Executive

Part 2 Priorities for improvement and Statements of Assurance from the Board

Towards the end of each financial year, the Trust worked closely with stakeholders to identify areas of improvement for the forthcoming year. This also allowed the Trust to reflect on the year's previous performance against the identified quality improvement priorities.

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

All the priorities were identified following a review by Trust Board on the domains of quality reported in 2021/22. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2022/23.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three priority improvement areas for 2022/23.

2.1 Update on improvement priorities for 2022/23

In December 2022 the Council of Governors and Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. Quality priorities were also identified and agreed for 2023/24. The improvement priorities contained specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

Performance has been managed through subcommittees to Trust Board. Operational groups within the Trust have been responsible for the implementation of the quality priorities and reporting to committees as required. Merseyside Internal Audit Agency (MIAA) undertook an audit of the Quality Account and provided an overall outcome of significant assurance. There is no national requirement for NHS trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account or Quality Report, with the latter no longer prepared.

2.1.1 Patient safety

Priority: 98% completion of MUST within 12 hours of ward admission and compliance with weekly MUST re-assessment

Reason for prioritising:
Aim for 98% compliance of MUST risk assessment on ward admission and weekly MUST re-assessment. This will improve patient outcomes by ensuring timely referrals to Dietitians and initiation of appropriate dietetic treatment plan.

Outcome: Partially achieved
We achieved compliance against the 98% target of patients have a weekly MUST re-assessment undertaken. The compliance for patients having a MUST risk assessment within 12 hours of admission did not meet the target of 98%. The overall compliance as at the end of March 2023 was 96%. The Trust will continue to monitor compliance against MUST risk assessments throughout the year.

Priority: Pilot the brain tumour optimisation pathway (initially Whiston Hospital patients)

Reason for prioritising:
Improve the pathway for patients with a brain tumour deemed unsuitable for surgery and require best supportive care. Significant unmet need identified for patient cohort resulting in patient not receiving right support/care.

Outcome: Achieved
Pilot complete at Whiston Hospital and results currently being audited. Roll out of pathway underway across the rest of the region, starting with Arrowe Park and Warrington Hospital.

Priority: Introduce same day admission/discharge (Surgery)

Reason for prioritising:
Creating safer pathways and processes for patients to be admitted and discharged on the same day as their operation. This will improve not only patient experience overall but will also reduce length of stay and mitigate against hospital acquired infections.

Outcome: Achieved
Same day discharge (SDD) pathway pilot underway with criteria led spinal patients. Dedicated area for SDD in-situ and failed SDD processes in place. Discussions underway to continue SDD pathway into other sub-specialty areas such as Functional and Oncology in quarter 1 of 2023/24.

2.1.2 Clinical effectiveness

Priority: Introduce Nutrition Champion Training Programme

Reason for prioritising:
This will improve patient outcomes through improvements to their nutritional care.

Outcome: Achieved
Nutrition, dysphagia and mouthcare e-learning has been uploaded onto ESR for all clinical staff. Dietitians have developed nutrition link champion training pack and resources. Train the Trainer presentation has been developed by Dietitians for the nutrition champions. A Nutrition Champion role has been allocated to at least one staff nurse and HCA in all ward areas.

Priority: Implement Virtual Reality (VR) simulator

Reason for prioritising:
Training occurs under the watchful eye of consultant neurosurgeons. The VR allows junior neurosurgeons to practice major procedures such as craniotomies in a virtual, but realistic environment mitigating against any potential patient safety risks that could arise in a live environment.

Outcome: Achieved
VR simulator purchased and is currently being used to train neurosurgical trainees at The Walton Centre. The VR simulator needs to be moved to a more suitable location for hosting external training programmes.

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

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

Outcome: Achieved
PIFU commenced in most neurosurgical areas (where it is clinically appropriate to do so). Uptake will be encouraged and monitored in each subspecialty service meeting to monitor the growth of PIFU uptake.

2.1.3 Patient experience

Priority: Develop a training programme for the Cheshire and Mersey Rehabilitation Network

Reason for prioritising:
Increase staff training for specialist rehabilitation practice and to identify and undertake quality improvement initiatives and evaluate the impact on patients, staff and the service. This will improve patient outcomes and experience and overall service delivery.

Outcome: Achieved
A network wide Education and Training Programme has been developed to meet the needs of the network in the delivery of safe and high-quality care for patients, and in the functioning of the network. The programme will be rolled out across all network teams and services in 2023/24 and evaluated to measure impact of the education and training, and results will be used to inform future programmes.

Priority: Introduce staff training to support people with communication difficulties

Reason for prioritising:
Providing support to patients, carers, families and staff is paramount in improving experience by increasing the understanding of those with communication difficulties.

Outcome: Achieved
The Trust has been successfully accredited to use and display the Communication Access symbol. This will assure patients, their carers, and their families that staff will receive training to support people with communication difficulties, and that their communication needs will be established at first contact and recognised throughout their appointments and inpatient stays. Subgroups of staff have already completed their training and we aim to roll this out to further groups across the Trust.

Priority: Reduce the number of complaints

Reason for prioritising:
Embed learning and actions to prevent re-occurrences.

Outcome: Not achieved
This has not been achieved and complaint numbers have increased in line with pre-covid figures. In quarter three, as communication and appointment arrangements has been a long-standing trend, the Patient Experience Team (PET) undertook a piece of work with divisions to review categories,

subjects and sub-subjects on the complaints model of Datix. This was to ensure that concerns received were categorised correctly to provide meaningful data to drive improvements.
The aim is to deep dive into the complaints and provide richer data in quarter one 2023/24 to facilitate learning and reduce complaints.

2.2 What are our priorities for 2023/24?

In December 2022, the Council of Governors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was successfully implemented and monitored. After this review, quality priorities were identified and agreed for 2023/24. The Quality Committee, Health Watch and Specialist Commissioners then identified the final priorities from those initially identified by the Council of Governors.

How progress to achieve these priorities will be monitored and measured:

Each of the priorities has identified lead/s who have agreed milestones throughout the year. Monthly meetings are held to review progress and support is given as required.

How progress to achieve these priorities will be reported:

Updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Quarterly quality meetings are held with commissioners to review quality assurance and provide external scrutiny and performance management.

2.2.1 Patient safety

Priority: 20% reduction in hospital acquired pressure ulcers

Reason for prioritising:
Pressure ulcers are preventable and there is a need to ensure patient harm is reduced and nursing standards of care are improved. During 2022/23 there were a total of 34 hospital acquired pressure ulcers, inclusive of category 2, deep tissue injury, mucosal and device-related pressure ulcers. We also had one unverified reported pressure ulcer.

Outcome required:
To have an overall 20% reduction in the number of hospital acquired pressure ulcers compared with the 2022/23 year end position. This will improve safe care and overall patient experience.

Priority: At least a 20% reduction in catheter acquired urinary tract infections (CAUTIs)

Reason for prioritising:
There has been an increase in catheter acquired urinary tract infections.

Outcome required:
A reduction in CAUTIs within year which will improve patient safety and experience.

Priority: 100% of staff trained in aseptic non-touch technique (ANTT)

Reason for prioritising:
There has been an increase in MSSA during 2022/23. This is a key intervention within our Healthcare Associated Infection Reduction Plan.

Outcome Required:
A reduction in healthcare associated infections (HAIs) which will improve patient safety by supporting effective education, competency assessment and safe clinical practice.

Priority: Introduce low stimulation room on Chavasse Ward

Reason for prioritising:
We need to provide patients who present with agitated behaviours a more suitable low stimulation, calming environment.

Outcome required:
To have a low stimulation space available on Chavasse Ward to help support the management of agitated and aggressive patients.

2.2.2 Clinical effectiveness

Priority: Introduce the use of lung ultrasound as a diagnostic tool into the Physiotherapy Critical Care Service

Reason for prioritising:
To support early recognition of abnormal lung pathology and ensure targeted care and treatment to patients. To provide real-time feedback on efficacy of physiotherapeutic interventions and allow staff to adapt/alter treatment approaches based on findings.

Outcome required:
Ensure all local processes and policies, associated with the introduction of the lung ultrasound, are available and supporting safe care.

Priority: Introduce electronic quality boards on each ward

Reason for prioritising:
To centralise information and provide the ward leadership teams with accurate, up-to-date data in the form of an electronic dashboard reporting monthly ward performance, patient safety data and unit feedback.

Outcome required:
Implement electronic ward dashboards which reflect accurate and up-to-date information.
Priority: Increase the number of MR scans performed daily by 10%

Reason for prioritising:
The MR scanners will be upgraded with new software which will reduce the time taken for each scan, thereby reducing total scanning time per patient.

Outcome required:
Improving patient experience by reducing time on the scan table, as well as increasing the number of patients that can be scanned per day.

2.2.3 Patient experience

Priority: Increase patient discharges before 12 midday by 10%

Reason for prioritising:
Discharging patients before 12 midday allows patients to go home when they are ready to, improving overall patient and family/carer experience as well as freeing up space earlier in the day for new patients who need to be admitted. The introduction of TTOs (To Take Out – prescribed medication) completed the day before planned discharge, more effective ward rounds, and the use of Caton Short Stay Ward (excluding complex discharges) will help avoid bottlenecks in hospital flow and reduce length of stay.

Outcome required:
Reduction in the length of stay for patients which will improve their experience, as well as patient flow.

Priority: Introduce an end-of-life and bereavement model to the Trust

Reason for prioritising:
The model is instigated at the point of recognition of dying and is used to support care throughout end-of-life, bereavement and beyond. Introducing the model will provide individualised, compassionate care to every patient and their family. Having the patient and family as the focus will enable us to meet the unique needs of each individual and their loved ones.

Outcome required:
Model introduced which will support and guide patients and their families during end-of-life care, and afterwards to improve patient care and family experience.

Priority: Trial Magnetic Resonance (MR) Guided Laser Treatment for epilepsy patients (Laser Interstitial Thermal Therapy – LITT)

Reason for prioritising:
Trialling the treatment for those who are not suitable for other forms of surgical intervention will provide a less invasive surgical solution to patients with drug-resistant epilepsy.

Outcome required:
Pilot LITT treatment for drug-resistant epilepsy patients. National Commissioning bid expected in 2023/24.

2.3 Statements of Assurance from the Board

During 2022/23, The Walton Centre provided and/or sub-contracted six relevant health services:
- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation
- Spinal Surgery
- Clinical Neurophysiology

The Walton Centre has reviewed all the data available to it on the quality of care in these relevant health services. We have interpreted this as services covered by our Quality Committee that are monitored by internal and external indicators; not necessarily a formal review.

The income generated by the relevant health services reviewed in 2022/23 represents 94.9% of the total income generated from the provision of the relevant health services by The Walton Centre for 2022/23.

2.3.1 Data quality

The data reviewed covers three dimensions of quality – patient safety, clinical effectiveness and patient experience which are all encompassed within the Quality Committee Terms of Reference and Trust Board.

The Walton Centre takes the following actions to improve data quality:
- The Trust continues to develop internal data collection systems to provide assurance to the Quality Committee in relation to the accuracy of data quality
- The Trust continuously reviews its internal processes in relation to the measurement and reporting of the quality indicators reported both to the Board and reported externally. This includes reviewing the quality indicators outlined within the Quality Accounts ensuring that there are standard operating procedures and data quality checks within each quality indicator process.

Ward to Board nursing quality indicator data collated over the last ten years includes data collection of information to support progress against the Quality Accounts and additional nursing metrics to provide internal assurance. This allows a clear focus for improving patient experience and delivery of quality care.

This information supports the Trust in building year-on-year metrics to show progress against important aspects of the patient journey.

Quality reviews are undertaken across clinical areas to provide an overview of compliance against standards to provide a full picture of the care delivered within each area and the Trust overall. The framework is designed around fifteen standards with each one subdivided into four categories including patient experience, observations, documentation and staff experience.

We now use the Tendable App to undertake reviews which is an electronic tool allowing the monitoring of trends and themes across the Trust and highlights new concerns that are recurrent issues.

2.3.2 Participation in clinical audit and national confidential

During 2022/23, nine national clinical audits and one national confidential enquiry covered relevant health services that The Walton Centre provides.

During that period The Walton Centre participated in 89% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2022/23 are as follows:

2.3.3 National audits

- Adult Critical Care (ICNARC / case mix programme)
- Severe Trauma – Trauma Audit and Research Network (TARN)
- National Emergency Laparotomy Audit (NELA)
- The Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Care at the End of Life (NACEL)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- Neurosurgical National Audit Programme (NNAP)
- UK Parkinson's Audit

2.3.4 National confidential enquiries

- Transition from child to adult health services

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	Awaiting final figure
Severe Trauma (Trauma Audit and Research Network)	Yes	100%
National Emergency Laparotomy audit (NELA)	N/A	No eligible cases
The Sentinel Stroke National Audit Programme	Yes	92%
National Audit of Care at the End of Life (NACEL)	Yes	100%
UK Parkinson's Audit	Yes	100%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT)	Yes	100%
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	No	0% = 1 unsubmitted eligible case
National Confidential Enquiry into Patient Outcome and Death		
Transition from child to adult health Services	Yes	100%

The reports of four national clinical audits were reviewed by the provider in 2022/23 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

National Audit	Actions
Adult Critical Care (ICNARC / Case Mix Programme)	Achievements 2022/23 • Move to v4.0 of ICNARC Casemix Programme (CMP) dataset • Transfer of database from WardWatcher to MedICUs system • As a result the audit input clerk has established links with local ICU audit teams to learn from and support each other • Teaching session from MedICUs to local units took place at The Walton Centre in April 2023 • The data demonstrates our outcomes are within expected ranges and have provided assurance that despite an increase in the number of deaths in ICU, the risk- adjusted mortality rates are at the same level as similar units for Q1 and Q2 2022 – 23.

<table>
<tr><td></td><td>Concerns
• System has been reliant on single individual to collect and input data.
• Staffing for data collection and input is less than GPICS recommendation.
• Therefore, there is a lack of resilience.
• V4.0 does contain more data that needs some support from clinical staff to ensure accuracy.

Opportunities
• ICNARC future plans for CMP include disease specific modules so there is the possibility of developing or using the system for neuro conditions eg subarachnoid haemorrhage. Data from these modules could help improve patient care by identifying problems in patient pathways.
• In the next year ICNARC is planning audits of patient experience in Critical Care, the diagnosis, prevention and management of delirium, and of nurse-staffing models in Critical Care. All are highly relevant to The Walton Centre but involvement will depend on timely data collection.
• If configured correctly, ICU EPR could potentially automatically download data to MEDICUs and reduce requirement for manual input.

Actions
• Support from the Outcome Team has been sought and provided to help with backlog of data entry.
• Job plan of data collector has been modified to increase time available.

Medical lead is preparing options appraisal paper to submit to ICU Operational Group and Divisional Team for increased clinical and electronic involvement in data collection and input.</td></tr>
<tr><td>Severe Trauma - Trauma Audit and Research Network (TARN)</td><td>• Case ascertainment is 100%+, which is above the national target of 80%
• Data accreditation is 96.3%, which is above the national target of 95%
• Median length of stay for patients (with an Injury Severity Score greater than 15) is 16 days, which is above the national Major Trauma Centre average of 11 days. This is due to the complex nature of trauma patients who are admitted with severe traumatic brain injury or spinal cord injury, there can also be delays for patients awaiting specialist rehab.
• The Walton Centre has a significant rate of survival, out of 470 patients only 408 were expected to survive based on probability, however 436 were observed survivors, which gave the Trust a Ws score (comparison statistic) of 3.36 with 95% confidence intervals of 1.49 to 5.23.
• The Walton Centre have continued to improve the time from incident to craniotomy, median time 293 minutes, which is</td></tr>
</table>

	below the national Major Trauma Centre average of 370 minutes, this also a decrease of 67 minutes compared to the previous year. • In comparison with other Major Trauma Centres nationally, The Walton Centre is showing as the third best centre for increased survivors. It is worth noting that the Trusts either side of The Walton Centre have substantially large confidence levels which indicates an unreliable data set. The Trust will continue to submit data to TARN and will review individual cases as appropriate.
The Sentinel Stroke National Audit programme (SSNAP)	• The Walton Centre's thrombectomy cases and declined referrals are reviewed at the Regional Thrombectomy MDT group. • Issues identified relating to data submission have been discussed with Walton Centre senior management. • The regional MDT group identify and discuss potential areas for improvement across the patient pathway.
UK Parkinson's Audit	• The results, from the only national Parkinson's audit in the UK, demonstrate ongoing delivery of excellent Parkinson's care. There continues to be almost ubiquitous access to specialist nurses or equivalent, and also to therapists. There have been significant improvements in many areas such as options for remote consultations, awareness of the importance of activity and exercise, bone health, and inductions for new therapists. • The areas for improvement vary across the different service types but some key themes have emerged, including early referral to therapy services, waiting times, standardized assessments, anticipatory care planning and advice about driving. The Walton Centre has signed up to participate in the Bone Health Improvement project.

2.3.5 Participation in local clinical audits

The reports of 61 local clinical audits were reviewed by the Trust in 2022/23 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:

Neurology clinical audits and service evaluations

Audit title	Actions
A single centre, retrospective cohort study of patients under the care of Neurology admitted to ICU (N 358)	• Findings disseminated January and March 2022 / Neurology Grand Round and Neuro ICU audit day. • **Issue:** Ongoing service evaluation • **Action:** To continue data collection to include 2022 patients. Further information to be captured
Assessment and management of swallowing in Parkinson's Disease patients (N 368)	• **Issue:** Missed information by clerking doctor. • **Action**: Highlighting issue about required line of questioning when clerking patients with Parkinson's Disease • **Issue:** Missed Malnutrition Universal Screening Tool (MUST) forms for some patients. • **Action:** Ensure patients who are admitted straight to theatres have their assessment done after theatre
Botox service audit during covid-19 pandemic and following service recovery (N 381)	• **Issue:** Botox for chronic migraine administered outside of 12 weeks • **Action:** Increase in capacity and additional clinics to be discussed with neurology division management
gammaCore™ service evaluation (N 390)	• **Issue:** Poor compliance with headache diaries for this group of patients on this treatment • **Action:** Discussion for potential standalone gammaCore™ clinic enabling clinical outcomes to be documented
Evaluation of the new Motor Neurone Disease (MND) key worker project at Wirral Hospice St John's (N 375)	• Results and recommendations fed back to Wirral Hospice St John's and the MND association for consideration and implementation
A retrospective real-world evaluation of fremanezumab (Ajovy) in the management of refractory chronic migraine (N 388)	• No actions necessary • Results disseminated to the headache multidisciplinary team.
Audit of genetic testing for patients with the SPG7 mutation (N 383)	• No actions necessary • Dissemination of results
Assessment of bone health in the neurology clinic - Fragility fracture or use of glucocorticoids (N 380)	• Dissemination of results • Raise awareness • Include in risk bulletin
Monitoring and safety in prescription of corticosteroids – second audit cycle (N 383)	• Need for more awareness and discussion of steroid monitoring in outpatients – discussed in neurology audit meeting • Include in risk bulletin

	• Review and update steroid monitoring guideline • Long term steroid guideline planned
Ensuring cognitive screening instruments used in routine clinical practice adhere to the Wilson-Jungner criteria for high test sensitivity and specificity, using binary receiver operator characteristic (ROC) plot and area under the curve (AUC) as a measure for adherence (N 310)	• Raise awareness • Disseminate results
Venous thromboembolism (VTE) prophylaxis prescribing and review post neurosurgery (N 377)	• Align the VTE Policy with the NICE guideline NG89-1.12 • Current review of VTE guidance underway • Ensure the spinal teams are more compliant with the VTE prophylaxis policy • Ensure that VTE prophylaxis prescribing is clearly highlighted to the doctor or prescriber during the weekend handover on a Friday
Antibiotic point prevalence audit (NRP 04)	• Improve review at 48-72 hours – Targeted antimicrobial stewardship (AMS) at 48-72 hr reviews of urine, chest and sepsis infections (involve SMART, pharmacists and junior doctors) • Dissemination of key points to prescribers via Walton Weekly every quarter
Audit of Allegro Volumetric for pre-operative brain tumours (N 378)	• **Issue:** Volumetric post contrast imaging with too small a field of view for use in surgical planning • **Action:** Education to external Trusts to The Walton Centre about the purpose of post contrast volumetric imaging
Audit of non-medical referrers for radiology under Ionising Radiation (medical exposure) Regulations (IR(ME)R) guidelines 2022 data (NRP 03)	• **Issue**: Non-medical referrer did not log out and another user requested an examination outside of an agreed protocol. • **Action**: Non-medical referrers advised to always log out. • Results disseminated – Director of Nursing, Radiology Directorate management meeting and staff management meeting
Audit of standards of communication of radiological reports and fail-safe notifications (NRP 20)	• No actions necessary • Results disseminated Radiology staff meeting and Directorate management meeting

Audit of CT contrast opacific of the abdomen (N 365)	• Discuss the following with consultant body:
	  o Consider bolus tracking abdomen and pelvis scans
	  o Determine contrast dose using a weight based look up table.
	• Further discussion and information gathering required to agree a safe protocol using weight-based contrast dosing

Standards for reporting and interpretation of fluoroscopy guided lumbar punctures in line with Royal College of Radiologists guidelines (NRP 08)	• No actions necessary • Following discussion with clinical governance lead, it was agreed to repeat audit every six months rather than

	quarterly due to the number of procedures completed in the timeframe • Findings presented at directorate management meeting
Recording of CT radiation doses and unsaved CT images (NRP 14)	• Staff reminder to highlight problematic themes and highlight the need for time-to-digital converter (TDC) images to be sent
Audit of delayed MRI for patients with reduced capacity (N 360)	• **Issue:** Ward staff delays in the completion of MR safety forms for patients with reduced capacity requiring next-of-kin contact • **Action:** Completed. Transfer responsibility for next-of-kin to be contacted by MR staff rather than ward staff
Audit to assess the suitability of line algorithm for visualisation of nasogastric tubes (NRP 16)	• Staff reminded to ensure standard chest X-ray and line algorithm image are both sent to patient access centre (PACS)
Audit of patient satisfaction for MR (NRP 01)	• Staff reminded to tell patients how they receive results via monthly briefs from principal radiographers
Audit of Patient Satisfaction Survey Results for patients attending for X-ray guided LP (NRP 01)	• No actions necessary – re-audit 12 months
Audit of prediction of level 2 bed utilisation post endovascular intervention (N 355)	• **Issue:** 51 elective cases cancelled due to lack of level 2 beds, and 7.81% of underprediction of level 2 bed utilisation • **Action:** Results fed back to bed management and multidisciplinary interventional radiology team • Discussed at directorate management meeting
Audit of exam time to report availability (NRP 12)	• Communication of results to all members of the directorate management team.
Protocol adherence for MRI lumbar spines in and out of hours (N 389)	• Reminder will be emailed to radiographic staff to vet the out-of-hours patients when they attend for lumbar MRI
Midterm outcomes of low profile visible intraluminal (LVIS) EVO stent-assisted coiling procedure for treatment of wide necked and complex intracranial aneurysms (N 379)	• No actions necessary
Adherence to weight based iodinated contrast administration for abdominal CT (NRP 27)	• **Issue:** Non-universal use of weight-based CT protocol **Action:** Discussed with CT lead potential for including visual prompt and/or guidance in CT room for reminder of weight-based contrast dosing for abdominal CT and how to calculate dose (inc. where to find calculator etc). Dissemination of audit results in Team brief / case review meeting. Presented – Neuroradiology Consultant meeting
Audit of standards for reporting and interpretation of ultrasound images in line with Royal College of Radiologists (RCR) and British Medical Ultrasound Society	• No actions necessary

(BMUS) guidelines 2022 (NRP 02)	
Audit of double reporting in line with Royal College of Radiologists guidelines (NRP 05)	• Communicated and distributed to all members of the directorate management team
CT Contrast Opacification of the Abdomen audit (Portal Venous Phase Enhancement at The Walton Centre – A Quality Improvement Project) – re-audit (N 410)	• No actions necessary • Disseminated in CT team brief and Directorate Management meeting (Radiologists)
Audit of epilepsy protocols in MRI (N 341)	• No actions necessary
Clinical Audit Action Plan to evaluate dose for whole spine imaging using the Multitom Rax (N 85)	• Discussion required to determine if any further changes to kilovoltage peak (kVp) should be made • Consider use of scoliosis follow-up parameter to reduce dose further
Audit to monitor the reject analysis rate for rejected plain film radiography in accordance with IR(ME)R Regulations (N 85)	• Problematic themes and how to rectify them highlighted to staff
Retrospective audit of clinical physiologist nerve conduction study tests to check quality assurance of waveforms and compliance with standard operating procedure (N 373)	• **Issue:** Compliance with the SOP is low with tests not performed appropriately based on the results obtained **Action:** Ask all staff to familiarise themselves with the SOP again • **Issue:** Missing demographics on both the nerve conduction velocity (NCV) machine and the printout report as well as the physiologist performing the test • **Action:** Ask all staff to ensure they input all demographics and ensure this is present on the printout. Speak to Optima to update the system on pulling the correct demographics through to the report. • **Issue:** In consistency with the display of the sensory amplitude data with different values being used to interpret • **Action:** Discuss with consultants for consensus how the data should be displayed and disseminate to all staff • **Issue:** No option to add if there is deformity or difficulty obtaining results which would account for artefact seen. Consultants would like a comment column added to the report for Physiologist to utilise and annotate • **Action:** Liaise with Optima to alter the physiologist report to include this comment column. To update physiologist when this is complete
Retrospective study of clinical physiologist carpal tunnel clinics/ulnar neuropathy at the elbow and investigating the need/referral for additional review	• Operator error is low, however this has led to a small minority of patients requiring re-examination in a consultant led EMG clinic. Therefore, clinical physiologists were reminded to familiarises themselves with carpal tunnel syndrome (CTS) SOP and provide an additional teaching

in Consultant electromyography (EMG) clinics (N 386)	session to refresh operator errors and ways to eliminate these
Compliance of EEG protocol standards in a routine EEG (N 370)	• **Issue:** Low compliance to certain standards of the protocol (initially) • **Action:** The protocol and compliance was addressed during a clinical physiologist session in detail, discussing the implications. The change was reflected in the next monthly results. Any further drop in compliance will be similarly addressed.
Monitoring "green" dietetic referral form completion that may have led to missed or delayed dietetic input (N 366)	• **Issue:** Patients potentially being missed to follow • **Action:** Discussed with clinical systems and agreed plan to access a list of these patients daily
Compliance with report writing standards for objectives swallowing assessments – FEES (N 394)	• **Issue:** Results fed back at SLT team meeting with actions around maintaining standards where 100% is achieved and reminders/discussion where this is not the case • **Action:** To ensure arears of improvement and infection standards which were under 100% are explicitly added to the template on Ep2 – i.e., add feeding recommendations heading to template
Naso-gastric (NG) Transition Feeding Audit (N 369)	• **Issue:** Premature nasogastric (NG) removal following commencement of oral nutritional intake on the neurosurgical and neurology wards risks compromising nutritional status of patients unnecessarily • **Action:** Rollout of protocol on neurosurgical and neurology wards
Evaluating the benefit of respiratory physiotherapist attendance at ITU follow-up clinic (N 295)	• The respiratory physiotherapy team will no longer routinely attend ITU follow-up clinic. Instead, a 'drop-in' agreement is in place by which clinicians present at follow-up clinic can bleep the respiratory physiotherapy team to attend if direct input or advice is required. Since discontinuation of routine attendance in August 2022, this drop-in agreement has not been used
Evaluation of service gap for tracheostomy service – is there a need for outreach community service to facilitate and re-assess tracheostomy discharge (N 391)	• **Issue**: Areas of particular delay in the process identified • **Action:** Discuss planning and processes with discharge co-ordinator • **Issue:** Service gap identified • **Action:** Presentation of data to team and department lead • **Issue:** Learning points to be identified to be disseminated to wider team • **Action:** Presentation of findings to associated MDT, Tracheostomy steering group - reach agreement as to how to escalate issues that fall outside the remit of the Lipton Ward MDT
A service evaluation of staff experience of Psychology within two community neurorehabilitation teams (N 362)	• The team had an away day and discussed the findings from the survey. There have been a number of significant changes in the Community Team in the last six months. The structure of the team (staffing levels etc.) and the model of working have been improved and this has brought

	with it a lot of changes in how the team operates (waiting times, organisation, staff pressure, etc.) • The team now operates with all clinicians picking up patients at the same timepoint, this way roles and goals are defined clearly from the start of the patient's input with the Community Specialist Rehabilitation Team (CSRT)
Evaluating the need for psychoeducation for patients with an acquired brain injury and their families/carers (N 374)	• Psychology team within the network to develop further psychoeducation videos for website. Assistants currently looking at developing videos an executive functioning. • To be discussed as a quality project within the network team • Discuss projects/new materials with families/carers • Share resources with patients
Functional neurological disorder (FND) management and its outcome (N 291)	• **Issue**: Patients that are admitted are not aware and might not agree with the diagnosis • **Action**: To ensure that patients are aware and had accepted the FND diagnosis • **Issue**: Patients not being appropriately screened or selected • **Action**: To screen patients by setting pre-admission guidelines • **Issue**: In most cases, there is no continuity of care in community for FND patients • **Action**: To refer or signpost the patients to the appropriate community teams or FND services • **Issue**: Staff concerns and limited skills to look after FND patients • **Action**: To provide support and provide education to the nursing staff to look after FND patients especially NEAD (non-epileptic attack disorder)

Neurosurgery clinical audits and service evaluations

Audit title	Actions
Traceability Audit 2021	**Key successes:** • 91% cases accounted for • All post-mortem instructions carried out • Removal of the failure code following last year's audit has removed various confusing issues **Key concerns:** • Two slides couldn't be located (HNC354) • Two slides found in the file but not recorded on the LIMS (HNC353) • Three tracers missing from the file (HNC355)

	Other observations: • Tracer found in file that was no longer needed • MAD requires a MAD positive and MAD negative slide but code on LIMS only generates one entry (PA60) **Key actions:** Code for MAD in LIMS only generates one slide where it also includes a negative-code has been updated to include two slides
Subarachnoid haemorrhage data collection audit	**Key successes**: • Vast majority of SAH data collected is in line with SBNS/RCSEng guidance • Data collection is accurate and has consistently improved over the last eight years • Neurovascular Team maintains a well-organised and accurate database meeting all of guidance mandatory criteria **Key concerns:** • The addition of long-term follow up data is not mandated by the guidance but is recommended and would therefore be a useful addition to future research from this database The addition of long-term follow up data is not mandated by the guidance but is recommended and would therefore be a useful addition to future research from this database
Oral ketamine to support outpatient and inpatient opioid weaning. Low dose intravenous ketamine for the treatment of Complex Regional Pain Syndrome (CRPS), refractory neuropathic pain, refractory headaches disorders, refractory visceral pain and opioid weaning	**Key successes:** • Outcomes for oral ketamine is collected prospectively to audit, if implemented • Low dose intravenous ketamine is a valid treatment option for patients with refractory headaches • Patients for opioid detoxification are now treated with a sublingual buprenorphine protocol and oral ketamine which should reduce the need for iv ketamine considerably • Except for the one CRPS patient there does not seem to be any demand for this indication at the moment **Key concerns:** • Formal consent required after clearly identifying and documenting purpose and initial goal for oral ketamine therapy on eP2 • Patient information leaflet needs to be written and approved outlining the rationale and purpose for oral ketamine in pain medicine • Review by consultant after six months if still on oral ketamine

	• Baseline liver function tests repeated after three months if still on ketamine including toxicology screen to check compliance and estimate plasma level **Key actions:** • Patient information leaflet now in use Key points for data collection now updated on Trust patient information system (eP2)
Visual Impairment Service Review	**Key successes:** • A significant number of patients had a preservation or recovery of central vision despite peripheral visual field loss • The ranges of Visual Field Defect were predominately graded minimal to subtle level of field loss **Key concerns:** • 23.40% patients had a VISN alert on their medical records while 77% were not identified or not supported for their visual impairment • Three patients certified sight impaired and severely sight impaired (75%) did not have an VISN alert **Key actions:** • Working group has been established to identify and improve healthcare access for patients with a disability visiting or staying at the Trust • Best practice guidelines for the visually impaired now in use • Sight loss patient information leaflet has been introduced Care Plan has been developed for eP2
An evaluation of the frequency and cause of isolated raised cerebrospinal fluid (CSF) total protein in WCFT patients	**Key successes:** • The audit results suggests that, in The Walton Centre population, an isolated, raised CSF total protein is a significant but non-specific finding. However, these findings could not be applied to a general population • This supports the well-established role of the CSF total protein test as a useful screening tool for neurological conditions that give rise to inflammation of the meninges or alterations in CSF flow. **No key concerns or actions**
Neuropathology report-content audit following the introduction of new changes in central nervous system (CNS) WHO book 2021	**Key successes:** • The essential changes that have been brought in following the publication of the 2021 WHO blue book were correctly applied in the neuropathology reports audited on CNS tumours **No key concerns or actions**
Research Request Forms R2 and R3 Horizontal Audit 2021	**Key successes**: • All the samples of the Liverpool Neuroscience Biobank at The Walton Centre (LNBW) that includes: Walton Centre Research Tissue Bank (WRTB) and Walton CSF Research Biobank (WCRB) documentation and paperwork have been

	released with correct respective forms and signed by either the Designated Individual or Person Designated and comply with Human Tissue Authority (HTA) regulations **No key concerns or actions**
Research Ethics Committee (REC) and Regional Governance Committee (RGC) Approvals Audit 2021	**Key successes:** • 26/26 (100%) had either an REC or an RGC number present or both which could be found on documentation/file within the Neuroscience Laboratories. This demonstrates full compliance with the HTA regulations **No key concerns or actions**
Low grade glioma audit	**Key successes:** • In accordance with current literature our figures show that the extent of resection is associated with increased progression free and overall survival • There has been a transition to using PCV chemotherapy since the 2018 NICE guidelines were introduced • The data has been shared with clinical oncologists at Clatterbridge Cancer Centre and North Wales **No key concerns or actions**
GIRFT Surgical Site Infection (SSI) Survey 2019	**Key findings:** • No conclusions can be drawn from the single infected posterior cervical instrumentation incident. (One of three cases): continue to monitor via surgical site infection reports • In depth review of EVD/CSF infections to be undertaken to provide an understanding of potential causes for these infections • In depth review of single level spine surgery infections to be undertaken to provide an understanding of potential causes for these infections • SSI recording and reporting is a labour-intensive paper based manual process and could be improved via digitalisation and automation • The data collection is incorrect to state that there is no SSI bundle: this is checked via the WHO checklist at the start of every case: hair removal, glycaemic control, temperature control and prophylactic antibiotics are confirmed prior to incision • Laminar flow has widely been discredited in surgical site infection prevention and is known to be harmful in cranial surgery due to excessive tissue desiccation **Key actions** • Implementation of a live digital dashboard • Education for the CNS teams from IPC regarding SSI underway • Digital version of SSI reporting form implemented • Rapid Reviews and or RCAs are now performed on CSF infections where necessary

	The One Together programme is in progress at the Trust to standardise theatre procedures and review contributory factors to SSI
Vertical audit – Neuropathology specimens	**Key successes:** • The specimen was handled in accordance with Trust and Neuroscience Laboratory policies, procedures and SOPs • All documentation was in date apart from the document HSB36 on the intranet which was replaced with HSB73.This was rectified immediately • SOP HSS34 updated to the new SOP template which includes all required information and the turnaround time stated on the intranet • The request card was completed correctly by both clinical staff and laboratory staff • PAT testing and PDRs already organised • Although the reporting of the sample breached the turnaround time of seven calendar days, TAT times are monitored monthly and as more than 80% passed in April when this specimen was received no further action is required **No key concerns or actions**
Intraoperative diagnosis versus final diagnosis 2021	**Key successes:** • Diagnostic accuracy for intraoperative specimens reported in 2021 was 95.3% against a target of 93.6% • The results are consistent from last year with 95.3% accuracy **No key concerns or actions**
Neurobiochemistry vertical audit 2022 - Serum Albumin	**Key successes:** • Process for quantifying serum albumin is working well. • The specimen was handled in accordance with Trust and Neuroscience Laboratory policies, procedures and SOPs. All documentation was in date **No key concerns or actions**
5-Aminolevulinic acid (5-ALA) use at The Walton Centre	**Key successes:** • The audit has highlighted that the use of 5-ALA has aided surgical resection, enabling greater resection in the majority of patients prescribed for at The Walton Centre. It has been used in accordance with NICE for HGG resections in 87% of cases **Key concerns:** • Some improvement could be made in ensuring the correct dose is prescribed and the appropriate monitoring (LFT) is carried out post procedure

	• Theatre documentation could be improved so future audit can more easily identify extent of resection and extent of fluorescence **Key actions:** Reiteration for consultants prescribing 5-ALA to ensure policy and process is adhered to in terms of dosing to ensure care provided is standardised
LNBW 20 Research Consent forms Audit 2021	**Key successes:** • 366/367 (99%) consent forms were complete and valid **Key concerns:** • 9/273 LNBW-WRTB consent forms (3.2%) were not signed by person taking consent. (3.2% in 2020) • 14/273 LNBW-WRTB consent forms (5.0%) of the wrong colour copy of consent forms received instead of white copy (2.4% in 2020). The consent forms are still valid • 16/94 LNBW-WCRB consent forms (16.9%) had been ticked instead of initiated. (12.3% in 2020) **Key actions:** • Retrospective completion of missing data • Refresher training to theatre staff
Management of subarachnoid haemorrhage	**Key successes:** N/A **Key concerns:** • Documentation on admission requires improvement • Clear targets were not documented • Design of proforma for admission to ICU required • New admission proforma for wards required (Vascular nurse specialist has completed) • Consideration for pre-Walton admission administration of Nimodipine required **Key actions:** • A programme of work is currently underway to digitise the documentation in ITU • New admission proformas for wards implemented

Trustwide clinical audits and service evaluations

Audit title	Actions
CSF Index and Oligoclonal band (OCB) results 2021 (NS 396)	• No actions necessary • Discussed / presented Neurobiochemistry – The Neuroscience Laboratories • Discussed at Neurology Governance and Risk as project also relevant to Neurology

If implementation is not deemed appropriate then outstanding actions are placed on the divisional risk registers.

Recommended actions resulting from clinical audit projects are reviewed and monitored monthly by the Clinical Audit Group.

The divisional clinical audit teams produce a monthly clinical audit activity progress report which includes registered audits, recommended actions from all completed projects for each division and the progress made towards implementation, these reports are discussed at the relevant Divisional Governance and Risk Group monthly meetings.

2.3.6 Participation in clinical research and development

The Trust's participation in clinical research demonstrates our commitment to improving the quality of care we offer and to wider health improvement.

Clinical staff actively maintain their involvement in the latest possible treatments and as a Trust recognise that active participation in research leads to successful patient outcomes.

1049 patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2022/23 were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority.

No yearly target was set for this financial year, however an approach is being developed to improve our systems to encourage a research-positive culture and diversify the research portfolio so that research is meaningfully embedded in the experience of all patients and service users.

There are currently 78 clinical studies open to recruitment at The Walton Centre, with a research pipeline of new studies in the feasibility and/or set-up phase (currently 39 but this number will increase as support investigators, via the expressions of interest process, will be ready to open at different points throughout 2023/24.

Having secured a collaboration with an external industry partner, Neuroscience Research Centre (NRC) patients now have access to participate in a Phase 2 clinical trial for fibromyalgia.

During 2022/23 the Trust has worked collaboratively with the following networks and organisations to attract NIHR funding to deliver and disseminate clinical research and innovation to inform service transformation and improvement:

- Clinical Research Network: North West Coast (CRN)
- Liverpool Health Partners (LHP) - SPARK
- Innovation Agency, the North West Coast's Academic Health Science Network
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC) now the ARC (Applied Research Collaboration)
- Local Higher Education Institutions
- Spinal Network
- Stroke Network
- Other NHS organisations
- Pharmaceutical companies (industry)

2.3.7 CQUIN framework and performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between The Walton Centre and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2022/23 and for the following 12-month period are available electronically at wcft.enquiries@nhs.net.

A proportion of the Trust's income in 2022/23 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINs in 2022/23 was £1,098,000.

2.3.8 Care Quality Commission (CQC) registration

The Walton Centre is required to register with the Care Quality Commission. Its current registration status is registered without conditions.

The CQC has not taken enforcement action against The Walton Centre during 2022/23. The CQC undertook an inspection, including well-led, during March and April 2019, which resulted in an Outstanding status for the second time.

No further formal assessments have been undertaken during 2022/23. CQC engagement meetings restarted in April 2023.

Ratings for The Walton Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Good ➔⬅ Aug 2019	Outstanding ↑ Aug 2019	Good ➔⬅ Aug 2019	Good ➔⬅ Aug 2019	Outstanding ↑ Aug 2019	Outstanding ↑ Aug 2019
Critical care	Good ➔⬅ Aug 2019	Good ↓ Aug 2019	Outstanding ↑ Aug 2019	Good ➔⬅ Aug 2019	Good ➔⬅ Aug 2019	Good ➔⬅ Aug 2019
Outpatients	Good Oct 2016	Not rated	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Rehabilitation services	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016
Overall*	Good ➔⬅ Aug 2019	Outstanding ➔⬅ Aug 2019	Outstanding ➔⬅ Aug 2019	Good ➔⬅ Aug 2019	Good ➔⬅ Aug 2019	Outstanding ➔⬅ Aug 2019

2.3.9 Trust data quality

The Walton Centre submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (December 2022) which included the patient's valid NHS Number was:

- 99.9% for admitted patient care
- 99.9% for outpatient care

The percentage of records in the published data (January 2022) which included the patient's valid General Practitioner Registration Code was:

- 99.9% for outpatient care
- 99.9% for admitted patient care

This year is the fifth year of the new Data Security and Protection Toolkit. The Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health Policy. Within the Toolkit there are 36 assertions and 113 mandatory evidence items.

Completion of this requires compliance with all assertions and all mandatory evidence items. The methodology remains the same every year whereby a mandatory independent audit continues to be required as part of the evidence process.

The Trust is on target to meet all assertions and mandatory evidence items for the Data Security and Protection Toolkit, which is due to be submitted to NHS Digital on 30 June 2023. This deadline was extended in line with Covid-19 and will now remain as the new submission date for future years.

The Trust has implemented action plans to aim to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 2022/23 Data Security and Protection audit requirements is currently ongoing throughout February and April 2023 and the Trust will then receive the outcome of this review in May 2023.
The latest figures from the NHS Information Centre Indicator portal are for 2011/12 and the national readmission rate was 11.45%. The website link is https://indicators.ic.nhs.uk/webview/

The Walton Centre was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

The Walton Centre undertook a Clinical Coding Data Quality Audit during the reporting period. The following table reflects the results of an audit carried out by an Approved Clinical Coding Auditor and the error rates reported for this period for diagnoses and procedure coding (clinical coding) was as follows:

The Walton Centre Internal Clinical Coding Audit 2022/23

Coding Field	2020/21	2021/22	2022/23	Difference 21/22-22/23	Mandatory	Advisory
Primary diagnosis	91.00%	96.70%	97%	+0.30%	90%	95%
Secondary diagnosis	86.00%	94.14%	95%	+0.86%	80%	90%

Primary procedure	97.00%	99.40%	98.5%	-0.90%	90%	95%
Secondary procedure	98.00%	93.87%	96%	+2.13%	80%	90%

Last year The Walton Centre took steps to improve data quality which is demonstrated in the improved scores above.

2.3.10 Learning from Deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendments Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning from Deaths' to quality accounts from 2017/18 onwards.

2.3.10.1 During 2022/23, 112 of The Walton Centre's patients died. This can be broken down by the following number of deaths which occurred in each quarter of that reporting period:

- 20 in the first quarter
- 40 in the second quarter
- 30 in the third quarter
- 22 in the fourth quarter

By 31 March 2023,106 case record reviews had been carried out in relation to 112 of the deaths included in item 2.3.10.1. Six case records are awaiting review.

In two cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 19 in the first quarter
- 39 in the second quarter
- 30 in the third quarter
- 18 in the fourth quarter

2.3.10.2 Zero representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the structured judgement review methodology. Prior to the National Quality Board report on Learning from Deaths, The Walton Centre had a robust

mechanism of mortality review where all deaths were reviewed in detail and reviewed in the mortality review group.

Zero case record reviews and zero investigations completed after 31 March 2022 which related to deaths which took place before the start of the reporting period.

Zero representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the process embedded within the Trust including a full health record review of each death and discussion at the respective Divisional Mortality Meetings.

Zero representing 0% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.11 Progress in implementing clinical standards for seven day hospital services

In the seven-day services framework, clinical standards (CS) 2,5,6 and 8 have been prioritised. We are fully compliant with clinical standards 5, 6 and 8.

The Trust continues to make progress with CS2. In the seven-day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a Consultant presence for review throughout seven days. As a specialist Trust there has been discussion with the seven-day services team regarding difficulties that arise for us with this standard.

All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, will usually have had investigations such as scans, and in neurosurgery admissions (which are the vast majority) the diagnosis will usually be clear.

All admissions are discussed with a Consultant prior to transfer and a management plan is formulated. There is a two-tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach /critical care trained nursing staff.

Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%. This has not been re-audited since 2019 due to the impact of the Covid-19 pandemic, but there are plans to re-audit this during 2023.

The mortality report continues to be reviewed quarterly at Quality Committee and Trust Board. This has not shown any trends in deaths by day of the week and day of admission.

In summary, the Trust continues to show an improvement in compliance with CS2 but due to being a tertiary centre, some patients may appropriately be treated on arrival by a senior trainee but are reviewed in a timely manner following this by a Consultant. In addition, there are other clinical standards which the Trust continues to progress well with.

Feedback from local patient experience surveys and reports from listening events held by Healthwatch Sefton) and Healthwatch Liverpool continue to be excellent on the standard of medical care. There have been no concerns raised over quality of care/Consultant presence on weekday or weekends. This does not feature as a theme of patient and family complaints.

There is an MDT ward round for all neurosurgery and critical care patients. This comprises medical, nursing, Advanced Practitioners (AP) and pharmacy staff. The SMART team join the ward round at weekends.

In neurology there is a weekday daily board round involving medical, nursing, pharmacy and therapy staff. This has been developed since 2015, particularly with the involvement of pharmacy and therapies.

Shift handovers: Each morning at 8am there is a neurosurgical handover meeting led by the Consultant on-call. All patients referred overnight (whether transferred or not) are discussed and scans reviewed. This is an MDT meeting involving medical, AP staff, SMART team coordinator and bed management team. There is a formal handover meeting at 8pm each weekday, coordinated by the SMART coordinator and involving junior medical staff.

There are well defined procedures for medical handover following each shift. At weekends, at 8.30am, there is a handover meeting attended by the Consultant neurosurgeon on-call, the trainee medical staff and SMART coordinator. In neurology there is a daily board round, including weekends. The role of SMART coordinator in safe handover is documented in the Trust policy 'Operational Guidelines for the Surgical and Medical Acute Response Team (SMART)'.

Transfer to community, primary and social care: There are daily Consultant reviews to support discharge. There is a complex discharge coordinator working during the week but not at weekends. This service is covered by the Bed Management Team or bleep holder at weekends. Ward-based pharmacists support the ward rounds and medications to take out (TTO) are completed by the pharmacist or AP. There are referral pathways for community settings and access and referral systems in place for all providers, social care and continuing health care. There is pharmacy support for TTO at weekends.

There is a process in place for repatriation to other Trusts, but since the onset of Covid-19 there has, at times, been a need to intentionally relax these criteria as part of mutual aid to the acute Trusts in our region. There is a weekly delayed discharge meeting to discuss any patients with a long length of stay and these are escalated as appropriate.

Quality improvement: The Trust mortality report is reviewed quarterly by Quality Committee and reported to Trust Board. The Trust Board receives a quarterly report from the Guardian of safe

working hours on junior doctor working hours. The Clinical Effectiveness and Services Group and Quality Committee regularly review clinical outcomes, with a view to driving continuous improvement. We collect robust clinical outcome data in 75% of all neurosurgical procedures, which is far higher than most neurosurgical units.

2.3.12 Speaking Up

The Trust's Freedom to Speak up Guardian (FTSUG) is proactive in ensuring staff members are given the opportunity to raise concerns. The FTSUG presents to clinical and non-clinical staff during their induction. Each individual staff member receives a business card with specific contact details should they wish to raise a concern and can arrange a meeting on/off site.

There are sixteen FTSU Champions in post to support speaking up across the Trust.

There is a dedicated section on the Trust intranet site which provides information in relation to speaking up. It includes how to speak up, who to speak up to, what happens when staff speak up and information on who the FTSU Guardian and Champions are, their pledges, and contact details.

We recognise that our staff may experience barriers at any part of the speak up cycle that may require staff to seek support outside of their team or line management routes. If staff make use of the FTSU service for support, we might also sign post to other services within the Trust such as Equality, Diversity and Inclusion, Unions, HR, Occupational Health, Anti-Fraud Specialist (not exhaustive list). Staff can also raise their concerns externally if they wish to do so.

Following the publication of the latest version of the Freedom to Speak up Policy for the NHS we have revised our policy which was approved and is held on the Trust Intranet site.

Drop-in sessions are scheduled throughout the year across each of the areas within the Trust.

Regular contact is made with those who speak up and other parties to ensure progress is being made in terms of a resolution. This also safeguards the person/team who raised the concern from experiencing detriment. Once a concern has been addressed and appropriate action taken the FTSUG meets with the individual raising the concern to provide an update and agree no further steps are to be taken. They are also asked to make contact with the FTSUG if they perceive to be treated unfairly following them speaking up.

2.3.13 NHS Doctors in Training

On average the Trust has approximately 52 HEE trainees on rotation at any one time that comply with Terms and Conditions for NHS Doctors and Dentists in Training (England) 2016. Some do not partake in any out-of-hours duties and therefore can be supernumerary to the service delivery. Therefore, if we have a gap for daytime duties only it will not have a detrimental effect on patient care as they are supernumerary to the workforce and there for training purposes.

Where a trainee is integral to the out-of-hours rotas the Trust will make arrangements to either employ a Locally Employed doctor to fill the daytime and out-of-hours or an agency locum or internal locum cover will be considered in the interim and until it can be recruited to via NHS Jobs.

The Trust also employs Clinical Fellows to supplement the trainee workforce and support both the elective and emergency work. The Medical HR Manager together with the Clinical and Divisional Mangers monitor the rotation periods and if additional doctors are required then action will be taken to recruit.

We have not had any exception reports against any gap in recruitment. The Guardian of Safe Working reports directly to Trust Board on a quarterly basis. Any exception reports have related to breaches in minimum rest requirements and have been satisfactorily dealt with by time off in lieu, plus payment.

Part 3 Trust overview of quality 2022/23

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2022/23.

Presented are quantitative metrics, specific to aspects of safety, effectiveness and patient experience which are measured routinely to assure the Trust Board regarding the quality of care provided, having also been shared at a number of assurance committees within the hospital.

Patient safety indicators

Trust acquired	2019/20	2020/21	2021/22	2022/23	National trajectory
C Difficile	5	3	8	7	8
MRSA Bacteraemia	0	0	0	0	0
E. coli	13	7	11	12	10
Minor and moderate falls	37	19	30	31	n/a
Never Events	1	0	2	0	n/a
Data Source: Infection Prevention and Control NHSE Set following review of previous years' performance using NHSE national calculation					

Clinical effectiveness indicators

Mortality	2019/20	2020/21	2021/22	2022/23
Neoplasms	13	7	8	15
Diseases of circulatory system	36	52	23	43
Injury, poisoning and certain other consequences of external causes	29	27	24	37
Diseases of the nervous system	9	15	7	13
Other	6	10	2	4
Total	93	111	64	112
Data Source: Patient Administration System				

Patient experience indicators

Patient experience questions	2019/20	2020/21	2021/22	2022/23
Were you involved as much as you wanted to be in decisions about your care and treatment?	95%	89%	89%	Results available Oct 2023
Overall did you feel you were you treated with respect and dignity while you were in the hospital?	99%	99%	93%	Results available Oct 2023

Were you given enough privacy when discussing your condition or treatment?	94%	84%	99%	Results available Oct 2023
Did you find someone (hospital staff) to talk to about your worries and fears?	82%	93%	93%	Results available Oct 2023
Data Source: CQC Adult Inpatient Survey				

3.1 Complaints

3.1.1 Patient experience, complaints handling and Patient and Family Centred Care

The Walton Centre acknowledges that attending hospital can be a difficult and frightening experience. This was particularly tough during a pandemic when visiting restrictions were in place. The Patient and Family Experience Team (PFET) provides a confidential support and advice service to patients, their families and carers, as well as helping to resolve enquiries and concerns and complaints on their behalf. This can be prior to, during, or after their visit to the Trust. They can be contacted by telephone, email, in writing, booking an appointment or in person whilst in the Trust.

Where concerns cannot be easily resolved informally or are of a more serious or sensitive nature, the Patient and Family Experience Team is responsible for supporting the patients and their families in managing and resolving the complaint via the formal complaints procedure. We pride ourselves on working with patients and their families and carers to resolve complaints in a timely way. When responding to complaints if they are upheld and require action and learning this is explained within and how the learning will be applied evidencing how services will be improved as a result of a complaint. We recognise that families are diverse and a family member is not always a blood relative of a patient. We respect this at all times and will always seek consent from the patient in order to investigate concerns or complaints on their behalf.

Throughout the past year, the Patient and Family Experience Team have:

- Continued to actively listen and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- Provided support to families of the bereaved advising and signposting them to through the correct process, i.e., the Medical Examiner or the Coroner
- Reviewed the Complaint Policy and Procedure to include more detail regarding Welsh complaints in line with Putting Things Right and additional information with regards to guidance on the Trust website.
- Continue to proactively engage with families/clinical staff by being involved at the earliest opportunity at best interest and multidisciplinary meetings during long admissions for rehab or prior to discharge
- Provide bi-monthly assurance to Trust Board by presenting complaints data/trends and analysis and updates on patient experience activity to the Executive Team
- Continued to support and engage with all volunteers and provide them with adequate, timely training and support.

- Continue to provide birthday gifts/cards/visits for inpatients, Sleep Well packs for inpatients all initiatives supported by The Walton Charity and connecting hearts for memory boxes
- Facilitated internal engagement listening events in partnership with Healthwatch to gain and act on feedback provided from patients and groups who represented them
- As part of the Mortality Governance Lead role/PFET developed a pathway to proactively provide family support following a death
- Continue to work in partnership with the Communications and Marketing Team to arrange a patient story for the monthly Trust Board meeting either in person or via MS Teams from each of the different service lines
- Introduced training for Band 6 prospective Ward Managers as part of the Building Rapport course
- Continue to provide junior doctors and Consultants in relation to good practice/documentation and when required to provide input into coronial enquiries, inquests and claims
- Provided on-site 1:1 support for staff prior to and during a high profile coroner's inquest
- Planned an on site Mock Coroner's Inquest provided by Trust solicitors
- High level learning from complaints/claims/coronial inquests and enquires share in quarterly governance bulletin
- Engagement and attendance at off site patient support groups
- Facilitated focus groups with view to gaining feedback to drive improvements
- Developed Patient and Family Centred Care workplan

3.1.2 Complaints management and lessons learnt

The Patient and Family Experience Team work proactively in collaboration with the Neurosurgical and Neurology divisions and Senior Nursing Team in order to investigate and manage complaints in an aim to meet the needs of each individual patient or family member and reach a resolution. This may involve meeting with patients or family members in their preferred place, including their homes, in order to reach the best outcome for them.

Every enquiry, informal concern and formal complaint is given careful triage and consideration. Each concern and complaint receives an appropriate investigation by the appropriate division and complainants receive their response in their preferred format. Those who raise concerns can received their response via a telephone call to give them an opportunity for further discussion, or response from the Patient and Family Experience Team (PFET) via email or letter. All formal complaints are responded to in writing by the Chief Executive and/or complainants may be offered a meeting with the senior staff from the respective division, supported by PFET.

The last 12 months have demonstrated that the complaints process is robustly embedded to ensure that complaints are addressed in a timely manner and that meaningful apologies are provided. All concerns and complaints are discussed by the Patient and Family Experience Team and the Divisional Management Teams at a weekly joint divisional meeting held on MS Teams. Progress is recorded each week and escalations made if required. Outstanding actions from complaints are discussed weekly and shared at relevant divisional governance meetings until the Divisional Directors are assured that actions are fully implemented and closed. This process ensures that all complaints are being carefully considered and appropriate investigations are in progress and to

ensure timeframes are met. Every effort is made to ensure that responses are comprehensive and that any lessons are learnt are outlines within the response. Draft responses are quality reviewed by the Deputy Chief Nurse and/or Medical Director before being reviewed by the Chief Executive.

Outcomes from complaints are reported monthly to the respective Divisional and/or Ward Manager, Risk and Governance committees and meetings within the Trust. Trends, themes and lessons learnt documented within the quarterly Patient Experience Report which is presented to Quality Committee. This report is also presented externally at our Specialist Commissioners meeting. Any trends in subject, operator or area of concern identified from complaints/concerns are escalated in real time to the Executive Team.

Complaints are reported and discussed with the Executive Team as part of the bi-monthly Patient Experience Update Report to offer assurance that the management process is robust and actions managed in a timely way and highlight any concerns or escalations.

Complainants are kept informed and updated during the process by regular contact from the team and feedback from those who have used the complaints process is used to help us improve and shape the service we provide. Compliments received following a concern or complaint are recorded on Datix as the team often receive feedback regarding the level of support they have received from the team during the process. Patient feedback is also shared at the daily Safety Huddle.

Examples of lessons learnt from complaints during 2022/23 include:

- A review of the Transition Service from child to adult services. This includes a review of processes under specific services, including epilepsy, including exploring options for education, alerts within clinical systems highlighting patients who have recently transitioned. The divisional team are working in partnership with other Trusts to drive this improvement work forward
- Improvements have been made to the headache service following a patient experiencing a delay in being issued with prescription. These plans include building requests into electronic patient records for headache service to prevent the risk of recurrence and avoid internal emails to prevent errors.
- Nursing – monthly audits to include wrist band compliance to be undertaken

3.1.3 Complaints activity

We use feedback from patients, families and carers who have used the complaints process to help us improve the care and service we provide. We have developed a patient and family centred approach so that complainants are kept informed during the investigation, with regular contact from members of the Patient and Family Experience Team.

- 138 new complaints were received in 2022/23, Q1(33), Q2 (26), Q3 (43), Q4 (36) which is an increase of 84% from 75 in 2020/21. This is in line with pre-covid numbers.
- There were 835 concerns received in 2022/23 compared to 745 in 2021/22 which is am 11.4 % increase and 400 enquiries, which is a 27% increase (compared to 306 the previous year). All enquiries and concerns were efficiently and effectively investigated and responded to by the Patient and Family Experience Team to prevent escalation.

- Despite the increase in the number of complaints received Trust have met their KPIs for responding to complaints as they aim to respond to Level 1 complaints within 25 working days and Level 2 within 45 working days.

Complaints received 1 April 2022 – 31 March 2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of new complaints received	33	26	43	36

This increase in complaints is not surprising and in keeping with the current pressures on the NHS. Trends included appointment arrangements, waiting times and communication.

A key element of the person and family centred care approach is focusing on the individual outcomes patients and families are seeking when they raise concerns. The Patient and Family Experience Team acknowledges all complaints and agrees the best way of addressing their concerns, in line with managing expectations. The Trust works in partnership to investigate any joint complaints with all other NHS organisations whereby care received within The Walton Centre is highlighted as a concern as part of any complaint they receive.

3.1.4 Duty of candour

The Trust fully acknowledges its duty of candour which supports one of its core values of openness. Incidents which fall under the requirements of the regulation are identified through the weekly scrutiny of the Datix Risk Management system.

All patients (or relatives in the event of a patient lacking capacity) who are involved in an incident falling under the requirements of duty of candour will be offered an apology as soon as possible. The patient/relative will receive a follow up letter (if not declined) with a written apology signed on behalf of the Chief Executive by the Chief Nurse. The patient/relative will be offered a copy of the investigation or a face to face meeting if required.

3.2 Local engagement – Quality Account

The Quality Account has evolved by actively engaging with stakeholders and using external feedback and opinion combined with thoughts and visions from staff within The Walton Centre. Trust Executives also participated in discussions with the local health economy and sought views on the services provided by The Walton Centre. The Trust has developed strong stakeholder relationships with local Healthwatch organisations, who have conducted numerous engagement events with patients and visitors at our Trust. The hospital has further developed relationships with charities including The Brain Charity, the Neuro Therapy Centre and Headway.

The Trust actively engaged with Governors through a forward planning event on all aspects of quality including choice of indicators for 2022/23.

3.3 Quality Governance

A Quality Governance framework was designed as a tool to encourage and support current good practice for quality governance in healthcare organisations. The Trust introduced a strategy which covers the three years from 2022 to 2025 and reflects the pace of change in the NHS due to the COVID-19 pandemic and the infrastructure changes brought about by the Health and Social Care Bill 2021. The new strategy sets out how we will expand our services further and will continue to innovate, research and develop. It also highlights what the key initiatives will be over the next three years, and how we will further develop our services across our regions, as well as developing national neuroscience services.

Our strategy aligns with national, regional and local system plans, including acute and primary care services, along with the voluntary and third sector, linking in with the Cheshire and Merseyside ICS place-based plans and those of One Liverpool, North Wales, and across Merseyside.

In developing the strategy, we involved staff from across the Trust, patients and carers, the voluntary sector, support groups, our Governors and members, and representatives from partner trusts, primary care and the ICS. There was positive engagement from staff and stakeholders, who clearly hold The Walton Centre dear to their hearts. We will continue to listen and engage and use that feedback to further influence our plans as we implement the strategy.

The strategy comprises five strategic ambitions which will enable us to continue to deliver world-class care to our patients and their families. The strategic ambitions are:

- Education, training and learning
- Research and innovation
- Leadership
- Collaboration
- Social responsibility

Underpinning these ambitions are seven enabling strategies:

- Quality - Ensuring the delivery of the highest quality of care to our patients and their families
- People - Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background
- Digital - Developing and implementing industry-leading digital solutions for our patients and our people
- Estates, facilities and sustainability - Taking a multidisciplinary approach to ensuring that sustainability in estates and facilities is at the heart of our work
- Finance and commercial development - Maximising use of resources, improving productivity and developing market opportunities to deliver best value for the Trust and the wider system
- Communications and marketing - Promoting our work as the only specialist neurosciences NHS trust and ensuring patients and staff receive the best quality information
- Charity - Supporting the work of the Trust through new opportunities and initiatives, in particular digital fundraising

3.4 First Walton Centre patient receives groundbreaking treatment for essential tremor

We have rolled out a new service using cutting-edge treatment for people living with essential tremor which is a neurological disorder that causes an uncontrollable shake or trembling in a part of the body. We are the first Trust outside London to deliver this new service. The procedure, trans-cranial MR-guided focused ultrasound, involves thermal tissue ablation targeted at the key areas of the brain causing the tremors. Eligible patients get one treatment to reduce the tremors on one side of their body. Current regulatory approvals demonstrate good clinical durability, with tremor relief maintained at three years.

3.5 New guidelines launched for fibromyalgia syndrome

One of our Consultants in Pain Medicine was one of the lead authors of new guidelines for the diagnosis of fibromyalgia syndrome (FMS). The new guidelines were launched at the Royal College of Physicians in Liverpool. These are the first UK guidelines for the condition and will have a significant impact on patients. The new guidelines aim to support clinicians in the diagnosis of FMS, without the need for rheumatology referral, preventing unnecessary surgery, enable patients to be placed on the appropriate treatment pathway earlier and empower patients to be more knowledgeable about their condition.

3.6 Specialist spinal service receives Centre of Excellence award

The Trust received Centre of Excellence status after delivering outstanding fully endoscopic spinal surgery to patients in Cheshire, Merseyside and North Wales. The award, given by RIWOspine, the manufacturers of the innovative fully endoscopic equipment, comes after The Walton Centre Charity funded the project in 2020. Gaining Centre of Excellence is a gold standard, making the hospital one of only a handful to achieve the status. One of our Consultant Spinal Surgeons is one of few surgeons in the country who can perform this type of surgery. The procedure is used to treat spinal conditions such as sciatica due to disc bulges and spinal stenosis, along with other ever evolving newer surgical indications. As part of the recovery process for some of the procedures, patients can be up and walking around merely hours after the surgery. In many cases, patients can go home the same day if they have recovered enough.

3.7 The Walton Centre launches its new Trust Strategy

In September 2022 we launched our new three-year Trust strategy, which sets out how we will continue to deliver excellent clinical outcomes and patient experience with our team of dedicated, specialist staff. The strategy reflects the pace of change in the NHS due to the COVID-19 pandemic and the infrastructure changes brought about by the Health and Social Care Bill 2021. Patients, their families and our staff are at the heart of the new strategy as is collaboration with our partners across the region – throughout the health, government, voluntary, education and third sectors.

3.8 Specialist neurosciences trust achieves University status

In September 2022 we became the newest member of the University Hospital Association. University hospitals are specialty trusts with significant involvement in research and education. Their research puts them at the forefront of developments in care and connections with industry, while their work in education makes them central to providing the future workforce. The Walton Centre is the country's only specialist neurosciences hospital, providing comprehensive neurology, neurosurgery, spinal, pain management and rehabilitation services at our site in Liverpool, and in satellite clinics across the north west and North Wales.

3.9 The Walton Centre operates on first patients using cutting-edge navigation in complex spinal surgery

Spinal patients at The Walton Centre can now benefit from a groundbreaking new surgical robotic navigation system which is one of the first of its kind to be used in the NHS. The 'ExcelsiusGPS®', manufactured by Globus Medical UK Ltd, enables patients spend less time in theatre and potentially reduce recovery time after major spinal surgery. The system involves a rigid robotic arm, tracked and fully navigated by a camera, which is then programmed to follow a trajectory pre-planned by our surgeons. This allows them to facilitate placement of spinal screws and interbody cages to an incredibly high level of precision.

3.10 New clinic making a difference for MND patients

A new service aimed at reducing the impact of one of the most devastating symptoms of Motor Neurone Disease (MND) is being piloted at The Walton Centre. Swallowing problems, known as dysphagia, affect at least two-thirds of all people with MND during the course of their illness. This can either result in choking and chest infections if food, drink or saliva goes backwards, or drooling if forwards. As well as significant health consequences, the impact of symptoms like drooling can result in considerable quality of life issues.

3.11 Tracheostomy Ted helps young visitors understand rehabilitation

Following the admittance of a patient, James, who had suffered a stroke caused by a massive bleed on the brain, Speech and Language Therapists worked with him and his family to demystify the impact of him having a tracheostomy.

After lifesaving surgery and treatment, James spent weeks in intensive care, and could only blink and use his big toe to communicate when he woke up. For a large part of his rehabilitation he had a tracheostomy which unsettled his young children and became difficult to explain. His Speech and Language Therapists saw how difficult this must have been and created 'Tracheostomy Ted' a teddy bear with its own tracheostomy, to support the patient and his young family.

3.12 Lighting innovators Circada launch first pilot at Trust to improve staff and patient wellbeing

Lighting firm Circada kickstarted its campaign to change people's relationships with their natural body clock with the launch of the inaugural pilot. The Walton Centre was the first Trust in the UK to take part. Circada's lighting technology works by changing the colour of the lighting throughout the day to match the daily and seasonal pattern of the sun, with superior and tailored light matched to

our biological needs throughout. Following the installation of the Circadian lighting system into part of the intensive therapy unit (ITU) at the hospital, a three-month pilot was undertaken. This will benefit patients and staff, and potentially improve patient flow by reducing the time spent in ITU.

3.13 Saving the day with the HALO service

In October 2021, Liverpool Football Club Women's goalkeeper, Rylee Foster, was involved in a serious road accident in Finland, and was thrown from a vehicle at high speed. She sustained several fractures to the bones in her neck as well as multiple serious injuries to the rest of her body. She was stabilised at a local hospital and flown back to Liverpool a week later. It was at that point that clinicians at LFC asked for experts at The Walton Centre to review her scans.

She was asked to come to the Trust immediately and was fitted with a Halo jacket, an external fixation device, which consists of an external metal frame that attaches to the head with four screws. Once fitted, it reduces the weight off the head on the neck and stops any movement of the neck, allowing the fractures to heal and repair. Without this, Rylee would have risked severe injury, maybe even paralysis. After several months in the Halo scans showed that Rylee's fractures were healing and she continues to recover.

3.14 Neurologist appointed to leading research programme

One of our Consultant Neurologists has been appointed to the North West CRN Advanced Research Scholars Programme. This programme is aimed at equipping tomorrow's clinical research leaders with the skills, knowledge and experience needed to become the Principal and Chief Investigators of the future. The Walton Centre has a proud tradition of delivering high-quality clinical neuroscience research, in collaboration with our local universities and commercial partners, to improve patient outcomes and experiences. As one of our five strategic ambitions in our three-year Trust strategy, it is a key area of focus, particularly attracting and developing highly skilled and motivated people, who want to support our research and innovation ambitions.

3.15 Professor of Pain Medicine at the Institute of Life Course and Medical Sciences

One of The Walton Centre's Pain Medicine Consultants, Andreas Goebel, attained a professorship with the University of Liverpool, after demonstrating substantial progress in research into causes and new treatments for chronic primary pain. His research includes developing an understanding the role of the adaptive immune system in causing severe, seemingly unexplained, chronic pain, focusing on Complex Regional Pain Syndrome (CRPS) and Fibromyalgia Syndrome (FMS).

3.16 Overview of performance in 2022/23 against national priorities from the Department of Health's Operating Framework

The following table outlines the Trust's performance in relation to the performance indicators as set out in the Department of Health's Operating Framework.

Performance indicator	2020/21 performance	2021/22 performance	2022/23 performance	2022/23 target
Incidence of MRSA	0	0	0	0
Screening all inpatients for MRSA	96.55%	97.94%	97.38%	95%

Incidence of Clostridium difficile	7	8	7	8
All cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	100%	94%	100%
All cancers: 62 days wait for first treatment from urgent GP referral to treatment	100%	100%	N/A	85%
All cancers: Max waiting time of 31 days from diagnosis to first treatment	100%	100%	100%	96%
All cancers: Two week wait from referral date to date first seen	98.9%	100%	99.5%	93%
All cancers: 28 Day faster diagnosis	N/A	98.75%	98.97%	70%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	N/A	N/A	N/A	N/A
Maximum six week wait for diagnostic procedures	19.33%	0.30%	0.37%	1%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant			

3.17 Overview of performance in 2022/23 against NHS Outcomes Framework

The Department of Health and NHSE/I identified changes to Quality Account reporting requirements for 2012/13 and subsequent rounds of Quality Accounts, following consideration by the National Quality Board of introducing mandatory reporting against a small, core set of quality indicators.

The indicators are based on recommendations by the National Quality Board, are set out overleaf. They align closely with the NHS Outcomes Framework and are all based on data that trusts already report on nationally.

If the indicators are applicable to us the intention is that we will be required to report:
- Our performance against these indicators
- The national average
- A supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

The data within this report is local data that has not been validated nationally.

During 2022/23 The Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.18 Indicators

The indicators are listed below and a response is provided if they are deemed applicable to the Trust. If the indicators are deemed not applicable a rationale for this status is provided.

1. **Summary Hospital-Level Mortality Indicator (SHMI): NOT APPLICABLE**

Rationale: This indicator is not deemed applicable to the Trust, the technical specification states that specialist trusts are excluded from this measurement and that this decision was made by the CQC in June 2011

2. **Percentage of patients on care programme approach:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health services

3. **Category A ambulance response times:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

4. **Care bundles - including myocardial infarction and stroke:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

5. **Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as gatekeeper during the reporting period:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health acute ward services

6. **Patient reported outcome scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery:**
   NOT APPLICABLE

Rationale: The Trust does not perform these procedures

7. **Emergency readmissions to hospital within 28 days of discharge:**
   APPLICABLE

Response:

	No. of readmissions	% of inpatient discharges readmitted
2020/21	139	4.25%
2021/22	201	4.56%
2022/23	210	4.40%
Change 2021/22 - 2022/23	9	-0.16%

Calculation of readmission rates is based on the national standard as defined within the Compendium of clinical and Health Indicators. (https://indicators.ic.nhs.uk/webview/).

The rates are for patients 16 years and over as The Walton Centre does not treat patients under the age of 16.

Actions to be taken:

The Walton Centre considers that this data is as described for the following reasons:
- The Trust recognises that the main causes for readmissions are due to infection and post-operative complications.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:
- Consultant review of all readmissions to ensure any lessons learnt are embedded into future practice
- A morbidity consultant lead has recently been appointed who has identified time within their job plan to review this process

8. Responsiveness to inpatients' personal needs based on five questions in the CQC National Inpatient Survey:
APPLICABLE

Response:

- The Trust is required to participate in the annual CQC National Inpatient Survey to allow benchmarking of the patients' experience with other NHS providers. The survey is recognised as being a key indicator of overall care for the organisation and regulators, including the CQC and commissioners. Picker Institute was commissioned by The Walton Centre together with 75 other NHS organisations to collate and present the organisation's results for each Trust
- The Walton Centre received their results for the 2021 survey in October 2022 and have been identified as performing **'Much Better Than Expected'** because our patients answered positively about their care across the entire survey and this was significantly above all other Trust averages. The Walton Centre Trust scored **Much better than average** in one of the 10 sections and **Better than average** in five sections
- The results highlight a 47.4 % response rate (previously 56% in 2020) with an average response rate of 39 % for other organisations.
- The Trust was rated 11th out of 134 Trusts nationally for overall positive patient experience, this is not comparable as the questions and data differed somewhat to the previous year.
- The questions had slightly changed for the 2021 survey and the CQC benchmark methodology to provide Trusts with more detailed results and the scores were categorised as:
  - Much better
  - Better
  - Somewhat better
  - Same
  - Much worse
  - Somewhat worse

National Inpatient Survey question	2017 Result	2018 National Comparison	2019 Result	2020 Result	2021 Result	2022 Result
1. Were you involved as much as you wanted to be in decisions about your care?	7.8	About the same	About the same	89% Better	Better	Results available Oct 2023
2. Did you find a member of hospital staff to talk to about your worries or fears?	6.0	About the same	About the same	93% Better	Somewhat better	Results available Oct 2023
3. Were you given enough privacy when discussing your condition or treatment?	8.6	About the same	Slightly worse	84% Better	Somewhat better	Results available Oct 2023
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.1	About the same	Better	92% Much better	Better	Results available Oct 2023
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.7	Better	Better	91% Much Better	About the same	Results available Oct 2023

To note: National Inpatient scores are out of a maximum score of ten

Friends and Family Test (FFT) - the Trust continued to meet internal targets of 30% response rate for inpatients with an overall annual rate of **45.98%** and a recommended rate of **98.09%** which is excellent.

For outpatients, the internal target of 90% recommended rate was exceeded at **94.46%** with a response rate of **5.76%,** there is not set internal KPI for average response rate is around 4.5%.

A digital platform is available for patients who have attended a virtual appointment via Attend Anywhere and they are able to provide real-time feedback following this appointment.

A business plan is currently underway with the aim to introduce SMS messaging to increase the response rate in 2023/24.

Patient and family experience initiatives

- The complaints policy was updated and reviewed in 2022
- Undertook a full review and re-design of the complaints module on Datix with the aim of more accurate reporting
- Engagement with divisions to implement escalation process to support staff in resolving concerns in the first instance
- In 2022 bespoke complaints training/support was provided for admin teams and prospective ward managers as part of the Aspiring Ward Manager Programme
- Patients, families and staff stories in various formats continue to be presented to Trust Board, and other committees such as Quality Committee. These can be verbally read on behalf of the patient, via live video link or recorded video to share their lived experience. Patient stories are identified from each of the difference service lines to be presented. The content may be positive, negative or indifferent, as it is recognised that it is important to share exactly how it was for the patient in their words so the impact of their experience can be heard.

- In 2022/23 the Trust Board received a story from a different service line each month supported by the Patient and Family Experience, and Communications and Marketing teams. The story will be presented in a format that is preferable to the patient, and they will be invited to attend virtually if they feel able to do so. This will enable a Q&A session after each story
- Qualitative feedback from friends and family test shared in poster format with ward managers on a monthly basis, including negative comments in order for them to action
- Various engagement events with external stakeholders including Healthwatch Sefton, Liverpool and attendance at various support groups including MND Wirral and Liverpool took place throughout 2022/23
- Volunteer website pages reviewed and updated to include new volunteer profiles
- Volunteer profiles installed on the main corridor to support the Why Walton? step of the six steps of the Patient and Family Centred Care journey
- New volunteer roles including Volunteer Therapy Dog, trolley service extended to staff and patients in the Sid Watkins building, new mobile library service commenced
- Carers passport relaunched to support families of patients
- New training developed for Cheshire and Merseyside Rehabilitation Network
- Introduced Transgender Awareness Sessions for all Trust staff
- Transgender Awareness workshop planned for Trust Board in April 2023
- Health and Safety Training for doctors reviewed to include the claims process
- Transgender, non-binary and gender fluid patient policy developed in partnership with Genderspace UK
- Patient and Family Experience staff are represented on the Trust staff network groups including LBGTQ+ and Disability Group
- Plans are underway for the Trust to recruit two Patient Safety Partners in line with PSIRF
- Home from Home Welcome Pack has been reviewed to include a QR code to take families to the website
- Home from Home Website information also has been updated
- Claims process reviewed to include clinical lead & claims manager to triage claim at earlier opportunity
- More in depth information included in junior doctors and Medical Health & Safety Training to provide education to staff
- Three patients with long-term conditions recruited for Neuroscience Programme Board in July 2022 and provided with support prior to, during, and post meetings
- Well-led focus group held in February 2022 as part of the Trust's overall well-led review
- Arteriovenous malformation focus group attended by staff member from PFET and volunteer
- Trust volunteer recruited to support with C.H.A.T Project is working with Liverpool College to develop a virtual reality software education tool aimed at young adults to increase awareness of the Consequence of Head Injury Acquired in Trauma
- Trust Volunteers formed part of the PLACE assessment
- Patients and families involved in providing feedback on plans for redesign and development of areas including new infusion suite on Sherrington Ward
- Partnership working with Mersey Society for Deaf People, to develop ways of how to improve services for the deaf community

- Family member of patient with learning disabilities (LD) identified to support with new initiatives for LD including requirement and recruitment of LD nurse
- Relaunch of Patient and Family Centred Care in March 2023 with work plan to progress via small working groups

The Walton Centre has taken the following initiative to further improve this quality indicator and so the quality of its services, by:

- A business case has been developed to introduce SMS feedback for Friends and Family Tests to continue to enhance and develop patient experience
- A specific workplan has been developed for the delivery of Patient and Family Centred Care for 2023/24
- Plan Trans Awareness sessions for 2023/24 with the aim for all disciplines of staff to attend

9. Percentage of staff who would recommend the provider to friends or family needing care: APPLICABLE

Response:

The Trust had a response rate of 42% for the 2022 national staff survey; the national average for acute specialist trusts in England for 2022 was 52%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work scored 70.3% against an average of 68.6% and the percentage of staff who would recommend the Trust as a place to receive treatment scored 86.5% which was the same as the average.

The findings for 2022 are arranged in the form of People Promises, there are seven people promises and two themes as follows:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale

The Trust scored higher than average in all elements of the NHS People Promise with the exception of “we’re always learning” which scored average but was an improvement on last years.

Staff engagement

Staff engagement is measured across three sub scores:

- Motivation
- Involvement
- Advocacy

The Trusts overall score for staff engagement is an improvement on last years score from 7.3 to 7.4 and is above the average of 7.2.

Morale

Morale is measured across three sub-scores:
- Thinking about leaving
- Work pressure
- Stressors

The Trusts overall score for morale remained the same as last year at 6.2 and is above the average of 6.1.

In addition to the annual staff survey, quarterly People Pulse surveys took place in April and July 2022 and January 2023. The purpose of these is to take a temperature check of how staff are feeling and in particular to assess how likely employees are to recommend The Walton Centre as a place to work and also as a place to receive treatment.

In April 2022 the results showed that 84.6% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 57.5% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In July 2022 the results showed that 79.8% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 57.1% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In January 2023 the results showed that 86.9% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 69.2% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

WRES

Four key questions make up the WRES section of the staff survey as follows:

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months - this score has increased from 2021 for white staff and all other staff with a higher percentage increase for all other ethnic groups.
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - this score is broadly similar to last year’s for white staff and has increased by 2% for all other ethnic groups.
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion - this score has increased by over 4% for white staff and decreased by 2.5% for all other ethnic groups.

- Percentage of staff experiencing discrimination at work from manger/team leader or other colleagues in the last 12 months - this score has decreased by 1.8% for white staff and increased by 5.1% for all other ethnic groups - this question is of particular concern.

533 white staff responded to the survey and 53 staff from other ethnic groups.

WDES

Seven key questions make up the WRES section of the staff survey as follows**:**

- Percentage of staff experiencing harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months - this score has increased for staff with or without a long-term illness (LTC).
- Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months - this score has increased by 5% for staff with a LTC and has decreased for staff without an LTC.
- Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months - this score has decreased by 4% for staff with a LTC and has increased slightly for staff without an LTC.
- Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it - this score has increased for both groups of staff and by 12% for staff with an LTC.
- Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion - this score has increased for both groups of staff.
- Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties - this score has decreased by 4% for staff with an LTC and increased slightly for staff without an LTC.
- Percentage of staff satisfied with the extent to which their organisation values their work - this score has increased slightly for staff with a LTC and by 5% for staff without.

443 staff without an LTC responded to the survey and 135 staff responded with an LTC.

The Trust intends to continue to work with staff side and staff through various engagement sessions to increase the response rates and percentage scores for the 2023 survey. A Trust action plan and Divisional action plans will be formulated and approved by Board.

<u>Volunteers</u>

Volunteers are considered an important and vital part of the team.

Volunteer roles include:
- Meet and greet
- Infection prevention volunteers
- Outpatient volunteers in the outpatient department and Radiology
- Neurobuddy volunteers providing support in ward areas
- Trolley – Treats and Sweets service across the Trust
- Mobile Library Service

- Reading Buddies
- Visiting service
- Pet Therapy Service

In 2022/23 volunteers have benefitted from:

- Quarterly newsletters
- Volunteer Week celebrations in June 2022
- Engagement and staff/volunteer support with local foodbanks
- Volunteer of the Month
- End of year celebration
- Participation in Patient Led Assessment for Care of the Environment (PLACE)

In 2022/23 we successfully fully re-introduced our volunteer service following the pandemic with new exciting roles. This has resulted in supporting patients and families and we aim to build on this further in 2022/23.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- Present a further business case to expand the service of FFT to SMS and voice feedback with the aim to increase the response rates

10. Patient experience of community mental health services: NOT APPLICABLE

Rationale: The Trust does not provide community mental health services

11. Percentage of admitted patients risk-assessed for venous thromboembolism: APPLICABLE

Response:

YEAR		Q1	Q2	Q3	Q4
2017/18	The Walton Centre	99.09%	99.69%	98.34%	97.17%
	National average	95.20%	95.25%	95.36%	95.21%
2018/19	The Walton Centre	98.52%	99.00%	98.86%	96.78%
	National average	95.63%	95.49%	95.65%	95.74%
2019/20	The Walton Centre	98.79%	98.97%	98.85%	98.58%
	National average	95.63%	95.47%	95.33%	Suspended due to Covid
2020/21	The Walton Centre	95.35%	98.17%	98.08%	97.94%
	National average	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid
2021/22	The Walton Centre	99.03%	98.7%	98.44%	98.6%
	National average	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid
2022/23	The Walton Centre	98.44%	98.43%	98.69%	98.88%
	National average	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid

The Walton Centre considers that this data is as described for the following reasons:
- VTE risk assessments are conducted within six hours of admission by nursing staff. If a patient is identified as being at risk of a VTE nursing staff can implement the use of mechanical VTE prevention (anti-thrombolytic stockings) and medical colleagues review the patient in terms of pharmacological interventions (prophylactic medications).

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:
- For any VTEs that do occur for inpatients at The Walton Centre a rapid review is triggered to be undertaken. Usually these are conducted by our medical team whereby a review of patient care, treatment and applied interventions are considered, noting any lapses in care and care delivery issues. Where required, actions are noted to address any practice issues and patients are fully informed of the harm that has occurred in line with the duty of candour process

12. Rate of C. difficile per 100,000 bed days amongst patients aged two years and over: APPLICABLE

Response:

Quality Accounts use the rate of cases of C. difficile infections rather than the incidence, because it provides a more helpful measure for the purpose of making comparisons between organisations and tracking improvements over time.

The Walton Centre C. difficile infections per 100,000 bed days:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
The Walton Centre	13.3	13.7	9.5	7.81	17.48	13.43

The Walton Centre considers that this data is as described for the following reasons:
- In 2022/23 The Walton Centre had a total of seven C. difficile infections against the trajectory set by NHSE/I of eight. Although we would have hoped for a bigger reduction this compares favourably well in comparison to other Trusts within the region.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:
- Implementation of the Infection Prevention and Control (IPC) Framework
- Clear objectives have been set for year one of the IPC framework delivery plan
- We have applied for Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) to demonstrate we have strong antimicrobial stewardship
- Following the implementation of Tendable we will utilise the app to analyse and audit outcomes to identify good practices and areas of were changes are required
- Use of technology e.g. Hydrogen Peroxide Vapour (HPV) and UV machine to support environmental cleanliness
- We will implement a digital HCAI surveillance programme

The Trust will continually strive to review and improve the quality of its service and aims to reduce healthcare associated infection, including C. difficile to ensure that all of our service users within the Trust, are not harmed by a preventable infection.

13. Rate of patient safety incidents per 1000 bed days

Response:

In 2022/23 1565 incidents occurred against 52,122 bed days (as per NLRS figures) this equals 30.03 incidents per 1000 bed days.

The Walton Centre considers that this data is as described for the following reasons:

- Improved incident reporting across the organisation as a result of raised awareness and Training. bimonthly Datix newsletter, Governance bulletin and monthly incident reporting training sessions
- Improved timeliness of incident investigation completion
- Improved timeliness of implementation of actions identified from investigation

The Walton Centre will take the following actions to improve this score, and so the quality of its services, by:

- Continuing to investigate all incidents ensuring any identified lessons learned are shared across all relevant staff groups. Where there are found to be gaps in care delivery, processes and policies will be updated and put in place to support the delivery of safe and quality care to ensure these incidents do not re-occur
- Continue with Datix incident reporting training across the organisation

The Trust will continue to:

- Discuss all investigations at the relevant meetings to ensure the sharing of learning Trust wide
- Conduct rapid reviews when required
- Share lessons learnt via the Governance safety bulletin
- Improve the reporting of incidents through discussions at the Trust safety huddle and Trust wide incident training sessions
- Implement the new incident decision tool, currently in testing phase, to support the Trust's reporting requirements

Annex 1

Insert commentaries once received

Annex 2 Statement of Directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period xx to xx
    - Papers relating to quality reported to the Board over the period xx to xx
    - Feedback from the commissioners including Liverpool, South Sefton and Southport and Formby and Knowsley xx
    - Feedback from governors dated xx
    - Feedback from local Healthwatch organisations – Liverpool dated xx
    - Feedback from the Council of Governors dated xx
    - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated xx
    - The National Patient Survey dated xx
    - The National Staff Survey for 2021 presented to Trust Board on xx
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated xx
    - The Care Quality Commission's inspection report dated xx
- the Quality Report presents a balanced picture of the NHS Foundation Trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

XX

Jan Ross

Chief Executive

Glossary of terms

ARC	Applied Research Collaboration
CAUTI	Catheter Acquired Urinary Tract Infection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
CSF	Cerebrospinal Fluid
CT	Computerised Tomography
EP2	Electronic Patient Record System
EVD	External Ventricular Drainage
FFFAP	Falls and Fragility Fractures Audit Programme
FMS	Fibromyalgia Syndrome
FTSUG	Freedom to Speak Up Guardian
FND	Functional Neurological Disorder
HCA	Health Care Assistants
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit and Research Centre
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MND	Motor Neurone Disease
MR	Magnetic Resonance
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
MSSA	Meticillin Sensitive Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NCABT	National Comparative Audit of Blood Transfusion
NEAD	Non Epileptic Attack Disorder
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
NQB	National Quality Board
PET	Patient Experience Team
PIFU	Patient Initiated Follow Up
RCA	Root Cause Analysis
SDD	Same Day Discharge
SJR	Structured Judgement Review
SMART	Surgical and Medical Acute Response Team
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
VR	Virtual Reality
VTE	Venous Thromboembolism
WCFT	The Walton Centre NHS Foundation Trust

NHS
The Walton Centre
NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Freedom to Speak Up Annual Report 2022/23	
Executive Lead	Morag Olsen, Interim Chief Nurse	
Author (s)	Julie Kane, Quality Manager & Freedom to Speak Up Guardian	
Action Required	To note	
Level of Assurance Provided		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- The purpose of this report is to provide the Board with an annual overview of the Trusts speak up arrangements during 2022/23
- The report provides information relating local processes, data and activities which includes the same for the National Guardians Office (NGO)

Next Steps

- The NGO Freedom to Speak Up Reflection Tool will be completed in line with national guidance. The tool will help identify strengths/gaps in individuals, the leadership team and the organisation
- Arrange an additional training session for the Speak Up Champions
- Launch the role of the Speak Up Champions in quarter one
- Triangulate data available across the Trust

Related Trust Strategic Ambitions and Themes	**Impact**		
Leadership	Quality	Equality	Workforce

Strategic Risks		
001 Quality Patient Care	004 Leadership Development	004 Operational Performance

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Freedom to Speak Up Annual Report 2022/23

Executive Summary

1. This report provides a summary of the activity undertaken across the Trust by the Freedom to Speak up Guardian (FTSUG) during 2022/23. It provides data relating to the numbers, types of concerns raised, the division and professional group.

2. The report also provides data and information from other teams and departments, within the trust, relating to speaking up.

3. Speaking up is about anything that gets in the way of providing good care. When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that all staff feel able to speak up so that potential harm is prevented. Even when things are good but could be even better, we should feel able to say something and should expect that suggestions are listened to and used as an opportunity for improvement.

4. It is important to have an open and transparent 'speak up' culture of improvement and learning where speaking up and raising concerns are welcomed. A positive speak up culture is essential to ensuring the organisation is well led.

5. The FTSUG operates independently, impartially, and objectively whilst working in partnership with individuals and groups throughout the organisation. The Trust has numerous Speak Up Champions to support speaking up and promote an open, responsive, compassionate, positive and safe culture.

6. The freedom to speak p process aims to encourage colleagues to speak up to stop potential harm and anything that gets in the way of patient care or that affects their working life. Encouraging and supporting staff to raise concerns and letting them know their concerns will be acted upon will have a positive impact on patient safety, promote good practice and ensure lessons are learnt.

7. The Trust recognises how important it is that staff and managers have confidence in the independence, confidentiality and fairness of the freedom to speak up process. We seek regular feedback from staff who have spoken up and from managers involved in addressing concerns and use this feedback to help us to improve the process and experiences of staff and managers in the future.

8. Making it easy for staff to raise concerns is important. There are a range of processes to support staff who wish to raise a concern which include an immediate manager, senior manager within the team/department, and HR processes such as dignity and respect. Trade union representatives are also available to support staff if they wish to raise a concern.

9. Staff should feel empowered, confident and safe to raise concerns and be confident that their concern will be addressed in the most appropriate way.

Background and Analysis

10. Following the Mid-Staffordshire inquiry and the Freedom to Speak Up review, Sir Robert Francis QC stated "Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level must promote a culture where speaking

up about legitimate concerns can occur without fear of harassment, bullying or discrimination". The full review and executive summary are available on via the following link Speak Up Report

11. The Principles for Responding to Speaking Up:

- There will be clear and accessible information on how to speak up
- Speaking up processes will be designed so that all workers can speak up easily
- Everyone who speaks up will be thanked
- Where appropriate, workers will be encouraged and supported to speak up locally
- If another organisation (e.g. another national body) better addresses a matter, workers will be supported to speak up to that organisation
- Workers will be offered information on other sources of advice and support
- Workers speaking up will be provided with a response in a timeframe that is made clear to them
- Responses to speaking up will include details setting out how the information provided was used for learning and improvement
- The confidentiality of those who speak up will be respected, subject to the need to ensure safeguarding requirements are met
- Where matters are raised anonymously, they will be responded to in accordance with these principles to the extent possible
- Workers will be given the opportunity to feedback on their experience of speaking up
- The speaking up arrangements' effectiveness will be monitored, and opportunities to improve taken

12. All NHS trusts in England are required, by the National Guardian's Office (NGO), to submit high level, anonymised data from the Freedom to Speak Up Guardian. The National Guardian's Office publishes regular benchmarking figures of the numbers and types of concerns raised which provides an opportunity to compare The Walton Centre FTSU activity with other trusts.

13. Freedom to speak up is for anyone who works in health. This includes any healthcare professionals, non-clinical workers, senior, middle and junior managers, volunteers, students, locum, bank and agency workers, and former employees

14. The National Guardian's Office is jointly funded by the Care Quality Commission (CQC) and NHS England and Improvement (NHS E/I).

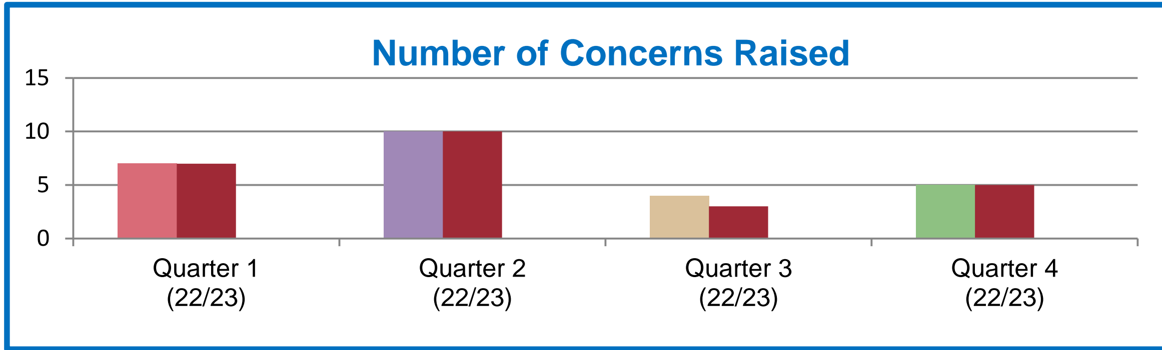
15. The National Guardian for the NHS reports annually to the boards of CQC and NHS E/I on the work of the NGO.

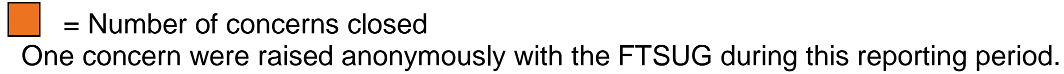
Local Data - 2022/23

16. During this reporting period, 2022/23, twenty six concerns were raised using the FTSU process.

17. The concerns raised were from each of the divisions and those raising the concerns included clinical, nursing and administrative colleagues.

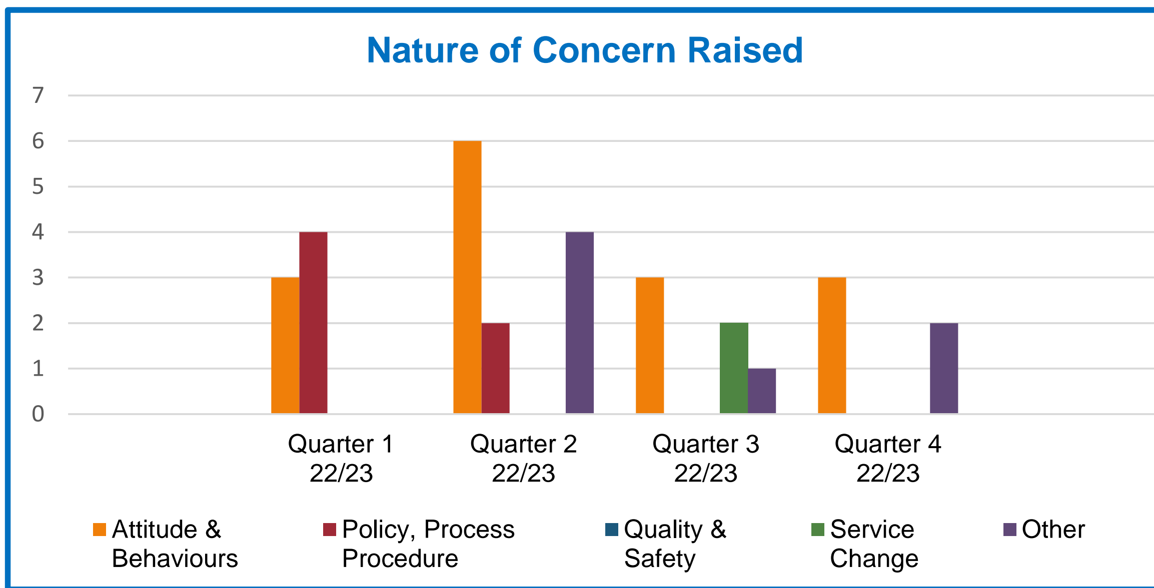
18. The graph below indicates how many concerns were raised during each quarter in 2022/23




= Number of concerns closed

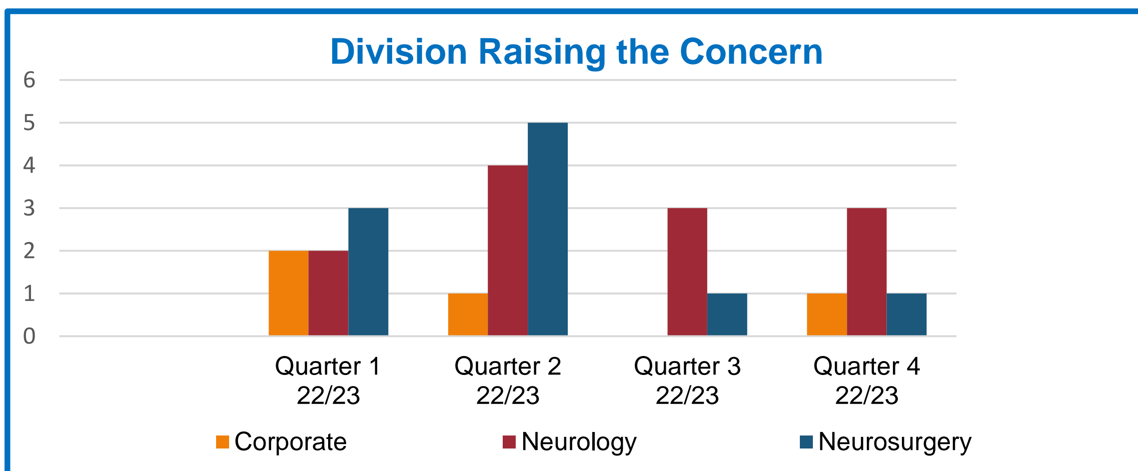
One concern were raised anonymously with the FTSUG during this reporting period.

19. The graph below indicates the nature of the concerns raised during each quarter in 2022/23



Note: Some concerns raised have more than one element and are displayed across several categories.

20. The graph below indicates the division raising the concerns during each quarter in 2022/23

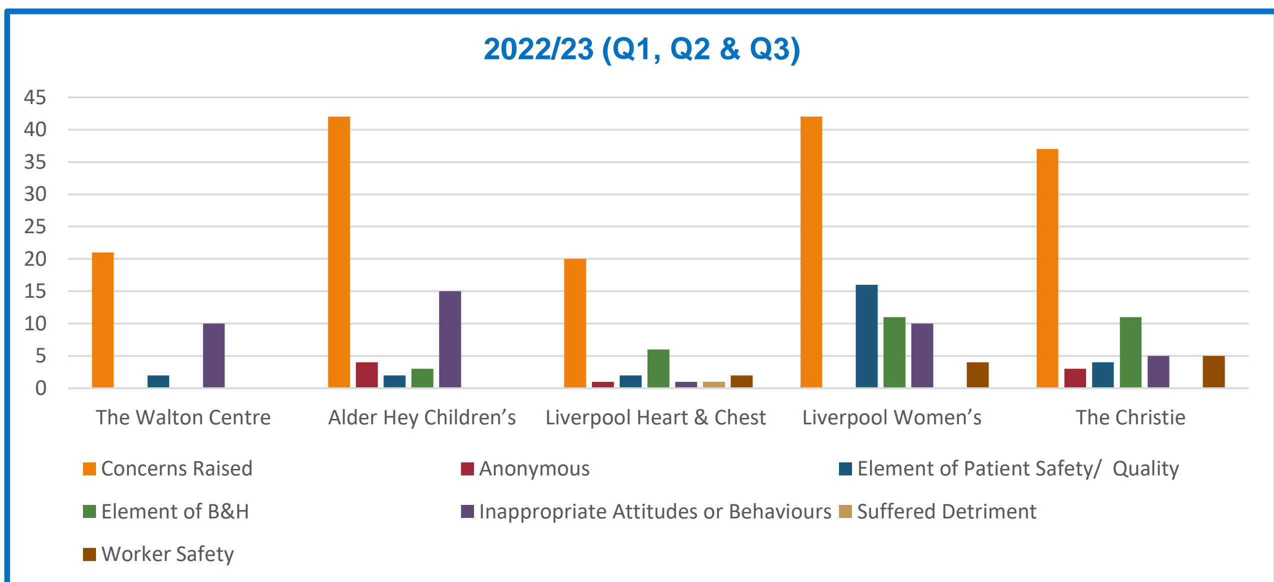


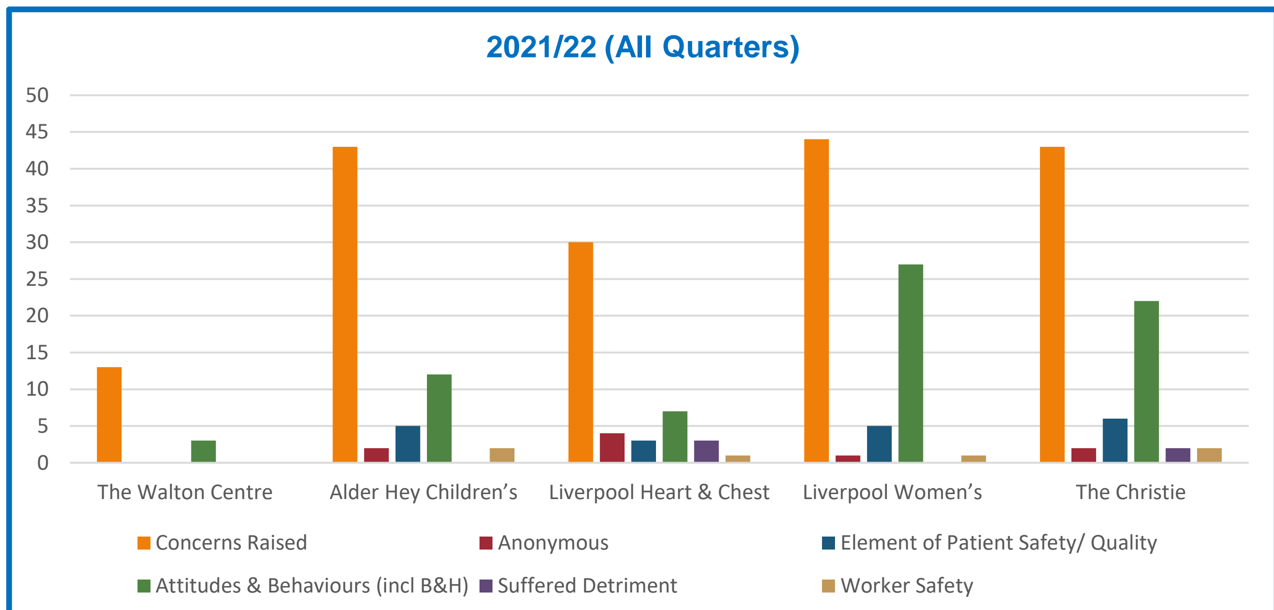
21. Themes which individuals are speaking up about to the FTSUG relate to attitudes and behaviours and service changes or change in practice which has resulted in communication breakdown.

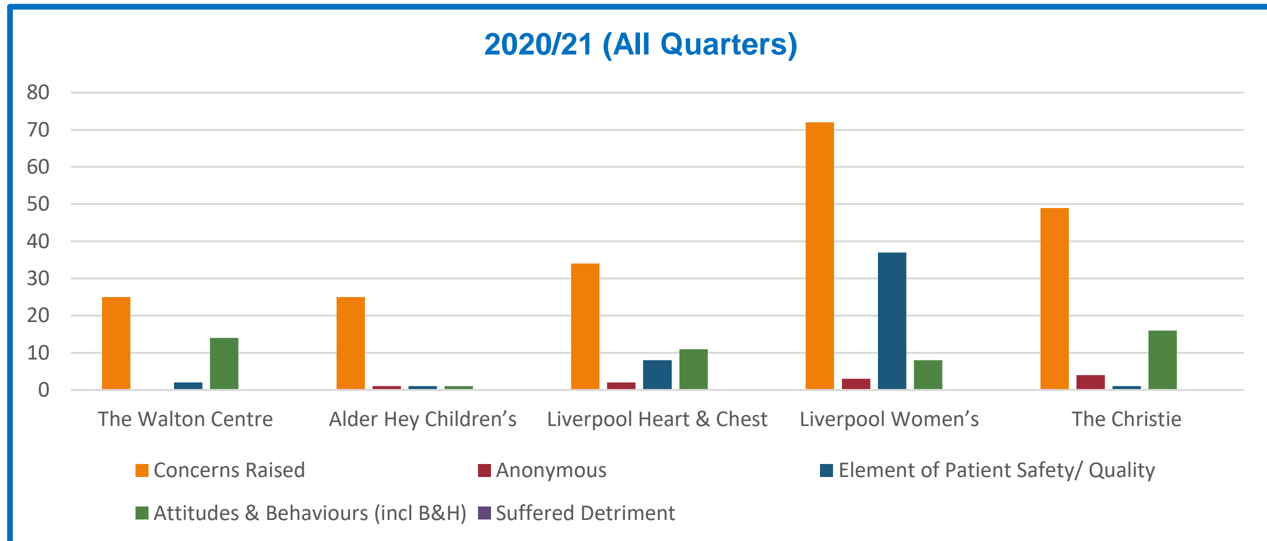
22. Feedback from colleagues speaking up to the FTSUG has been positive. Some of the feedback is below:

- ❖ "I just want to thank you for everything, and for being a listening ear when I needed it"
- ❖ "I would speak up again, I am confident to do so"
- ❖ "I felt that I was listened to and had good, regular feedback"
- ❖ "I think it is very hard to speak up in The Walton Centre and your advice was professional, thank you"
- ❖ "I would speak up again, I felt very supported and reassured by yourself. Thank you for your help!"

Speak Up Benchmarking Figures







What do the numbers mean?

23. It is always difficult to interpret whether a high number of concerns is a positive or negative indicator.

24. We want staff to feel confident in raising their concerns with their supervisor or line manager as part of business as usual and would hope the low numbers speaking up to the FTSUG is an indicator that concerns are being raised and addressed locally and is therefore a good sign.

25. On the other hand if there were larger numbers of concerns raised with the FTSUG this could be seen as positive as staff are aware of the speak up process and have an increased confidence in the importance of the speak up role.

26. Information from the NHS Staff Survey, which includes speaking up, is detailed within this report.

National Guardians Office (NGO)

27. The NGO issued a minimum dataset for Trust's to assist with internal and external reporting.

28. Each quarter the FTSUG submits a return to the NGO to enable national benchmarking to be undertaken.

29. The information required is listed below:
    - Number of concerns raised within the quarter
    - Number of concerns raised anonymously
    - Number of concerns including an element of patient safety/quality of care
    - Number of concerns including an element of worker safety
    - Number of cases including elements of bullying and harassment
    - Number of cases including other inappropriate attitudes and behaviours
    - Number of incidents where disadvantageous and or demeaning treatment (often referred to as detriment) is identified as a result of speaking up

30. The Trust's FTSUG collects information from those who have raised concerns by asking the following questions:
    - Given your experience, would you speak up again
    - Please explain your above response

31. Once a case in closed, with the agreement of the individual raising the concern, they are asked to make contact if they feel they are being treated differently following them raising a concern.

Nobody should fear or suffer detriment as a result of speaking up and they are encouraged to speak up if they do.

32. The Freedom to Speak Up Guardian attends local and national meetings/conferences. The NGO continues to support the network of guardians and monitors the implementation of the role and the development of the speak up culture across organisations.

33. On 9th March 2023, the NGO held the national conference for FTSUGs, Champions and Leaders. Key areas included exploring ways to remove barriers to speaking up, hearing from leaders about what freedom to speak up means to them, why it is essential to organisations and sharing good practice.

34. The Executive and Non-Executive Leads for Raising Concerns have joined webinars with other leaders who shared best practice across organisations, heard about the new Freedom to Speak Up Policy and the recently published Reflection and Planning Tool which is accompanied by the Guidance for Leaders document.

Fear and Futility

The National Guardians Office shared information in relation to fear and futility, please see below.

Professor Chris Cowton, Associate Director at the Institute of Business Ethics, explored how to overcome two barriers to speaking up - fear and futility and provided the following:

A well-designed speak up system is a great tool. For organisations, it provides opportunities to find out what is not working well, perhaps nipping a problem in the bud before it becomes a crisis. For individuals, it provides the chance to have their voice heard, to raise their concerns in a protected environment. In principle.

However, to move from speak up system availability to an active speak up culture involves overcoming some impediments. Our research backs up what others have noted before: that 2Fs get in the way, namely, *fear* and *futility*.

First, fear. The Institute of Business Ethics' Ethics at Work survey of 10,000 employees across 13 countries showed that the most common reason for people not to report misconduct they had witnessed was fear of retaliation. Such retaliation can take many forms, such as being passed over for promotion or alienated by colleagues. That is why it is so important for senior leadership to be consistent in their message that retaliation against someone for speaking up will not be tolerated.

However, even if employees are reasonably reassured about protection from retaliation, there is the second F to address: namely futility, or a lack of belief that corrective action will be undertaken if a speak up report is made. Our Ethics at Work survey showed that this was a major barrier. Why bother going to the trouble of reporting misconduct if you don't think anything will be done about it?

One of the challenges in dealing with a perception of futility is that, when someone does actually make a report, they can be disappointed with the feedback they receive. It's therefore important to manage their expectations of what they will hear about the progress of the case and the eventual outcome – especially given that, for good HR or legal reasons, it's often not possible to provide detailed information about what happened as a result of the investigation. Providing thanks for the report and reassurance that an investigation took place, whether or not the allegation (if that is what it was) was upheld, is often the best that can be done – although, returning to our first F, following up to ensure that no retaliation has been experienced is also important.

Freedom to Speak Up Guardian Update

35. The FTSUG operates independently, impartially, and objectively whilst working in partnership with individuals and groups throughout the organisation. The Trust also has Speak Up Champions to support speaking up and promote a positive and safe culture.

36. During 2022/23 the FTSUG continued to use various channels to communicate the role of the speak up function and the importance of raising concerns which included a dedicated speak up section on the trust intranet, speak up Month in October, undertaking ‘walkabouts’ and scheduled ‘drop in’ sessions across the Trust, recruiting Speak Up Champions and attendance at various groups/meetings.

37. The FTSUG actively promotes opportunities for staff to speak up about issues of concern and is available for staff to discuss and raise their concerns. She often helps staff with ways to address their concerns directly with relevant managers or, if this is not possible, the FTSUG will bring the issues to the attention of another individual such as a Team Leader, Divisional Director or Clinical Director. This is only done with the agreement of the person raising the concern.

38. Following the escalation of a concern the FTSUG will remain in contact with the person speaking up and those who the concern has been escalated to in order to ensure actions are being taken. The FTSUG will also ask if the person raising the concern is suffering detriment as a result of speaking up which unfortunately is a reason why staff do not speak up nationally which has been in the media.

39. Once a case is closed an email is sent by the FTSUG to the individual raising the concern asking for feedback.

40. Feedback has been positive from those who have spoken up to the Freedom to Speak Up Guardian. Some of the feedback is below:

    - “I just want to thank you for everything, and for being a listening ear when I needed it”
    - “I would speak up again, I am confident to do so”
    - “I felt that I was listened to and had good, regular feedback”
    - “I think it is very hard to speak up in The Walton Centre and your advice was professional, thank you”
    - “I would speak up again, I felt very supported and reassured by yourself. Thank you for your help!”

41. Following the publication of the latest version of the Freedom to Speak Up Policy for the NHS we revised our policy, which was approved at the Staff Partnership Committee, and is accessible via the Trust intranet.

42. The NGO published a revised FTSU Reflection and Planning Tool which all organisations are required to complete by January 2024. The Executive Lead for Raising Concerns is responsible for completing the tool.

43. The tool is set out in three stages, as per below:
    - Stage 1 Sets out statements for reflection under the eight principles of speaking up
    - Stage 2 Involves summarising high level actions to be taken over the next 6-24 months to develop speak up arrangements. This will help the FTSUG and Executive Lead for Raising Concern carry out more detailed planning
    - Stage 3 Summarises high level actions the Trust need to take to share and promote strengths. This will enable other within the Trust and the wider system to learn

44. An initial meeting with the FTSU Guardian, Executive and Non-Executive Leads for Raising Concerns and the Deputy Chief People Officer took place in quarter three 2022 to undertake an initial review of the tool. A further meeting has been scheduled for June 2023 to review the tool in greater detail and populate each section.

45. The NGO published a refreshed Development Guide (previously named Education and Training Guide) in March 2023. The focus of the refreshed guide is guardians' personal growth and development of skills, including updated resources and information on inclusivity and psychological safety. During and following the completion of the online self-assessment tool (in conjunction with the Development Guide) this will help the FTSUG build on existing skills and experience and will support them in identifying ongoing leaning, areas for development and will facilitate conversations with line mangers and leaders.

46. FTSUGs are required to complete speak up refresher training each year. The training has been developed to support continued learning and development. It gives assurance that the FTSUGs have up-to-date knowledge as the freedom to speak up landscape is ever evolving.

47. A revised Refresher Training Module was released in April 2023. Guardians are required to complete the revised training by 30th November 2023.
48. The FTSUG has undertaken the Mental Health First Aider Training.

49. The FTSUG is currently being accredited to become a Neurodivergent Champion.

50. In quarter four 2022/23 the Trust launched three staff networks including the Race Group, Disability Group and the LGBT+ Group which the FTSUG attended. These networks provide a 'safe space' for staff to speak openly and an opportunity to raise any issues/concerns directly which will be followed up via the most appropriate route.

51. Information relating to speaking up is available on the Intranet which includes how to speak up, who to speak up to, what happens when staff speak up and information on who the FTSU Guardian and Champions are, their pledges and contact details.

52. Meetings with the FTSUG, Executive and Non-Executive Leads for Raising Concerns and the Chief People Officer will commence in May 2023. This offers the opportunity for all concerns raised with the FTSUG to be reviewed confidentially and anonymously if necessary. These meetings will be scheduled monthly.

53. The group will agree the most appropriate way of addressing each concern raised and will track and follow up to ensure issues are being addressed in the most appropriate way and that feedback has been given to the person raising their concern.

54. Meetings are scheduled quarterly with the FTSUG, Chair and Chief Executive to keep them appraised of activity. The most recent meeting took place in April 2023.

55. The Trust launched the national first module of speak up e-learning for all staff. It was agreed the first module is mandatory and is to be completed by all staff groups.

56. The current compliance figures for the first module of e-learning stands at 76.52%.

57. The second module of e-learning 'Listen Up' is to be completed by all line managers. This module will be made available in quarter two 2023/24.

58. Senior Leaders within the Trust are required to complete the third module of the e-learning, entitled 'Follow Up'.

59. We experienced a number of glitches following the launch of the first e-learning module. If the launch of the second module is uneventful then the third module will be made available.

60. The FTSUG continues to attend virtual regional meetings throughout the year to keep

appraised of national guidance, plans going forward and to share views and learn from peers.

61. The FTSUG presented an Assurance Report to the Audit Committee, in accordance with the NHS Audit Committee Handbook, which is to review the Trusts processes in relation to raising concerns to ensure there is a system of internal control. The FTSUG will present an annual assurance report to the Audit Committee moving forward.

Speak Up Champions

62. During October 2022 ‘speak up’ month staff expressed their interest in becoming ‘Speak Up Champions’.

63. The Champions role is to promote speaking up and empower staff to raise their concerns. They will raise awareness around speaking up, promote the role within groups and departments and role model the values and behaviours associated with speaking up and listening.

64. FTSU Champions are available to all staff across the Trust who work in clinical and non-clinical roles. They will meet with colleagues, listen to their concerns about patient or staff safety and will explore options with those speaking up and direct them to the appropriate personnel, process or guidance document to assist you with your concern. Staff will always be thanked for speaking up.

65. Overall, sixteen colleagues expressed their interest in becoming a Speak Up Champion.

66. Six Champions have undertaken the in-house speak up training, which was delivered by the FTSUG, in February 2023.

67. A further training session will be scheduled during quarter one 2023/24 for the remaining ten colleagues to complete their training.

68. The FTSU Champions undertake the first module of the speak up e-learning prior to undertaking the in-house speak up training.

69. Following their training the role of the Speak Ip Champions will be launched in corroboration with the Communications Team during quarter two 2023/24.

Triangulating Information/Themes/Data

70. The National Guardians Office have documented the data that could be compared to identify wider issues which includes:

    - Patient Safety
        - Patient Complaints
        - Patient Claims
        - Serious Incidents
        - Near Misses
        - Never Events

    - Employee Experience
        - Grievance Numbers and Themes
        - Employment Tribunal Claims
        - Exit Interview Themes
        - Sickness Rates
        - Retention Figures
        - Staff Survey Results
        - Polls/Pulse Surveys

- Workforce Race Equality Standard and Workforce Disability Equality Standard Data
- Levels of Suspension
- Use of Settlement Agreements

Patient Experience Team – Data/Update

71. Overall we received 138 new complaints in 2022/23.

72. The top three themes throughout the reporting period are below:
    - Diagnosis & Treatment – Patient disagreement with diagnosis, Patient disagreement with treatment plan and Misdiagnosis
    - Communication – Conflicting clinical information, Failure to communicate service change and Lack of continued support
    - Inpatient concerns – Delay in receiving medication, Lack of medical update to patient, Patient concerns not escalated and Quality of care poor

73. Overall 835 concerns were received in 2022/23.

74. The top three themes throughout the reporting period are as follows:
    - Communication – Patients unable to contact department by telephone, Lack of continued support, Clinical information not clear and Failure to communicate waiting time
    - Diagnosis & Treatment – Urgent review requested, Delay in medication (homecare) and Disagreement with treatment plan
    - Waiting Times for – New appointment, Follow up appointment and Admission date

75. Further analysis is required to explore actual themes and trends of the complaints and concerns being received.

Human Resources Team Data/Update

76. There were no specific themes to note which came via the HR route.

77. Exit Interview Themes – staff left the trust for promotion/work life balance

78. In line with the National Guardians Office the following will require further analysis to explore whether the FTSUG role is as effective as it is needed to be, therefore, the following themes will be the focus for the first half of 2023/24:
    - ➢ Exit Interview Themes
    - ➢ Sickness/Absence
    - ➢ Turnover

    TEA (Talking, Engagement and Actions) Sessions:

79. Virtual and face to face TEA sessions took place in July and August of 2022. These were mostly held virtually with one being face to face with the Chief Executive and Chief People Officer. Moving forwards these will alternate between the two.

80. The Executive Team met to discuss feedback from these sessions and confirmed the themes echoed those fed back through the national NHS Staff Survey, quarterly People Pulse surveys and were reflected in the work already ongoing across the Trust.

81. Listed below are key themes from the sessions including actions being taken:
    - Technology and Systems
        - ❖ Review of IT structure and processes
        - ❖ 'Bedding in' the Digital Aspirant progress and move into business as usual
        - ❖ Executive oversight

    - Reward and recognition

- End-to-end review of process of recognising staff achievement
- New instant recognition awards
- Launch of retirement certificates
- Refreshed Employee of the Month and Good Catch in-hospital displays

- How we communicate with each other, and share information and good news
  - Increasing non-digital channels for staff communication
  - Refresh of wall space throughout the hospital, with new spaces for sharing good news and patient feedback
  - TV screens in staff areas for Trust communication
  - Increased focus on hospital brand and sharing good news externally

- Staff wellbeing – including the rising cost of living
  - Promotion of Health and Wellbeing plan, including monthly Wellbeing Wednesdays, wellbeing advocates, Mental Health First Aiders, and safety at work
  - Opening of staff wellbeing hub in the main building later this yea
  - Plans in place for a new staff rest area in the main building following the reconfiguration of other services
  - Engagement with Joseph Rowntree Foundation to support staff on the cost of living

- Rationale for decision making
  - Leadership is a key focus for the Trust, and a strategic ambition in the new Trust strategy
  - Identifying staff for the Building Rapport, and Ward Manager courses and ensuring staff have protected time and support to attend these
  - Review of policies and processes around recruitment
  - Better communication of changes in structures and positions

2022 NHS Staff Survey Results

- Over 1.3 million NHS employees in England were invited to participate in the survey between September and December 2022
- 264 NHS organisations took part, including all 215 trusts in England which give a response rate of 46% (down from 48% in 2021)
- At each organisation, all eligible staff were invited to take part in the survey
- Since 2021, the survey questions have been aligned with the NHS People Promise, which sets out in the words of NHS staff the things that would most improve their working experience. There were an additional two themes within the 2022 survey which related to staff engagement and morale
- 636, 348 staff responded to the survey:
  - ❖ 593,977 online responses (594, 974 in 2021)
  - ❖ 42,371 paper responses (53,620 in 2021)

We have a voice that counts - Speaking up about concerns (National Data)

The following percentage of staff said they……

2022 - 61.5% feel safe to speak up about anything that concerns them in their organisation
2021 - 62.1%
2020 - 65.7%

2022 - 48.7% were confident that their organisation would address their concern
2021 - 49.8%

We have a voice that counts – Concerns about clinical safety (National Data)

The following percentage of staff said they……

2022 - 71.9% would feel secure raising concerns about unsafe clinical practice
2021 - 75.0%
2020 - 72.7%

2022 - 56.7% were confident that their organisation would address their concern
2021 - 59.5%
2020 - 60.5%

Feeling secure to raise concerns (National Data)

- ➢ The sub-score for raising concerns declined from 6.5 in 2021 to 6.4 this year
- ➢ There were declines on all measures relating to raising concerns, both relating to raising concerns about clinical safety and speaking up more generally
- ➢ The greatest deterioration was seen in the percentage of staff who would feel secure raising concerns about unsafe clinical practice. Having improved between 2019 and 2021, this measure declined by 3.1 percentage points from 75.0% to 71.9%, with a return to the 2019 level.
- ➢ There was a decline across all types of trusts, although agreement remains highest in Community Trusts (80.9%) and Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts (76.8%)

82. In response to the NHS staff survey results the National Guardian, Dr Jayne Chidgey-Clark, said: “It is disappointing that the staff survey results reflect a decrease in workers’ confidence to speak up, and especially concerning that this includes about clinical matters. However, fostering a culture where speaking up is supported, and actions taken as a result is the responsibility of each and every one of us. Whether you are a government minister, a regulator, a board member or senior leader; whether you work in a department, in a team, on a ward, or in a GP practice. No

one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wakeup call to leaders at all levels that Freedom to speak up is not just a 'nice to have' – it is essential for safe services."

2022 NHS Staff Survey Results – The Walton Centre

Top Level Results

- Above the national average in all People Promise elements and the two additional themes, apart from one where we were the same
- Best in class for 'we work flexibly'
- Improved score from 2021 almost across the board
- Issues remain around violence against staff
- Appraisals are still below the national average, but sub-scores are above average
- New issues highlighted – priority of patients and addressing/feedback of concerns

WRES Results

- Four key questions make up the WRES section of the staff survey as follows:
  - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public. This score increased from 2021 for white staff and all other staff with a higher percentage increase for all other ethnic groups
  - Percentage of staff experiencing harassment, bullying or abuse from staff. This score is broadly similar to last year's for white staff and increased by 2% for all other ethnic groups
  - Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. This score increased by over 4% for white staff and decreased by 2.5% for all other ethnic groups
  - Percentage of staff experiencing discrimination at work from manger/team leader or other colleagues. This score decreased by 1.8% for white staff and increased by 5.1% for all other ethnic groups

WDES Results

- Seven key questions make up the WDES section of the staff survey as follows:
  - Percentage of staff experiencing harassment, bullying or abuse from patients/service users, relatives or the public. This score increased for staff with or without a long-term illness (LTC)
  - Percentage of staff experiencing harassment, bullying or abuse from managers. This score increased by 5% for staff with a LTC and has decreased for staff without a LTC
  - Percentage of staff experiencing harassment, bullying or abuse from colleagues. This score decreased by 4% for staff with a LTC and has increased slightly for staff without a LTC
  - Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. This score increased for both groups of staff and by 12% for staff with a LTC
  - Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion. This score has increased for both groups of staff
  - Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This score has decreased by 4% for staff with a LTC and increased slightly for staff without a LTC
  - Percentage of staff satisfied with the extent to which their organisation values their work. This score has increased slightly for staff with a LTC and by 5% for staff without

2022 NHS Staff Survey Results – Benchmarking

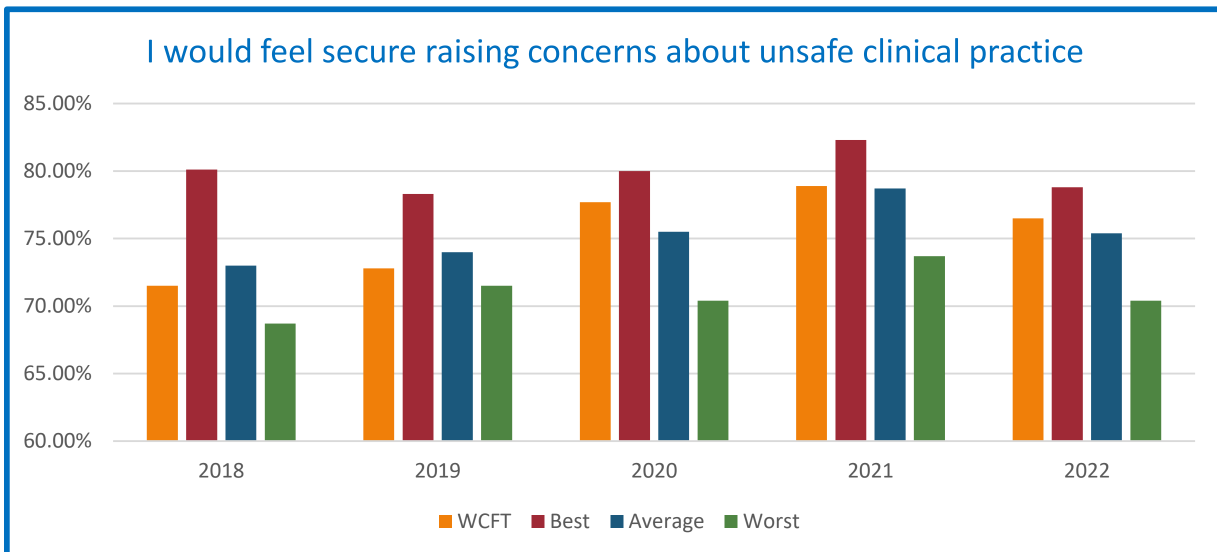
Overview/Reponses:

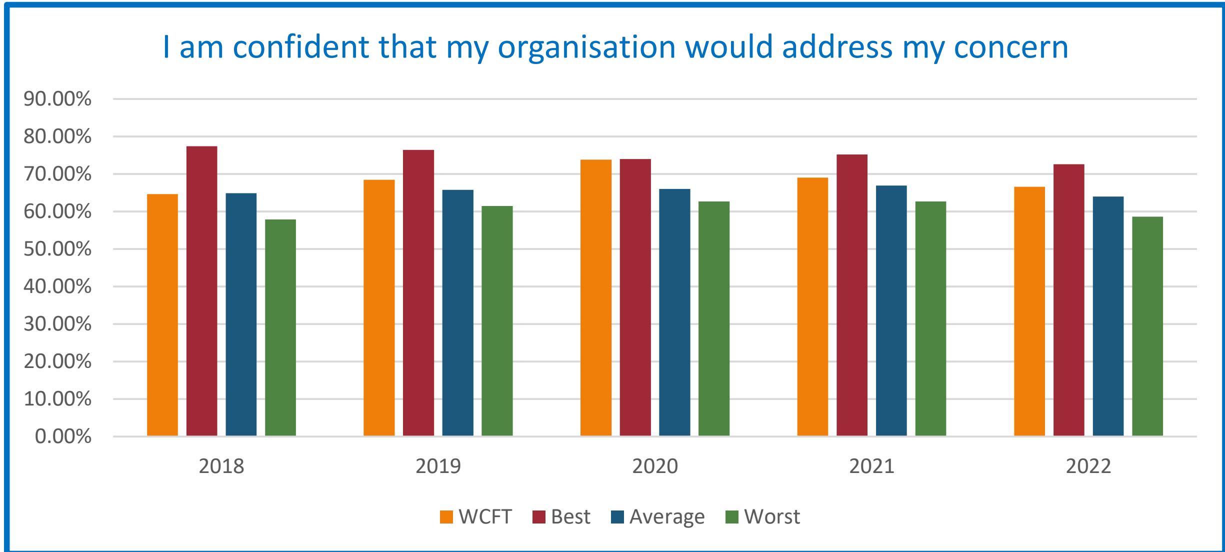
- The number of Walton Centre staff who responded to the survey was 614
- The overall response rate for the Trust was 42%
- We were benchmarked against a group of 13 Acute Specialist Trusts
- The median response rate for the group was 52%
- The number of completed questionnaires within the group was 15013

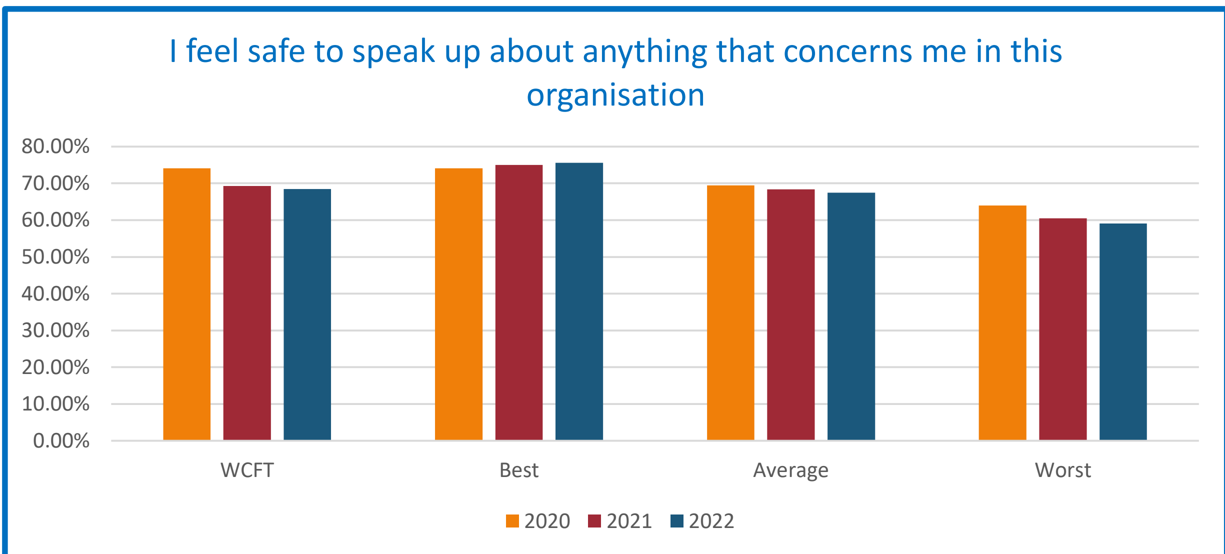
How do we rank?

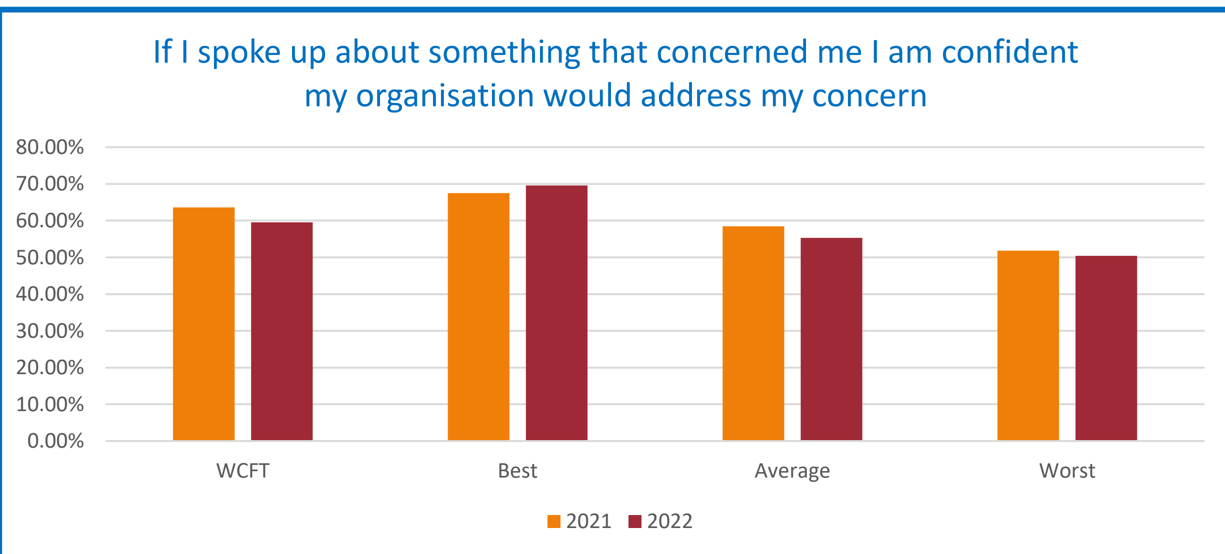
- Second highest for 'we have a voice that counts'
- Second highest for 'we work flexibly'
- Third highest for 'we are a team'
- In the top half for all People Promise areas
- Sixth for 'would recommend the organisation as a place to work', third in the North West

People Promise Elements and Themed Results – Raising Concerns:









Next Steps

83. The Trust is committed to continuing to learn and improve its systems and processes for raising concerns. Examples of learning outcomes include:

- FTSU Guardian
  - Continued support of the FTSU Guardian through the national development programme
  - Refresher training to be completed by November 2023

- FTSU Champions
  - Launch the role of the Champion and increase visibility
  - Learning events to be held with the FTSU Champions going forwards

- Staff Voice
  - Encourage staff to share their lived experience. Staff networks provide a safe place for staff to share their stories

- Communication
  - Provide updates, key messages around speaking up via the staff intranet
  - Triangulation of data/information from multiple sources

Conclusion

84. The Freedom to Speak up Policy for the NHS has been reviewed, revised and approved. It is accessible via the Trust Intranet Site.

85. Upon completion of the speak up in-house training we will launch the Champions via posters, the intranet, safety huddles, Team Brief, Walton Weekly and will undertake regular ‘walkabouts’.

86. Roll out of a further two speak up e-learning modules which are to be completed by line managers and senior leaders.

87. The Board is asked to note that the FTSU Guardian is in place and accessible to all staff. She functions independently in line with requirements from the National Guardian’s Office and continues to promote the role of speaking up mostly through face-to-face engagements with local teams. She encourages Heads of Departments to invite her to team meetings to give an overview of the role.

88. Meetings have been scheduled to review and complete the Freedom to Speak Up Reflection and Planning Tool which is a requirement by the NGO and is to be completed by January 2024.

89. The Trust Board can be assured that our staff have many routes to raise/discuss their concerns.

Recommendation

90. To note the content of this report for the purposes of assurance.

91. To continue to promote and support the role of the FTSU Guardian at the Trust.

Author: **Julie Kane**
Date: **19th May 2023**

NHS
The Walton Centre
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 19/05/23		**Report of:** Audit Committee
Date of last meeting: 16/05/23		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Head of Internal Audit Opinion 2022/23 • External Audit Progress Report 2022/23 • Draft Financial Accounts 2022/23 • Draft Annual Report 2022/23 • Principal Risks 2023/24 • NED Independence Annual Report 2023/24 • Fit and Proper Persons Annual Report and Policy 2023/24 • Information Governance Annual Report 2022/23 and Workplan 2023/24 • Cyber-Security Annual Report 2022/23 • Clinical Audit Annual Report 2022/23
2.	**Alert**	• None
	Assurance	• The Head of Internal Audit Opinion provided Substantial assurance that the Trust had a good system of internal control in place for 2022/23 which are designed to meet the Trust's objectives. • The Committee received the External Audit Progress Report, and no concerns were raised. • The Committee received the Draft Financial Accounts. The final version of the Financial Accounts would be presented to the Committee at the Extra-Ordinary meeting in June. • The Draft Annual Report was received by the Committee, and it was noted that the report would be audited by the external auditors and the final version would be submitted to NHSE by 30 June 2023 and laid before parliament. Minor amendments were requested by the Committee. • The Committee received the 2023/24 Principal Risks and updated Risk Appetite Statement for 2023/24. • The Fit and Proper Persons Annual Report was received by the Committee which highlighted no concerns. A new policy was approved which reflected the removal of the annual criminal convictions check for staff. • The Committee received the 2022/23 Information Governance Annual Report and the workplan for 2023/24. The Trust met the 95% target for the information governance e-learning and passed the mandatory assertion within the DSP toolkit. There had been an increase in the he Freedom of Information requests in 2022/23.

		• The 2022/23 Clinical Audit Annual Report was received by the Committee, and it was noted that good progress had been achieved on the action plan. The Committee would conduct periodic deep dives on some clinical audits to better understand how the process worked. • The Committee received the 2022/23 Cyber-Security Annual Report, and it was highlighted that Cyber-Security Plan would be presented at the Audit Committee meeting in July following the release of the NHSE Cyber-Security Strategy 2023-2030 at the end of May 2023.		
	Advise	• The Committee received the Non-Executive Director's Independence Annual report, and one NED was not able to agree all qualifying. The Committee reviewed in detail the declaration and agreed that this NED was independent in approach and thinking despite links to other organisations and could continue to be considered independent.		
2.	**Risks Identified**	None		
3.	**Report Compiled by**	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 11/05/23		**Report of: Neuroscience Network Programme Board**
Date of last meeting: 11/05/23		**Membership Numbers: 15 (Quorate)**
1.	**Agenda**	The Neuroscience Programme Board considered the agenda below: • Getting it Right First Time (GiRFT) spinal update • Integrated Care Board (ICB) / System update • Cheshire and Mersey Rehab Network (CMRN) review • Neurosciences Programme Board effectiveness review and terms of reference • National Institute for Health and Care Excellence (NICE) guidance regarding sub-arachnoid haemorrhage update • Regulatory changes regarding Valproate usage • Epilepsy preconception study • Hot topics from other hospitals
2.	**Alert**	**Cheshire and Mersey Rehab Network Review** A draft specification for the review had been compiled with working groups to be convened and further updates would be provided as this work progressed. This is now being led by NHS England. **Regulatory Changes Regarding Valproate Usage** The Medicines and Healthcare products Regulatory Agency (MHRA) have made regulatory changes regarding the usage of sodium valproate due to the risks posed for in-utero exposure. This also pertains to the male population as well as female. A system approach and process was required to initiate prescribing of sodium valproate which would include two clinicians signing off the prescription. Work was underway to explore solutions and collect the required information.
	Assurance	**Spinal Getting it Right First Time (GiRFT) Update** The Trust was compliant with eleven of the twelve actions identified with work underway to ensure compliance with the remaining action. It was noted that GiRFT had published expectations and guidance around Cauda Equina Syndrome and work was underway across the region to review the regional challenges and record as a risk at Integrated Care Board level.
	Advise	**Integrated Care System Update** The Carnall Farrar Liverpool Clinical Services Review made twelve recommendations regarding more collaborative working and optimisation of facilities on each site with

		joint committees formed to review this. This review was focussed on the Liverpool area however it was recognised that there was a need to review the wider provision of Neuroscience care. **NICE Guidance Regarding Sub-Arachnoid Haemorrhage Update** Advice was sought following publication of updated NICE guidance regarding sub-arachnoid haemorrhage and it was advised that if a CT scan was undertaken within six hours and reported by a Neuroscience Radiologist then this would be acceptable however this was contingent on how the patient was recovering and dependant on clinical suspicion. **Epilepsy Preconception Study** The Programme Board received a presentation on the risks associated with usage of sodium valproate during pregnancy and conception and the importance of preconception care for women with epilepsy. **Neurosciences Programme Board Terms of Reference Review** It was recognised that patient representation remained difficult to achieve and work was ongoing to improve consistency in this area. Feedback on the terms of reference was welcomed and the terms of reference will be amended to consider any feedback received and then submitted to the next meeting for approval.		
3	**Risks Identified**	None		
4.	**Report Compiled by**	Medical Director	Minutes available from:	Corporate Secretary

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Report to Trust Board
1 June 2023

Report Title	Neurosciences Programme Board (NSPB) Annual Effectiveness Review and Terms of Reference	
Executive Lead	Andy Nicolson, Medical Director	
Author (s)	Katharine Dowson, Corporate Secretary	
Action Required	To decide	
Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*		
✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

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

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23
- ToR to be formally approved by the Integrated Care Board (ICB)

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

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*		
002 Collaborative Pathways	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*		
Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
NSPB	11 May 2023	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Neuroscience Programme Board Effectiveness Review and Terms of Reference

Executive Summary

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

2. Key Achievements for the Committee this year were:
   - Expansion of membership including three patient representatives although attendance is not consistent
   - Maturing working relationship with ICB
   - Actions completed in a timely manner

"the Group works well and the focus has consciously shifted away from internal Walton Projects."

Proposed Changes

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These were reviewed by the Committee and there are no further proposed changes to the membership, purpose or duties following the annual review.

4. The ToR at Appendix 3 are the proposed version for 2023/24. Paragraph 17 was amended on the advice of the Information Governance Manager in order to reflect updated legislation and the new text proposed is in red.

Conclusion

5. The Board is asked to agree the revised Terms of Reference before formal approval from the ICB.

Recommendation

To agree.

Author: Katharine Dowson
Date: 23 May 2023

Appendix 1 – NSPB Draft Terms of Reference May 2023

Appendix 1

Neuroscience Network Programme Board

TERMS OF REFERENCE

Authority/Constitution

1. The Neuroscience Network Programme Board (the Committee) is authorised by the members of the Cheshire and Merseyside Integrated Care Board.

2. The Committee has no executive powers delegated from the authorising Board or The Walton Centre NHS Foundation Trust (the Host).

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

4. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

5. The purpose of the Committee is to improve neurology and neurosurgery outcomes for the Cheshire and Merseyside population through improving equality of access, at scale best practice pathways in neuroscience conditions via clinically led work streams that will enhance quality, reduce variation and drive efficiencies in support of the Integrated Care System (ICS) Strategy and the NHS Long Term Plan.

Membership

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

- Senior Responsible Officer (TWC Medical Director) (Chair)
- Programme Director
- Representatives of Cheshire and Merseyside Acute Trusts
- Cheshire and Merseyside Neurological Alliance
- Chief Operating Officer (TWC)
- Chief Finance Officer (TWC)
- Place-based Commissioner Representative
- Divisional Representative (TWC) – Neurosurgery
- Divisional Representative(TWC) - Neurology
- Finance Leads
- Local Authority Representative
- Musculoskeletal Network Representative
- Patient Representatives
- Primary Care Clinical Lead / GP x2

- Public Health Lead
- Specialised Commissioner
- Clinical Lead for Transition to Adult Care

7. The Committee will be deemed quorate when the SRO is present (or nominated deputy) with at least six other members present, this must include clinical representation.

8. In the event that the Chair of the Committee is unable to attend a meeting, members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

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

10. Colleagues from local government, NHS or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

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

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

Duties

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

- Establish a Strategic vision for networked neuroscience care across the ICS footprint and develop a collaborative strategic plan to implement this vision
- Support the Cheshire & Merseyside (C&M) Places by using population demographics, demand forecasts, benchmarks & capacity analysis to assess the current performance for the system identifying key issues for the local population
- Work as a system to identify key issues and their drivers, quantify the size of challenge, model impact of solutions and prioritise transformation programmes
- Ensure effective collaborative mechanisms are in place across C&M to oversee delivery of the networked neuroscience services along the whole pathway
- Act as a specialist subject matter expert reference group for the stakeholder organisations, advising on the role and strategic direction of the Neuroscience Network programme within the ICS
- Be responsible for the development of the overall Neuroscience Network programme set by the ICS Board and the Transformation Programme Board , including recommendations on resource utilisation, effective outcomes, timescales and financial allocation

- Undertake financial modelling at both Place and STP level to identify the main drivers of current performance and quantify the impact of the 'do- nothing' versus changing scenarios
- Consider and review relevant metrics, support the development of appropriate performance measures such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks.
- To identify opportunities and make recommendation to the C&M ICB and the nine Places to meet the strategic objectives of the ICS (Whole System Integration, Acute Sustainability, Mental Health and LD Sustainability, Carter at Scale, Prevention at Scale)
- Make recommendations on investment and disinvestment in Neuroscience Network programmes to the ICS Board, Places and individual organisations as appropriate
- Monitor and oversee the working of the groups to account for the delivery and outcomes of projects associated to the overall Neuroscience Network programme
- Create an environment where all organisations within the C&M footprint for Neuroscience Work Streams can facilitate delivery of the objectives

14. Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas outlined above.

15. Provide assurance to the host on compliance with associated legislation, national reporting and regulatory requirements, best practice and progress against objectives.

16. The Committee will also keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed

Data Privacy

17. ~~The Committee is committed to protecting and respecting data privacy. The Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).~~ The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

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

Reporting

19. The Committee will be accountable to the ICS Transformation Programme Board and will report to The Walton Centre's Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

20. Specific items for information/ action will form part of communications to the wider membership.

Administration of Meetings

21. Meetings shall be held every other month with additional meetings held on an exception basis at the request of the Chair or any three members of the Committee. There shall be a minimum of five meetings per year.

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

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

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

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

Review

26. The Terms of Reference shall be reviewed annually and approved by the ICB.

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

Reviewed by the Committee: May 2023
Approved by the ICB: tbc
Reviewed by the Host Board: 1 June 2023
Review Date: March 2024

NHS The Walton Centre NHS Foundation Trust

Report to Trust Board
1 June 2023

Report Title	Trust Wide Mortality Report: Learning from Deaths (Quarter 4 2022-2023)
Executive Lead	Dr Andy Nicolson, Medical Director
Author (s)	Pat Crofton, Governance Lead for Mortality
Action Required	To note

Level of Assurance Provided.

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

Key Messages.

- There were 22 inpatient deaths in Quarter 4 2022/23, 20 in neurosurgery, 2 patient deaths the neurology division. 17 patients were admitted as emergencies, 4 were elective admissions and 1 patient was transferred from ITU care in a satellite hospital for expert epilepsy management.
- The Mortality Surveillance Group provides oversight of compliance with the mortality review processes. This group provides assurance that the causes and contributory factors of patient deaths have been considered and appropriately responded to in an open and transparent manner.
- End of life care is examined in detail as part of the initial mortality reviews. In 2 patient deaths within Q4 which were presented at surgical mortality areas of good practice have been highlighted.
- The significant delay at HM Coroners Liverpool has greatly reduced in Q4, the clinical governance lead for mortality has met with the lead coroners' officer and inquest outcomes will be provided for all Walton Centre referrals. Going forward those outcomes will be reported via the Divisional Governance reports and (if relevant) included in this report.

Next Steps

- Learning from Deaths Policy has been approved by CESG, related policies / Standard Operating Procedures (ongoing).
- The MSG will continue with monthly meetings and will monitor the action logs from Divisional mortality groups.

Related Trust Strategic Ambitions and Themes	**Impact**		
Quality of Care	Quality	Not Applicable	Not Applicable

Strategic Risks

001 Quality Patient Care	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised, and actions agreed**
Quality Committee	18/05/2023	Dr Andy Nicolson *Chief Medical Officer*	

Executive Summary.

1. This report provides an overview of deaths in Quarter 4 2022 / 2023.The report also details progress of compliance with national guidance regarding Learning from Deaths of patients in our care.

Background and Analysis

Number of in-patient deaths Q4 2022-2023.

Month	January	February	March
Total	6	7	9
Ward Areas	2	3	2
Critical Care	4	4	7

Number of deaths by Quarter 2022-2023

Quarter	Total	Critical Care	Acute ward areas
Q1	20	11	9
Q2	40	28	12
Q3	30	18	12
Q4	22	15	7

2. In line with the National statistics There has been an increase in inpatient deaths over the year 2022/23, a total of 112 compared to 64 in 2021/22, the majority being in critical. care.

3. There have been 22 inpatient deaths in Q4, a reduction from Q3. As with previous quarterly reviews, the highest number of patient deaths occurred in ITU, and were related to trauma and life-threatening vascular events. Ongoing retrospective Data from the Intensive Care National Audit and Research Centre (ICNARC) up to September 2022 has shown all mortality measures remain within the expected ranges during this period when compared to similar units.

4. Of the 22 deaths there were
    - 18 patients admitted as emergencies.
    - 4 were elective admissions planned for surgery for cranial tumours.
    - 3 patients had secondary metastatic tumours.
    - 1 patient had a primary malignant tumour; however, her surgery was cancelled, and the plan of care changed to end of life care.

Speciality

Vascular	**Trauma**	**Spinal Trauma**	**Oncology**	**Neurology**	**CSF infection**
8	**5**	**2**	**4**	**2**	**1**

5. All deaths were referred for either Coronial or Medical Examiner (ME) team review. There were 7 direct coroner referrals, and 15 ME referrals.

6. 2 ME referrals were escalated for further scrutiny by the coroner.

7. The Governance Lead for mortality is engaged with the Liverpool Coroner's Office and has provided feedback regarding issues in the referral process which have caused delays for bereaved families.

8. The backlog of referrals at the coroner's office is significantly reduced related to Q3. They are now able to provide timely inquest outcomes to assist with the Trust mortality review processes.

9. All families of patients who die in critical care are approached regarding organ donation if suitable. There were 4 patients whose families expressed their consent to organ donation.

10. Of the 22 deaths in Q4, 18 deaths have been subject to initial review with 4 outstanding reviews.

11. All reviews are now discussed at the Mortality Surveillance Group (MSG) Of the 112 inpatient deaths in 2022/23, 47 deaths have had second review by the group.

12. 29 deaths have been accepted as unavoidable with no further action. The remaining 18 deaths, although it was acknowledged there was no degree of avoidability, have been discussed at divisional mortality groups. This allows for the divisional clinical teams to have focused discussion regarding treatment of patients who die within our care. In line with Learning from deaths advice, care prior to admission is also a focus of the review.

13. Following discussion at surgical mortality, there are 2 cases where feedback to the referring hospitals has been considered appropriate.

14. End of life care and any concerns raised by families are also included in discussions. 14 patients were actively referred to the Specialist Palliative Care team for advice and support. Patients and families who are referred for organ donation are supported by the specialist nurses for organ donation within critical care.

15. A patient first seen in 01/03/2021 and following delays was later diagnosed with a rare malignant brain tumour. The patient underwent post-fossa surgery on 22/02/2022 followed by a period of critical care. On the 5/03/22 and following a CT scan attended theatre for insertion of an external ventricular drain.

16. Sadly, there was no neurological recovery following the drain and death was confirmed on the 6/03/2022. The patient death was discussed with HM coroner and a death certificate issued.

17. Following an internal mortality review completed by the Trust, this was shared with the patient's family, the CQC, HM coroner and the commissioners.

18. HM coroner has agreed to an inquest and a PIR is planned for 24/05/2023, an inquest date is to be confirmed.

19. The Governance lead for mortality and the patient experience team are supporting the bereaved family.

Conclusion

20. The number of deaths in Q4 has reduced compared with Q3 and remains predominantly in critical care. There were no deaths which were deemed avoidable.
21. Over the year 2022/23 there was an increase in deaths in comparison to the year 2021/22.

Recommendation

To note.

Author: Pat Crofton, Clinical Governance Lead for Mortality
Date: 10/5/2023

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Report to Trust Board
1 June 2023

Report Title	Patient Experience Q4 & Annual Report 2022/23	
Executive Lead	Morag Olsen, Interim Chief Nurse	
Author (s)	Lisa Judge, Head of Patient Experience Emma Sutton, Patient Experience & Engagement Manager Julie Elwill, Claims Manager	
Action Required	To note	
Level of Assurance Provided		
☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- To provide an annual overview of activity and detailing activity in Q4. This includes concerns, complaints, claims, police requests, coronial activity, volunteer services and engagement together with trends and learning.
- To note the increased number in complaints received in the 12-month period which is back to pre-covid numbers.
- To be assured that the Trust have robust complaints and claims management processes in place to ensure that they are actioned and managed to a high standard and lessons learnt are implemented.

Next Steps

- Following the thematic review of the complaint's module on Datix in Q3, the data will not be comparable for Q4, improved thematic reporting will be reported from Q1 2023/24.

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

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

001 Quality Patient Care	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised, and actions agreed**
Quality Committee	18 May 2023	Lisa Judge, Head of Patient Experience	Details of incidents to be removed where potentially identifiable
Hospital Management Group	22 May 2023	Lisa Judge, Head of Patient Experience	NA

Patient Experience Team (PET) Activity Quarter 4 and Annual Report

Executive Summary

1. This combined report provides an overview of the activity, outcomes, trends, and actions for both Q4 and annually for 2022/23. The data included pertains to enquiries, concerns, complaints, claims, coronial inquests, Friends & Family Test (FFT), compliments and volunteers. Any concerns/complaints pertaining to the nine protected characteristics are reported within this report, together with any action required. All cases under investigation relating to enquiries, concerns, complaints are discussed at a weekly meeting with both the Neurology and Neurosurgery Divisional Teams to determine progress. Here any open actions from closed complaints are monitored and evidence required by the Divisions is collated.

2. The SPC and themes charts for FFT, complaints/concerns and Balance Score Card for Claims have been appended for information.

Background and Analysis

3. **FEEDBACK - Patients, Families & Carers – Our Compliments & testimonials** ☺
The Patient Experience Team received 337 compliments, 55 of which were received in Q4 from patients, families and carers in relation to the care, treatment and service they have received from staff at the Trust in 2022/23. This is an increase compared to 211 in 2021/22 and reflects the high quality of care delivered to our patients.

   All compliments received are shared with any named staff members via email, as well as line managers/senior team. Teams are encouraged to log compliments on Datix received via their departments or share with PET to log. Positive patient feedback is shared at the end of the daily safety huddle.

   A small snapshot of patient feedback is included below:

‘From that first consultation and the time you personally took to quickly arrange for my wife to spend some time on the Chavasse ward, everything and everyone we encountered at The Walton Centre gave us the distinct impression that at long last, my wife was safely in the hands of people who genuinely cared for my wife’s wellbeing, which is not something I could say about certain members of your highly specialized profession. Actually, the phrase “thank you” barely starts to cover what Jean, myself and indeed all of my wife’s close family would really like to say to everyone who has been, (and will continue to be for whatever time she is going to need it), a part of my wife’s health, wellbeing and care team, but I suppose those two short words will have to suffice.’

‘To each and every person on Lipton Ward. I just want to thank you from the bottom of my heart for looking after my husband the way you have, you have all been so friendly, kind and extremely caring towards us all, even when we have not deserved it. Each and every one of you go above and beyond when you don't have too, but you do no matter what. You have been there for me keeping me positive and turning this horrible time into a positive pleasant one. Honestly, you don't know how amazing you all are. Everyday you all have a smile on your face. You truly are angels to me and i will be eternally grateful to you all. Most hospitals do not have the compassion and care you all have, and no amount of training can give you that neither, it is something you all have within you’.

‘I recently attended as an outpatient. I had been waiting months for an appointment. Eventually I met with Dr Matis who was very caring in his explanation of my condition etc. He took time and patience to explain things. My appointment was on time. I have also had cause

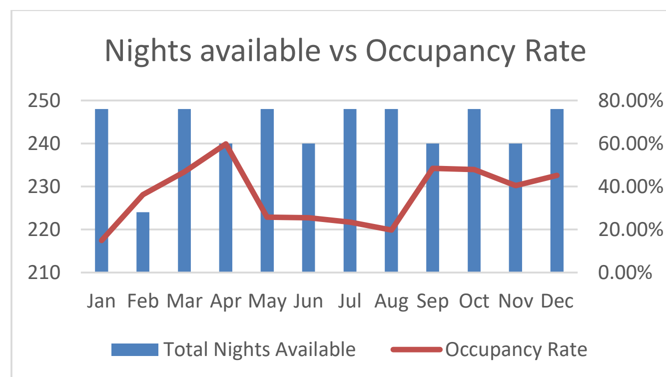
to call his secretary again and she is also very professional taking time out of her busy day to go through something with me. The radiography staff were also excellent reassuring and caring even though they had new a machine to use and were learning the 'ins and outs'. It is far too often that the NHS get slated for their services so I thought I would just say a big thank you to all involved in my care'.

'To all the staff in theatre who cared for me so well and Jefferson ward. My experience was above and beyond what she expected. The theatre staff were so supportive, and I cannot thank you all enough as would not have got through this difficult time without you. You are all experts in your field'.

'I was admitted for 5 weeks to The Walton Centre and was 'very poorly' as had been diagnosed with an abscess on her spine, sepsis and pneumonia. I felt extremely ill. The care and treatment have been given is more than incredible. I had a wonderful experience and thinks all the nursing and HCA staff are unbelievable, and nothing is too much trouble. During my time on Caton ward there was a friendly atmosphere and teamwork was apparent. I was so privileged to be in your care and have not come across a member of staff at Walton who does not greet you with a smile and will be forever grateful'.

4. HOME FROM HOME (HfH)

Our HfH relatives' accommodation is for family members who need urgent accommodation following an admission for urgent care or treatment. The accommodation is funded by TWC Charity and managed in line with the Relative's Accommodation Policy where a specific criterion needs to be adhered to with regards to who can use the facility and length of stay. We recognise that families are diverse, and we always aim to be fully inclusive and careful consideration is given when allocating rooms.



Throughout 2022, a number of families stayed in the accommodation after exceptional circumstances had been considered and approved by the Execs. As occupancy rate fluctuated between 15-60%, it was noted that between Jan-March 2023 visiting restrictions remained in place due to covid and accommodation was used by staff. Recommendations were made to the Charity Committee to increase occupancy rates going forward and provide further opportunities for the families of our patients. These recommendations include families of long-term patients, of those reaching end of life, families of long-term patients in rehab and

use of the rooms for staff under special circumstances. As it has been noted that 73 occupancy days were lost due to different circumstances involving facilities/maintenance, the committee have also been asked to consider procuring a new hotel-type booking system to improve efficiency, data quality and manage occupancy rates more efficiently. All agreed recommendations will be included in the Relatives Accommodation Policy.

The HfH Welcome Pack has been reviewed and includes a QR code which directs to the charity page of the website. In addition, all guests are now being provided with a Welcome Letter to outline criteria and expected length of stay.

Below is a snapshot of testimonials received from families.

'What a super facility, after emergency spinal surgery my husband will be fit to leave the hospital tomorrow and return to IOM. Thank you for the opportunity to stay with him during our hours of need. Thank you to all staff who work so hard to make a very stressful and difficult time a positive one'. *Isle of Man*

'Thank you so much to the staff and charity for letting us stay here, me, my sister and mum have come from the isle of man after my dad was in a serious accident. This place is great. We appreciate the cereal and the staff who have supported us are really nice'.

'I would like to give my heartfelt thanks to Jen and all of the team that make Home from Home very special. You have all been so supportive, friendly and welcoming. I felt as thought I was being wrapped in an *adult comfort blanket*. Special thanks also to all the fundraisers and donors who have enabled this accommodation to exist for relatives in their time of need. This really is an amazing place'.

'My son is about to be discharged today and I want to thank everyone here at Home from Home. A place of calm and respite that allowed me to charge my batteries for the task of supporting and reassuring my boy. The journey is not over, but to know that when we come in here in the future, we will be cared for in the most extraordinarily wonderful way is so reassuring. Hope is everything and this environment has allowed me to cultivate mine. We will return to Porthmadog to heal, and we will wish you all well for all you do.' North Wales

'Thank you to the hospital for all your efforts to save by gorgeous boy (38) although the outcome was the worst that we could expect, we know you tried your best. We could not save my boy, but the care and attentions has been second to none and my family and I would like to thank you all for trying so much. Thank you for Home from Home, as it really was for such a long time for us when we needed it most'. **Shropshire**

'Thank you for allowing me to stay here with my dying husband. He has had a life-threatening injury and was airlifted from the IOM. I would not have been able to stay with him had it not been for Home from Home. A 5 star stay, beautiful boutique décor and super room. Thank you for saving me as well and for your support. I will be forever grateful'. Isle of Man

'Thank you so much for your hospitality and understanding to all the lovely people involved in Home from Home. A lovely peaceful environment and much appreciated during the toughest time in our life. You truly are a godsent to us as we have travelled from Cambridge to be with our son. You

have helped alleviate all the stress and provide a place of comfort during our most difficult time'.
Cambridge

Next steps:
PET and the Charity plan to work together to consider new promotional materials including capturing feedback and sharing family stories and the policy will be reviewed to include new criterion.

5. **PATIENT/FAMILY ENGAGEMENT & INVOVEMENT**

- **Patient Experience Group -** meet quarterly, and their purpose is to ensure the values are translated into behaviours in the way we treat our patients and families and the experiences they have when receiving care and treatment. The membership includes key staff including senior nurses, operational managers, communications team, equality & diversity lead, together with governors, external partners such as Neuro Alliance and Health watch representatives across the region.

- **Proactive Engagement -** the team proactively engage with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meetings during long admissions for rehabilitation or prior discharge.

- **Carers Passport -** this was coproduced with the Cheshire & Mersey Patient Experience Group with carers for carers and was launched in the Trust in 2022 and re-launched in early 2023.

- **Inpatient Listening Events -** facilitated by Healthwatch Sefton in November 2022 and Healthwatch Liverpool in January 2023 involved speaking directly to patients, visitors, and family members. Any concerns addressed immediately by HoPE and Matrons and report to be presented at Patient Experience Group in May 2023.

- **Wirral & Cheshire & Mersey MND Support Group -** HoPE attended groups in January & March, feedback was shared with Clinical Lead and Dep Divisional Nurse for Neurology. Further engagement at support group will be explored as part of the PFCC workplan.

- **AVM Focus Group -** was attended by both a member of staff from PET and a volunteer with this condition who found the group to be most beneficial. The plan is to hold a formal annual meeting and set up a local support group for patients facilitated by Vascular Specialist Nurses. PET staff member will attend to support and engage with patients.

- **Neuroscience Programme Board -** patient representatives with long term conditions including Parkinson's Disease, Motor Neurone Disease and Muscular Sclerosis have been attending the NS Board virtually for the last 10 months. The reps meet with HoPE both prior to and following the meeting for support and work is underway to evaluate this process.

- **Well Led Focus Group -** held as part of the Trust's Well-Led review when a random sample of patients were invited to participate. Positive feedback received for the engagement in this process.

- **Partnership - C.H.A.T Project** is working with Liverpool college to develop a virtual reality software education tool aimed at young adults to increase awareness of the Consequence of Head Injury Acquired in Trauma. A young patient/volunteer with lived experience has been recruited to support with this project and identified an interested party to the project team to join to progress this work.

- **EoL Committee Patient/Family Input** - plans in place to recruit a patient/family member to the EoL Committee within next 6 months. HoPE to work with Specialist Nurse for Organ Donation to progress this work and identify a person(s) of interest to work with the Trust progress the EoL Strategy.

- **Patient Safety Partners (PSPs)** - work is progressing in line with the Patient Safety Incident Response Framework (PSIRF), and progress is reported via the monthly PSIRF Task & Finish Group.

- **Mersey Society for Deaf People (MSDP)** - engagement with the aim of improving the service we provide to the deaf community. Progress will be shared with Patient Experience Group/ Equality, Inclusion & Diversity Group and discussed with ED&I lead to take any suggestions forward. MSDP advised to make contact with HoPE to share stories at Board.

- **New Transgender, Non-binary Gender Fluid Policy** - co-produced following engagement with Genderspace UK to promote equality, diversity and inclusion across the Trust.

- **Patient Experience Training** - Delivered as part of the Aspiring Ward Managers training programme with positive feedback and plans to deliver future sessions. Training sessions delivered to admin staff in different departments across the Trust. Agreed Cheshire & Mersey Network for a bi-annual bespoke training to be delivered across the network and to be included in Building Rapport Programme.

6. **CQC NATIONAL INPATIENT SURVEY** - The Trust is required to participate in an annual CQC National Inpatient Survey to allow benchmarking of the patients' experience with other NHS providers. The Trust were ranked 11th out of 134 Trusts national for overall positive

patient experience, this is not comparable as the questions and data differed from the previous year but were ranked Better Than Expected which is an excellent result. A full report and action plan were presented to the Trust Board.

7. **FRIENDS & FAMILY TEST (FFT)**

In 2022/23 the Trust have a KPIs for FFT response rate for Inpatients of 30% and recommended rate of 90%.

For Outpatients, the internal rate usually sits around 5% with a recommended rate KPI of 90%. Results are report as part of the monthly Integrated Performance Report.

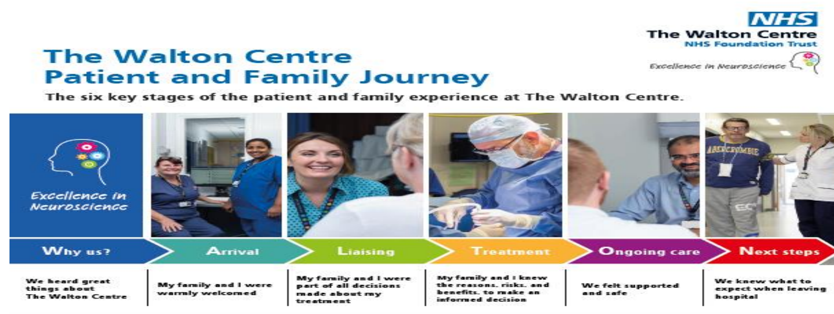
A monthly poster for each area highlighting response and recommendation rates plus any positive and negative feedback for actioning. Positive feedback is shared at the daily safety huddle and the Divisional Nurse Directors undertake review of any negative comments with teams to consider if there are any current, themes trends, if these are new or known issues to inform future work plans and this is to be discussed at Ward Managers Risk & Governance Meetings.

In Q4, a trend noted in relation *food being not as hot as it should be* following discussions with ISS, actions were implemented to support with this and amend lunchtime menus. Comments continue to be monitored closely.

Next steps: A business case is progressing by the Senior Nurse Team with a view to reviewing the way we capture FFT responses with the aim of receiving real time feedback with the latest analytics. This will provide patients with the option not only to provide feedback via post card as at present, but to respond via text, online or leave a voice message recording of their experience. This service can provide high level results at a glance by each area and a dashboard word cloud with the ability to dive deeper and view results specific to each area/department with comments report available from ward to board. Other local Trust who have procured the SMS text service have a noted an increased response rate across all areas.

See Appendix 1 for SPC charts.

8. **PATIENT & FAMILY CENTRED CARE (PFCC)**



The 6 steps of the Patient and Family Journey to support the delivery of Patient & Family Centred Care was reviewed in February 2023 with new graphics which are being displayed across the Trust. A new PFCC workplan had been developed led by Dep Chief Nurse, HoPE and Matrons to drive the six steps and promote the use of the carer's passport with a particular focus on CRU and Lipton ward.

In April 2023, the focus has been on reinstating family rooms on the wards which were used by staff when visiting was suspended during covid. This has been met by some challenges from staff, but we recognise the importance of restoring these areas on wards to support patients and families. Other plans include working groups to be developed to drive both inpatient and outpatient initiatives.

To support the first step **Why Us/Walton?** New volunteer profiles have been installed to promote this step together with the volunteer service.

Next steps:
The workplan for 2023/24 will be monitored via the Patient Experience Group and reported to Quality Committee via the Chair's report.

9. VOLUNTEER SERVICE

Our volunteers are an invaluable and important part of the Trust and an integral part of the Patient Experience Team and support our patients, families, and staff. Volunteering is open to everyone over the age of 16, of any gender identity, culture, ethnicity, and all levels of ability. 32 volunteers are currently in roles across the Trust.

Volunteers play a vital role in delivering services to the NHS and this is particularly so at The Walton Centre. The Trust recognises the huge role that our volunteers have in supporting patients, enriching patient experience and bringing communities together. We acknowledge that volunteer roles are essential to reduce the pressure on services and support staff. They are part of the hospital team that delivers an outstanding patient experience.

In Q4, the volunteers kindly donated >1,200 hours and two new volunteers were recruited, in addition to another 2 waiting to start following HR clearance.

Three volunteers have been presented with 'Volunteer of the month' and a new exciting service has commenced with the introduction of a Mobile Library Service. This includes books/puzzles and activity books such as adult colouring for patients to take and use to promote relaxation and recovery. Our Sweets & Treats Trolley also expanded the service to Sid Watkins Building which has boosted sales and been positively received by all.

Within Q4, links have been made with the ED&I Lead to discuss how best to support our current volunteers and new starters with disabilities. Involvement in the Trust's workplace Safari was positive offering volunteering opportunities to students from various schools across Liverpool.

Volunteer Annual Achievements:

- Reviewed information on website, developed volunteer profiles.
- Introduced Volunteer Pet Therapy Dog which has been very successful especially in rehabilitation.
- Re-introduce Volunteer of the Month, presented by the Trust's Chairman.
- Volunteers took part in Visual Impairment Training facilitated by a local charity DAISY.
- Reward and recognition – our volunteers each were given a gift as a token of appreciation from the Team & Trust.
- Networking with NHS England who offer guidance to support the growth and develop volunteering in the NHS and local Trusts.

Next Steps:

- New services include Volunteer work with a member of the Philharmonic Orchestra to chaperone when delivering 'music therapy' to our patients on CRU.
- Expanding the service of the Reading Buddy with training provided by The Reader organisation.
- Review opportunities for ED&I training such as Transgender awareness.
- Nominate for external recognition including Room to Rewards and Point of Light awards.
- Plans to raise the profile of volunteers internal and external through social media, Neuromatters, the Trust's Safari Workshop, Edge Hill University, and other external agencies.

- Develop new roles in line with meet the Trust's needs.
- Recruitment drive via NHS jobs

10. **PATIENT & FAMLIY STORIES** are presented to the Trust Board monthly, and these include stories from patients, family members and staff. Stories are delivered in person, via MS teams from different service lines and throughout the year have included stories from families of a patient following organ donation and how staff went above and beyond. Experiences have included the relative of a patient with a Learning Disability shared their positive aspects of the experience at the Walton Centre together with the general challenges that come with caring for a loved-one with a LD. Other stories have included first-hand lived experience from a patient who underwent a thrombectomy following transfer as an emergency and the impact that our volunteer who provides pet therapy has on our patients and families.

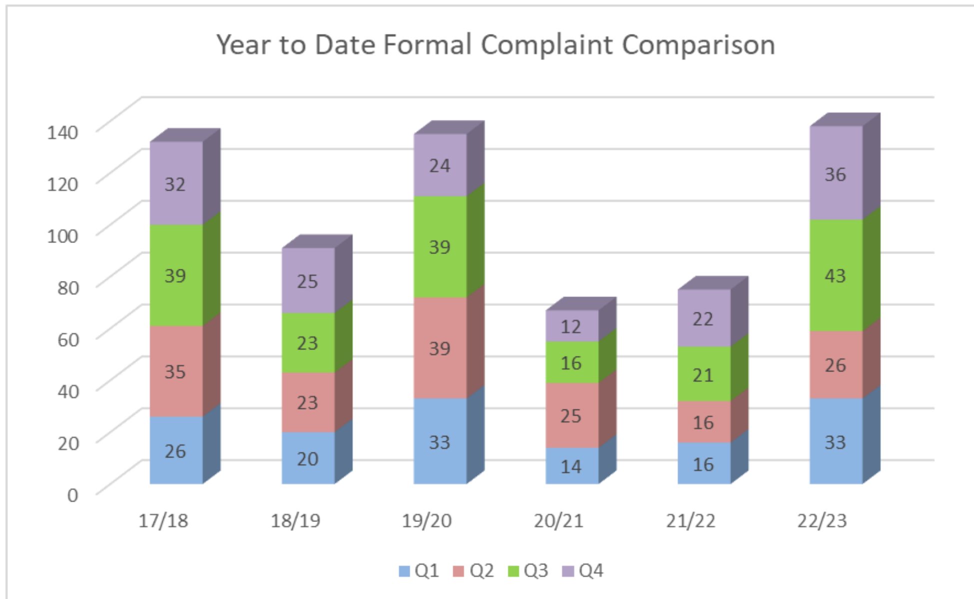
11. **COMPLAINTS**
All complaints were acknowledged within 3 working days in line with Trust KPIs.

12. It should be noted that, 18 complaint responses within the year have been renegotiated from a level 1 (25 working days) to a level 2 (45 working days) with one extended to a level 3 (65 working days) following requests from Divisional Management Teams, as the investigations were incomplete for various reasons and/or response is not available to PET from the division within the required timeframe.

13. In Q4, 4 requests for re-negotiations were escalated and approved by Deputy Chief Nurse.

    - *(NS) Further time required as family unable to attend initial meeting date due to bad weather to discuss complaint re: misdiagnosis. New date set awaiting family confirmation.*
    - *(NL) Clinical lead wished to discuss consultant response further with Medical Director.*
    - *(NL) Division joint complaints with LUFHT and awaiting input from another Trust.*
    - *(NL) Division not completed investigation within timeframe, complaint involved 1 clinician. DDN approved for this occasion.*

14. The numbers of formal complaints received in 2023/24 has increased and reached pre-covid levels as indicated in chart below.



15. It had been identified that communication and appointment arrangements had been a long-standing trend in subjects of complaints and concerns, which was also reflected in Q2 and Q3. PET acted and undertook a piece of work to review categories, subjects and sub subjects within the complaints model of Datix. This was to ensure that concerns received were categorised accurately to provide meaningful data to drill down to areas and drive improvements.

16. The aim of the review was to deep dive into the subjects/categories for concerns/complaints, for example, it was noted that under the subject Appointment Arrangements, all concerns pertaining to an appointment i.e., *patient unhappy with the outcome of an appointment or delay during appointment* were recorded within this category which was not entirely accurate. The work entailed looking back at all the sub-subjects of concerns/complaints for the previous year and rebuilding the form with new categories, subjects, and sub subjects. This work was complete at the end of Q3 and agreed with the Divisional Management Teams and Deputy Chief Nurse. This went live on the system from Q4 2023/24 with the aim to review and amend any technical hitches prior to the next financial year. This will permit collation of the recording of complaints/concerns to be more appropriate and in detail. The data extrapolated will include new speciality groups for e.g., epilepsy and includes a multiple-choice option to map to staff groups to highlight areas or staff groups of concern.

17. **Complaints Data**
In Q4 36 new complaints received, 12 related to inpatient/day case episodes, 24 were in relation to outpatient care and services.

Number of new complaints received	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	**Q4 22/23**
Overall	16	16	22	22	33	26	43	**36**
Neurology	10	9	9	10	10	10	21	14
Neurosurgery	6	5	11	11	20	11	19	12
Cross divisional	0	2	1	1	0	4	2	5

Corporate	0	0	1	0	3	1	1	5

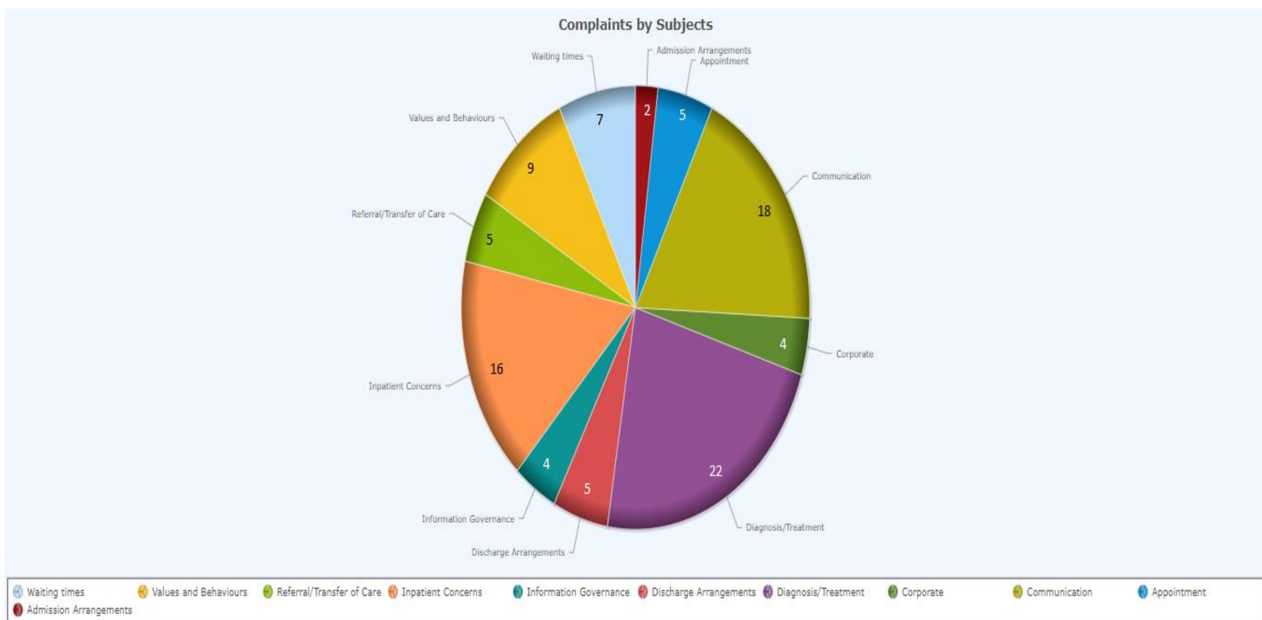
18. Overall, **138 new complaints** were received in 2023/24, **36** of which in Q4.

19. In Q4, 4 concerns were escalated to complaints as patients/families required further clarity or requested a formal response. Annually, 23 concerns have been escalated from a concern to a complaint, the themes include disagreed with the factual clinical information provided or disagreed with the priority of their appointment/referral and therefore wish for their concern to be escalated further and receive a formal response.

20. Of the 36 new complaints in Q4, 31 have since been closed.

21. In terms of the divisional split of complaints; Neurology received 14 in Q4 and 55 annually and Neurosurgery 12 in Q4 with 62 annually. In Q4, 5 cases were cross-divisional (11 annually), and 5 cases were corporate, with 10 annually.

22. **Complaint Themes & Trends** for Q4 are detailed below.



As detailed above the top three themes can be broken down further as follows:

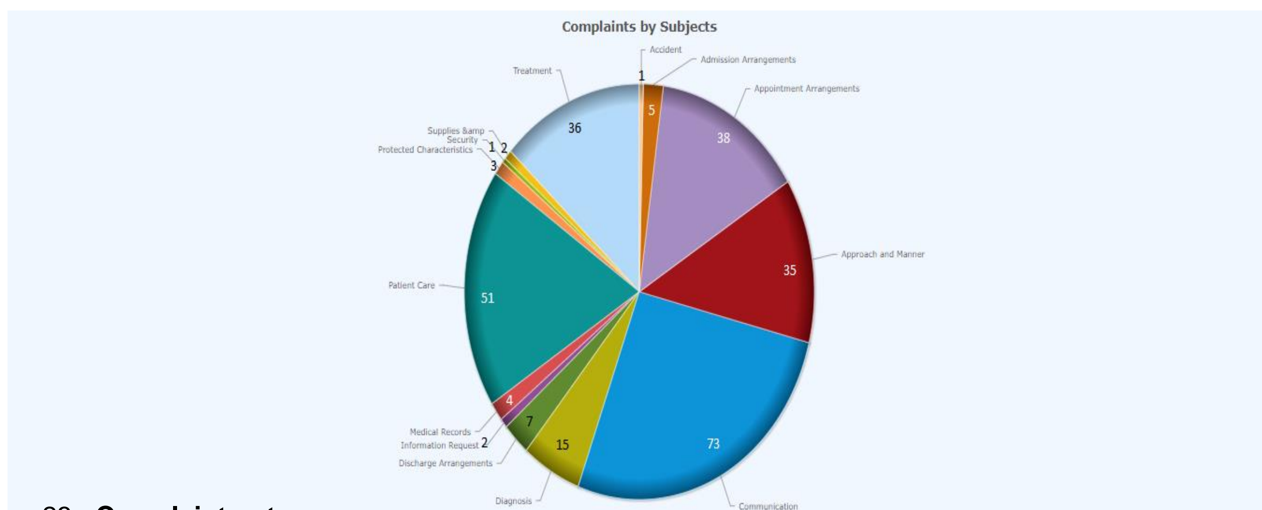
Diagnosis & Treatment – Patient disagreement with diagnosis, Patient disagreement with treatment plan and Misdiagnosis.

Communication – Conflicting clinical information, Failure to communicate service change and Lack of continued support.

Inpatient concerns – Delay in receiving medication, Lack of medical update to patient, Patient concerns not escalated and Quality of care poor.

Due to the change in subjects (themes) from the beginning of Q4, we are unable to make direct comparison against previous quarters.

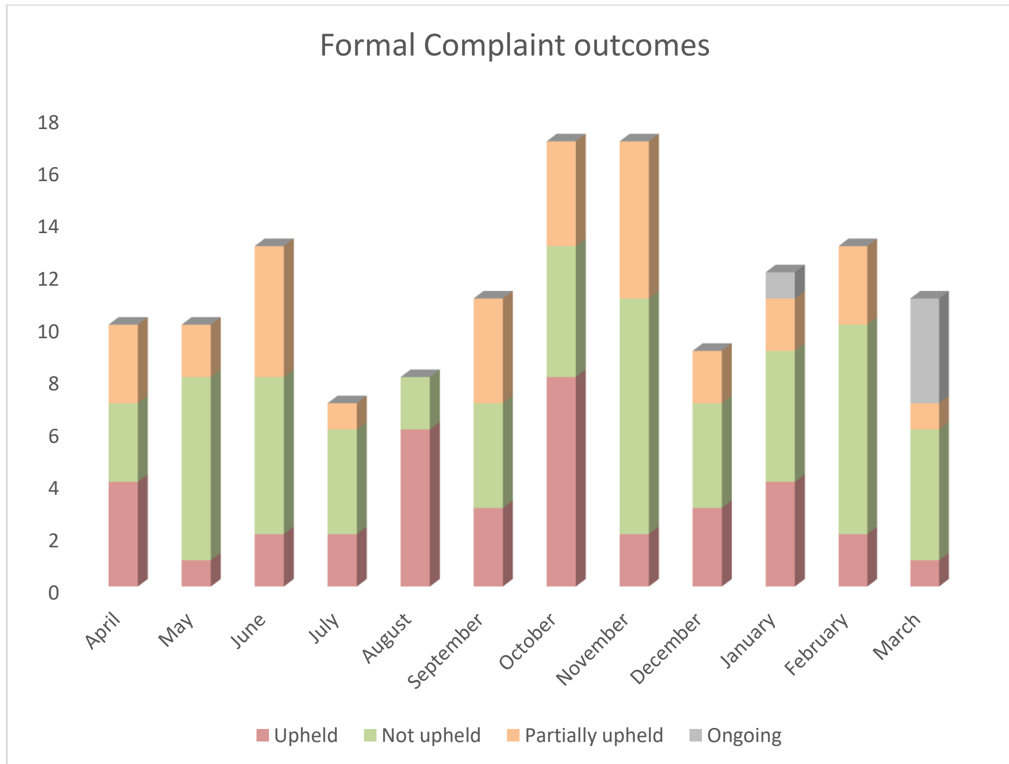
Outlined below, the following chart shows the overall themes highlighted from complaints from Q1-Q3.



23. **Complaint outcomes**

In Q4, 45 complaints were closed, of which 20 were in the Neurology division, 18 in the Neurosurgery division, 4 complaints were cross divisional and 3 corporates. Of the 45, 10 were upheld, 8 partially upheld and 20 not upheld, meaning there was no action or learning identified.

Of the 138 complaints received in 2022/23, 133 have since been closed, 38 were upheld, 33 partially upheld and 62 not upheld. Examples of actions and learning can be seen in section 22.



24. 2 complaint cases were re-opened in Q4 and have since been closed; 1 of which was upheld and 1 not upheld (in line with outcomes following the initial investigation).

25. Annually 38 complaints were upheld: 17 neurology and 16 neurosurgery, plus 3 cross divisional and 2 corporate.

26. Annually, 162 complaints were closed (including new and re-opened cases).

27. Protected Characteristics, in Q4, 0 complaints, 2 concerns raised regarding patient's stating they were discriminated against because of their gender and disability. These were not upheld following review.

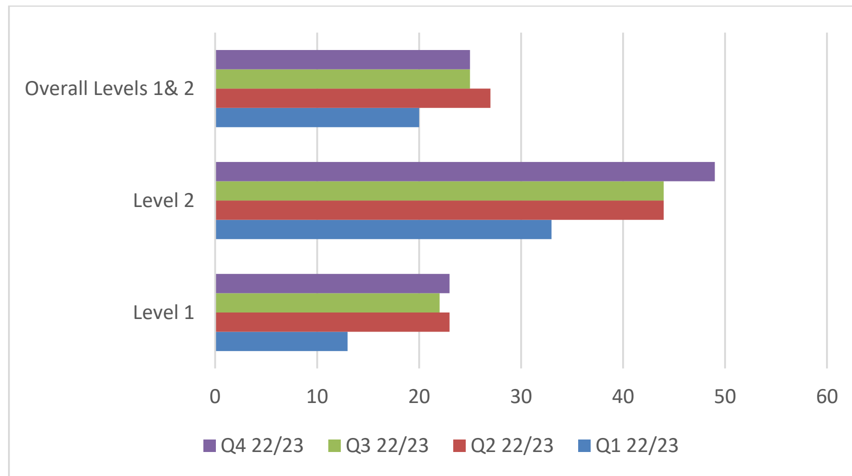
    Annually 3 complaints and 6 concerns were raised regarding patient's feeling they were discriminated against as a result of either their race, disability, or gender.

    1 complaint was upheld in relation gender and actions/learning include:
    - Alert to all medical staff of the implications of the Gender Recognition Act 2004.
    - Implementation of a patient specific transgender policy.
    - Transgender awareness sessions delivered for staff.

28. **Complaint Response Times**
    Of the 138 new complaints received, 120 were categorised as Level 1 (response target 25 working days), 34 were categorised as/escalated to Level 2 (response target 45 working days) and 1 was categorised as Level 3 (response target 65 working days).

    Despite the increase in complaints, the annual current overall response times for written responses is 27 days; 25 Level 1, 44 Level 2, 58 Level 3. All within the Trust's KPIs.

For complaints closed within Q4, 10 breached the initial or extended response due date. Annually 53 complaint responses breached the initial due date. A new process was implemented in Q4 whereby Divisions were asked to request escalation to Level 2 with approval from the Dep Chief Nurse with a rationale if responses times could not be met.



Average Response working days	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Overall Levels 1 & 2	20	27	25	22	28	28	28	25
Level 1	13	23	22	17	25	25	26	23
Level 2	33	44	44	36	38	42	44	49

29. High level actions following complaints in Q4/Annually

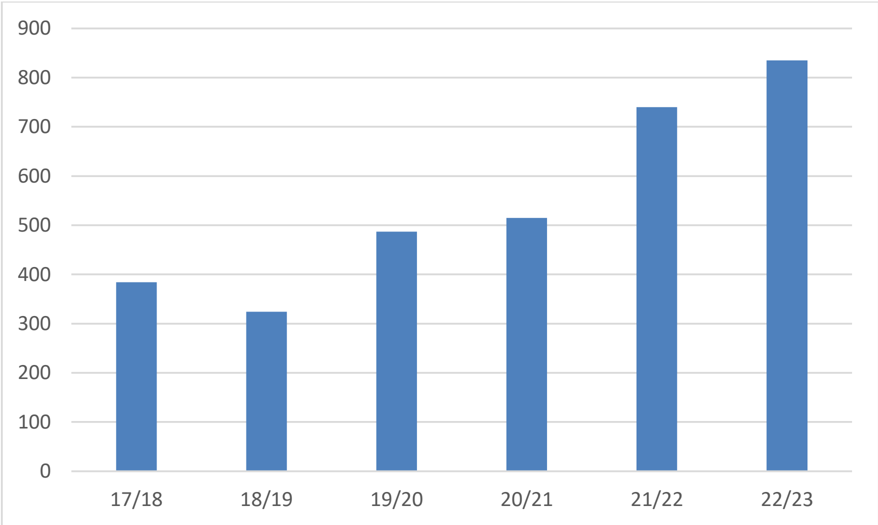
Lessons Learnt (division)	**Action**	**Outcome**
Q1 Failing in care – delay in diagnosis (NL) – considered maladministration and injustice by Public Services Ombudsman for Wales	• Complaint Policy reviewed to include Welsh Patients and Putting it right. • Recognition of distress and inconvenience caused to patient in failure of upholding initial complaint. • Case discussed at NL Risk & Governance.	No recurrence of subject of complaint.
Q1 Transgender awareness (NL/Cor) Patient's transgender status shared without their express consent.	• Alert to all medical staff from Medical Director to refresh clinicians' knowledge of the implications of the Gender Recognition Act 2004. • Transgender awareness training to be offered to all staff with ongoing sessions planned. • New Transgender, non-binary policy implemented.	Lessons learn embedded and Awareness session held with Trust Board in May and plans for 4 sessions for 2023/24 for all staff
Q2 Improved Communication (Cor/NL)	• Improved internal processes introduced for records management and introduction of spot check audits. • Medical staff reminded of timely incident reporting.	No recurrence of subject of complaint and shared within division.
Q2 Wound care management (NS)	• Face to face training with nurse specialist teams supporting ward-based nursing staff with	Training completed and no recurrence

	training in relation to post-operative advice and wound care management.	of subject of complaint.
Q3 Headache Service (NL) Improvements required following a delay in patient receiving headache medication.	• Divisional team/IT to build requests into electronic patient records for headache service to prevent risk of recurrence and avoid need for internal emails and prevent errors. To form part of nursing documentation review.	This work is still progressing.
Q3 Communication (NL) trend noted in relation to breakdowns/shortfalls identified within secretariat.	• Learning addressed with team at monthly meeting. • PET/Engagement Manager developed bespoke training session to include how to deal with difficult calls and situations, based on real scenarios. Training held with admin staff via MS Teams March 2022. • Face to face training sessions held with Aspiring Ward Managers as part of the Building Rapport programme.	Training received well by Neurology Admin staff. Positive feedback received from Aspiring Ward Managers and this training will form part of the course going forward.
Q3 Transition Service – (NL) improvements identified to patients transitioning from child to adult services.	• Division to review processes to transition patients under specific services, including epilepsy, including exploring options for education, alerts within clinical systems highlighting patients who have recently transitioned. The team are working with other Trusts to drive this work forward, in addition to improving information provided to transitional patients to inform them of options and where to seek advice. Action plan continues to be progressed led by Dep Divisional Nurse.	This work is ongoing with regional teams and will progress within the Division in 2023/24.
Q3 Nursing - patient with Learning disability did not have wrist band insitu (cross divisional). Identified nurses would benefit from neurodiversity training. (cross divisional).	• Monthly audits relating to wrist band compliance to be undertaken, to be added to Tendable and included in the monthly audit checks trust wide. This forms part of the nursing documentation work in partnership with IT. • L&D met with the Brain Charity to progress this training.	No repeat of complaint subject and continues to be audited. L&D plan to introduce training in 2023/24
Q4 Nursing (NS) multiple aspects of nursing care.	• Implementation of a new electronic prescribing systems which will make PRN medication more identifiable for staff. • The Trust has implemented securement devices to try to mitigate the risk of catheter tubes becoming misplacement, pulled or tangled. • Spinal Nurse Specialists to provide ward-based education in relation to post-operative bladder scanning. • Medication/communication issues included in a learning newsletter to be shared with all staff.	Work in progress.
Q4 Headache service (NL) Process required to ensure patient receive appropriate and timely clinical review	• Booking process reviewed to ensure robust process in place. • Headache co-ordinator appointed following business case.	Work is in progress.

prior to extending medication prescriptions.		
Q4 Communication of service changes.	• Divisional team to create a FAQ for admin teams to support them in questions asked regarding changes to services and staffing to ensure they are delivering correct, appropriate and consistent information to patients.	Work in progress.

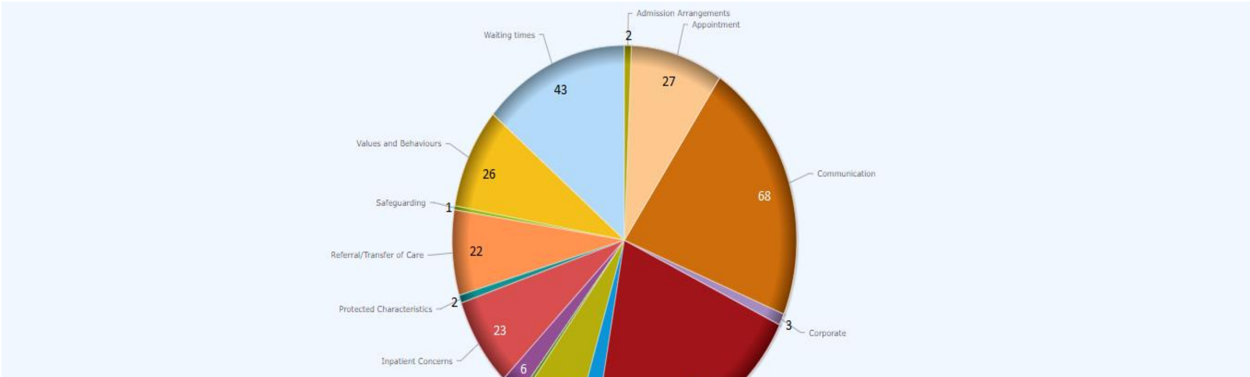
30. **CONCERNS**

835 concerns were received in 2022/23, with 200 received in Q4. Please note comparison to previous years in chart below.



All concerns are received via PET and triaged then reviewed with the divisional teams on a weekly basis to ensure timely responses**.**

Key Themes for concerns Q4 and Annually



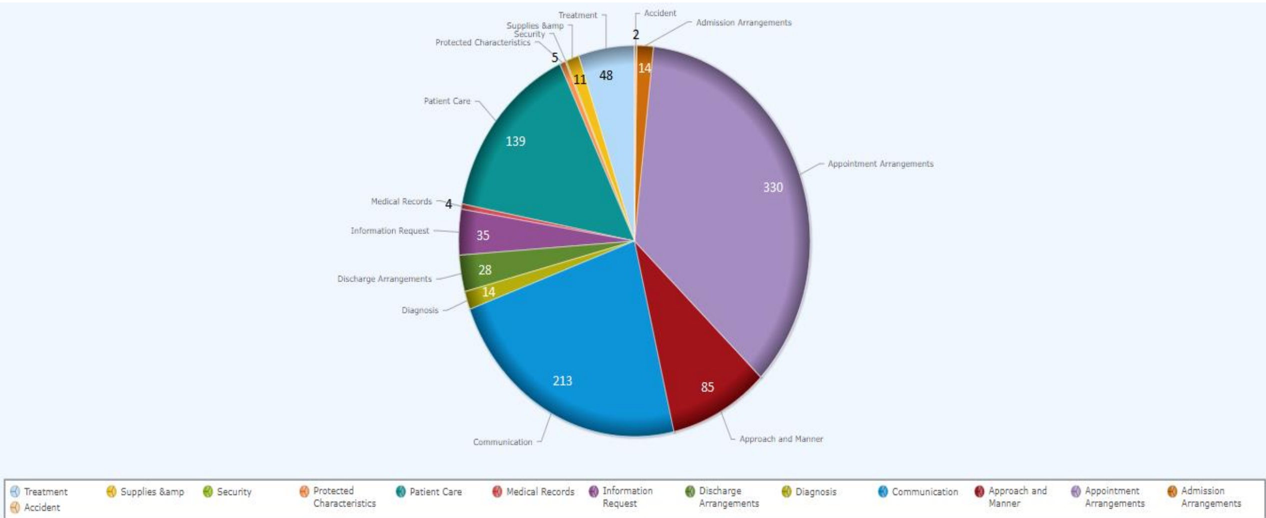
As detailed above the top three themes can be broken down as follows:

Communication – Patients unable to contact department by telephone, Lack of continued support, Clinical information not clear and Failure to communicate waiting time.

Diagnosis & Treatment – Urgent review requested, Delay in medication (homecare) and Disagreement with treatment plan.

Waiting Times for – New appointment, Follow up appointment and Admission date.

As outlined in relation to complaints, due to the change in subjects (themes) from the beginning of Q4, we are unable to make direct comparison against previous quarters, outlined below, however, is the overall themes highlighted from concerns from Q1-Q3.



31. **ENQUIRIES**
    398 enquires were received in 2022/23, compared to 307 in 2021/22 and 262 in 2020/21. Themes include:

    Enquiries regarding Home from Home facilities, current waiting times, how to gain access to medical records and travel enquiries.

32. **COMPLAINTS SUMMARY**

In 2022/23, 162 complaints were closed (including new and re-opened cases), 816 concerns and 398 enquiries were resolved demonstrating a highly performing complaints management process, meeting KPIs despite an increase in the complaints received.

Increases in the number of concerns and enquiries demonstrate resolution at the earliest opportunity before escalating to a complaint. Concerns and enquiries differ in nature as an enquiry is raised, often to request information from a neutral position whereas a concern is often raised following a negative experience. Divisions continue to embed actions and are monitoring trends and themes. All lessons learnt are discussed at Divisional Risk & Governance Meetings.

33. **CORONIAL & POLICE STATEMENT/REQUESTS**

4 coroner's requests were received in Q4 making a total of 18 annually and 20 police requests were received in Q4 making a total of 62 annually.

Following requests, PET triage and request statements from appropriate staff involved in care and submit to the requesting coroner/police force together with copy records if required. The Claims Manager will manage any requests received where the Trust have been given interested party status, Inquest availability is requested, or the investigations holds a potential risk for the Trust.

34. **CORONIAL INQUESTS**

For Q4, the Trust were required to attend 4 Inquests either by Teams or in person to give evidence. One of these Inquest was a high-profile case which had escalated from a complaint initiated in 2018. All inquests were closed with no risks highlighted for the Trust and no Regulation 28 reports issued.

To prepare and educate staff on coronial investigations, plans are in place for the Trust's solicitors to hold a mock inquest to give staff the opportunity to understand the coronial investigation process and give some insight into a final Inquest Hearing.

Details of all new and closed inquests is included in Appendix 3.

35. **CLAIMS**

All claims are discussed at monthly Divisional Governance and Risk meetings and new claims that have not had a risk assessment at the time of the alleged incident are presented at bi-weekly Serious Incident Review Group (SIRG) meetings. Balance Score Card for Claims is included in Appendix 4.

Over the last year, the claims process has been reviewed with Medical Director and Clinical Leads and the following process will be implemented:

- Following receipt of new claims, the Claims Manager, Consultant, and Clinical Lead will meet to discuss the consultant response to Letter of Claim and determine if any lessons can be learned and to offer support if necessary.
- Claims Manager will provide damages quantum quarterly to Clinical Lead for discussion at Assurance Meeting.
- Monthly Governance and Risk Claims Report will be discussed at quarterly Clinical Effectiveness and Services Group.

Next steps:

- Training for the claims/coronal process has been reviewed to provide details on process and will form part of Medical Health & Safety Training in 23/24.

- Trust Solicitors will provide a summary of suggested lessons learned going forward following closure of claims which will be shared for learning purposes.

- It is planned that Trust Solicitors will facilitate education sessions commencing in May 2023 which will include subjects, best interest decisions, Court of Protection, capacity and safeguarding.

36. **Lessons Learnt from Closed Claims -** Poor documentation and allegations relating to informed consent remains an ongoing theme in many of the claims received and this continued through 2022/23. To mitigate this is highlighted to junior doctors during induction and to clinical staff at mandatory training to raise awareness. The Trust is looking to purchase an informed consent software package to be incorporated into its IT software.

    Appendix 3 - contained patient identifiable information and has therefore been redacted under section 40 of the Freedom of Information Act 2000.

Conclusion

37. Providing a positive patient and family experience, treatment and support is an essential part of healthcare together with clinical effectiveness and safety. At The Walton Centre we recognise the importance of receiving and responding to the feedback received from patients, families and carers and actively seek to be a learning organisation which is underpinned by quality and improvement.

38. Throughout 2022/23, The Patient Experience Team have continued to develop their services for patients and families, and this includes the improvements made in how complaints are captured on Datix providing richer data. The recent improvements made to the Complaints Datix module, and the review of subjects and categories used to record concerns/complaints, will mean direct comparisons to previous data will not be possible but more meaningful data will be captured going forward.

39. Although complaints and concerns activity has increased, the Trust has robust complaints and claims management processes in place to ensure that all received are triaged and investigated appropriately in line with the Trust policy. This is demonstrated in the timeliness of complaint responses in line with current targets.

40. The improvements in the claims management process and reviewed training for staff has proved beneficial and this will continue into 2023/24 with education sessions planned.

41. The Trust was once again rated one of the Best Trusts in England for the CQC National Adult Inpatient Survey and were ranked Better than Expected being 11th out of 134 Trusts for overall positive patient experience. This shows that the Trust put listening into action and help drive service improvement from the feedback from patients and families.

42. Finally, the team were proud to be finalist in the Patient Experience National Awards for the implementation of the Patient Support Assistant Project which was initiated after being awarded external funding. This resulted into the introduction of many initiatives to improve

patient experience as a result. Two team members received Employee of the Month within the 12 months period; The Claims Manager received a well-deserved accolade of Employee of the Month for the expertise and support provided to staff, especially during a high-level case and the Patient Experience Engagement Manager was awarded for her commitment to patient and family centred care. In addition, another team member was awarded the Above and Beyond for Patient Experience in the Trust's Annual awards.

43. For 2023/24 we plan to lead the way in developing further the training and support for staff at the Trust and at the Cheshire & Merseyside Network to identify new ways to learn from the feedback we are given and improve engagement, involvement and inclusion.

Recommendation

- To note

Author: Lisa Judge
Date: 22 May 2023

Appendix 1 – SPC Friends & Family Test
Appendix 2 – SPC complaints in line with activity
Appendix 3 – Redacted under Section 40 of the Freedom of Information Act 2000
Appendix 4 - Claims Quarterly Balanced Score Card

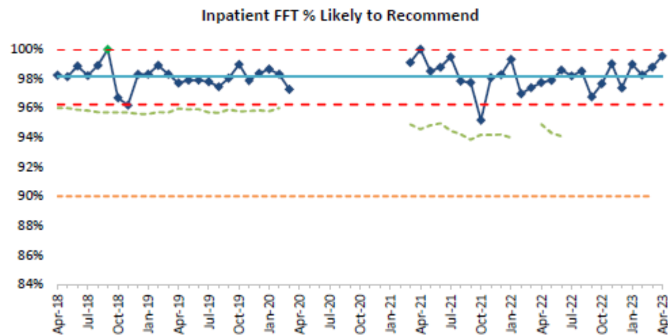
Appendix 1 - Friends & Family Test

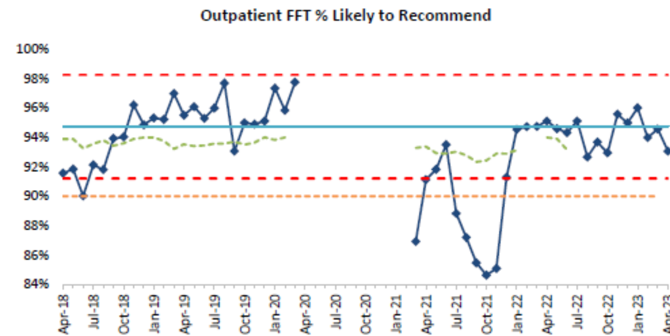
The Walton Centre NHS
NHS Foundation Trust

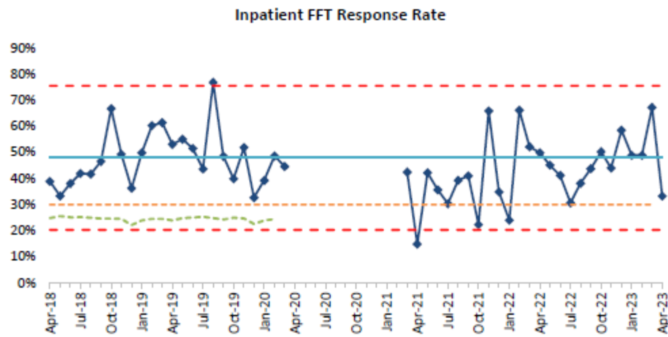
Quality of Care

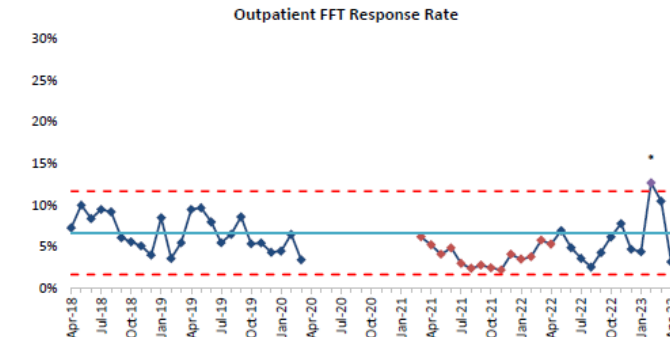
Family and Friends Test

Response rates are low in April again, this is being investigated but may still be due to the problems in collection of the cards which delayed last months results.









*The increase in OP response rate, though genuine, may be slightly inflated by a data collection issue at the end of January which meant that some January responses have been counted in February.

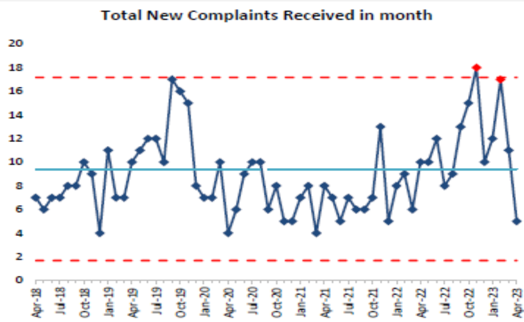
Appendix 2

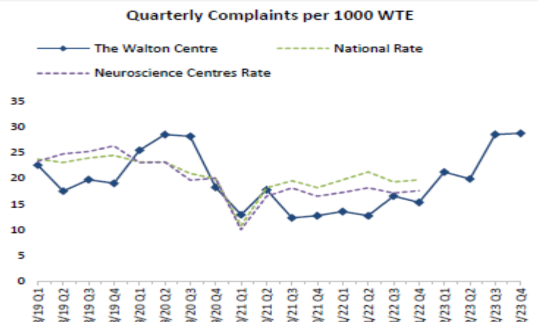
The Walton Centre NHS
NHS Foundation Trust

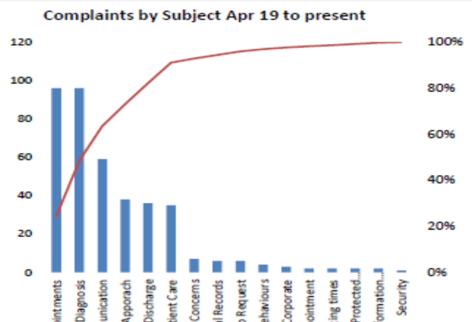
Quality of Care

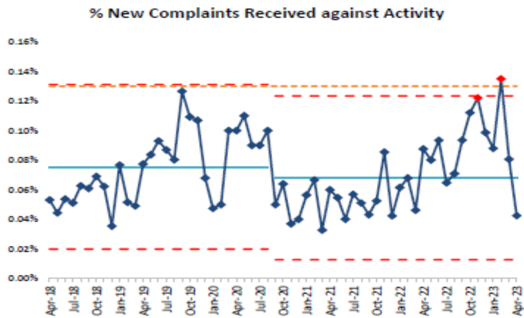
Complaints

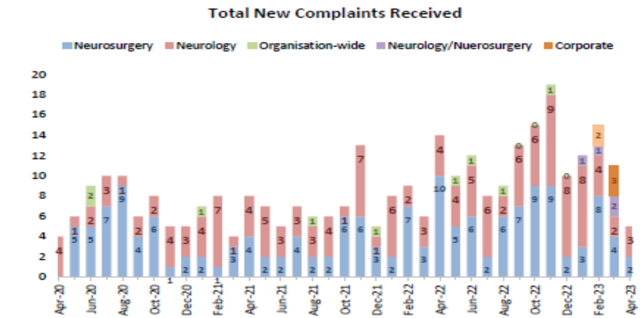
In April 2023 the trust receieved five new complaints. Two of these complaints related to Communication and one each to each of Information Governance, Diagnosis/Treatment and Inpatient Concerns. Five complaints in month is a reduction back below the mean but remains within normal variation.











Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	45	19	11
22/23	51	31	33
22/24*	1	0	0

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

Appendix 3 – Redacted under Section 40 of the Freedom of Information Act 2000

Appendix 4

Total value of claims is the total of those closed in the quarter and can be up to multiple claims.

Trust Wide	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Total new claims received	7	7	5	4	9	7
Neurosurgery claims	4	4	2	3	6	3
Neurology claims	2	1 Neu/NS	1	0	1	3
Claims across Division			1	0	2	0
Corporate claims	1	2	1	1	0	1
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	10	8	6	14	4	6
Number of closed claims in quarter	6	6	6	6	8	7
Value of closed claims - Public liability	£0.00	£0.00	£8,700.00	£0.00	£0.00	£31,008
Value of closed claims - Employer liability	£0.00	£0.00	£6,940.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£29,824	£1,291,650.	£334,627.	£239,783	£71,235	£69,319