NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 4th March 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
4th March 2021
Virtual Meeting
WCFT
09:30 – 10:45

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.35	Minutes and actions of meeting held on 4th February 2021	J Rosser	Decision (d)
STRATEGIC CONTEXT				
4	09.40	Chair and Chief Executives Update	J Rosser/ H Citrine	Information (v)
5	10.00	COVID-19 Update	H Citrine/ Execs	Information (v)
6	10.10	Integrated Performance Report	CEO/Execs	Assurance (d)
7.	10.30	Reducing Burden & Releasing Capacity	P Buckingham	Approval (d)
8.	10.35	Board Assurance Framework	L Salter	Assurance (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • HCP Memorandum of Understanding • Freedom to Speak Up Guardian Report • Board Cycle of Business 2021/22 • Business Performance Committee - Chair's Report				
CONCLUDING BUSINESS				
9	10.45	Any Other Business	J Rosser	Information

Date and Time of Next Meeting:
1st April 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

4th February 2021

Present:

Mr S Crofts	Non-Executive Director – Deputy Chair
Ms K Bentley	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Vlasman	Acting Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary

Observing:

Mr J Kitchen	Public Governor – North Wales

Trust Board Attendance 2020-21

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

TB113-20/21 **Welcome and apologies**

Mr Crofts welcomed those present to the meeting via Microsoft Teams and noted that Mr J Kitchen was observing in his capacity as Public Governor for North Wales and Mr C Murphy was observing as a member of the public.

Apologies were received from Ms J Rosser and Ms L Salter.

TB114-20/21 **Declarations of interest**

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

TB115-20/21 **Minutes of the meeting held on 3rd December 2020**

Mr Topliffe clarified that the final paragraph under item TB102-20/21 should read "Mr Topliffe requested that a report detailing how risks to delivery of the 2020/21 Capital Programme were being managed be submitted to the next Business Performance Committee meeting". Subject to this amendment, the minutes of the meeting held on 3rd December 2020 were agreed as a true and accurate record. The action log would also be amended to reflect this update.

TB116-20/21 **Chair & Chief Executive Report**

Ms Citrine reported that a new Neurosurgeon, Mr Farouk Olubajo, had been recruited following a strong field of candidates and rigorous recruitment process.

Ms Citrine and Dr Nicolson had met with Professor Marson and Professor Louise Kenny from the University of Liverpool to discuss the potential for additional joint appointments. Work to explore this had been on hold due to the pandemic but was now being progressed. The Trust had also registered an ambition to become a University status hospital and proposals on the work required for this status were being explored.

A meeting was held with Jackie Bene, Chief Executive of the Cheshire and Merseyside STP, to discuss the Neuroscience Programme which was undertaken by the Trust across Cheshire and Merseyside. A review of all programmes was underway however the Trust had connected the Neuroscience Programme with the digital programmes and discussions around this were underway. A briefing had been delivered to the STP who were undertaking a review to prioritise programmes, and determine which would be supported financially, as there were a number of projects which required streamlining following COVID.

Further meetings had been held with the Specialist Trusts group in Liverpool. The group continued to work closely together and a joint response to the ongoing consultation on changing the landscape was underway. Additional meetings with the Federation of Specialist Hospitals had also taken place feeding back on the consultation as had previously been discussed. Ms Citrine advised the Board that an updated Memorandum of Understanding (MoU) for the Health Care Partnership had been received on 3 February 2021 and noted that the MoU would be considered at the next Board meeting on 4 March 2021.

The Board:

- **noted the report.**

TB117-20/21 **COVID-19 Update**

Ms Citrine briefed the Board on the current COVID situation and noted that a decision had been taken by the In-Hospital Cell to reduce P3 and P4 activity to enable a focus on COVID activity across the region. She advised that a Gold Command rota had also been implemented on a 7 days per week basis to monitor capacity at each Trust and noted that all of the Specialist Trusts in the Mersey region were supporting efforts to manage additional COVID-related activity. She then provided an overview of the measures taken at The Walton Centre, Alder Hey and Liverpool Heart and Chest to support critical care activity.

Ms Citrine advised that, while there had been a modest reduction in the number of COVID admissions during the previous week, demand remained high with most trusts in the

region reporting that circa 30% of inpatients were COVID patients. She noted that the acuity of patients appeared to be higher during the current wave, which was resulting in more patients being escalated from wards to critical care, and noted the Trust had received patients in its critical care unit during January 2021.
On a more positive note, Ms Citrine advised that 73% of staff had now received the first dose of the COVID vaccination and noted that Trust staff were supporting delivery of the vaccination programme in the Aintree Vaccination Hub. She also noted that Trust had been deployed to support the Greater Manchester Nightingale Hospital as part of a regional initiative. Ms Citrine concluded her briefing by noting plans to implement a LAMP testing programme from 1 March 2021.
In response to questions from Ms Rai, Ms Vlasman advised that there were currently 23 COVID inpatients in the Trust. Ms Citrine advised that two members of staff had been deployed to support the Nightingale Hospital for an eight week period. She also provided an overview of occupancy levels and noted that Acute trusts were currently operating at approximately 95% capacity with Specialist trusts reporting occupancy levels of circa 86%.
Ms Citrine shared a communication received from Chris Hopson, Chief Executive of NHS Providers, which provided an overview of NHS achievements over the last year and highlighted that the NHS had treated more than 320,000 COVID positive patients with one positive patient admitted to critical care almost every 30 minutes. The largest vaccination programme in history was underway and the NHS had continued to provide care to millions of non-COVID maternity, cancer, urgent and emergency patients while managing record levels of staff sickness and absences including staff having to isolate.

The Board:

- **noted the report.**

TB118-20/21 **Consent Agenda**

The lead Directors provided a brief overview of the key points from their reports in the Consent Agenda. The Board then agreed the following actions in relation to each Consent Agenda item:

- **Quarter 3 Governance Report** - Received and noted
- **Quarter 3 Mortality & Morbidity Report** - Received and noted
- **Integrated Performance Report** - Received and noted
- **Quality Account 2019/20** - Endorsed the final version of the Quality Account and noted publication post-Board meeting
- **Audit Committee Chair's Report** - Noted the report and approved revised Terms of Reference included at Annex A of the report
- **Quality Committee Chair's Report** - Received and noted
- **Business Performance Committee Chair's Report** - Received the report and noted that an IT Case Note Scanning Business Case would be presented to the Board for approval on 4th March 2021
- **Research, Innovation & Medical Education Committee Chair's Report** - Received and noted
- **Neurosciences Programme Board Chair's Report** - Received and noted
- **Charity Committee Chair's Report** - Received the report and noted approval of the 2019/20 Annual Report & Accounts under authority delegated by the Board. It was noted that the final version of the document had been circulated to Board

members for reference prior to submission to the Charities Commission in advance of the 31st January 2021 deadline

- **Strategic BAME Advisory Committee (SBAC) Quarterly Report** - The Board approved outcomes of the review of Board recommendations set out at Appendix A of the report with progress to be monitored by SBAC. The Board also approved the Improvement Ambitions set out at Appendix B of the report.

TB119-20/21 **Reflections on the Meeting**

It was felt that the consent agenda had worked well. It was highlighted that the front sheets for some reports did not reflect that the reports had been considered at other committees prior to submission to Board.

TB120-20/21 **Any Other Business**

Mr Burns updated that the process had begun to prepare for the Well Led review and the Trust had commissioned MIAA and AQUA to assist with this. Initial meetings had been held and the Trust had then been advised of changes to the framework with the CQC concentrating on other issues during the pandemic. The Trust was advised by both MIAA and AQUA to stand down any further work until the CQC were in a position to resume normal activities. Ms Citrine noted that it was good practice for Trusts to carry out their own self-assessments but advised that plans had been paused due to the need to focus on COVID-related activities.

The Board:

- **noted the update.**

There being no further business the meeting closed at 10.11am

Date and time of next meeting
Thursday 4th March 2021 at 09:30 via Microsoft Teams

TRUST BOARD
Matters arising Action Log
February 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
22.05.20	**TB16/20-21**	**COVID 19 Update** Director of Workforce to provide an update on the national and local position in relation to annual leave of staff.	M Gibney	**June 2020** There had been no national update on the matter and it was not expected until the end of the financial year. **February 2021** Mr Gibney confirmed that this issue had been resolved.	~~June 2020~~ February 2021	
03.12.20	**TB99/20-21**	**Matters Arising** Mr Burns to clarify with Ms Hindle if the amendments to approval limits within the Scheme of Reservation and Delegation could be implemented immediately.	M Burns	**February 2021** These limits were approved at the Board meeting in November 2020 and the emergency powers policy would be updated to reflect this.	February 2021	
03.12.20	**TB102/20-21**	**Integrated Performance Report** A detailed plan around how risks were being managed relating to the 2020/21 capital plan to be submitted to Business Performance Committee	M Burns	**February 2021** An amendment to the capital plan would be submitted to BPC in February.	February 2021	
03.12.20	**TB103/20-21**	**Infection Prevention and Control Board Assurance Framework** An update report to be added to the cycle of business for June 2021	J Hindle	**February 2021** An update report was added to the cycle of business.	February 2021	
03.12.20	**TB112/20-21**	**Any Other Business – Power Outage** Ms Ross to confirm if any lasting issues remain following the power outage	Ms Ross	**February 2021** Ms Ross conformed there were no residual issues from the power outage.	February 2021	
03.12.20	**TB112/20-21**	**Any Other Business – Charity Committee Accounts**	Mr Burns	**February 2021** Charity Committee accounts were	February 2021	

		Charity Committee accounts to be submitted to Board for ratification following approval at January Charity Committee meeting		forwarded to Board members for comments prior to being approved at the Charity Committee meeting held in January and submitted to the Charities Commission on 31st January 2021.		
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **May 2020** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ March 2021	

Actions not yet due

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

REPORT TO TRUST BOARD

Date 04/03/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Deputy Chief Executive
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence
Previously considered by:	• Committee Quality Committee Business & Performance Committee

Executive Summary

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

The ongoing COVID-19 pandemic has impacted the performance of a number of measures. Following a request from the Cheshire and Merseyside Hospital Cell, the Trust stepped down elective activity from mid-January with the exception of patients who urgently require surgery within one month, in order to support staffing our critical care surge capacity and support mutual aid within the Cheshire and Merseyside region. Cancer Performance has remained above targets as the Trust has continued to prioritise this activity and 6 week wait target for diagnostics has been for achieved for three consecutive months. Healthcare Acquired Infections and Harms have remained within expected low levels.

A ward scorecard has been added to the IPR this month to enable a high level overview of key performance metrics at ward level, in month.

Key Performance Indicators – Caring

Opportunity for Improvement Measures

Complaints – The number of complaints received has remained at a consistent level; however there have been significant improvements made to the timeliness that complaints are responded to. Total number of complaints received per 1000 WTE is above both the national average and other Organisations with a large neurosciences service when compared with published data. It should be noted that national data has been suspended due to COVID-19; however local data shows a reduction in the last two quarters.

Key Performance Indicators – Well Led

High Performing Measures

Agency Spend

Staff Friends & Family Test

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

Opportunity for Improvement Measures

Nursing Turnover - This has significantly improved over the last year and has shifted towards the target even though it has not been met yet and it outside of the lower control limit. At Divisional level, performance has significantly improved within Neurosurgery and is below the 10% target.

Sickness/Absence_In January 2021 this was outside of expected limits, with the rate increasing across all Divisions. January also saw an increase in long term sickness contributing to the overall increase.

Appraisals – Compliance dropped below target and is now at 78%. At divisional level compliance has dropped in all areas and the training team are currently working with individual departments to improve compliance.

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – local performance is on plan with the exception of MSSA which has passed its year end trajectory. The Trust is generally in line with national benchmark average, also with the exception of MSSA in which incidences have increased in 20/21.

Harm Free Care – Incidences of harm remain low and are performance within expected variation.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

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

Underperforming Measures

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

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity – During January 2021; Daycase and Follow Up Outpatients performed above our target for % of recovered activity of 19/20. Elective, Non Elective and New Outpatients were below the target. During January the Trust stepped down elective activity with the exception of patients who urgently require surgery within one month, this was following a request from the Cheshire and Merseyside Hospital Cell in order to support staffing our critical care surge capacity, and mutual aid within the Cheshire and Merseyside region. Daycase activity outside of theatre continued and Elective theatre sessions which were cancelled for Consultants were converted to alternative programmed activities including additional outpatient clinics.

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

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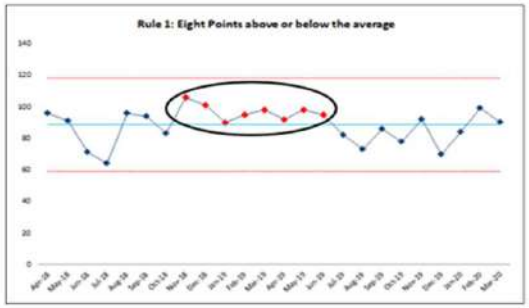
Board KPI Report
March 2021

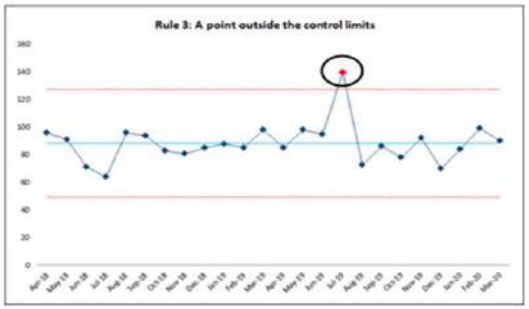
Data for January 2021 unless indicated

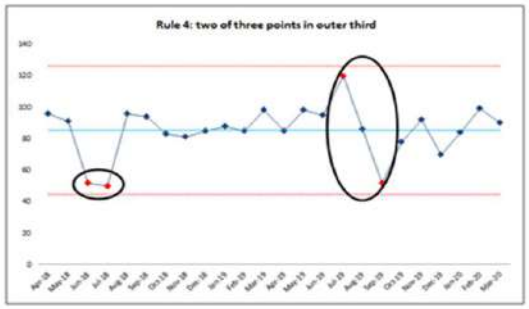
SPC Charts Rules

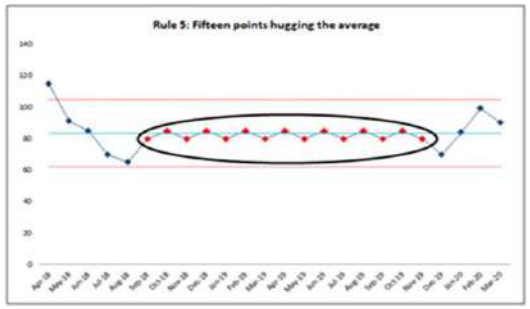
The Walton Centre NHS Foundation Trust

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









All SPC charts will follow the below Key unless indicated

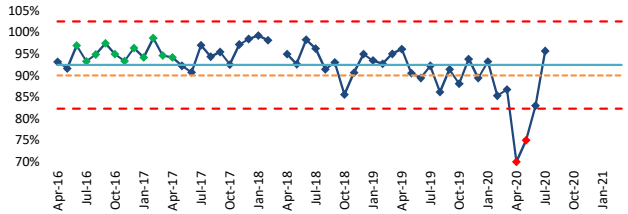
Actual — UCL — Average — LCL — National Average — Target

Operational

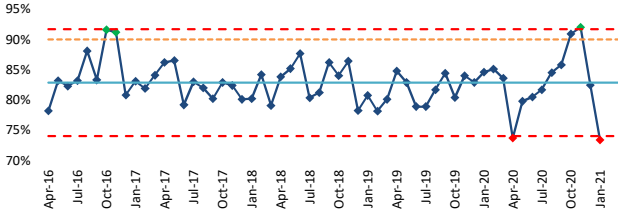
Effective - Theatres

The Walton Centre
NHS Foundation Trust

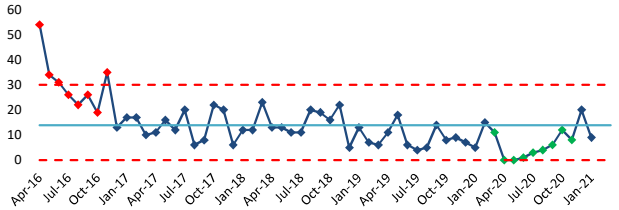
Theatre utilisation of Elective Sessions



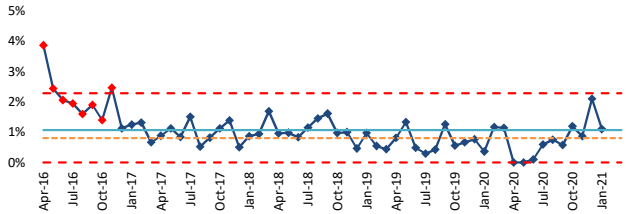
Theatre utilisation of in Session Time



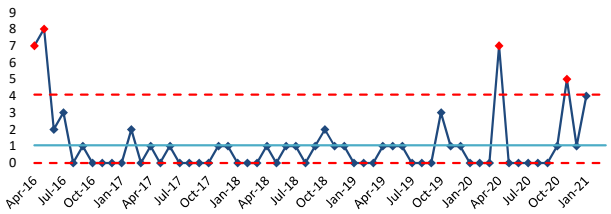
Number of Cancelled operations non clinical (on day)



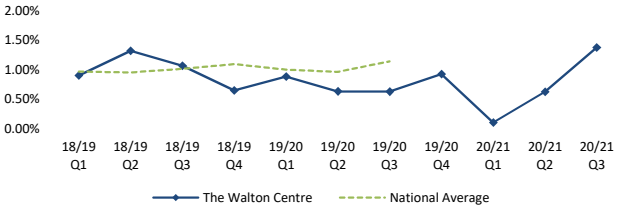
% of Cancelled operations non clinical (on day)



Number of cancelled operations not re-admitted within 28 days



Non Clinical Cancelled Ops as a % of Elective Admissions



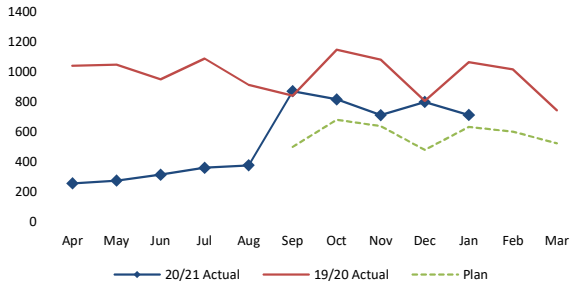
Excellence in Neuroscience

Operational

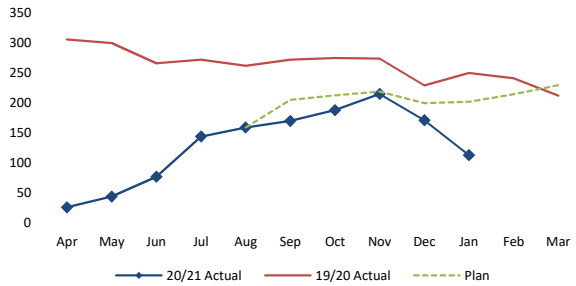
Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

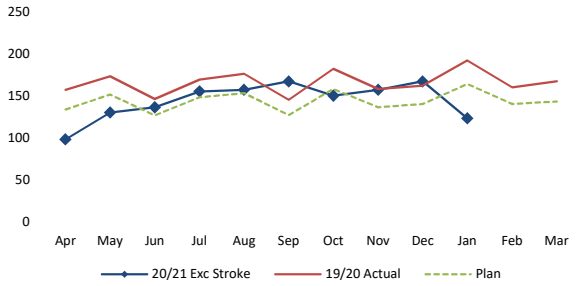
Daycase Activity v Plan



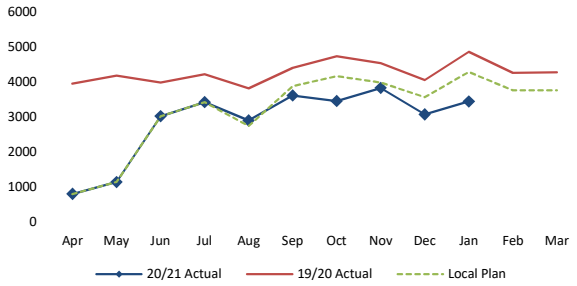
Elective Activity v Plan



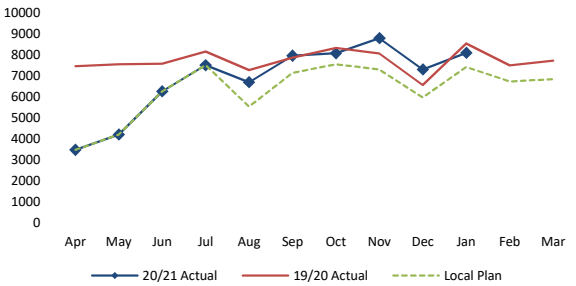
Non Elective Activity v Plan



New Outpatients Activity v Plan



Follow Up Outpatients Activity v Plan



January 21 Activity Performance

POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	66.92%	59.43%
Elective	45.20%	80.74%
Non Elective	75.00%	85%
New Outpatients	70.80%	88.18%
Follow Up Outpatients	94.72%	86.77%

Narrative

During January, the Trust once again stepped down elective activity with the exception of patients who urgently required surgery within one month, daycase activity outside of theatre continued. Elective theatre sessions which were cancelled for Consultants were converted to alternative programmed activities including patient validation exercises, additional outpatient clinics etc. This resulted in Daycases and Follow Up Outpatients exceeding the phase 3 plans however Non Electives, Electives and New Outpatients were under target.

Quality of Care

Well Led - Workforce KPIs

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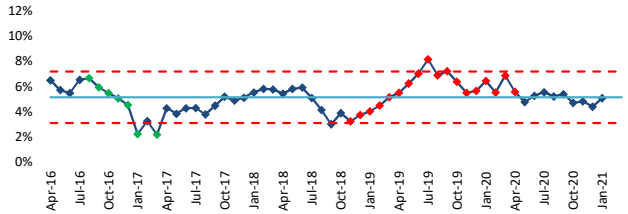
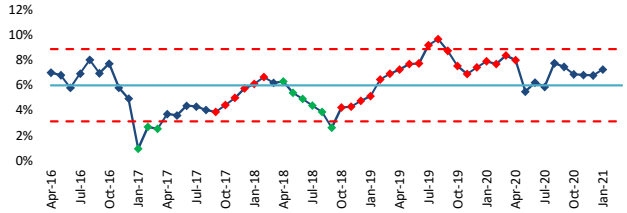
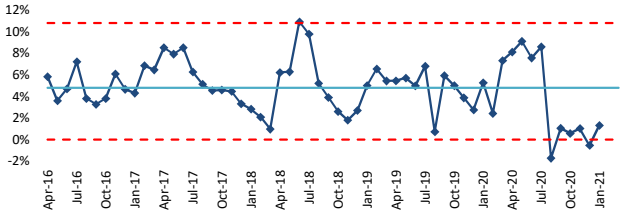
Overall Vacancy Level %



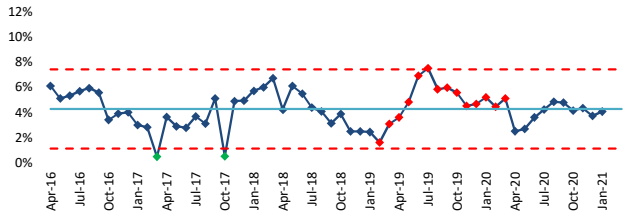
Nursing Vacancy Level %



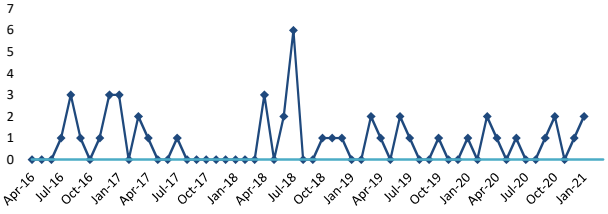
Medical Vacancy Level %



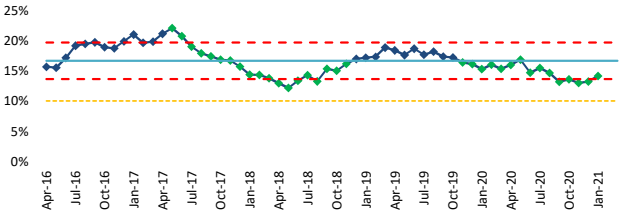
Other Staff Vacancy Level %



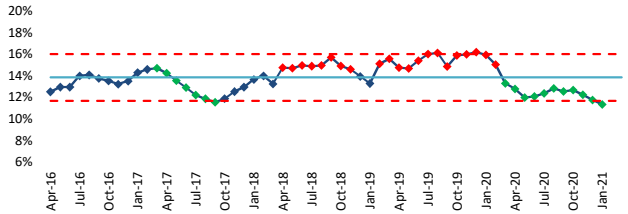
Medical Leavers



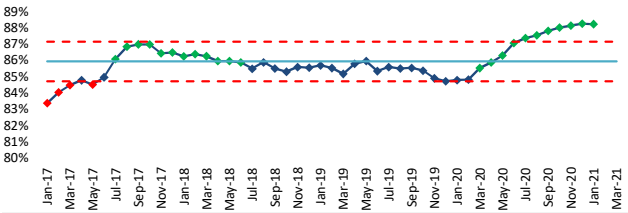
Nursing Turnover (Rolling 12 months)



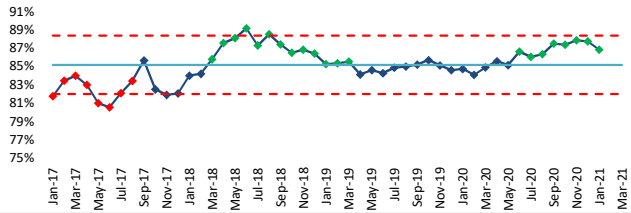
Other Staff Turnover (Rolling 12 months)



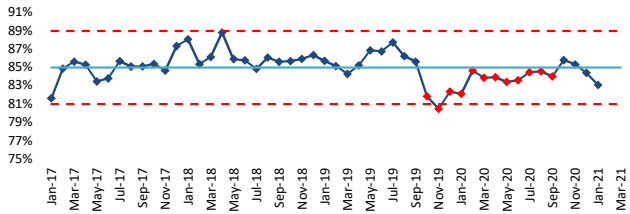
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



Narrative

Nursing Turnover

Nursing turnover has significantly improved over the last year and is within special cause variation. At division level, the target is also outside of the control limit for neurology and neurosurgery, however Neurosurgery experienced special cause variation in Jan 21 and is below the target.

Sickness/Absence

Sickness/Absence is outside of expected limits. Sickness has increased across all Divisions, with Corporate Services outside of expected levels also.

Staff Stability

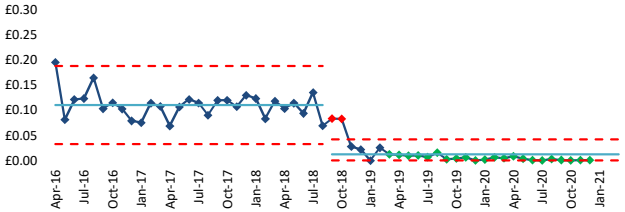
Staff stability index for all staff has significant improved since March 20, this looks driven by more nursing staff remaining in post for 12 months.

Quality of Care

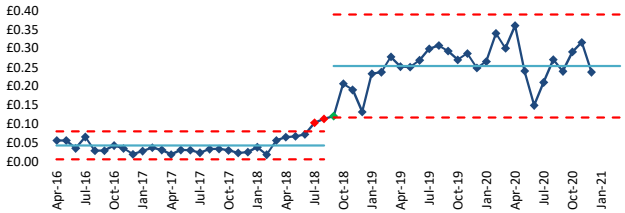
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

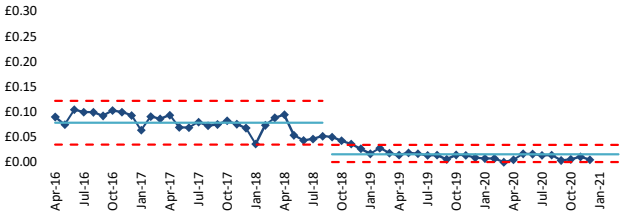
Nursing & HCA Agency Spend (£m)



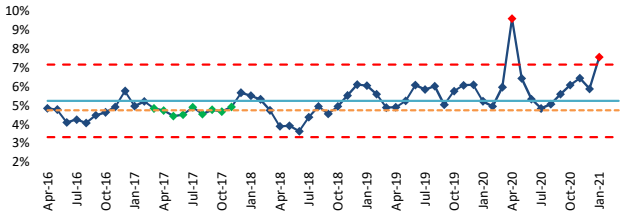
Nursing & HCA Bank Spend (£m)



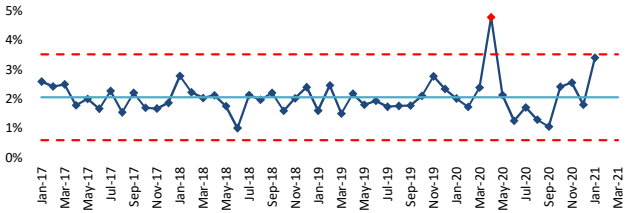
Nursing & HCA Overtime Spend (£m)



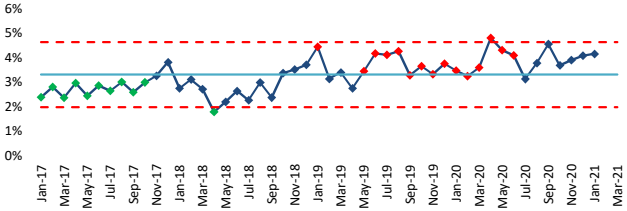
Sickness/Absence (Monthly)



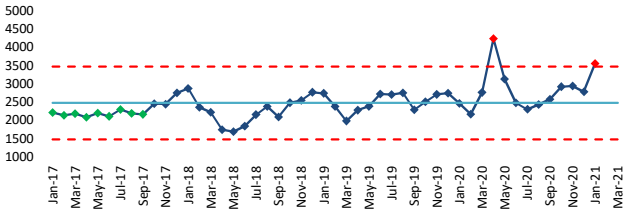
Short Term Sickness/Absence (Monthly)



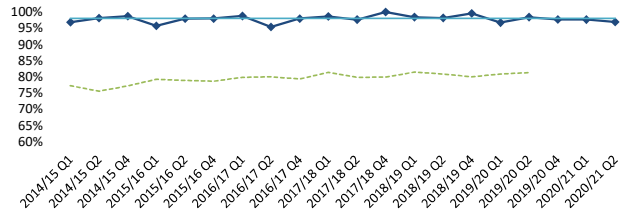
Long Term Sickness/Absence (Monthly)



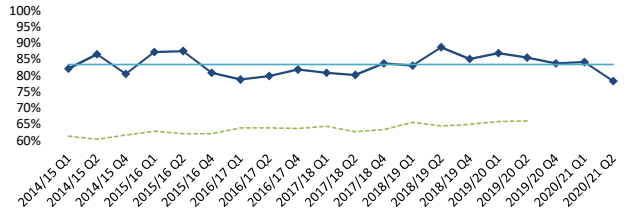
Lost Days due to Sickness/Absence (Monthly)



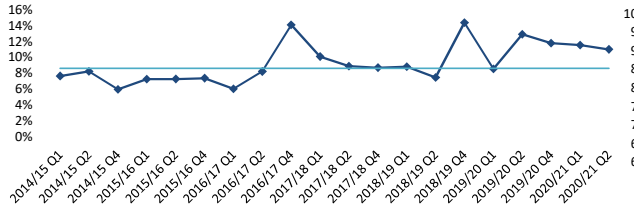
Staff FFT - % Recommend as Place of Care



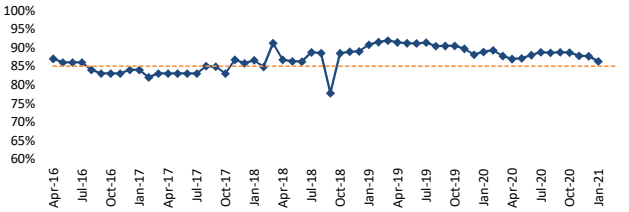
Staff FFT - % Recommend as Place of Work



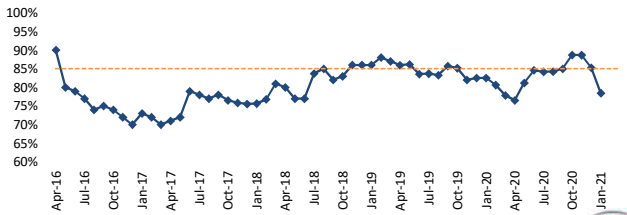
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)

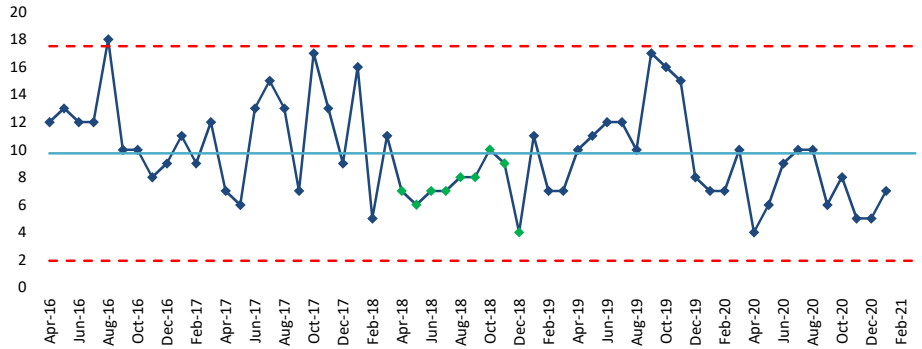


Quality of Care

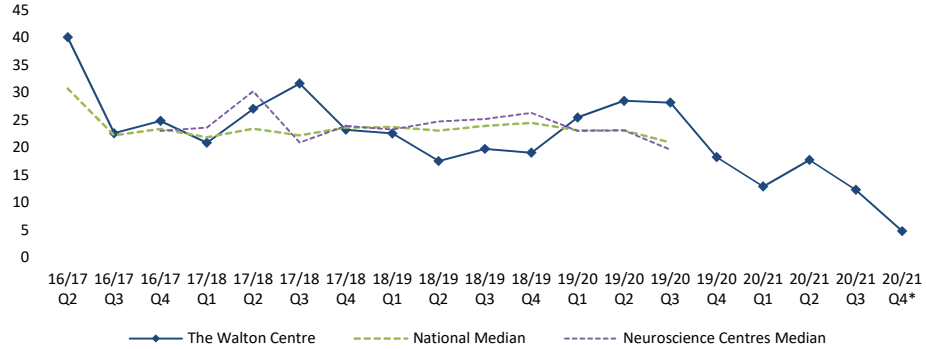
Caring - Complaints

The Walton Centre NHS Foundation Trust

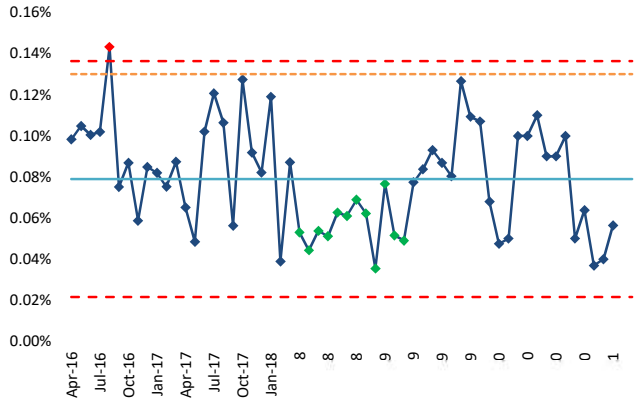
Total Complaints Received in month



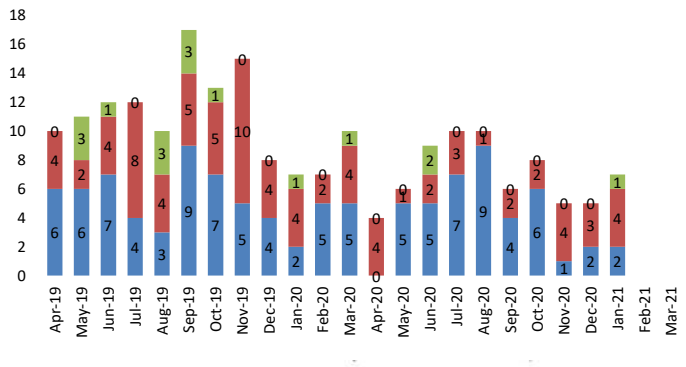
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In January 2021 the Trust received 7 complaints. 2 Neurology (1 Reopened), 4 Surgery (3 Reopened) and 1 Corporate.

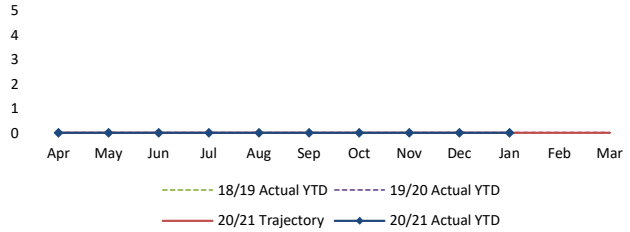
The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received per 1000 WTE is above both the national average and other Organisations with a large neurosciences service. Local data shows a reduction in Q4 and Q1. Publication of national data has been suspended due to COVID-19.

Quality of Care

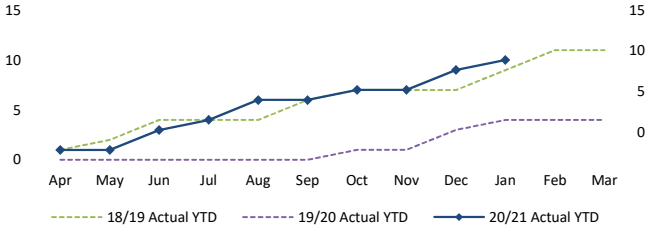
Safe - Infection Control

The Walton Centre NHS Foundation Trust

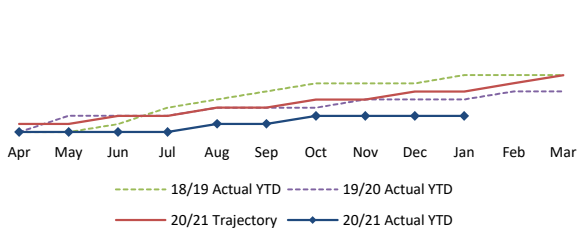
MRSA Bacteraemia



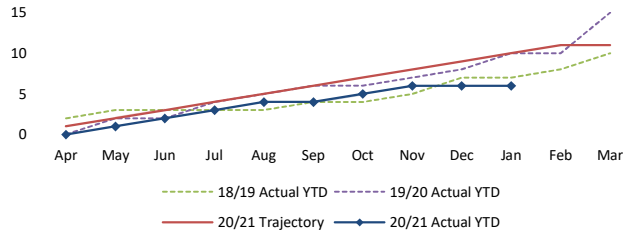
CPE



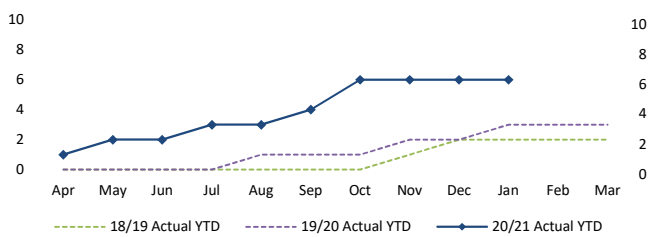
C.Diff



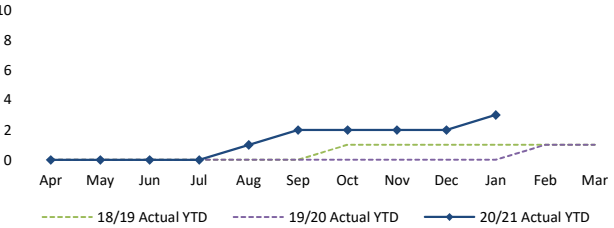
E.Coli



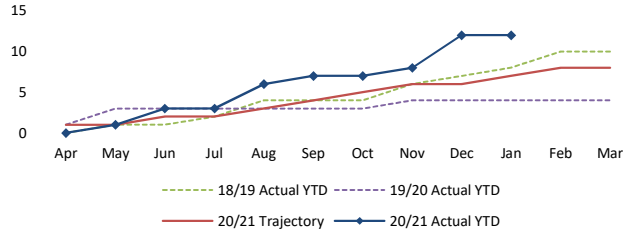
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		2	1				1	**4**
Caton		1					2	**3**
Chavasse				1		2	1	**4**
CRU		1			1			**2**
Dott		4		1	2		1	**8**
Horsley		2	1	3	2	1	7	**16**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**10**	**2**	**6**	**6**	**3**	**12**	**39**

January Breakdown by Ward

CPE - Horsley X1
PB - Chavasse X1

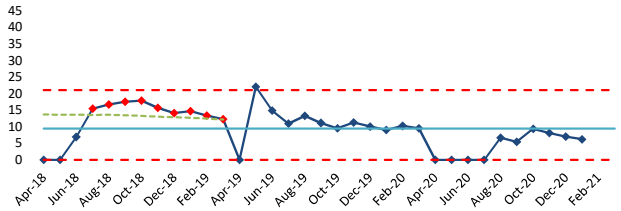
Excellence in Neuroscience

Quality of Care

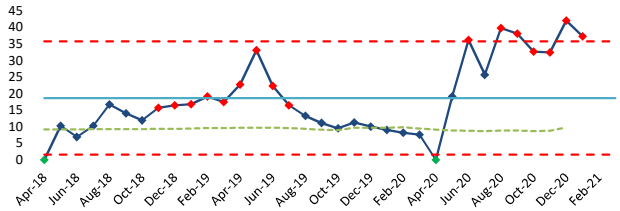
Safe - Infection Control

The Walton Centre
NHS Foundation Trust

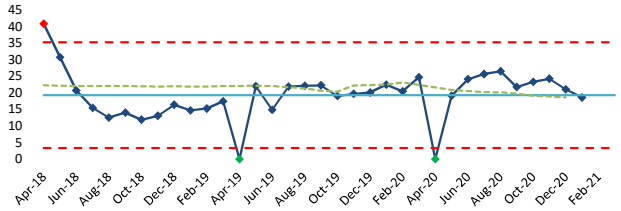
C.Diff Rate per 100,000 Bed Days YTD



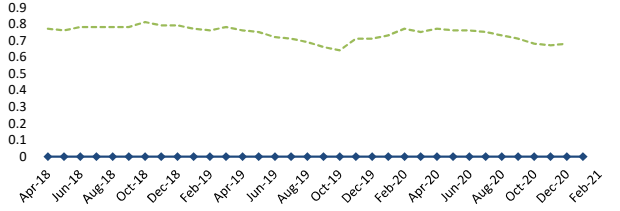
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

All infection types are within their 20/21 YTD trajectory level in January 21, with the exception of MSSA for which there has been twelve recorded instances against a year end trajectory of eight.

MSSA rates per 100,000 bed days are significantly above expected levels and the national average.

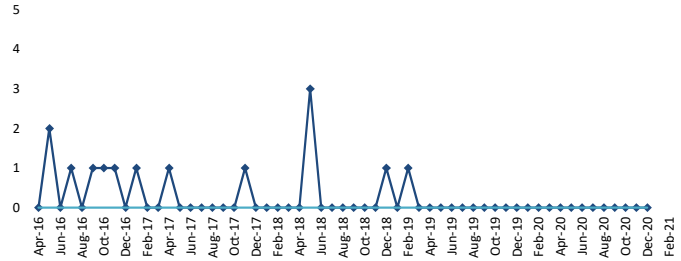
E.Coli rates have typically been better or in line with the average, while MRSA has been consistently better.

Quality of Care

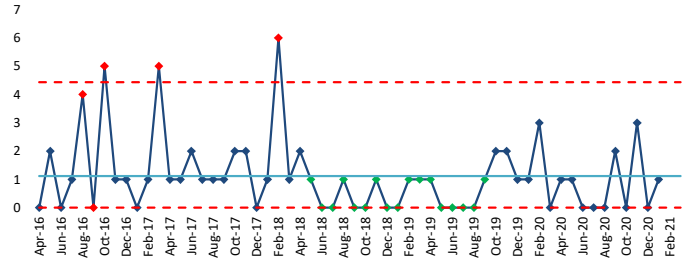
Safe - Harm Free Care

The Walton Centre
NHS Foundation Trust

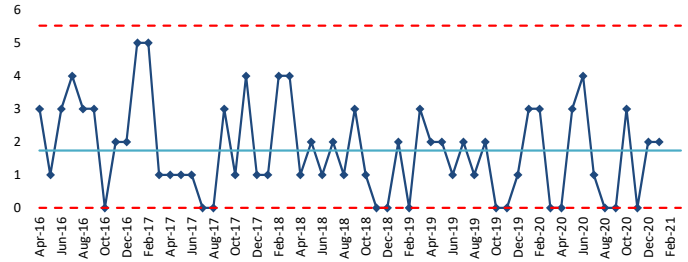
Total Moderate or Above Harm Patient Falls



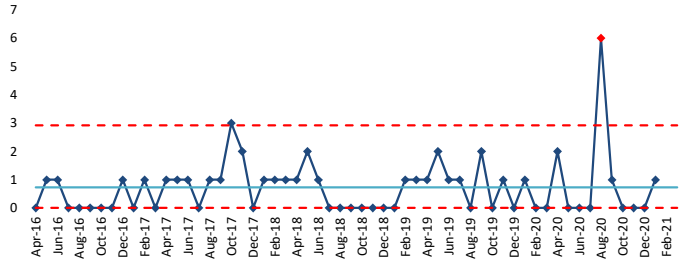
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no falls which resulted in moderate or above harm in January 21.

There was one Hospital Acquired Pressure Ulcers in January 21

There were two CAUTI incidences in January 21

There was one VTE incidence in January 21.

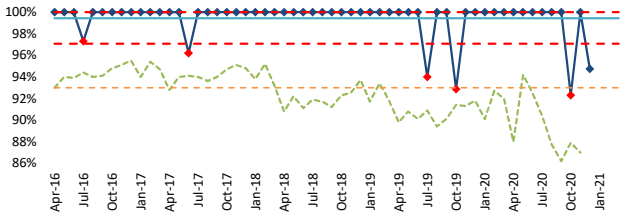
All harm measures are within normal variation.

Operational

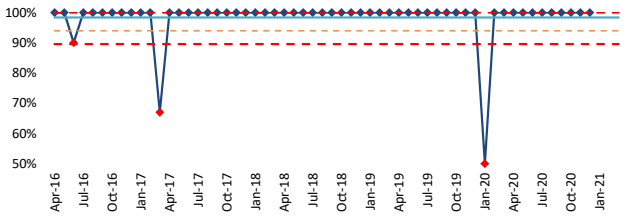
Responsive - Cancer

The Walton Centre
NHS Foundation Trust

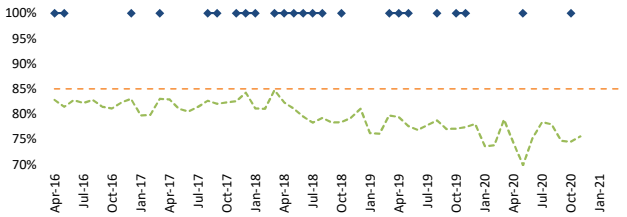
14 Day Performance



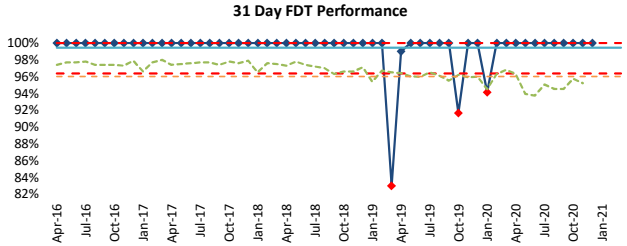
31 Day Subsequent Performance



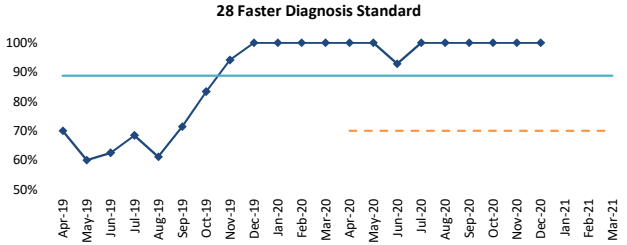
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

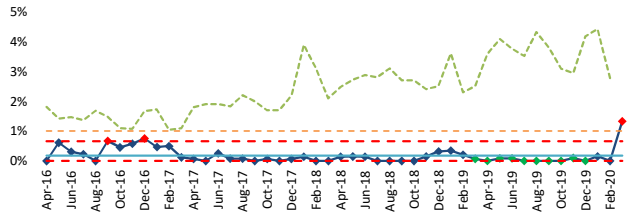
The Trust has continued to see and treat all cancer patients throughout December as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

Operational

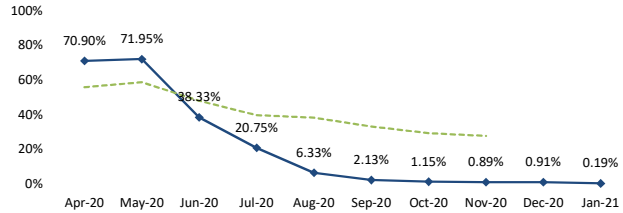
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

6 Week Diagnostic Performance (16/17 - 19/20)



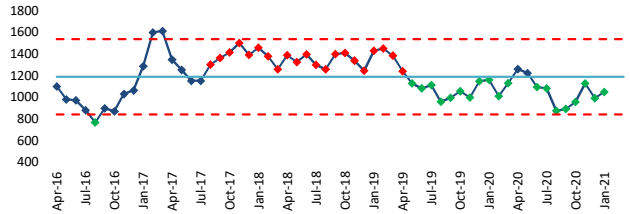
6 Week Diagnostic Performance (20/21)



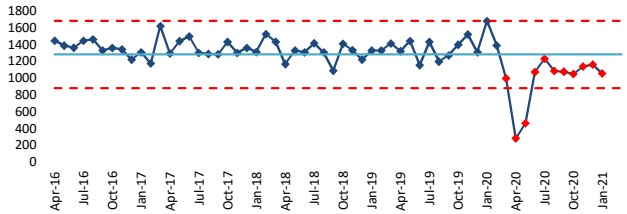
Narrative

Diagnostic performance in January 21 was 0.19%, resulting in two patients waiting over six weeks at month end. Performance has improved significantly since May, however due to Infection Prevention and Control measures Radiology capacity is at 90% therefore any increase in demand may impact performance.

Total Diagnostic Waits at Month End



Total Diagnostic Activity in Month



Excellence in Neuroscience

Ward Scorecard

January 2021

The Walton Centre NHS Foundation Trust

	Safe Staffing				Workforce		Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Sickness Rate	Vacancy Rate	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	84%	137%	99%	146%	12.32%	16.59%	0	0	1	0	0	0	0	0
Caton	122%	102%	122%	102%	9.62%	6.18%	0	0	0	0	0	0	0	0
Chavasse	126%	213%	142%	191%	25.54%	18.07%	0	0	1	1	0	0	0	0
Dott	95%	142%	99%	151%	12.43%	10.55%	0	0	0	0	0	0	0	0
Lipton	101%	134%	102%	144%	11.32%	18.05%	0	0	0	0	0	0	0	0
Sherrington	93%	100%	104%	100%	19.68%	33.65%	1	0	0	0	0	0	0	0
CRU	136%	154%	98%	225%	5.15%	7.41%	0	0	0	0	0	0	0	0
Horsley ITU	102%	132%	99%	106%	10.22%	-0.95%	0	0	0	0	0	0	0	0

WELL LED

Finance

Trust I&E	In month			Year to Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,992	8,941	(51)	87,038	87,582	544	105,022	105,849	827
Exclusions	1,786	1,512	(274)	17,855	17,332	(523)	21,427	20,904	(523)
Private Patient	1	8	7	27	57	30	29	68	39
Other Operating	428	449	21	4,546	4,852	306	5,402	6,055	653
Total Operating Income	**11,207**	**10,910**	**(297)**	**109,466**	**109,823**	**357**	**131,880**	**132,876**	**996**
Pay	(6,111)	(6,249)	(138)	(60,340)	(60,449)	(109)	(72,565)	(72,897)	(332)
Non-Pay	(2,435)	(2,607)	(172)	(24,305)	(25,261)	(956)	(29,168)	(30,344)	(1,176)
Exclusions	(1,785)	(1,323)	462	(15,163)	(14,392)	771	(18,736)	(17,963)	773
COVID / Reserves	(503)	(272)	231	(5,186)	(4,253)	933	(6,408)	(4,639)	1,769
Total Operating Expenditure	**(10,834)**	**(10,451)**	**383**	**(104,994)**	**(104,355)**	**639**	**(126,877)**	**(125,843)**	**1,034**
EBITDA	**373**	**459**	**86**	**4,472**	**5,468**	**996**	**5,003**	**7,033**	**2,030**
Depreciation	(403)	(404)	(1)	(4,029)	(4,036)	(7)	(4,834)	(4,845)	(11)
Profit / Loss On Disp Of Asset	0	0	0	2	3	1	2	3	1
Interest Receivable	0	0	0	5	5	0	5	5	0
Financing Costs	(52)	(51)	1	(517)	(512)	5	(620)	(614)	6
Dividends on PDC	(95)	(113)	(18)	(920)	(948)	(28)	(1,102)	(1,138)	(36)
I & E Surplus / (Deficit)	**(177)**	**(109)**	**68**	**(987)**	**(20)**	**967**	**(1,546)**	**444**	**1,990**
Capital donations I&E impact	**19**	**19**	**0**	**178**	**61**	**(117)**	**216**	**106**	**(110)**
I & E Surplus / (Deficit)	**(158)**	**(90)**	**68**	**(809)**	**41**	**850**	**(1,330)**	**550**	**1,880**

In response to the COVID-19 pandemic, the financial regime has now moved into another phase, with the trust now being monitored against the year-end forecast of £1.1m deficit submitted in December (based on expected forecast at that time). The HCP has now been provided with a final target for 2020/21 and work is on-going to ensure that this can be achieved whilst maintaining resource into next year. The Trust will be submitting an improved forecast as part of this process.

From October (Month 7), the key changes from reporting in April – September (Month 1-6) are:

- 'Block' funding received for Top-up, COVID related costs & growth (based on fair share of sector funding) for M7-12 rather than being reimbursed directly via retrospective top-up;
- No retrospective monthly top-up funding will be received to bring Trust to breakeven.

At month 10, the Trust reported a £90k deficit position. This is a £68k improvement on the planned position.

The in-month position includes £0.1m spend incurred as a result of COVID-19.

The Trust is forecasting a year-end surplus position of £0.6m (after the impact of donations), which is an improvement of £1.9m against the planned year end position (and a £1.0m improvement against the previous forecast). This is due to one off benefits received in month 9 and month 10. The financial position will be monitored to see if there are opportunities to improve the final position.

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Jan-21	Movement
	£'000	£'000	£'000
Intangible Assets	49	35	(14)
Tangible Assets	82,591	80,318	(2,273)
TOTAL NON CURRENT ASSETS	**82,640**	**80,353**	**(2,287)**
Inventories	1,232	1,215	(17)
Receivables	9,287	7,062	(2,225)
Cash at bank and in hand	26,673	41,318	14,645
TOTAL CURRENT ASSETS	**37,192**	**49,595**	**12,403**
Payables	(18,088)	(29,541)	(11,453)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(31,215)**	**(11,453)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,380**	**950**
Provisions	(639)	(613)	26
Finance Lease	(115)	(78)	37
Loans	(25,031)	(23,635)	1,396
TOTAL ASSETS EMPLOYED	**74,285**	**74,407**	**122**
Public Dividend Capital	27,554	27,696	142
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,167	(20)
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,407**	**122**

STATEMENT OF CASH FLOW - 2020/21	January-21 Plan	January-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(988)**	**(20)**	**968**
Non-Cash Flows In Operating Surplus/(Deficit)	5,457	5,493	36
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**4,469**	**5,473**	**1,004**
Increase/(Decrease) In Working Capital	14,073	15,805	1,732
Increase/(Decrease) In Non-Current Provisions	(23)	(26)	(3)
Net Cash Inflow/(Outflow) From Investing Activities	(5,377)	(4,176)	1,201
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**13,142**	**17,076**	**3,934**
Net Cash Inflow/(Outflow) From Financing Activities	(2,152)	(2,430)	(278)
NET INCREASE/(DECREASE) IN CASH	**10,990**	**14,645**	**3,656**
OPENING CASH	**26,673**	**26,673**	**0**
CLOSING CASH *	**37,663**	**41,318**	**3,656**

*Cash flow inclusive of an additional month of commissioner payments due to providers having to deal swiftly with the Covid-19 outbreak. This is likely to reverse in March unless national policy changes

COVID-19 expenditure:

YTD £2.5m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

In month (January) spend was £148k.

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

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	Jul-20 Actual £'000	Aug-20 Actual £'000	Sep-20 Actual £'000	Oct-20 Actual £'000	Nov-20 Actual £'000	Dec-20 Actual £'000	Jan-21 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	49	91	97	35	110	1,140
Annual leave provision	287	(287)	52	0	0	0	0	0	0	0	52
PPE	62	148	259	63	10	94	0	17	(5)	4	652
Decontamination	9	8	(2)	6	(3)	9	4	0	0	2	33
Agile working	21	(19)	1	92	0	3	97	30	58	12	295
ITU	5	2	(3)	0	2	0	(2)	0	38	0	42
Other	37	24	18	23	18	33	32	19	22	20	246
TOTAL	**520**	**130**	**516**	**302**	**123**	**188**	**222**	**163**	**148**	**148**	**2,460**

Other spend includes providing free car parking for staff, increasing the number of staff uniforms for staff and a contribution towards storage costs at the Liverpool arena for PPE.

Capital

In month variance - £96k above plan.

Year to date variance - £2,295k below plan.

The full year plan includes £0.5m of additional non-recurrent funding (increased in year to £1.1m) allocated by NHSE/I for critical infrastructure costs (to reduce backlog maintenance).

With the increase in capital funding finance have been working closely with divisions to identify deferred schemes which can be delivered by 31st March 21 to ensure that the plan is delivered.

The Trust has been allocated £0.8m from DHSC, £0.5m for an additional CT scanner which will be utilised by the Trust and to provide additional diagnostic capacity for the local system and £0.3m for the procurement of a new e-rostering system.

The detailed capital forecast is being monitored and reviewed weekly by Director of Finance and Director of Ops and Strategy.

CAPITAL

	Annual Plan £'000	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
Division							
Heating & Pipework	978	0	136	(136)	978	657	321
Estates	368	31	3	28	307	136	171
IM&T	1,283	107	116	(9)	1,069	368	701
Neurology	2,122	44	(25)	69	2,036	11	2,025
Neurosurgery	1,702	141	51	90	1,418	337	1,081
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,099)	(138)	0	(138)	(1,765)	0	(1,765)
TOTAL (excl. COVID-19)	**4,504**	**185**	**281**	**(96)**	**4,043**	**1,509**	**2,534**
COVID-19	0	0	0	0	0	239	(239)
TOTAL	**4,504**	**185**	**281**	**(96)**	**4,043**	**1,748**	**2,295**

Capital spend in month is £281k.

There is £136k capital spend on phase 3 heating/pipework scheme.

There has been £116k of IM&T spend on EP2, computers on wheels refresh and on staffing for projects, £3k on estates schemes, £12k spend for the new scanner in Neurology offset by a reversal of £37k in relation to finalising costs for the MRI scanner replaced in 2019/20 and £51k on anaesthetic machines in Neurosurgery.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 2020/21 phase 3 planning process.

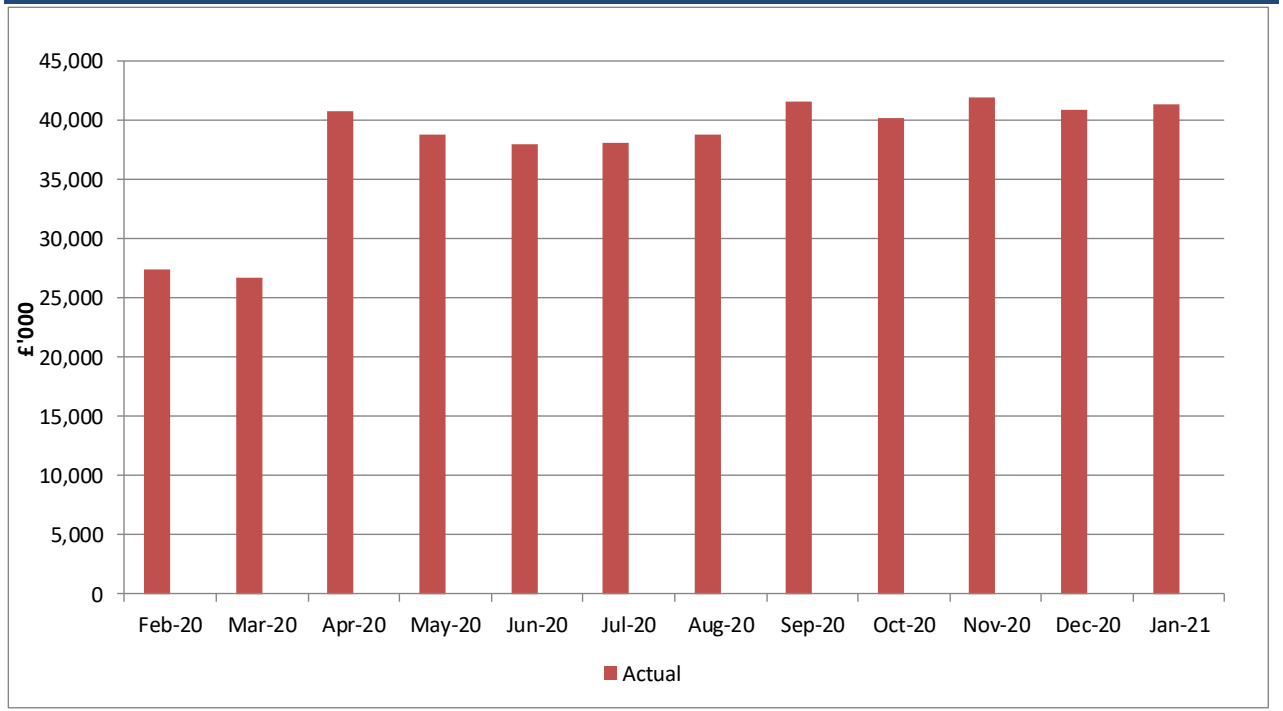
NHS I/E are in regular contact to monitor spending.

Although year to date spend is below plan, it is anticipated that it will be in line with the plan by the end of the year. This is primarily due to the installation of the CT scanner.

As of the end of January:

Actual Cash Balance: £41.3m

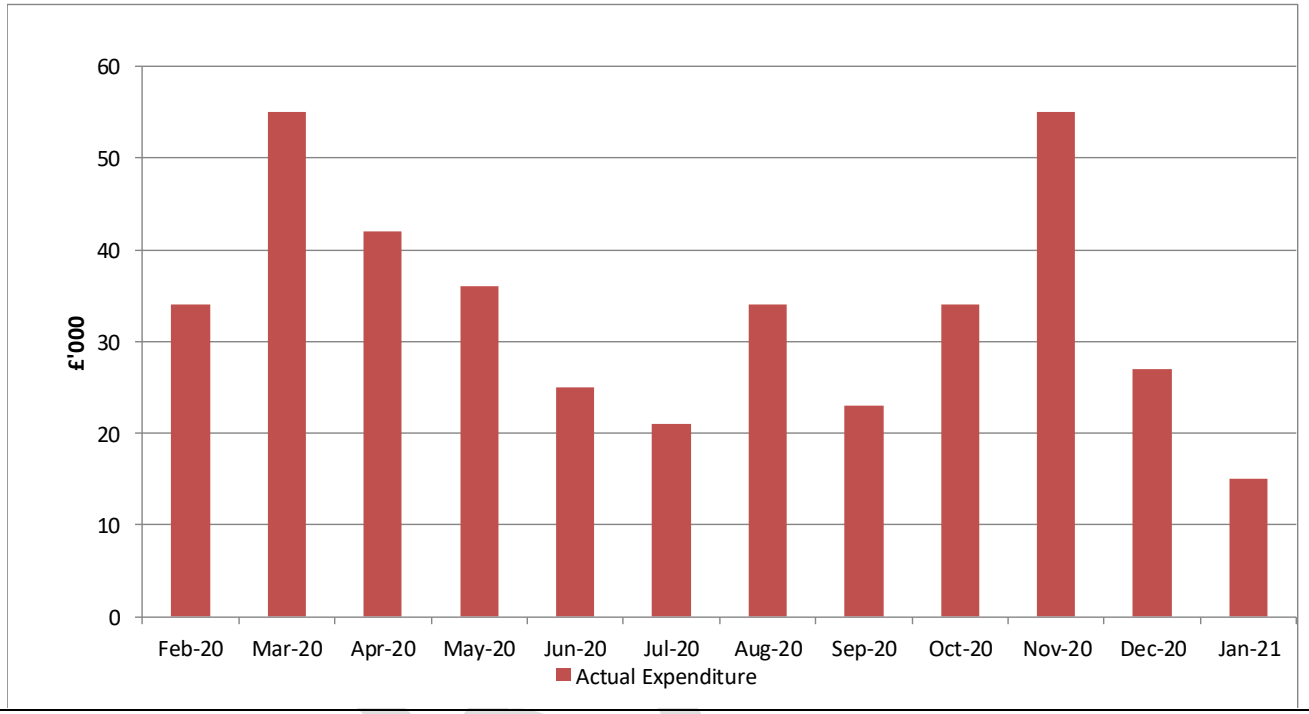
Number of days operating expenses = 119 days



The Trust cash balance at the end of January was £41.3m. This is an increase of £0.4m from the end of December.

The cash position includes an additional month of block payment received in January relating to February for the new financial arrangements to cover the COVID-19 pandemic.

Notification has been received that the block payment will not be made in March to bring contract payments back in line, so the level of cash will reduce.

Agency Expenditure: In month Actual: £15k YTD Actual: £312k	**Monthly Agency Expenditure (Rolling 12 months)**  	Agency spend incurred in January was £15k, a decrease of £12k compared to December. At the end of January, £55k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions for 2020/21

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

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the year and income being based on block values determined nationally (based on 2019/20 expenditure between November 2019 and January 2020). To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable COVID-19 and other known cost increases from 2019/20 (e.g. CNST contributions). This was the position for M1-6 with a block element of funding being allocated for Top-up, COVID-19 and growth to C&M HCP for M7-12 which is to be distributed to all organisations;
- The trust is currently being monitored against the year-end forecast of £1.1m deficit submitted to NHSE/I and C&M HCP in December;
- An Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M6-M12). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then will receive a retrospective financial penalty. This will not be applied in September or October given the impact of Covid patients in the C&M system and it is not expected that it will be applied over the remainder of the financial year due to the impact of the 2nd and 3rd waves;
- 2020/21 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this allocation does not include any phase 2 COVID-19 capital requirements or additional PDC allocated for specialist capital projects;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

As a result of the 3rd wave of COVID further guidance has been received around 2021/22:

- 2021/22 business planning deferred for at least first 3 months of 2021/22;
- Current financial regime is to continue for at least the first 3 months of 21/22 (and possibly the next 3 months dependant on levels of COVID);
- Exercise looking at 'exit run rates' for 2019/20 and 2020/21 is being undertaken by NHSE/I to determine potential level of contract funding for 1st quarter of 2021/22;
- System level targets will continue.

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

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 2020/21 and 2021/22 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	Block payments for English commissioners planned income are based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. Assumed income for Welsh commissioners is consistent with this approach (per guidance released M7-12), although high cost exclusions are now based on a pass through cost and volume basis. As part of this guidance, if activity has reduced by more than 25% below the block contract payment it will be adjusted by 10% in value increasing to a maximum reduction of 20% in value if activity reduces by more than 50%. Given that the Trust has had to cancel elective activity in January and February to support the regional COVID response there is a risk that Welsh activity will be at least 25% less than prior year activity which would mean that the contract penalties would be applied. This could result in a £720k reduction in income. National discussions are taking place around this but at this point, the original agreement remains in place. IOM are only paying for actual activity that has been delivered (which is reflected within the financial position), again resulting in an under payment compared to centrally assumed levels of income in line with 2019/20 outturn. Although there was an increase in activity between M6-M10.
Current/ Future NHS Financial Framework	For the remainder of the year block funding will remain in place but COVID-19 will not be retrospectively reimbursed, with central funding allocated to the HCP for the rest of the year. C&M HCP is expected to achieve a breakeven position by the end of the financial year. STP's were required to submit phase 3 recovery plans for activity (and associated financial implications) on 1st September with final plans being

	submitted on 21st September. As part of this process the Trust has been completing phase 3 forecasts based on anticipated levels of activity to understand the financial implications for the Trust which have been submitted to the C&M Healthcare Partnership with final submissions submitted in late October. The trust is now being monitored against a year-end forecast of £1.1m deficit. This was taken from a revised submission in December. The level of forecast financial deficit across C&M has reduced to c. £11m and this is currently being accepted as the final position for C&M. However, discussions will continue to be held with NHSE/I about future expectations in light of the 3rd wave of COVID. As a result of the current national position with COVID notification has been received that 2021/22 financial planning has been deferred for at least 3 months. In addition to this, it has been confirmed that current financial arrangements will remain in place for at the 1st 3 months of 2021/22. However it is still to be confirmed as to the value of the plan/ block funding for the Trust for Q1 in 2021/22. An exit run rate exercise is being carried out across the NHS which is likely to determine these allocations.
Elective Incentive Scheme	The Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity. The Trust has under-performed against this target in M6-M10 (mainly in relation to the levels of elective activity) and as such may receive a retrospective financial penalty (if these are applied to individual organisations). However during this period, the system has had greater than 15% of beds filled with COVID related patients, and as such the Trust is not expecting a retrospective financial penalty for this period. NHSE/I have confirmed that the EIS will not be applied to C&M for M6 and M7 and it is not expected that it will be applied over the remainder of the financial year due to the impact of the 2nd and 3rd waves. Any potential financial impact of the Elective Incentive Scheme is currently outside the reported forecast position as requested by the HCP.

Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult. However, this is likely to be greater than 1.1% given the additional NHS investments in 2020/21. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements but it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as fewer patients will be able to be seen given the additional PPE/ social distancing requirements). It should be noted that it has been agreed by C&M HCP that Trust elective activity will be cancelled for at least 4 weeks to be able to support the regional response to COVID. This will both have a financial impact but also will impact on waiting times and future recovery of activity.

REPORT TO BOARD OF DIRECTORS

4th March 2021

Title	**Managing the COVID-19 Pandemic - Reducing Burden and Releasing Capacity**
Sponsoring Director	Hayley Citrine – Chief Executive
Author (s)	Paul Buckingham – Interim Corporate Secretary
Previously considered by:	

Executive Summary

The response to the coronavirus (COVID-19) emergency situation requires NHS organisations to operate differently to normal business as usual practice. The purpose of this report is to set out the Trust's approach in response to correspondence from NHS England & NHS Improvement dated 26 January 2021. A copy of this correspondence is included for reference at Annex A to this report.

The Trust's approach to the areas set out in the NHSE/I correspondence is detailed at s3.1 of the report with details of delegated levels of authority and emergency powers arrangements included at s3.2 and s3.3 respectively.

Action required by the Board:	The Board of Directors is recommended to: • Receive the report and note the Trust's position on areas set out in correspondence from NHSE/I dated 26 January 2021 (included at Annex A). • Endorse the delegated authority and emergency powers arrangements set out at s3.2 and s3.3 of the report.
Related Trust Ambitions	• Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Related Assurance Framework entries	Risk ID 001 – COVID-19
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	

1.0 Introduction

1.1 The response to the coronavirus (COVID-19) emergency situation requires NHS organisations to operate differently to normal business as usual practice. The purpose of this report is to set out the Trust's approach in response to correspondence from NHS England & NHS Improvement dated 26 January 2021.

2.0 Background

2.1 The Board of Directors initially approved revised governance arrangements for management of the pandemic situation on 30 April 2020. These arrangements, which aimed to facilitate both agile decision-making and streamlined business agendas to ensure appropriate operational focus, were gradually eased as the impact of the pandemic situation began to reduce during the summer and autumn of 2020.

2.2 However, Board members will be fully aware of the deteriorating situation over the winter period' with significantly increased infection rates and hospital admissions which resulted in further national 'lockdown' arrangements being implemented from 6 January 2021. There has been unprecedented pressure on NHS services, both regionally and nationally, in recent weeks in both managing capacity and ensuring delivery of both a national vaccination programme of unparalleled scale and complexity and continuity of non-COVID care. In this context, Ms A Pritchard, Chief Operating Officer, NHS England & NHS Improvement, wrote to Trusts on 26 January 2021 with guidance on reducing the burden and releasing capacity to facilitate appropriate operational focus. A copy of this letter is included for reference at Annex A to this report.

3.0 Approach

3.1 The Trust's approach to the areas set out in the NHSE/I correspondence of 26 January 2021 is detailed in Table 1 below:

Table 1

Areas for NHS organisations to consider	Trust's Response
1. Board and Sub-Board Meetings • Trusts should continue to hold Board meetings but streamline papers, focus agendas and hold virtual, not face-to-face meetings. No sanctions for technical quorum breaches (e.g. because of self-isolation). • For Board Committee meetings, Trusts should continue Quality Committee meetings, but consider streamlining other Committees. • While under normal circumstances the public can attend at least part of Board meetings, Government social isolation requirements constitute 'special reasons' to avoid face-to-face gatherings as permitted by legislation.	• The Trust has reviewed its approach to Board agendas and reintroduced streamlined agendas with effect from the Board meeting held on 4 February 2021. Substantive agenda items will be focused on key operational matters. • A Consent Agenda approach has been introduced to assist with the streamlining of meeting and mitigate the risk of business backlog. • The Quality Committee continues to meet in accordance with its normal business cycle. All other Board Committees also continue to meet utilising streamlined agendas and the Consent Agenda approach where appropriate. • All Board and Committee meetings are held vitually using MS Teams.
2. FT Governor Meetings • Face-to-face meetings should be stopped at the current time. Virtual meetings can be held for essential matters e.g. transaction decisions. • FTs must ensure that Governors are (i) informed of the reasons for stopping	• Council of Governors and associated meetings are currently being held on a virtual basis. We plan to continue with this approach utilising streamline agendas where necessary. • The Chair maintains regular contact with the Lead Governor and holds fortnightly virtual briefings for members of the Council of Governors. Governors also have access to the Trust's weekly news bulletin

meetings and (ii) included in regular communications on response to COVID-19 e.g. via webinars/emails.	'Walton Weekly'.
3. FT Governor and Membership Processes • FTs are free to stop/delay Governor elections where necessary. • Annual Members' Meetings should be deferred. • Membership engagement should be limited to COVID-19 purposes.	• The Trust deferred elections to the Council of Governors in 2020 as a result of the pandemic situation. It is currently planned to hold elections during the period June-August 2021 in order to mitigate the risk that level of vacancies will affect meeting quoracy. • The Trust held a virtual Annual Members' Meeting in September 2020 and currently plans to hold the next meeting in September 2021. These plans will be reviewed and may be adjusted dependent on the prevailing circumstances. • Normal membership engagement activities continue to be suspended.
4. Annual Accounts and Audit NHSE/I wrote to the sector on 15 January 2021 to make the following adjustmnents to reporting requirements: • Extending the 2020/21 accounts and audit year end timetable • Allowing Providers to apply for a further extended timetable for submitting 2020/21 financial accounts • Deferring introduction of IFRS 16 to 2022 • Simplifying the 'agreement of balances' exercise	• The Audit Committee was briefed on the revised timetable at its meeting held on 19 January 2021. • The Trust applied for the further extended timetable (submission date of 29 June 2021 as opposed to 15 June 2021) on the advice of External Audit. The request for extension was subsequently approved by NHSE/I.
5. Quality Accounts – Preparation • The deadline for Quality Accounts preparation of 30 June is specified in Regulations. DHSC is currently reviewing whether Regulations should be amended to extend the 30 June deadline for 2020/21.	• The current deadline of 30 June 2021, and the likelihood that this may change, has been noted.
6. **Quality Accounts and Quality Reports – Assurance** • Requirements for FTs to include this within their 2020/21 Annual Report have been removed. •	• Noted and confirmed that External Audit are aware that there is no requirement to undertake assurance review of the 2020/21 Quality Report.
7. Annual Report • The options available to simplify parts of the Annual Report that were introduced in 2019/20 are available again for 2020/21. •	• Noted. The work plan for the 2020/21 Annual Report was circulated for action on 19 February 2021.
8. Decision-making Processes • While having regard to their Constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	• The emergency powers arrangements initially approved by the Board on 30 April 2020 remain in place. See section 3.2 and 3.3 of the report.

Reporting and Assurance	
1. Constitutional Standards • Relevant standards and arrangements detailed at Annex A of NHSE/I letter dated 26 January 2021.	• The Trust continues to analyse and report on performance against constitutional standards via the divisional management structure. • The Trust continues to submit data returns as required. • The IPR contains the relevant standards and continues to be reported to Trust Board. NEDs have the opportunity to submit questions in advance of the meeting where they are seeking greater assurance.
2. Friends and Family Test • Reporting requirement to NHS England and NHS Improvement has been paused. However, Trusts have flexibility to change their arrangements under the new guidance and published case studies show how Trusts can continue to hear from patients whilst adapting to pressures and needs.	• The Trust resumed completion of the Friends & Family Test (FFT) in January 2021 utilising electronic means of data capture where appropriate. The Trust has no plans at present to suspend FFT.
3. Operational Planning • The 2021/22 planning and contracting round will be delayed; it will not be initiated before the end of March 2021 and we will roll over the current financial arrangements into Q1 2021/22.	• Noted. The Trust has commenced 2021/22 planning for internal purposes.
4. Long Term Plan: System by Default • System by Default development work (including work on CCG mergers) has been restarted. NHSE/I actively encourages system working where it can help manage the response to COVID-19. We will keep this work under review to ensure it continues to enable collaborative working and does not create undue capacity constraints on systems.	• Noted. The Trust continues to participate in collaborative system working in both local and regional systems.
5. Long Term Plan: Mental Health • NHSE/I will maintain Mental Health Investment guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.	• Noted.
6. Long Term Plan: Learning Disability and Autism • NHSE/I will maintain the investment guarantee.	• Noted.
7. Long Term Plan: Cancer • NHSE/I will maintain its commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response, and restoration and maintenance of cancer screening and symptomatic pathways.	• Noted.

8. NHSE/I Oversight Meetings • Virtual meetings will be held. Streamline agendas and focus on COVID-19 issues and support needs.	• Noted.
9. Corporate Data Collections (e.g. licence self-certs, Annual Governance Statement, mandatory NHS Digital submissions • Will look to streamline and/or waive certain elements. Delay the Forward Plan documents that FTs are required to submit. • We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.	• Noted. The Trust will ensure compliance as and when further guidance is promulgated.
10. CQC routine assessments and Use of Resources assessments • CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHSE/I continues to suspend the Use of Resources assessments in line with this approach.	• Noted.
11. Provider transaction appraisals / CCG mergers / Service reconfigurations • Complete April 2021 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors. • Complete April 2021 CCG Mergers. • Where possible and appropriate we will streamline the process to review any reconfiguration proposals, particularly those designed in response to COVID-19.	• Noted. The Trust does not have any pending transaction appraisals or service reconfigurations.
12. 7-day Services Assurance • Suspend the self-cert statement.	• Noted.
13. Clinical Audit • Given their importance in overseeing non-Covid care, clinical audits will remain open. This will be of particular importance where there are concerns from patients and clinicians about non-Covid care such as stroke, cardiac etc. • However, local clinical audit teams will be permitted to prioritise clinical care where necessary – audit data collections will temporarily not be mandatory.	• Noted.
14. Pathology Services • We need support from Providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent and consumables.	• Noted.

Other Areas including HR and staff-related activities	
1. Mandatory Training • New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate.	• Mandatory training being undertaken where possible within prevailing restrictions.
2. Appraisals and Revalidation • Indications are that the Appraisal 2020 model is helping to support doctors during the pandemic, however we recognise with rising pressures in the system appraisals may need to be reprioritised, so appraisals can be declined. If appraisals are going ahead, please use the revised shortened Appraisal 2020 model. • The GMC has now deferred revalidation for all doctors who are due to be revalidated between 17 March 2020 and 16 March 2021. • The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between March and December 2020.	• Noted
3. CCG Clinical Staff Deployment • Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline. • CCG Governing Body GP to focus on primary care provision.	• Not applicable, CCGs only.
4. Repurposing of CCG non-clinical staff • Non-clinical staff to focus on supporting primary care and providers to maintain and restore services.	• Not applicable, CCGs only
5. Enact business critical roles at CCGs • To include support and hospital dischare, EPRR etc.	• Not applicable, CCGs only.

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

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

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

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

The Board of Directors subsequently approved an adjustment of these levels as part of a periodic review of the SoRD and Standing Financial Instructions which was completed on 5 November 2020. Consequently, the current delegated levels and associated emergency powers are as follows:

Value	Standard Delegation	Emergency Powers
Up to £25,000	Divisional Directors/ Deputy DON/	Director of Operations & Strategy or Director of Nursing & Governance
£25,001 to £35,000	Deputy Director of Finance	Director of Finance
£35,001 to £60,000	Other Executive Directors	Chief Executive **or** two Executive Directors jointly
£60,001 to £100,000	Director of Finance	Chief Executive or 2 x voting Executive Directors
£100,001 to £150,000	Chief Executive (Executive Team)	Chief Executive or 2 x voting Executive Directors
£150,001 to £500,000	Business Performance Committee	Emergency Powers - Chief Exec or 2 Executive Directors and Chair acting jointly and after having consulted with at least 2 Non-Executive Directors. The exercise of such powers shall be reported to the next formal meeting of the Board for ratification.
£500,001 and above	Board of Directors	Board of Directors or Emergency powers in the event that a meeting of the Board will not take place (SO 5.2 refers)

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

4.0 Recommendations

4.1 The Board of Directors is recommended to:

- Receive the report and note the Trust's position on areas set out in correspondence from NHSE/I dated 26 January 2021 (included at Annex A).
- Endorse the delegated authority and emergency powers arrangements set out at s3.2 and s3.3 of the report.

Classification: Official

Publications approval reference: 001599

Skipton House
80 London Road
London
SE1 6LH

To:

- Chief executives of all NHS trusts and foundation trusts
- CCG Accountable Officers

Copy to:

- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Chairs of ICSs and STPs
- NHS Regional Directors

26 January 2021

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

The NHS is facing unprecedented levels of pressure from the COVID-19 pandemic. Whilst numbers of admissions are plateauing and beginning to decline in some parts of the country, they continue to grow in others and the number of patients in hospital and in critical care with COVID-19 will take some time to reduce. At the same time the NHS is delivering a national COVID vaccination programme of unparalleled scale and complexity, whist also continuing to provide non-COVID care.

Therefore we will continue to support you to free up management capacity and resources to focus on these challenges. Following our letters in March and July last year, this letter updates and reconfirms our position on regulatory and reporting requirements for NHS trusts and foundation trusts, including:

- pausing all non-essential oversight meetings
- streamlining assurance and reporting requirements
- providing greater flexibility on various year-end submissions
- focussing our improvement resources on COVID-19 and recovery priorities
- only maintaining those existing development workstreams that support recovery.

We will keep this under close review, making further changes where necessary to support you. In addition, we will review and update the measures set out in this letter in Q1 2021/22.

Once again, we appreciate the incredible level of commitment and hard work from you and your teams that has helped the NHS rise to meet the challenges of the last year, and in particular these past four weeks.

Yours sincerely

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

The system actions

Changing NHSE/I engagement approaches with systems and organisations

Oversight meetings will continue to be held by phone or video conference and will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis to ensure they are appropriate. We have reprioritised our improvement and support effort to focus on areas directly relevant to the COVID-19 response, in particular:

- GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge coordination.
- National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, e.g. video consultation and patient-initiated follow up, maximising diagnostics and clinical service capacity, supporting discharge priorities etc.
- With CQC, we continue to prioritise our special measures work to give the appropriate support to the most challenged systems to help them manage COVID-19 pressures.

1) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually, not face-to-face. No sanctions for technical quorum breaches (e.g. because of self-isolation). For board committee meetings, trusts should continue quality committees, but consider streamlining other committees. While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation. All system meetings to be virtual by default.	Organisation to inform audit firms where necessary
2.	FT Governor meetings	Face-to-face meetings should be stopped at the current time[1] - virtual meetings can be held for essential matters e.g. transaction decisions. FTs must ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 e.g. via webinars/emails.	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary. Annual members' meetings should be deferred. Membership engagement should be limited to COVID-19 purposes.	FTs to inform lead governor

[1] This may be a technical breach of FTs' constitution but acceptable given Government guidance on social isolation

No.	Areas of activity	Detail	Actions
4.	Annual accounts and audit	We wrote to the sector on 15 January to make the following adjustments to reporting requirements: • extending the 2020/21 accounts and audit year end timetable • allowing providers to apply for a further extended timetable for submitting 2020/21 financial accounts • deferring introduction of IFRS 16 (new leases accounting standard) to 2022 • simplifying the 'agreement of balances' exercise	Organisation to continue with year-end planning in light of updated guidance
5.	Quality accounts - preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. DHSC is currently reviewing whether Regulations should be amended to extend the 30 June deadline for 2020/21.	No action for organisations at the current time
6.	Quality accounts and quality reports - assurance	We are removing requirements for FTs to include this within their 2020/21 annual report.	Organisations to inform external auditors where necessary
7.	Annual report	We wrote to the sector on 15 January confirming that the options available to simplify parts of the annual report that were introduced in 2019/20 are available again for 2020/21.	Organisation to continue with year-end planning in light of updated guidance
8	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

2) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (e.g. A&E, RTT, Cancer, Ambulance waits, MH LD measures)	See Annex A.
2.	Friends and Family test	Reporting requirement to NHS England and NHS Improvement has been paused. However, Trusts have flexibility to change their arrangements under the new guidance and published case studies show how Trusts can continue to hear from patients whilst adapting to pressures and needs.
3.	Operational planning	The 21/22 planning and contracting round will be delayed; it will not be initiated before the end of March 2021 and we will roll over the current financial arrangements into Q1 21/22.
4.	Long Term Plan: system by default	System by Default development work (including work on CCG mergers) has been restarted. NHSEI actively encourages system working where it can help manage the response to COVID-19. We will keep this work under review to ensure it continues to enable collaborative working and does not create undue capacity constraints on systems.
5.	Long Term Plan: Mental Health	NHSE/I will maintain Mental Health Investment guarantee. As a foundation of our COVID-19 response, systems should continue to expand services in line with the LTP.
6.	Long Term Plan: Learning Disability and Autism	NHSE/I will maintain the investment guarantee.
7.	Long Term Plan: Cancer	NHSE/I will maintain its commitment and investment through the Cancer Alliances and regions to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response, and restoration and maintenance of cancer screening and symptomatic pathways.
8.	NHSE/I Oversight meetings	Be held online. Streamlined agendas and focus on COVID-19 issues and support needs.

No.	Areas of activity	Detail
9.	Corporate Data Collections (e.g. licence self-certs, Annual Governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements. Delay the Forward Plan documents FTs are required to submit. We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.
10.	CQC routine assessments and Use of Resources assessments	CQC has suspended routine assessments and currently uses a risk-based transitional monitoring approach. NHSE/I continues to suspend the Use of Resources assessments in line with this approach.
11.	Provider transaction appraisals CCG mergers Service reconfigurations	Complete April 2021 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors. Complete April 2021 CCG Mergers. Where possible and appropriate we will streamline the process to review any reconfiguration proposals, particularly those designed in response to COVID-19.
12.	7-day services assurance	Suspend the self-cert statement.
13.	Clinical audit	Given their importance in overseeing non-Covid care, clinical audits will remain open. This will be of particular importance where there are concerns from patients and clinicians about non-Covid care such as stroke, cardiac etc. However, local clinical audit teams will be permitted to prioritise clinical care where necessary – audit data collections will temporarily not be mandatory.
14.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID-19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables.

3) Other areas including HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate
2.	Appraisals and revalidation	Indications are that the Appraisal 2020 model is helping to support doctors during the pandemic, however we recognise with rising pressures in the system appraisals may need to be reprioritised so appraisals can be declined. If appraisals are going ahead, please use the revised shortened Appraisal 2020 model The GMC has now deferred revalidation for all doctors who are due to be revalidated between 17 March 2020 and 16 March 2021. The Nursing and Midwifery Council (NMC) has also extended the revalidation period for current registered nurses and midwives by an additional three months for those due to revalidate between March and December 2020.
3.	CCG clinical staff deployment	Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline CCG Governing Body GP to focus on primary care provision
4.	Repurposing of non-clinical staff	Non-clinical staff to focus on supporting primary care and providers to maintain and restore services
5.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc

Annex A – constitutional standards and reporting requirements

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

A&E and ambulance performance – Monitoring and management against the 4-hour standard and ambulance performance continues nationally and locally, to support system resilience.

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

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

Screening: Cancer (Breast, Bowel and Cervical) and Non-Cancer (Abdominal Aortic Aneurysm, Diabetic Eye and Antenatal and Newborn Screening) – We will continue to track the maintenance of all the screening programme pathways (including the initial routine invitations, and the ongoing diagnostic tests).

Immunisations – All routine invitations should continue to be monitored via the NHSEI regional teams.

The Weekly Activity Return (WAR) will continue to be a key source of national data, and the Urgent and Emergency Care daily SitRep. This is vital management information to support our operational response to the pandemic, and we require 100% completion of these data with immediate effect. Guidance can be found here.

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

Title	Designation	Frequency
Critical Care Bed Capacity and Urgent Operations Cancelled	Official Statistics	Monthly
Delayed Transfers of Care	Official Statistics	Monthly
Cancelled elective operations	Official Statistics	Quarterly
Audiology	Official Statistics	Monthly
Mixed-sex Accommodation	Official Statistics	Monthly
Venous Thromboembolism (VTE)	Official Statistics	Quarterly
Mental Health Community Teams Activity	Official Statistics	Quarterly
Dementia Assessment and Referral Return	Official Statistics	Monthly
Diagnostics weekly PTL	Management Information	Monthly
26-week Patient Choice Offer	n.a. - trial	weekly

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

The Walton Centre NHS Foundation Trust

Report to the Board of Directors
Date: 4th March 2021

The Walton Centre NHS Foundation Trust

Title	**Board Assurance Framework 2020-21**
Sponsoring Director	Lisa Salter Director of Nursing and Governance
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	• Executive Team

Executive Summary

The purpose of this report is to present the Board Assurance Framework (BAF) 2020/21 to the Board of Directors for review and approval. There are currently a total of 13 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, were reviewed by the Executive Team during meetings held on 13 January and 17 February 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table at s3 of the report details the movement in risk scores during 2020/21.

There has been no significant movement in risk scores with the exception of Risk ID 001, which reflects the worsening position associated with the COVID-19 pandemic over the winter period, that resulted in a further national lockdown with effect from 6 January 2021. There has also been a decrease in the risk score for Risk ID 013, Capital, which reflects mitigation of the risk associated with the level of Capital availability to support the 2020/21 capital programme. Board members should also note the significant changes made to the content of Risk ID 011, Partnerships, to ensure focus on the potential risk associated with the planned establishment of an Integrated Care System (ICS).

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Board Assurance Framework supports the Annual Governance Statement which is a requirement of the annual report in line with the NHS Improvement Annual Reporting Manual.
Action required by the Board	The Board of Directors is recommended to: a) review and approve the BAF content as detailed at Appendix 1 b) approve the inclusion of the new risk relating to Medical Education (Risk ID X1) c) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board

1.0 Introduction

The purpose of this report is to present the Board Assurance Framework (BAF) 2020/21 to the Board of Directors for review and approval.

2.0 Background

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

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

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

An effective BAF:

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

The Board agreed the principal risks to delivery of the strategic objectives in April 2020 and Board Committees have maintained oversight of the principal risks relating to their remit during the reporting period. The BAF was last reviewed by the Board on 5 November 2020.

3.0 Updated position

There are currently a total of 13 principal risks identified in the BAF and each of these risks, together with associated mitigating actions and assurances, were reviewed by the Executive Team during meetings held on 13 January and 17 February 2021. The current BAF entries are included for reference at Appendix 1 to this report and content which has been updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table below details the movement in risk scores during 2020/21.

Risk ID	Title	Q1	Q2	Q3
001	**Covid-19** Impact of COVID-9 on delivery of strategic objectives	**20**	**15**	**20**
002	**QIP** Failure to achieve the recurrent QIP financial plans	**16**	Removed	
003	**Operational Performance** Inability to meet operational performance standards	**20**	**20**	**20**
004	**Harm to Staff** Inability to prevention harm to staff	**12**	**12**	**12**
005	**Quality** Inability to deliver the benefits within the Quality Strategy,	**12**	**16**	**16**
006	**Our staff** Inability to attract, retain and develop sufficient numbers of qualified staff	**12**	**16**	**16**
007	**Estates** Inability to maintain the estate to support patient needs	**12**	**12**	**12**
008	**Digital** Inability to deliver the benefits of the Digital Strategy	**12**	**12**	**12**
009	**Cyber Security** Inability to prevent Cyber Crime.	**16**	**16**	**16**
010	**Innovation** Inability to identify innovative methods of delivery	**12**	**12**	**12**
011	**Partnerships** Inability to influence partnerships and the future development of local services impacts on organisational sustainability	**N/A**	**16**	**12**
012	**Research and Development** Inability to maintain and grow the Trust's research and development agenda.	**N/A**	**12**	**12**
013	**Capital** Allocation of capital set by the STP to the Trust will not support the full capital plan for 2020-21	**N/A**	**16**	**9**
014	**Financial Plan** Inability to deliver the financial plan for 2020-21	**N/A**	**12**	**8**

There has been no significant movement in risk scores with the exception of Risk ID 001, which reflects the worsening position associated with the COVID-19 pandemic over the winter period which resulted in a further national lockdown with effect from 6 January 2021. There has also been a decrease in the risk score for Risk ID 013, Capital, which reflects mitigation of the risk associated with the level of Capital availability to support the 2020/21 capital programme. In addition, greater certainty around delivery of the 2020/21 financial plan has resulted in a reduction of the risk score from 12 to 8, Risk ID 014 refers. Board members should also note the significant changes made to the content of Risk ID 011, Partnerships, to ensure focus on the potential risk associated with the planned establishment of an Integrated Care System (ICS).

One new risk has been identified for adding to the BAF following review by the Research, Innovation & Medical Education (RIME) Committee:

X1	**Medical Education** Ongoing capability to deliver Medical Education.

A copy of the proposed BAF entry is included for review by the Board at the end of the BAF at Appendix 1.

4.0 Next Steps

A report will be presented to the Board at the next meeting on 1 April 2021 seeking approval of the principal risks which will form the BAF content for 2021/22. This report will follow consideration of current and proposed BAF content by relevant Board Committees during March 2021.

A particular focus for preparation of the 2021/22 BAF should be on ensuring that a principal risk has been identified for each of the strategic objectives. At present, there are two objectives; provide more services closer to patients' homes and be recognised as excellent in our patient and family centred care, where principal risks have not been identified.

5.0 Recommendations

The Board of Directors is recommended to:

a) review and approve the BAF content as detailed at Appendix 1
b) approve the inclusion of the new risk relating to Medical Education (Risk ID X1)
c) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board

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

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

	Consequence	Likelihood	Rating
Initial	Catastrophic 5	Almost Certain 5	25
Current	Catastrophic 5	Possible 4	20
Target	Catastrophic 5	Unlikely 2	10

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Loss of life, Patients / Staff 2. Disruption to business as usual 3. High levels of sickness absence	~~Current figure UK deaths 44,896~~ ~~Liverpool region in Tier 3~~ ~~Wales currently in Lockdown~~ **National Lockdown with effect from 6 January 2021**

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

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

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Terms of Reference, membership and reporting arrangements re Ethics Committee to be finalised	AN	End of April	Completed
2	Ongoing participation in regional and national plans	JR	March 2021	On track

Risk 003	Date risk identified April 2020	Date of last review:	February 2021
Risk Title: If the Trust does not see and treat patients in a timely manner then it will not meet the NHS constitutional standards leading to poor patient outcomes and experience, regulatory scrutiny and reputational damage.		Date of next review:	April 2021
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	1 Deliver Best Practice in care and treatments
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Operations and Strategy

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Draft Operational Plan 2020-21 - discussed at Exec Feb 20 2. Workforce Plan 2018-2019 3. COVID-19 Recovery Plan Phase 3 4. Job Planning for consultants - Ongoing for 2020-21 5. Regional Operations Meeting – Weekly 6. Cheshire & Merseyside EPRR Network Meeting – twice per week 7. National Call – NHSI – Weekly 8. Performance Dashboard in Real-time	1. Draft plan based on assumptions pre COVID-19 2. Workforce plans do not take into account impact of sickness, shielding requirements due to COVID-19 3. COVID-19 Recovery Plan based on assumptions of business as usual pre COVID and does not factor in patient staff behaviours and new ways of working 4. Real time visibility of Performance data 5. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 6. Lack of clarity re waiting time standard - RTT /Average wait going forward 7. Increase in pain referrals across C&M due to de-commissioning of service at other providers 8. ~~Failure of diagnostic standard~~

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

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Transformation Board to be formally established and re-focused to address outpatient productivity flow and theatres in the context of COVID-19 Recovery	DoSO	~~March 2020~~ June 2020	Delayed
2	Implementation of COVID Recovery Plan to increase activity	DoSO	End of July	Phase 1 complete
3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	Delayed
4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	End of July	Not started
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue	DoSO	End of June	On track
6	Continued Job Planning for consultants for 2019-20	DoSO	Mar 2021	On track

Risk ID: 004	Date risk identified April 2020	Date of last review:	February 2021
Risk Title: Due to the specialist nature of patients with a higher incidence of violence and aggression, if the Trust does not establish effective processes to prevent harm, ~~to staff from patients~~ then staff and/or patients may experience physical harm which could lead to high turnover, sickness absence, litigation and regulatory scrutiny.		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

Linked Operational Risks				Consequence	Likelihood	Rating
455	If controls are not put in place to manage violent and aggressive patients, then there is a risk to staff safety. (Neurology Division.)	12	Initial	Major 4	Almost Certain 5	20
			Current	Major 4	Possible 3	12
			Target	Moderate 4	Unlikely ~~2~~ 3	~~8~~ 12
Risk Appetite	Cautious					

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Physical Injury /- Emotional/psychological impact on staff and other patients - Low morale - Increased sickness levels - Litigation - Involvement with Regulators e.g. HSE, CQC, NHE/II - Increase in staff turnover	**Physical Assaults on staff** **2018/19** **Q1 = 45 Q2 = 34** **Q3 = 50 Q4 = 18** **2019/20** **Q1 = 27 Q2 = 45** **Q3= 40 Q4 = 29** **2020/21** **Q1 = 22 Q2 = 56** **Related Claims** 1 claim received in 2019/20 **Staff Survey (relating to staff reporting physical harm)** **2020 - 20.3% (**against the national average of 4.1%) **2019 - 22.3%** (15.25% higher than acute specialist sector average of 5. 7%) **2018 – 21.9%** (National average 2018 over 6.7%, compared to best performing Trust at 1.8%)

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Violence and Aggression Policy - approved Feb 2018 2. Lone Worker Policy - approved Feb 2018 3. Mental Capacity Act Policy - approved Jul 2019 4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach) 5. Security Function (ISS) 6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required 7. Personal Safety Trainer Programme of work Apr-2019 8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 9. Additional Consultant reviews RVs where V&A has increased 10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot) 11.Restraint Training rolled out in CRU	1. Lack of agreed KPI's within the Security Contract 2. Compliance with statutory and mandatory training 3. Restraint Training to be rolled out across all wards 4. **Psychologist sessions to be rolled out to all wards**
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – daily Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – bi monthly Violence and aggression Group – Transformation Board - monthly **Level 2** Annual Governance Report – Quality Committee Quality Dashboard – Quality Committee – monthly 2020 **Level 3** Staff Survey 2020 Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance Oct 2018 – actions completed Dec 2019 Quarterly review meetings with commissioners CQC Inspection Report 2019 Investors in People Health & Wellbeing Gold – re-accredited May 2019	1. Outcome of Shiny Minds App to be evaluated 2. Lack of benchmarking data across similar Trusts 3. Evaluation of LAST LAP (Looking After Staff That Look After People) initiative required 4. Outcome of Investors in People re-evaluation for 2020 not yet received

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

1	KPI's for the Security Contract to be developed and monitored by the Health Safety and Security Group	LS	~~End of Nov 19~~ Oct 2020	Delayed
2	Continued focus on statutory and mandatory training compliance Trust Wide – in line with new social distancing requirements	MG	End of March 2021	On track
3	Pilot of Shiny Minds App to be evaluated	MG	~~End of March 2020~~ ~~September 2020~~ December 2020	Delayed
4	Benchmarking of nurse turnover of similar Trusts across Cheshire & Merseyside	LS	End of Sept 2020	Complete
5	Roll out of Looking After Staff to Look after Patients to all wards	LS	End of Aug 2020	Not started
6	Audit of LASTLAP to be completed	LS	Jan 2021	Not started
7	Outcome of Investors in People to be reported	MG	Jan 2021	On track
8	Roll out of Restraint Training across all wards	LS	March 2021	**On track**
9	**Roll out of psychology sessions across the wards for staff health and well being**	**LV**	**March 2021**	**On track**

Risk ID: ID005	Date risk identified April 2020	Date of last review:	February 2021
Risk Title: If the Trust does not deliver the benefits identified within the Quality Strategy, then excellent patient and family centred care will not be sustained leading to potential harm, poor patient experience and reputational damage		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Best practice care
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Key objectives not met - Poor - patient experience - Reputational damage - Standards of care	1. Increase in reported deaths from 78 in 2018/19 to 92 in 2019/20. 2. An increase in the number of formal complaints received with 129 in 2019/20 compared to 95 in 2018/19 3. 1 Never Event – November 2019 4. 15 cases of E Coli against a threshold of 12 for 2019/20 5. Operation or procedure wrongly sited – December 2019 6. 2 Category 3 Pressure Ulcers – December 2019 / Feb 2020 7. Increase in Nosocomial Infections **Data to be updated to reflect relevant performance during 2020/21**

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

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Review of all Trust Strategies to ensure alignment of priorities in year 1/2	J Ross	~~April 2020~~ Aug 2020	Not started

2	Recruit to Tissue Viability Team or test alternative options to fulfill the role	L Vlasman	~~May 2020~~ Sept 2020	Completed
3	Transformation Board and reporting arrangements to be introduced	J Ross	~~February 2020~~ June 2020	Completed
4	On-going participation in discussions to ensure influence in future system wide plans	H Citrine	~~March 2020~~ March 2021	On track
5	Recruit to additional post within the IPC Team to lead on the response to Covid	L Vlasman	March 2021	On track

Risk ID: 006	Date risk identified April 2020	Date of last review:	February 2021
Risk Title: **If the Trust does not attract, retain and develop sufficient numbers of qualified staff, both medical and nursing, in shortage specialties, then it may be unable to maintain service standards leading to service disruption and increased costs**		**Date of next review:**	April 2021
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Workforce and Innovation

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning 2019 3. Five year education plan to ensure supply 2017 4. Quality Strategy Sept 2019 5. People Strategy revised in line with the national People Plan Sept 20 6. Staff Experience Action Plan Oct 20 7. Partnership working with universities to recruit newly qualified staff 8. Extension of apprentice roles July 2019 9. Involvement with Regional Talent Management Board 10. WCFT Health and Wellbeing Programme 11. NHSP Bank 12. Collaborative Bank within NWest 13. COVID-19 Recovery Plan 14. MoU across C&M in relation to staffing during COVID-19 15. National Nursing Bursary – 2020/21 16. Staff Survey regarding working during COVID-19 17. Agile Working Project 18. De-briefs following first wave of COVID 19. Mental Health First Aid Training 20. **Collaborative International Recruitment** 21. **Virtual recruitment days for Qualified Nursing staff**	1. Implications of Brexit i.e. Visas on recruitment not yet known 2. Changes to pension arrangements 2020/21 and implications for recruitment and retention still not understood 3. Traditional training no longer appropriate due to social distancing and therefore alternative delivery methods to be developed 4. Continued national shortage in supply of nursing staff 5. Lack of clarity regarding annual leave and TOIL nationally

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

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

Risk ID: 007	Date risk identified April 2020	Date of last review:	February 2021
If the Trust does not deliver the priorities within the Estates Strategy then the existing estate may not meet the needs of patients or support operational performance leading to poor patient experience and reputational damage and a building/ estate not fit for purpose.		**Date of next review:**	April 2021
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Operations and Strategy

Linked Operational Risks				Consequence	Likelihood	Rating
305	Legionella positive samples found in water outlets in Walton Centre.	16	Initial	Major	Almost Certain	
				4	5	20
301	Fire Safety Compliance	12	Current	Major	Possible	
				4	3	12
			Target	Major	Unlikely	
				4	2	8
Risk Appetite	**Cautious**					

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

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

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

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

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

Risk ID: 008	Date risk identified April 2020	Date of last review:	February 2021
Risk Title: **If the Trust does not maintain and improve its digital systems through implementation of the Trust's Digital Strategy, it may fail to secure digital transformation leading to reputational damage or missed opportunity**		**Date of next review:**	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:5	Adapt advanced technology and treatments enabling our teams to deliver excellent patient and family centered care.
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

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

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

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

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Outpatient Digital Group monthly Inpatient Digital Group – monthly – digital champions within the Divisions Clinical Systems Safety Group – monthly Digital Programme Board – bi-monthly IGSF –monthly **Digital Prioritisation Group - quarterly** Clinical Risk Group Executive Team review of C&M Hospital Cell Digital Objectives **ISMS Certification IS27001 accreditation September 2020** **Level 2** Quarterly updates on digital strategy progress to BPC **Specialist Trust Digital Group** **C&M CIO Digital Collaboration Group** **Level 3** Critical Applications Audit – Jan 2020 ePatient Neurophysiology system – Limited Assurance Jan 2020 Digital Matrix Index score 2018	~~The move towards remote working will present different challenges going forwards and require different types of support to ensure that staff are able to work offsite seamlessly. At the current time these challenges are not all known.~~ **Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives (to be completed and agreed Q1 2021/22).** **Awaiting final MoU from NHS Digital to approve access to the Digital Aspirant Programme along with associated funding.**

ISMS Certification IS27001 accreditation Aug 2019 Cyber security CertCare progress monitored by NHS digital Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to STP by C&M Digit@LL	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Approval of the milestone plan by Digital Programme Board	AN	~~April 20~~	Complete
2	Regular updates regarding the Trust's Digital objectives and alignment to the C&M Hospital Cell objectives around digital to Exec Team	MB	March 2021	On-track
3	**New Digital Strategy**	**MB**	**May 2021**	**Commenced**
4	**Digital Aspirant MoU signed by all parties**	**MB**	**March 2021**	**On-track**

Risk ID: 009	Date risk identified: April 2020	Date of last review:	February 2021
Risk Title: If methods of Cyber Crime continue to evolve then the Trust may receive a cyber-attack leading to service disruption, loss of data and financial penalties.		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Linked operational Risks		Consequence	Likelihood	Rating
~~None identified~~ **A cyber security attack could impact on a wide range of Trust operations / systems / processes depending on the area targeted.**	Initial	Major 4	Almost Certain 5	20
	Current	Major 4	Likely 4	16
	Target	Moderate 3	Possible 3	9
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of operational and clinical disruption or a ransom; - Potential financial loss due to loss of activity - Likely to lead to financial, business and operational impacts as well as reputational damage; - potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover - Non-compliance with Data Protection Laws/NIS Directive - Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.	Q1 72 Carecerts (3 High, 3 Medium,66 Low Level) Q2 67 Carecerts (6 High Level, 61 Low Level) **Q3 66 Carecerts (2 High Level, 64 Low Level)**

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 TIAG review of CareCERTs - Weekly Cyber Security Awareness Presentation to Executive Board - July 19 **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board July 2020 **Level 3** ISO27001 – accreditation August 2019 for 3 years MIAA audits of Data Security and Protection Toolkit –Jan 2020 - Substantial Assurance **(draft outcome Jan 2021 – Substantial Assurance)**	1. Cheshire & Merseyside system wide recovery response not tested 2. Third party assurances required regarding satellite sites 3. Ongoing work with NHS Digital to inform funding requirements

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Close working with MIAA to inform C&M system wide disaster recovery exercise	MB	~~Aug 2020~~ March 2021	On track

2	Cheshire & Merseyside Digital Cyber Group supporting work to establish 3rd party assurances of satellite sites. assurances of cyber security. Delayed due to change of working practice post Covid	MB	~~Aug 2020~~ March 2021	On track
3	On-going work with NHS Digital to inform funding requirements for Cyber Security post Covid	MB	~~Aug 2020~~ March 2021	On track
4	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid	MB	~~Aug 2020~~ March 2021	On track

Risk ID: 010	Date risk identified: April 2020	Date of last review:	February 2021
Risk Title:		Date of next review:	April 2021
If the Trust does not identify innovative methods of delivery then it will not maintain its centre of excellence status leading to unwarranted variation, increased costs and an inability to meet the future needs of patients.		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
• Inability to retain clinical staff if unable to fulfil their innovation/research ambitions • Ensuring sufficient workplace capacity to maintain innovative practices, treatments and boundary scanning • Ensuring that the inevitable financial **and Covid-19** pressures do not distract from the Trust's commitment to innovation • Challenging **risk aversion,** complacency and the status quo where employees become demotivated • Too many innovations that are not fully implemented, acknowledged and celebrated • The Trust's innovation agenda becoming weakened in an environment of meeting/emerging system change • Local and national political **developments** ~~drivers e.g. COVID-19, Brexit, Ministerial changes etc.~~	Initial	Major 4	Almost Certain 5	20
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
1. Trust reputational impact at a time of system change **and Covid-19 impacts** 2. Inability to **improve patient care and** deliver efficiencies 3. External scrutiny e.g. CQC well-led	Achievement of Innovation Strategy Objectives: • Short term (2019/20) **– Largely completed (some Covid-19 delays)** • Medium term (2020/22) **– Largely completed (some Covid-19 delays)** • Long term (2022/24) – **To be progressed**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Innovation Strategy 2019/24 2. Innovation Pipeline 3. Stakeholder Analysis 4. Innovation Strategy Communication Plan 5. ~~Initial infrastructure~~ **Development** of internal processes **/ information resources** to support innovation 6. Developing additional funding streams 7. **Investors in People accreditation (2020)**	1. Competitor Analysis to be completed **(to be finalized when Communications & Marketing Manager starts in March 2021)** 2. Wider consultation with Trust stakeholders still emerging and managed through the communications plan **(some Covid-19 delays. Consideration required on how best to involve patients in innovation decision making)** 3. ~~Innovation / innovative approach not currently a key requirement within business planning/business case methodology~~ 4. **Complex** alignment between Innovation and ~~Transformation needs defining~~ **other teams has progressed significantly but more work is needed** 5. **Multi-team working to improve consideration of innovations developed outside the Trust and address risk aversion** 6. Innovation processes. **guidance** and methodology not yet fully developed 7. Income generation model **(for the Spinal Improvement Partnership)** approved but contracts still being negotiated 7. ~~Work with Procurement, Service Improvement and clinical teams to develop processes to improve the consideration of innovations developed outside of the Trust~~

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Innovation Team Meeting – monthly • Medical Innovation Group – bi-monthly • **Regular innovation meetings with procurement, IT, IG, service improvement, clinical and other teams** • Executive Team approval of innovation business cases and initiatives **Level 2** • Innovation bi-monthly update to RIME Committee • RIME Committee Chairs Report to Trust Board • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • CQC Inspection report 2019 • CQC well-led criteria now includes innovation	1. ~~Innovation Working Group with wider membership needs to be established to formally review innovation activity – core group established with additional members invited as required~~. 2. ~~Workforce Innovation Group to be reviewed in light of alignment to Service Transformation agenda - workforce innovation and service transformation agendas aligned i.e. Agile Working Programme~~ 3. Benefit realization for innovative business cases not yet feasible due to limited ~~timescale~~ **time that Trust has had Innovation posts in place** 4. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency **and potentially commercial innovators** to identify appropriate process 5. ~~Investors in People accreditation for 2020~~

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Competitor analysis to be 1inalized and presented to Trust Board	DW&I/HCE&M	TBC (due to COVID-19)	On hold
2	~~Meeting to be undertaken with Service Transformation Lead to align innovation and service transformation agendas~~ **Further engagement of stakeholders through communication and engagement (including patient involvement)**	DW&I/**HCE&M**	~~July 2020~~ **Review progress Q3 2021/22**	~~Completed~~ **On track**
3	Benefits realization of Multitom Rax Business Case to be presented to Executive Team and Trust Board	DW&I	April 2021	On track

4	~~Establish Innovation Working Group~~ **Further development of innovation processes and guidance**	DW&I/**HCE&M**	~~July 2020~~ **Q3 2021/22**	~~Completed~~ **On track**
5	Peer Review/review process	DW&I/**HCE&M**	~~TBC(due to COVID-19)~~ **Q3 2021/22**	~~On hold~~ **On track**
6	Income generation initiative **(Spinal Improvement Partnership)** being prioritised	DW&I/HCE&M	~~October 2020~~ **March 2021**	On track
7	Investors in People Assessment	DW&I	October 2020	**Completed**

Risk ID: 011	Date risk identified: April 2020	Date of last review:	February 2021
Risk Title: ~~If the Trust does not establish effective partnerships within the health economy then it may be unable to influence the future development of local services, leading to unintended consequences for the sustainability of the Trust~~ **Establishment of a Cheshire & Mersey ICS will change the external landscape and how the Trust operates and influences within Cheshire and Merseyside with a potential risk that this could have a negative effect on the Trust.**		**Date of next review:**	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Strategic Priority:	All Strategic Priorities
		Assurance Committee:	Trust Board
		Lead Executive:	Chief Executive

Linked Operational Risks		Consequence	Likelihood	Rating
~~None identified~~ **Potential link to all high level operational delivery risks**	**Initial**	**Major** **4**	**Almost Certain** **5**	**20**
	Current	**Major** **4**	**Possible** **4** **3**	~~**16**~~ **12**
	Target	**Major** **4**	**Unlikely** ~~**3**~~ **2**	~~**12**~~ **8**
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
~~Failure to deliver objectives~~ ~~Reputational damage~~ **Potential reduction of Trust autonomy with a consequent impact on delivery of objectives.**	Hospital Cell and Governance arrangements determined at regional level without consultation Changes in national policy due to COVID-19

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Trust Strategy 2019-2023 ~~2. Stakeholder Analysis~~ 3. Communication and Engagement Strategy 2020 4. Active membership of Cheshire and Merseyside Health Partnership (C&MHCP) and Collaboration at Scale Programme 5. Member of Liverpool Health Partnership 6. **Member of Liverpool PLACE** 7. Member of Trauma ~~Network~~ **Partnership** 8. ~~Member of Out of Hospital Cell Group~~ **CEO one of 4 CEOs leading In Hospital Cell** 9. Membership of Specialist Trust Alliance 10. Medical Directors Group STP level 11. Chief Operating Officer Group STP level 12. Membership of DOFs Group STP level 13. Management Side Chair of NW Staff Partnership Forum 14. **Membership of Director of Nursing Group STP level** 15. **Membership of Director of Workforce Group STP level** 16. **Neuroscience Programme Board – Quarterly** 17. **Revised MoU provides for Specialist Trusts to have 1 x Chair and 1 x CEO representative on the HCP Board which will aid influence**	1. Hospital Cell and Governance arrangements ~~provide authority to larger providers~~ **potentially result in greater influence for larger providers** 2. Financial arrangements now determined across STP level 3. **Clarity on the ability of Provider trusts to influence future ICS arrangements** 4. **Completion of review of Stakeholder Analysis** 5. **Lack of clarity on planned legal challenges and full details of White Paper**

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

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

Risk ID: 012	Date risk identified: April 2020	Date of last review:	February 2021
Risk Title: If the Trust does not maintain and grow the Trust's research and development agenda it may negatively impact upon its centre of excellence status leading to loss of income, reduced profile and inability to recruit/retain the most ambitious clinical staff.		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research, Development & Innovation (RD&I) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
• Ensuring sufficient workplace capacity and capability to maintain, grow and develop the research function • Establishing a sustainable financial model that balances income streams, notably commercial income • Inability to secure sufficient grant based funding • The Walton Centre brand not aligned to research ambitions and/or not strong enough to attract commercial sponsors • Portfolio of research not aligned to key strategic priorities for the Trust (e.g. spinal centre of excellence developments) or for the region given key needs in neuroscience related ill health (e.g. neurological disability in early life, chronic pain, neurodegeration) • Competing and emerging system change • Local and national political drivers e.g. COVID-19 and in the short term, the implications of Brexit negotiations on promoting/ attracting research	Initial	Major 4	Almost Certain 5	20
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Cautious**			

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

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

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

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

Risk ID: 0013	Date risk identified October 2020	Date of last review: February 2021
Risk Title: There is a risk that the allocation of capital set by the STP to the Trust will not support the full capital plan for 2020-21 **There is therefore a risk that the Trust will overspend the capital allocation or defer schemes which may result in maintenance and revenue costs or deterioration of the Estate.**		**Date of next review:** April 2021
		CQC Regulation: 17 Good Governance
		Ambition: Be financially strong and invest in services
		Assurance Committee: Business Performance Committee
		Lead Executive: Director of Operations and Strategy

Linked Operational Risks		Consequence	Likelihood	Rating
None Identified				
		Moderate	**Possible**	
	Initial	**3**	**3**	**9**
		Moderate	**Possible**	
	Current	**~~4~~ 3**	**~~4~~ 3**	**~~16~~ 9**
		Moderate	**Possible**	
Risk Appetite	**Target**	**3**	**3**	**9**

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on STP footprints and based on the Trust's initial capital plan (not final). The plans were oversubscribed and therefore there was no opportunity for the trust to submit a higher final plan (given the planning round was suspended due to Covid-19). - On-going replacement equipment will not be able to be paid through capital given the Trust's Capital Resource Limit (CRL) has been set at £4.0m; - Any overspend on capital against out CRL will need to be covered by the other Trusts in the STP (reducing their ability to spend capital); - Impact on revenue budgets should there be a risk to patient safety;	Between the draft plan and the intended final plan submission, some additional material capital requests have been raised. The Trust was provided with additional CRL in 2019/20 and spent in line with this; however it will not have the flexibility to do this in year and has competing requirements as well as committed schemes totaling c£3.8m which gives it minimal flexibility at all in the management of the programme.

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular forecasting of the capital position between Finance and the key stakeholders to understand the latest projected year end spend. Capital Management Group – discusses any capital expenditure up to £50k and includes work around prioritizing schemes when there are pressures on the budget /forecast. Business case and approval process at this forum to manage value for money. **Level 2** Executive Team - Expenditure up to £100k is approved through this group with regular updates on the capital programme presented. Business case and approval process at this forum to manage value for money. **Level 3** Business Performance Committee / Board – capital plan approved and all cases >£100k ~~<£250k~~ **£500k** are approved by BPC and above ~~£250k~~ **£500k** are approved by Board. **Participation in the regional Directors of Finance meeting.**	1. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend. 2. Priorities may change in year which may lead to pressures against the plan. 3. Market prices may differ from estimates once equipment is purchased. 4. 2020/21 planning process suspended so unable to submit a final capital plan. Process managed through STP. 5. **Assurance on ability to spend balance of allocation during Q4 2020/21**

Corrective Actions:	**Action**	**Forecast**	**Action**

To address gaps in control and gaps in assurance		Owner	Completion Date	Status
1	Long term capital plan to be completed to ensure all requirements and replacements known	DoF/DoSO	31 Mar 21	On track – continuous review
2	Operational Management Board to help manage priorities and help to manage demand	DoS		Completed
3	Ensure that maintenance contracts are all up to date so equipment covered	DoF/SoSO	Ongoing	On track
4	Regular capital forecasts to provide up to date position on the year end projections	DoF	Ongoing	On track
5	Continued discussions with STP DoF to ensure aware of capital pressures and so allocations forthcoming as required from other provider underspends.	DOF	Ongoing	On track

Risk ID: 0014	Date risk identified October 2020	Date of last review:	February 2021
Risk Title: If the Trust does not deliver the financial plan for 2020-21due to the changes in the financial framework and the impact of Covid-19 then it will fail to meet its financial duties and may be unable to deliver its strategic objectives leading to regulatory scrutiny		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Underlying Operational Risks		Consequence	Likelihood	Rating
None Identified	Initial	Major 4	Likely 4	16
	Current	Major 4	Unlikely ~~Possible~~ 2~~3~~	8~~12~~
Risk Appetite	**Cautious**	Target Major 4	Unlikely 2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Financial risk rating may decline and lead to increased regulatory scrutiny • Potential breach of statutory duties • Inability to deliver strategic objectives • Loss of decision making responsibilities	~~Currently forecasting a year end deficit of £1.5m – this has not been formally accepted as a final position.~~ **Original plan submission of £1.5m deficit. Given overall C&M position, HCP were requested to improve the position. Currently (M10) forecasting a year end surplus of £0.5m for HCP submission. This position could change depending on performance in M11-12 (including uptake of further activity.**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Financial plan submitted for 2nd half of year 2020-21 - October 20 2. Capital Programme – approved by HCP August 20 **and regularly monitored by Capital Management Group** 3. Finance and Procurement Strategy – approved July 2019 4. Budgetary Control Process including run rate information - monthly 5. Standing Financial Instructions (SFI's) & Scheme of Reservation and Delegation – approved ~~Oct 2019~~ **November 2020** 6. Divisional Finance meetings to highlight on-going financial issues - monthly 7. Block Contract in place due to COVID-19 **(to remain in place for Q1 2021/22 and may be extended to Q2)** 8. **Current allocations in second half of year are improving the Trust's position against plan/forecast.**	1. Financial plan not approved – overall balance at HCP level so further submissions likely to be required; **Overall HCP financial plan not approved. Ongoing forecast submissions have been required on a regular basis to assess closure of the financial gap.** 2. Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21 – run rates only a guide rather than a control; 3. Block contract based on 19/20 values and not fully representative of 20/21; **Given that the block contract will remain in place for Q1 2021/22 it is currently not clear whether the block contract values will be amended and whether they will be representative of 2021/22 given the intermittent stop/start of elective activity and potential ongoing Covid requirements** 4. **Formal p**lanning approval governance processes not in place due to rapid turnaround of submissions; ~~5. Elective incentive scheme may result in loss of income to the Trust which is not factored into the current deficit position;~~ 6. QIP plan ~~may still~~ **will** be required **in 202/22** to close the gap to individual plans **(although value not yet clear)**. Planning delayed due to pandemic response **(until at least Q2 2021/22)**; 7. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance 8. **NHSE/I negotiated a reducing contract value with Wales as activity reduces in tranches of 25%. This could reduce payments should lockdown mean that activity is cancelled.**

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monitoring expenditure and income against budgets via Finance Covid allocation to recover directly related costs Bed Management Meetings – daily Performance Management Review meetings – monthly Executive review of financial position ~~and recovery plans – weekly~~ **monthly** NHSI/E review of financial position ~~and recovery plans – weekly~~ **on a regular basis** **HCP review of system-wide financial position – monthly** **Level 2** Integrated Performance Report – monthly review by Business Performance Committee Integrated Performance Report – review by Trust Board each meeting	1. Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21; 2. Financial Framework suspension means Trust not being managed via regulator directly but through system / regional approach which is reviewing overall balance; 3. Covid expenditure audit by external party yet to be carried out so unsure if any expenditure will need to be repaid; 4. **Covid cost allocation insufficient to cover actual costs incurred.**

Financial Plan **2021/22 internal business planning being undertaken despite national delay in business planning** ~~Update on Recovery Plan reviewed by BPC Jan 2020~~ ~~Weekly review of Recovery Plan by Execs~~ **Level 3** Internal Audit review of Accounts Payable – ~~High Assurance – Apr 20~~ **Substantial Assurance Jan 2021** Internal Audit review of Accounts Receivable – High Assurance – ~~April 20~~ **Jan 2021** Treasury Management Review – High Assurance – ~~April 2020~~ **Jan 2021** Internal Audit review of General Ledger – High Assurance ~~April 2020~~ **Jan 2021** Internal Audit review of Budgetary control (including CIP) – high assurance - ~~April 2020~~ **Jan 2021** Internal Audit review of financial reporting – High Assurance – April 2020 ESR Payroll – Substantial Assurance – April 2019 GIRFT Review – Spinal Contract Review Meetings with Commissioners – bi-monthly Internal Audit review of coding systems – Substantial assurance – Dec 19	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	~~Weekly~~ **Bi-monthly** update to Finance NED to ensure NEDs are kept up to date with latest finance requirements	DoF	March 2021	On track
2	DoF on HCP planning group weekly calls	DoF	March 2021	On track
3	Raising issues with non-English commissioners to NHSI/E	DoF	March 2021	On track

Risk ID: X1	Date risk identified: December 2020	Date of last review:	February 2021
Risk Title: Ongoing capability to deliver Medical Education.		Date of next review:	April 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Lead research, education and innovation, pioneering new treatments nationally and internationally
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Director of Workforce and Innovation

Linked Operational Risks		Consequence	Likelihood	Rating
•	Initial	Major	Almost Certain	
	Current	Major	Possible	
	Target	Major	Unlikely	
Risk Appetite	Cautious			

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

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Neurology registrar engagement in undergraduate education is encouraged and facilitated. They attend the UG operational working group and support the undergrad programme facilitating and developing aspects of the timetable. These measures engage junior doctors and ensure they are developing an appreciation for education delivery. They are encouraged to develop as educationalists by senior colleagues and for those that remain at the trust will be supported by CSD to hone experience as they progress. We have evidence this approach is successful by the appointment of a former trainee to the role of deputy CSD, other registrars due to be appointed who demonstrate interest in contributing to education which will be supported by the ed team Students and doctors in training have been able to remotely join teaching via MS teams and Zoom. Feedback has been good suggesting delivery has been successful. **Level 2** **Level 3**	1. Medical Education Committee now reports to RIME and will provide quarterly performance updates as well as an annual report of activity as a means to assure the Board of activity and performance against the HEE Quality Framework. This is a new relationship and the effectiveness will be evaluated over the next year.

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

Covid 19 Risk Register
Date report produced 24.02.2021

ID	Opened	Source of Risk	Risk Description	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
806	01/10/2020	Business Continuity	**If school children are sent home due to displaying Covid 19 symptoms, parents will need to self-isolate for 14 days and children will need to be swabbed then there is a risk of reduced staffing in all areas of the trust during this period of time.**	Moderate	Almost Certain	High 15	1.Systems in place for the swabbing of children including a SOP 2. No children under the age of 2 to be swabbed at the trust 119 to be used for this group of children. 3. Support provided to the management of swabbing arrangements and outpatients department 4. Daily staffing and bed meetings to manage safe staffing. 5. Daily safety huddle and daily command and control. 6. Daily communications 7. Close working with NHSP 8. Close working with the bed management team to ensure we are using bed capacity appropriately 9. Redeploying staff across all areas.	1. Reliance on bank and agency and redeployment of staff. 2. Dependant on LUHFT for swab results. 3. Shifts not covered low fill rates.	1. Team in place for managing and arranging the swabs and the governance around this 2. SOP in place. 3.Daily safety huddle / command and control.	1. Being able to manage the amount of children sent home from school and the reduction in staffing. 2. Reduced capacity in the lab to process the swabs and delays in results and further delays in getting staff back to work.	1. Continue with daily safety huddle, command and control and bed meetings 2. Working closely with NHSP to see if all staff can be registered on NHSP 3. Ensure SOP is used and staff are compliant 4. Work closely with LUHFT to ensure that the text messaging service is in place	01/03/2021	Deputy Director of Nursing & Governance
793	07/07/2020	Business Continuity	**If increased cancellations, capacity/demand and limitations on the number of patient visitors continue, due to Covid-19, then there is a risk of poor patient experience and outcomes.**	Moderate	Almost Certain	High 15	1. Divisions working towards getting back to normal activity - via telephone/video consultations in order of patient need. 2. New telephone line in PACs recording calls. 3. Any identified themes and trends are escalated to Deputy Director of Nursing and Governance and Director of Nursing and Governance. 4. Patients receive regular updates and communication from the division. 5. Visiting continues to be restricted due to the increased levels of Covid 19 across Cheshire and Merseyside	1. As this is a new risks there are currently no identified gaps. Will continue to monitor.	1. Patient Experience Team escalating all new concerns/complaints on a weekly basis in a weekly meeting with both Divisions. 2.Regular communication with patients and families from the Division. 3. Calls to loved ones campaign initiated by the Divisional Nurse Directors using Ipads, mobile phones and social media.	1.Will continue to monitor for gaps in assurance, currently none.	1. None currently identified.	31/03/2021	Deputy Director of Nursing & Governance
807	01/10/2020	Business Continuity	**If compliance with the 2 metre social distancing rule is not adhered too, then there is a risk of staff contracting Covid 19.**	Major	Likely	High 16	1.All staff are provided with appropriate PPE 2.Social distancing is enhanced in all staff rooms 3.Posters and floor markings are in place 4.Patient day rooms are now in use for staff to be able to manage breaks across 2 areas to support with social distancing 5.Staggered break times 6. Additional staff areas i.e. marque sort to support social distancing during staff break time.	1.Non-compliance with IPC control measures	1.Continuous promotion of IPC guidelines 2.Managers working with the areas to ensure social distancing is maintained 3.Daily safety huddle 4.Daily walkabout to monitor the use of PPE 5. Observational audits by the IPC team.	1.Non-compliance with IPC guideline and social distancing	1.Continue with promotion via daily safety huddle 2.Regular communications reminding staff of PPE guidance 3.Managers to review all of their break areas to ensure they are compliant with social distancing 4. Additional areas that can be used for breaks to be implemented into break areas.	27/03/2021	Deputy Director of Nursing & Governance
813	15/10/2020	Business Continuity	**If the Walton centre is required to support the C&M system with capacity there are several associated risks including training and development – staff may not be experienced in caring for and managing different conditions. Neuroscience patients will have reduced access to services and will wait longer.**	Major	Likely	High 16	1.Support system decision making ensuring clinical outcomes are taken into account. 2.TWC CEO is part of the hospital cell 3.TWC MD participates in a weekly call 4.TWC director of operations supports all regional calls 5.Phase 3 plans submitted	1. Overall decision making is made at a system level	1. Commissions aware of TWC clinical decision making and current waiting list size they are supportive are continuing with elective activity Discussions taking place with LUFT about available capacity that would support the system with minimal impact on neurological patients.	1. none currently identified.	1. Currently none identified	01/03/2021	Deputy Chief Executive
796	13/07/2020	Business Continuity	**If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19.**	Major	Likely	High 16	1.Implementation of national guidance to reduce nosocomial infections 2. COVID-19 screening regime 3. Infection Prevention Policies and SOPs. 4. Daily updates via safety huddle and communication bulletin 5. Compliance with Operating framework for urgent and planned services within hospitals 6. Chavasse is designated RED ward 7. SBARs and action plan 8. Observations of PPE	1. Potential for asymptomatic Covid-19 positive patients to be admitted to trust 2. Non compliance with IPC control measures. 3. Communication process between transferring organisations	1. SITREP to NHSE/I 2. Surveillance outcomes 3. Screening programme 4. Covid-19 BAF 5. Covid-19 dashboard	1.Non compliance with IPC interventions as per guidance 2.potential of importing COVID-19 cases from the community 3. Delay in transferring symptomatic patients to Chavasse	1.Outbreak meeting held daily as required. 2.Rescreening of patients then repeat screening in 5 days then at 14 days to enhance detectability. 3.Enhanced staff and patient screening 4.Admitted patients must be symptomatic or positive to move onto Chavasse ward (reinstate Chavasse as the red status ward). Symptomatic patients to remain in amber bay 5. Staff breaks reviewed to enable social distancing 6.Ensure enhance cleaning is completed (2 stage process) 7.Daily meeting to be held in the boardroom 9am (1/2 hour) – bed managers to maintain ward patient status on the wall. 8. Continue to liaise with PHE 9. Ensure 2 metre guidance is adhered to.	29/03/2021	Lead Nurse Infection Prevention & Control/Tissue Viability
797	13/07/2020	Risk Assessment	**If controls are not put into place to prevent surgical face masks being used for self-harm attempts of suicide, there is a risk to patient safety.**	Catastrophic	Unlikely	Mod 10	1. Patients monitored and observed closely. 2. Any concerns escalted appropriately. 3. Neuropsychiatry and Neuropsychology input when required 4. Masks only used within clinical areas.	1. No gaps in controls, storage space to be provided for surgical masks to ensure they are placed in a safe storage area.	1. No incidents to date August 2020. 2. Neuropsychiatry service monitored and manages any risk identified.	1. Patients may not express suicidal tendencies.	1. None currently identified	25/03/2021	Neuropsychiatry Specialist Nurse

ID	Opened	Source of Risk	Risk Description	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
827	13/01/2021	Business Continuity	**If the level of activity associated with Welsh specialist activity fall below 25% of prior year levels there is a financial risk to the Trust due to the national agreements put in place (where a percentage of block income will be withheld dependant on the reduction in activity levels). It is more likely that activity will fall below the agreed levels as a result of the 3rd wave of COVID-19 as elective activity is likely to be cancelled to help the region wide response to the pandemic). There is also a financial risk to the Trust if IOM related activity reduces materially (as the IOM administration is paying for activity undertaken).**	Moderate	Likely	Mod 12	1.NHSE/I have agreed a payment mechanism with Wales for months 7-12 which means that block income will be received but with income being withheld if activity falls below agreed percentages compared to last financial year. 2.Close monitoring of activity levels compared to last financial year. 3.On-going dialogue with NHSE/I around the national agreement (and amounts of income withheld if activity falls below certain levels) given the 3rd wave of COVID currently being experienced (and requirement to cancel elective activity to support the region). 4.The Trust has implemented a number of new ways of working to meet COVID guidance including Telehealth.	1.IOM & Welsh affordability likely to be more of a problem going forward and strength of relationship cannot mitigate this. 2.Requirement to cancel elective activity to support region wide response to 3rd wave of COVID-19. 3.Patients unwilling to attend appointments due to fear of COVID-19. 4.Patients access to digital technology. 5.Reduced capacity due to social distancing/ IPC requirements.	1.Regular review of risks at Board level and on-going review of mitigations 2.Monthly report to BoD and BPC regarding income position and any issues with commissioners 3.Regular updates to BPC 4.On-going dialogue with NHSE/I 5.On-going communication with commissioners	1.Uncertainty whether financial framework will be amended as a result of wave 3 covid 2.Uncertainty of financial framework post March 2021 3.We have no control over the NHSE/I decisions around the financial framework going forward 4.Previously agreed contracts unlikely to be honoured 5.IOM have stated that they will only pay on a PBR basis	1.Risk will continue to be monitored by Board of Directors and through Business Performance Committee 2.Continue to discuss risk around Wales financial agreement with NHSE/I 3.Financial modelling of finances to be carried out once new financial framework is published 4.Year end financial forecasts regularly undertaken to understand potential financial risks	31/03/2021	Deputy Director of Finance
810	09/09/2020	Adverse Event /Incident	**If a neurosurgical registrar were to test positive for COVID then there is a risk that the on call system could collapse. This is due to the office space being too small to accommodate social distancing.'**	Major	Possible	Mod 12	1. Registrars to wear masks 2. Meetings via MS Teams to minimise face to face attendance 3. Shared desks in secretariat	1.Mask wearing during breaks	1. None currently identified.	1. None currently identified.	1. None Currently identified.	31/03/2021	Divisional Director of Neurosurgery
812	15/10/2020	Business Continuity	**If staffing levels decrease, then there is a risk to staff's health and wellbeing and work life balance not being maintained.**	Major	Possible	Mod 12	1. Well established health & wellbeing programme 2. Shiny minds resilience app available for staff 3.Closed staff Facebook for mutual support 4.Regional/National helpline 5.Trust 24/7 counselling 6. Mental Health First Aid training has commenced. 7. Access to Cheshire and Merseyside Resilience Hub	1. No face to face support.	1.Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. 2.Work with NHSP to ensure gaps are covered 3.Testing capacity is sufficient to date.	1. Ability to manage absences across the Organisation	1. On line training for Mental Health First Aiders 2. Debriefs to learn lessons 3. Review of health and wellbeing communications 4. Daily safety huddles, and tactical command groups	25/03/2021	Deputy Director of Workforce & Innovation
798	20/07/2020	Business Continuity	**If staffing levels are unable to be maintained within the Pathology departments, as a result of Covid 19, there is a risk to service delivery.**	Moderate	Likely	Mod 12	1. Environmental risk assessments detailing social distancing and other measures to reduce risk of transmission of Covid-19 while working in the laboratory. 2. Neuroscience Labs Business Continuity Plan in place.	1. Many measures in place however cannot guarantee elimination of transmission risk. 2. Track and trace may require all staff within each department (Neuropathology or Neurobiochemistry/Neuroimmunology) to self isolate even with safety measures in place. 3. BCP does not take into account loss of ALL staff within the department.	1. None currently identified.	1. None currently identified.	1. None currently identified.	29/03/2021	Quality & Governance Manager The Neuroscience Laboratories
783	05/05/2020	Business Continuity	**If the Covid-19 pandemic continues for an extended period, then there is a risk to staff safety following evidence indicating Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected by Covid-19.**	Major	Possible	Mod 12	1. Staff will be advised to follow guidance on shielding as and when appropriate. These employees cannot remain in work during this time, but if well, may wish to explore home working. 2. Adjustments to working practices may include working remotely or moving to a lower risk area. 3. Actions to be taken for staff will depend upon their medical condition and how stable it is. 4. Where a condition is unstable and there may be an increased risk to staff, Managers may seek support from the Occupational Health & Wellbeing Team and/or HR. 5. Staff redeployed or working from home will be fully supported in completing their role. 6.BAME staff have been offered access to the vaccine as a priority.	1. Currently no gaps in controls	1.Risk Assessment Guidance - COVID-19 made available via communications to staff. 2. All BAME staff have received an individual letter with a risk assessment attached asking them to discuss with their manager. 3. All managers have been asked to ensure they proactively speak to all of their BAME and vulnerable staff to complete a risk assessment 4. Decisions about possible redeployment, special leave, working from home will be agreed with the individual based on the results from the risk assessment 5. monitor uptake of vaccine.	1. The possibilities of remote working for clinical staff are reducing . Opportunities for redeployment to a lower risk area are reducing	1. Risk Assessments for all vulnerable staff are now completed . Actions taken for individual staff will depend upon the outcome from the risk assessment.	30/03/2021	Deputy Director of Workforce & Innovation
779	20/04/2020	Business Continuity	**If an increased demand for oxygen supply continues across the Trust (supplied by Aintree University hospital), due to Covid 19, then there is a risk that oxygen supply to patients may be affected.**	Major	Unlikely	Mod 8	1. Liaison with Aintree to keep consumption levels under review 2. Increased monitoring 3. Increased deliveries from O2 supplier 4. clinical and estates co-ordination	1.Unknown escalation of COVID-19 patients requiring oxygen support 2. Walton Centre dependent upon Aintree Hospital bulk liquid oxygen supply	1. LUH document "oxygen infrastructure review - COVID-19 clinical scenario response" 2. Regular readings taken from back-up oxygen manifold. 3. Feedback from Aintree re:site wide situation and Walton Centre consumption. 4. Predicted calcs undertaken between S Shaw / S Holland & Mike Hill 5. Regular contact between Command and Control, Estates team, Risk team and Anaesthetics team 6. Back up/resilience plan in place 7. Various NHSEI Cas Alerts	1. Aintree Hospital back up plan involves moving Walton Centre onto "older" bulk oxygen supply which is normally reserved for resilience. This may compromise our system resilience options	1. Close communication between Aintree and Walton Centre Estates teams 2. Continual monitoring of VIE and back up supply 3. local agreement with oxygen supplies for top up of VIE and bottle exchange/delivery, as needed 4. Increased maintenance 5. close liaison between clinical and estates teams	30/03/2021	Estates Manager
774	08/04/2020	Business Continuity	**If staffing levels within the Material Management Team are unable to be maintained, as a result of covid 19, then there is a risk to transfers of supplies to clinical areas and service delivery.**	Major	Unlikely	Mod 8	1. Staff situation is monitored by Acting Head of Procurement and Head of Materials Management on a daily basis to ensure that there are sufficient staff to manage delivery of stocks onto wards and clinical areas. 2. A number of finance staff are also being trained in materials management so that they can cover staff absence if required 3 .Ordering of stocks can be done remotely	1. No gaps in controls	1. Deputy DoF constantly monitoring staff situation and ensuring that staff are trained to support this area	1. Given the high infection rate if a number of cover staff from other departments are also unable to support then this may delay stock put away	1. Continue to expand the pool/resource of staff that are trained to cover with stock put away duties.	28/03/2021	Deputy Director of Finance

ID	Opened	Source of Risk	Risk Description	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
775	20/04/2020	Business Continuity	**If safe staffing levels are unable to be maintained as a result of Covid 19, then there is a risk to patient care.**	Moderate	Possible	Mod 9	1. Specialist Nurses working on wards. 2.Other clinical staff supporting ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3.Admin staff redeployed where possible, register of staff who can support the wards held centrally. 4. Working closely with NHSP. 5.Considering staff from national Bring Back Staff campaign. 6.Staffing reviewed through Command and Control twice daily	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness or may need to return to their own areas of work	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Work with NHSP to ensure gaps are covered	1. Being able to manage absences across the organisation. External factors i.e. no summer school clubs for child care	1.Daily Huddle. Command and Control room. 2. Daily review of staffing. Redeployment register held centrally. 3.HR team supporting ward managers with management of absences. 4. Local and National Health and Well being programme of support in place. 5.Daily communications to staff. 6. Donations being received for staff	31/03/2021	Deputy Director of Workforce & Innovation
773	08/04/2020	Business Continuity	**If supplies of PPE equipment continue to be of short supply nationally, then the Trusts may not have sufficient PPE for staff to treat patients.**	Moderate	Possible	Mod 9	1. Trust stock levels are now stable, the Trust has additional reusable PPE and clinical consumables. 2. Nationally this is recognised as an issue. This has resulted in the introduction of a national stock recording and ordering system. 3.Regionally Trusts are working together and ensuring that orders of stocks are being received and distributed. 4. A 'mutual aid' system has been implemented across C&M to enable Trusts to share stock where there are shortages. 5. Daily stock returns (including usage levels) are submitted to NHSE and C&M collaborative. 6. WCFT is also working closely with other Specialist Trusts to ensure that all organisations have equitable share of supplies (e.g. WCFT have received a supply 8833 3M masks from Bridgewater and CWP).	1. Trust dependant on the Department of Health/NHSE for deliveries of PPE and critical consumables. The situation has improved in the past months with daily deliveries of PPE. Daily monitoring of stock levels and usage help identify potential shortages in advance.	1. Deliveries for Covid stock are now reaching the Trust, due to increased availability on a national basis. 2. Head of Procurement and Head of Materials Management are in constant contact with Supply Chain and also wards to ensure that stocks are kept as complete as possible moving to a 'push model' of supply (supplying people who need it). 3. Sufficient stock for the majority of PPE items are now received with other key items being monitored on a daily basis. 4. Daily stock levels (and usage) provided to NHSE and C&M collaborative to ensure that all Trusts have adequate stocks (through a mutual aid scheme). 5. Shortages are raised via NHS England's National Supplier Disruption Service to ensure stocks do not deplete.	1. Central Teams/MOD determine PPE to be delivered by Push, therefore they do not always supply the required PPE. Global shortages for specific PPE with no suitable alternative e.g. FFP3 3M 8833 masks. Lack of freedom to source PPE through local procurement as items will be provided through the national route. PPE shipments will not be guaranteed to support increased activity within the Trust. 2. PPE shipments may not be guaranteed to support increased activity within the Trust.	1. In partnership with other Trusts/Social Care etc., potential to work collectively to develop the local PPE supply chain to mitigate risks (in support of anchor institution objectives).	30/03/2021	Deputy Director of Finance
808	01/10/2020	Business Continuity	**Neurology Division - If safe staffing levels are unable to be maintained as a result of COVID 19, then there is a risk to patient care and activity performance within the Neurology division. This includes staff absences due to childcare i.e. children being sent home from school with or without symptoms.**	Moderate	Possible	Mod 9	1. Redeployment of Specialist Nurses working on wards. 2. Identified other clinical staff suitable to work in ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3. Admin staff redeployment where possible, register of staff who can support the wards held centrally 4.Working closely with NHSP. 5. Ward staffing reviewed through daily bed meeting. 6. Testing capacity for household members. 7. Established rotation of working from home practices for key admin staff. 8. Cross Divisional weekly activity performance meeting. 9. Virtual, telephone and face to face outpatient activity in place aligned to phase 3 guidance.	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness/childcare responsibilities/self isolation or may need to return to their own areas of work. 2. Outpatient activity ceasing if COVID surge happens, there is a risk the medical and specialist nurses will be needed to increase staffing numbers in ward areas.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Wards working with NHSP to ensure gaps are covered 2. Testing capacity is sufficient to date. 3. No externally reportable activity breaches.	1. Being able to manage absences across the divisional admin and clinical teams. 2. External factors i.e. school clubs for child care / children being sent home from school.	1. None currently identified.	25/03/2021	Divisional Director of Neurology

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

Report to the Board of Directors
Date: 4th March 2021

Title	**Cheshire and Merseyside Health and Care Partnership – Memorandum of Understanding**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	
Executive Summary The purpose of this report is to seek an endorsement from the Board of Directors for the latest version of the Cheshire & Merseyside Health & Care Partnership (HCP) Memorandum of Understanding (MoU).	
Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	There are no associated legal implications and/or regulatory requirements at the current time.
Action required by the Board	The Board of Directors is recommended to: a) receive the report and note the HCP correspondence and associated documents included at Appendices 1-3. b) confirm adoption of the HCP Memorandum of Understanding v8 included at Appendix 4.

1.0 Introduction

The purpose of this report is to seek an endorsement from the Board of Directors for the latest version of the Cheshire & Merseyside Health & Care Partnership (HCP) Memorandum of Understanding (MoU).

2.0 Background

Mr A Yates, HCP Chair, had sought to engage members of the Partnership in discussion and engagement on the content of the draft MoU in early December 2020. Feedback from this engagement was subsequently considered by the HCP Board on 27 January 2021. Mr A Yates then wrote to members of the Partnership on 2 February 2021 providing a summary of the matters discussed by the HCP Board together with copies of the documents considered by the Board. Also included was a document which sets out a number of areas for further work together with a description of how the Partnership will progress the areas or support dialogue. These documents are included for reference as appendices to this report as follows:

- Appendix 1 – Cheshire & Merseyside HCP Letter dated 2 February 2021
- Appendix 2 – Summary of actions and commitments
- Appendix 3 – Report to HCP Board on 27 January

The letter from Mr A Yates dated 2 February 2021 concluded with a request for members of the Partnership to adopt the MoU and confirm their intentions by 12 March 2021. The HCP Board would then receive an update on partner intentions at their March 2021 meeting.

3.0 Current position

Review of the Partnership MoU coincided with the publication of the NHS England/Improvement (NHSE/I) consultation on Integrated Care Systems. As set out in the HCP letter of 2 February 2021, the MoU is not designed to respond to the points raised in the NHSE/I consultation, but provides a foundation and shared understanding from which to explore ICS developments and implications.

The MoU has previously been approved by the Board and the current draft document (v8), included at Appendix 4, mainly incorporates minor editing changes on points of accuracy or clarification, although two distinct areas have been updated as follows:

- Section 3.2.1.4 Active Members of our Communities – This new section has been added to signpost the ambition of the partnership and organisations within the system to the sustainability agenda, social value and the powerful role and potential that public sector organisations can play in their communities.
- Annex 6 – This section details proposed membership of the Partnership Board.

Board members should note that Annex 6 provides a degree of assurance that the interests of specialist trusts will be represented at the Partnership Board with the incorporation of a specialist trust Chair and Chief Executive as members of the Board. The Chief Executive is currently engaging with colleagues from the other specialist trusts to determine who the representatives on the Partnership Board will be.

The overall content of the current version of the MoU is consistent with the intentions of Partnership members and adoption by the Board is recommended.

4.0 Conclusion

It is evident that development of the MoU is taking place in an environment characterised by uncertainty and expected change. Of equal importance to the MoU is the broader direction of travel for ICS development, particularly given release of the Government White Paper in early February 2021. Consequently, the HCP has committed to a further review of the MoU no later than six months into 2021/22.

Following the meeting of the Partnership Board held on 27 January 2021 a summary of agreed actions was produced and is included for reference at Appendix 2. This summary sets out how a number of matters will be developed as the Partnership matures as an emerging ICS, primarily relating to engagement, development or interactions across Cheshire and Merseyside. The Trust should commit to full engagement with the HCP in progressing relevant actions as part of the Partnership's Development Plan in 2021/22.

5.0 Recommendations

The Board of Directors is recommended to:

a) receive the report and note the HCP correspondence and associated documents included at Appendices 1-3.
b) confirm adoption of the HCP Memorandum of Understanding v8 included at Appendix 4.

Cheshire and Merseyside
Health and Care Partnership

Date: 2 February 2021

Dear Colleagues,

Partnership Memorandum of Understanding (MoU)

You will recall I wrote to you in early December inviting discussion, engagement and feedback on our draft MoU. I want to thank all of you for your largely positive and constructive engagement in this dialogue.

Our review of the Partnership's MoU coincided with the publication of NHSE/I consultation on Integrated Care Systems. The MoU is not designed to respond to the points raised in the NHSE/I consultation which provide us with a number of discussion points and areas to explore, together, over the coming period. Our MoU provides a foundation and shared understanding from which to start this exploration.

By adopting the MoU we aim to:

- Document the Partnership's current arrangements
- Provide clarity on our starting point and a foundation to those engaged within the Partnership but also our stakeholders
- Set out the Partnership's vision, mission, aims and values
- Detail the Partnership's developing governance arrangements
- Provide assurance to partners and NHS oversight bodies on our direction of travel and intentions

We discussed the MoU and feedback at our Board meeting on 27 January. To support wide engagement and full understanding of the issues raised, considered and the suggested way forward I have provided you with a copy of the paperwork we considered.

A number of significant points of note were put forward through our engagement on the MoU and during our preparation for ICS designation. It is unlikely the MoU will ever be the right vehicle for addressing all such points. I have therefore enclosed an annex which sets out a number of areas of work and describes how the Partnership will progress these areas or support dialogue. My expectation is that this approach will provide you with clarity on the way forward and identify where it is not possible to provide definitive answers, now, while also retaining the clarity and purpose of the MoU.

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A smaller number of points warrant fuller explanation and clarification on the way forward as follows:

- The Partnership committed to reviewing the MoU after a period of not more than 6 months into the next financial year
- Discussions will continue on the best way to secure appropriate Primary Care representation and engagement at the Partnership Board. However following feedback and discussion at the Board we propose that to support the importance of effective representation Primary Care will, going forward as now, have two positions on the Board when nominated or elected
- It is recognised that the membership of the Partnership Board - set out at Annex 6 of the MoU - describes our aspiration and expectation over time for Board membership as the Partnership moves towards ICS statutory responsibilities. Discussions will take place with CCGs, shortly, to explore and define appropriate transition arrangements covering the year ahead. Recognising the current statutory roles and responsibilities within our system. Discussions will also commence with Local Authority colleagues about how and when we establish the proposed political representation on the Board
- We have sought to enhance the wording of the MoU to reflect our commitment to social value and social responsibility, our carbon reduction intent and references to inequalities and the breadth of linkages across the partnership (housing and education etc).

My hope is that you will receive this correspondence and provide your support by adopting the updated MoU. In doing so I know you will recognise the status and intent of the MoU as a platform to build from, acknowledge the complimentary but distinct work that will be initiated by the Partnership to support the wider development of how we work together.

I propose that the March Board receive an update on the intention of partners in respect of approval of the MoU and I would therefore ask for notification of your intention and progress within your organisation by no later than 12 March.

Should you wish to discuss this further Ben Vinter remains available as a resource to support your discussions and Jackie Bene and Alan Yates also remain available to discuss with senior leaders as needed.

Our system is interwoven, mutually dependent and complex. Through alignment and a tight focus on priorities in *Place* together with working at scale when it benefits the public we can make a genuine positive difference to everyone in Cheshire and Merseyside having a great start in life, and getting the support they need to stay healthy and live longer.

Finally, let me direct your attention to Partnership microsite:

https://www.cheshireandmerseysidepartnership.co.uk/partnership-assembly

Regards

Alan Yates
Chair, Cheshire and Merseyside Health and Care Partnership

Enc:

- Annex one – Summary of actions, commitments or offers from the Partnership
- HCP Board Report – Memorandum of Understanding – Comments from partners
- MoU v8

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Annex one

Summary of actions, commitments or offers
from the Partnership

Further to discussions at the Partnership Board on 27 January 2021 the below sets out how a number of important matters will be developed as the Partnership matures as an emerging ICS primarily relating to engagement, development or interactions across Cheshire and Merseyside.

The areas detailed are not included in the MoU because this is either not the right place for such matters to be recorded, as work needs to take place across the partnership in some areas, or because we are not yet sufficiently clear on the statutory frameworks we may have to work within.

Accordingly a number of areas of work will be initiated by the Partnerships' executive, alongside partners, as follows:

1. The Partnership's Development Plan through 2021/22 will include work to define, develop and explore implementation of:
    - ICS Architecture: Assurance & Transformation which may include further development of mutual accountability in practice in Cheshire and Merseyside
    - System governance
    - A refreshed approach to programme delivery – including a focus on outcomes and clarity of objectives
    - Consistent ambition and progress in Place / ICP Development
    - Leadership Capacity & Capability – ensuring leadership across all areas of vertical and horizontal integration and developing and embedding assurance capability
    - Streamlined Commissioning – Establishing a fully functioning JCCCG and the expected integration between collaboratives and the Partnership
    - System Plans – Maximising alignment between place and system plans. Ensuring critical enabling infrastructure plans are well developed in areas such as Estates, Capital and Digital
    - Provider collaboratives – Delivering our roadmap for establishment of provider collaboratives detailing the purpose, form, leadership and governance requirements
    - Partnership working and collaboration (especially with local government colleagues)
    - HCP communications and engagement
    - Delivering NHS performance and assurance oversight

- Workforce Transformation and Planning

2. Development of terms of reference, for HCP groups or forums, which will provide more clarity on their interrelationship and accountabilities. This piece of work will include the redefinition of the role of the Partnership Coordination Group no later than August 2021

3. That definitions and arrangements for clinical leadership in new systems and ways of working form an early piece of work to be considered by both the emerging Provider Collaborative and our ICP Forum

4. That our ICP Forum consider whether any specific measures or steps are needed to maximise the role, value and contribution of Health and Wellbeing Boards, consistently, in our systems

5. That a number of related potential roles or expectations for ICP or Places be explored via our ICP Forum or ICP's themselves:
   - Use and applicability of VCS Compact
   - How place delegations will be exercised / granted and how escalations should occur to the Partnership Board. In keeping with a response to our engagement we recognise the outcome of this work will likely have an influence on who and which organisations need to be represented in which forums and groups

6. That discussions continue with partners on the basis of developing a Political Assembly a part of the Partnership's established governance

7. The Partnership has formally recorded a number of legitimate queries and areas requiring exploration on how statutory arrangements and interlinkages might work in future – while we can discuss this and like issues we recognise we may only fully know the requirements we will need to work toward when and if legislation is brought forward. The same position is true around how and when an ICS, once established, might be required to trigger action plans or manage any disputes.

Memorandum of Understanding
Comments received from partners

Report To:	**Cheshire and Merseyside Health and Care Partnership Board**
Date of Report:	27/01/21
Report Author(s):	Ben Vinter
Purpose:	Provide the Board with: • An update on feedback from consultation on the MoU with partners • Recommendations on the approach to this feedback • Opportunity for the Board to provide guidance on the next steps and timescales
Recommendation(s):	That the Board give consideration to the points raised in response to the circulated MoU and support the recommendations for response or progress of actions as detailed in section 3. Noting the recommendations fall into two broad categories: • Imminent action / amendment supporting final drafting • Medium / longer term actions which may be incorporated in future versions of the MoU The Board support and propose the adoption of MoU by the Partnership as an accurate and timely description of the Partnership and its present ambition.

1. Context

In drafting the Memorandum of Understanding (MoU) the aim was to respond to the challenge set by the Partnership Assembly in autumn 2020 to provide:

- Clarity on the way the partnership works and aspires to work in the future - striking the balance of achieving strategic vision while remaining in touch with local variation
- Enhanced recognition of Place including providing a framework for an increased proportion of Local Authority membership,
- Clarity on the role of the Partnership – a convenor of the Cheshire and Merseyside health and care system.

When drafting and discussing the MoU the Board and the majority of our partners recognised that the Partnership is, currently, at a particular point in its development. From here there is more for us to do in describing our arrangements, for example, over the next immediate period developing terms of reference but also over a longer timeframe and with more complex engagement to continue our development and co-production. This means some of the work we now need to do and our response to some feedback will continue through 2021/22, and beyond, as we agree the arrangements that will work for our system.

This version of MoU and its hopeful adoption, imminently, is the start of this discussion and journey, not the end point.

Accordingly, at this time, the MoU's ambition was deliberately limited to:

- Documenting the Partnership's current arrangements
- Providing clarity on our starting point and a foundation to those engaged within the Partnership but also our stakeholders
- Setting out the Partnership's vision, mission, aims and values
- Detailing the Partnership's developing governance arrangements
- Providing assurance to partners and NHS oversight bodies on our direction of travel and intentions

The recent publication by NHSE/I of its consultation – Integrating Care: The next steps to building strong and effective integrated care systems across England – coincided with our circulation of the MoU which had been sometime in the drafting. To some extent this was fortuitous as the publication began to describe a set out options and choices that will shape our future direction of travel. However the publication of an NHSE/I consultation should not be confused with the value, purpose or intent of the MoU. The MoU is not designed to respond to the points raised in the NHSE/I consultation rather their publication starts a description of supplementary choices and challenges we now need to work through, together, for which our MoU provides a foundation and shared understanding from which to start.

At the time this work was initiated and through discussion with the Partnership Board in November and December you recognised and agreed that the MoU represented a first step, that it would iterate both from this draft following consultation but also that it would need to evolve and develop through 2021/22 as, for example, we define what common expectations we have for Places or as our Providers explore what provider collaboration means within a Cheshire and Merseyside context.

2. Feedback

General

A broad range of partners particularly from local authorities, providers and the voluntary sector saw value in the MoU as providing a foundation and in setting out our ambition, aims and values clearly stating the ethos of collaboration and partnership, and the significant emphasis on primacy of Place.

NHSE/I consultation and potential future changes

A number of partners recognised that as NHSE/I thinking evolves and policy develops, over the coming period, there will be more clarity that the Partnership and in turn the MoU or other system frameworks need to explore with stakeholders and ultimately define by agreement.

More definition and detail on next stage developments – governance, assurance and system architecture

A number of Partners, in particular Place representatives, requested further clarification on areas we know represent a programme of work that needs to be progressed, together, through 2021/22 namely more detail and definition of:

- Governance arrangements and linkages between groups both at a Partnership level and throughout the partnership
- Accountability and any relevant performance frameworks
- How Place fits within and works with the ICS

A number of responses, particularly from local authorities and NHS providers, sought clarification on the scope and nature of streamlined commissioning and the way in which one CCG will work in our system. This line of enquiry is understood but the Board is reminded that the CCGs in Cheshire and Merseyside have begun to define the issues they see current value in working together on, at scale, from a commissioning perspective and that more details on the way forward are likely to emerge from the outcome of NHSE/I's consultation in due course.

Representation

A number of colleagues requested clarification on representation and membership of groups including HCP Board representation. The Board will recall that we were clear in the MoU that this is an area of work, across the Partnership's apparatus, that we need to initiate during quarter four of 2020/21 and it should welcome recognition that this work now needs to be progressed. A number of responses also requested greater detail on the scope and membership of the Partnership Assembly.

The Board will be aware that work is ongoing among providers across our system to define and scope their work whether this be through Provider Collaboratives or the emerging Primary Care Network Forum. The Board will recognise that one of the outputs of this work will be to reflect these groups equally critical role in the work of the Partnership including through representation.

Clinical Leadership

A number of colleagues also fed back on the need to be clearer on the role and place for clinical leadership and involvement. The Board should recognise this is work that needs to be done and to an extent, at a Partnership Board level, this will link to and be influenced by the work referred to directly above. However the system must also await NHSE/I proposals in respect of the future of CCGs and how and if membership is specified.

The significant value of local and Place based working for clinical voice, across all professions, but also democratic input already commonly secured should also be acknowledged.

Delivery and outcomes

Some responses requested more detail on what the Partnership will deliver and how. The importance of this task is understood and needs to be worked on, together, across the Partnership but there remains a question of if an MoU is the best place to describe such detailed areas of work.

The Partnership's Development Plan defines, at a high level, a number of significant areas of work which HCP and partners need to progress, together, this includes a focus on ICS level programmes but also a number of areas related to system plans and capability as called for by partners in their responses. Such work should include clearer definition of outcomes,

maximise common understanding of the Partnership's aims and metrics where appropriate in line with the feedback provided by partners.

Health and Wellbeing Boards
A number of colleagues called out the role of Health and Well Being Boards (HWB). The MoU sought to recognise this role and the Partnership is committed to Place based working including current forms of partnership working, collaboration and oversight. The Board should be conscious that matters such as linkages between Place based arrangements and their development with or through HWBs needs to be co-created across the partnership, link to thinking on the role and development of Integrated Care Partnerships and to an extent be proposed by the convenors of those Boards.

Local Authorities
Some responses queried the notion of a local authority lead role in the Partnership. While the Board will recognise there is more to work to do in this area, not least in respect of any legislation that may be brought forward by the government, the Board has previously been clear that the role and nature of an ICS requires a fundamentally different way of working. Local authorities alongside all system partners should and do have lead roles in ICS working.

In response to the request for feedback on the MoU a number of local authorities responded and took opportunity to advise the Partnership of the Liverpool City Region view on the NHSE/I consultation calling for*:*

- *A new statutory reciprocal duty of collaboration to improve population health and address health inequalities on all NHS organisations and local authorities;*
- *A legal requirement on ICSs to involve Health and Wellbeing Boards (HWBs) in the development of plans and to devolve the development of place or locality plans to HWBs;*
- *A new power for HWBs to "sign off" on all ICS plans;*
- *Arrangements for commissioning to continue to have a strong place-based focus, with a strong and proactive role in HWBs in approving commissioning plans; and,*
- *A statutory duty on ICSs to be accountable to their local communities through existing democratic processes.*

The DASS perspective to the NHSE/I proposals was also shared with us and provided feedback in the following areas:

- *Primacy of Place is paramount; "place" being each local authority area;*
- *Each local authority "place" must be represented in future governance arrangements for the Cheshire and Merseyside ICS;*
- *The agreed governance for Cheshire and Merseyside at "system" and at "place" level must address historic democratic deficits in NHS governance;*
- *There should be formal recognition of Health and Wellbeing Boards as the strategic decision-making bodies for ICPs in each "place", given that they are already best positioned to support improved outcomes in the wider determinants of population health; and,*
- *There should be formal assurance that budgets will be devolved to "place", and that any and all residual budgets to be retained at Cheshire and Merseyside level will be agreed in advance by each "place".*

The above points are interesting areas of debate and discussion but are not matters that can all be addressed by the MoU. The Partnership makes a continued commitment to work

inclusively, collaboratively and to co-create solutions that work for Cheshire and Merseyside. We also acknowledge that the Partnership is not, at this time, a statutory body and we await NHSE/I feedback to its consultation. However the Board will recognise the challenge put forward and feels strongly about local representation and connections across systems. To that extent proposals are contained within the recommendations section which seek to provide for enhanced and clearer representation responding to the ambition described.

Since the time when the MoU was circulated the Chair and Chief Officer have been continuing their engagement with local authorities and discussing the role a Political Assembly, elected representatives and local authorities can and should play through the partnership and at a Partnership Board level. These points are addressed in the recommendations section.

Patient and Public Engagement

Some suggestions have been received that the Partnership can and should place greater emphasis on patient and resident engagement. In particular there was a suggestion that we should place the patient and public at the centre of 'our integrated, system approach to collaboration'. It is suggested that the Board support this welcome emphasis.

Feedback has also suggested that the MoU should make greater recognition of the way the Partnership either does or aspires to engage with patients and the public. It is suggested given the current status of the ICS that the current balance, described between existing statutory organisations and the Partnership, is appropriate. The Board may, however, wish to encourage even stronger emphasis in this area, to ensure patient and public engagement forms a core part of the system's development plan and will wish to remain mindful on both the legislation and the right thing to do in this area as and if changes are brought forward.

Health inequalities and wider determinants of health

A number of comments received related to the extent to which the Partnership can address matters beyond what might traditionally be considered the focus of health and care. Suggestions and emphasis on these points get right to the very heart of what the Partnership hopes and expects to achieve:

- Tackling health inequalities and improving lives needs new partnerships that 'liberate the potential' in people. It will be important the Partnership is not just co-ordinating existing health and social care organisational support e.g. education, housing, business, industry and enterprise
- Social responsibility, the response to inequalities and the role of anchor institutions could be more explicit in the MOU
- The wider role of other partners in achieving health and wellbeing outcomes that look at a 'whole person approach' could be described in the MOU

Innovation

It was suggested that the MoU should reference the Partnership's potential to innovate.

Climate Change

It was suggested that the MoU should reference the Partnership's contribution and commitment to tackling climate change.

Digital and data

It was suggested that the MoU should reference the Partnership's contribution and need for system level work programmes to address the health and wellbeing needs of the C&M population, which are data led, using data intelligence and associated measurement will need to inform the Partnership level programme prioritisation and determine progress.

3. Recommendations

In response to the themes summarised above and the significant amount of feedback that was received in response to the request for engagement in the Partnership's Memorandum of Understanding it is recommended that the Board:

A. Recognise and acknowledge the broadly positive nature of the responses supplied

B. Thank all system contributors for their engagement

C. Acknowledge the status, place and timing of the MoU as a foundation in the Partnership's development. Agreeing that it is not, was not intended to be and cannot expect to be the complete word on partnership working, system integration, or Cheshire and Merseyside health and care

D. Acknowledge that over the next quarter work will be progressed, in partnership, which begins to define some of the issues raised through this engagement. For example, terms of reference and the redefinition of the role of the Partnership Coordination Group which it may be appropriate to be appended to future versions of the MoU. However other, more significant bodies of work, such and ICP development or programme design and delivery will need to be developed and potentially referenced in future versions of this document but may never appropriately form part of it

E. Commit to a full review of the MoU being initiated by 31/3/22 or following the implementation of any legislation by government related to integrated care systems

Turning to the more specific themes arising from the consultation it is recommended that the Board:

F. Recognise and acknowledge the areas of work that will be progressed, collaboratively, and which form part of the Partnership's Development Plan through 2021/22 covering the following areas:

- Developing and enhancing ICS Architecture: Assurance & Transformation
- Review and refine system governance
- Implement a refreshed approach to programme delivery
- Support consistent ambition and progress in Place / ICP Development
- Leadership Capacity & Capability – ensuring leadership across all areas of vertical and horizontal integration and developing and embedding assurance capability
- Streamlining Commissioning – Establishing a fully functioning JCCCG and the expected integration between collaboratives and the Partnership
- System Plans – Maximising alignment between place and system plans. Ensuring critical enabling infrastructure plans are well developed in areas such as Estates, Capital and Digital
- Provider collaboratives – Delivering our roadmap for establishment of provider collaboratives detailing the purpose, form, leadership and governance requirements.
- Partnership working and Collaboration (especially with local government colleagues)
- Communications and Engagement
- Delivering NHS performance and assurance oversight
- Workforce Transformation and Planning

G. Given the stage of the Partnerships development, the extent of engagement that has been undertaken during the preceding 9 months and the feedback that has been received in response to the MoU it is proposed that the Board consider amendments to its membership reflecting, proportionate, system orientated participation and representation as follows:

   i. A representative from each of our nine Local Authority area within the ICS footprint. We understand it is the intention of system leaders that these representatives will be political representatives
   ii. A CEO and a Chair representing acute providers
   iii. A CEO and a Chair representing mental health and community providers
   iv. A CEO and a Chair representing specialist providers
   v. A Primary Care Network representative. Assumed to be the Chair of the Primary Care Network Forum
   vi. A CCG Accountable Officer
   vii. A CCG Clinical Chair
   viii. A Public Health representative
   ix. A VCSE representative
   x. An NHSE/I representative

   xi. From the Partnership, itself, it is proposed that the Chair, Chief Officer and up to 3 executive director posts will be full or voting members of the Board. Other directors will attend.

H. In response to the need for greater clarity on clinical leadership that this be identified and form an early piece of work to be considered by both the emerging Provider Collaborative and our ICP development forum

I. That our ICP forum consider whether any specific measures or steps are needed to maximise the role, value and contribution of Health and Wellbeing Boards in our systems

J. That in addition to recognising and supporting the proposal for Local Authority representation on the Partnership Board that discussions continue with partners on the basis of developing a Political Assembly a part of the Partnership's established governance

K. Supports amendments to the MoU to reflect proposals made in respect of:
   i. Placing patients and residents at the centre of 'our integrated, system approach to collaboration'
   ii. Tackling health inequalities and improving lives needs new partnerships that 'liberate the potential' in people. It will be important the Partnership is not just co-ordinating existing health and social care organisational support e.g. education, housing, business, industry and enterprise
   iii. Social responsibility, the response to inequalities and the role of anchor institutions could be more explicit in the MOU
   iv. The wider role of other partners in achieving health and wellbeing outcomes that look at a 'whole person approach' could be described in the MOU
   v. Innovation
   vi. Climate Change
   vii. Digital and data

Annex One

Responders

- Cheshire West and Chester Council
- Halton MBC
- Knowsley MBC

- Alder Hey Children's NHS FT
- Cheshire and Wirral Partnership NHS FT
- Liverpool University Hospitals NHS FT
- Liverpool Women's NHS FT
- Mersey Care NHS FT
- NW Boroughs Partnership NHS FT
- The Walton Centre NHS FT
- Warrington and Halton Hospitals NHS FT
- Wirral Community Health and Care NHS FT

- NHS Cheshire
- NHS Liverpool
- NHS South Sefton
- NHS Southport and Formby
- NHS St Helens

- Healthy Wirral – incorporating all partners
- Cheshire West Integrated Care Partnership – a representative
- VCFSE representatives

Pre consultation responders:

- St Helens MBC
- Warrington Borough Council

Our thanks is recorded to all those responding. Any omissions are not deliberate and can be corrected.

Cheshire and Merseyside
Health and Care Partnership

Memorandum of Understanding

V8

January 2021

Contents

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1. Foreword

This draft Memorandum signifies an important step in the maturing of the Cheshire and Merseyside Health and Care Partnership. Much good work has gone on before now and I wish to honour those who made and continue to make practical progress in supporting the integration of health and care in the nine places of the Partnership. I also want to recognise the work of those who have developed and supported the specialist programmes of work and the collaboration at scale which has benefitted the people of Cheshire and Merseyside.

We are clearer now about the Partnership. We know we want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer. We are committed to tackling health inequalities and improving the lives of our poorest fastest. We believe we can do this best by working in partnership.

And we know we will make these things happen best when we support and enable joint and integrated work in the 9 Council areas, sometimes known as Places in Cheshire and Merseyside. If we are to work on a bigger population than Place we need to know why this is the best way to do it, otherwise we operate locally.

As we have made progress over the last year or so, the point has been made clearly that the purpose of the Partnership and the arrangements of the Partnership need to be stated and understood. The Partnership Assembly held in September 2020 confirmed emphatically that this must be done.

What follows is a draft description of the Partnership's purpose and arrangements. It does not seek to be finally definitive. It will change over time by consent. COVID-19 has caused great distress and disruption but it has also increased an understanding of what is possible, lowered barriers between organisations and has increased the pace of change. Amongst other things we expect legislation next year which could change the legal status of the Partnership. Consequently, the following is designed to be a foundation document from which we can develop and not a statement for the next several years. We will develop it together and inclusively.

Alan Yates
Chair
Cheshire and Merseyside Health and Care Partnership

2. The centrality of place

The NHS and the Councils, within the partnership, have broadly similar definitions of place. We aspire for all of our Councils, CCGs, Healthcare and voluntary sector providers and Healthwatch organisations to be active partners and participants in their respective local place-based partnership arrangements.

The extent and scope of Place arrangements are determined locally, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making between NHS and Local Authorities. Other key members of these partnerships include:

- Primary Care Networks
- Specialist community service providers
- GP Federations
- Voluntary and community sector organisations and groups
- Housing associations.
- Other primary care providers such as community pharmacy, dentists, optometrists
- Independent health and care providers including care homes.

The ‘primacy of Place’ and its associated neighbourhoods is sacrosanct to ensure that:

- The lead role of Local Authorities in the integration of care and system design is recognised.
- System design is built on a Place based approach.
- Place at the local authority level is the primary building block for integration between health and care and other sectors of the service system.
- Political engagement, democratic input and legitimacy (stewardship).
- the non health & care aspects of Local Authority’s portfolios are included in the health determinants consideration

Within a criteria based framework Places determine how they achieve outcome improvement, including how they come together to deliver this (i.e. their own model of service delivery) estimated to represent the considerable majority of all care improvement. It is at this level that we expect to continue to see significant local authority, community engagement and determination of the most appropriate location for care to be recieved.

2.1 Our Local Government Partners in Local places

The Cheshire and Merseyside Health and Care Partnership includes nine local government partners. The City Council, four Metropolitan Councils of the Liverpool City Region and four unitary authorities from Cheshire. These authorities lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and local Health and Wellbeing Boards (or equivalent). They work with the NHS as commissioning and service delivery partners, as well as exercising powers to scrutinise NHS policy decision making. When we refer to health and care, the Partnership, it is all of these functions combined with voluntary and community sector provision and the NHS that is our focus.

Cheshire and Merseyside Health and Care Partnership is committed to working with both local authorities and NHS organisations, as equal partners, recognising that each part of the partnership provides a distinct contribution to the collaboration.

Local government's regulatory and statutory arrangements are separate from those of the NHS. As part of this memorandum of understanding all members of the Partnership, including Councils, commit to the mutual accountability principles for the partnership which are described later in this document. However, because of the separate regulatory regime certain aspects of these arrangements will not apply, for example, Councils are not subject to a single NHS financial control total and any associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected Councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

3. Introduction and context

This Memorandum of Understanding (Memorandum) is an understanding between the Cheshire and Merseyside Health and Care Partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, reduce health inequalities and to improve the quality of their health and care services.

Cheshire and Merseyside Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations from across our nine places, with a strengthened partnership with local councils developed since this time. We are not, therefore, a new organisation but a collaboration that consolidates and combines our ambition, approaches and initiatives to meet the diverse needs of our citizens and communities.

Since our establishment we have made progress in building our system's capacity and infrastructure and established our principles and preferred way of working. Such foundations will enable and empower us to achieve our aims going forward. We expect to develop a medium to long term plan for the partnership by the spring of 2021.

3.1 Purpose

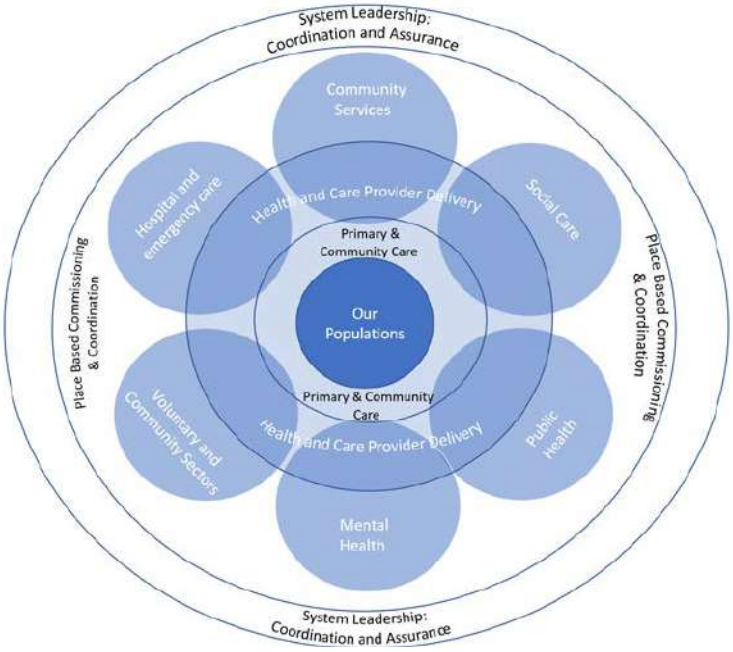
The purpose of this Memorandum is to formalise our partnership arrangements. We do not seek to introduce a hierarchical model; rather provide clarity through a framework, based on the principle of subsidiarity, to ensure collective ownership and coordination of delivery. This approach also provides the basis for a refreshed relationship with national NHS oversight bodies[1], who retain responsibilities for NHS delivery but retain a key interest in seeing the NHS work in partnership.

The Memorandum is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. Rather the Memorandum provides a shared understanding between the Partnership's participants of our collective objectives and purpose. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils.

The Memorandum should be read in conjunction with the Partnership's Plans and local Place priorities. The primacy of Place remains sacrosanct for the Partnership.

[1] We have a current Accountability Agreement in place between the Partnership and NHSE. We expect our current agreement to be reviewed which may result in a refresh.

3.2 Our integrated, system approach to collaboration



Our Partnership is grounded in the principle of collaboration which begins in each of our neighbourhoods.

For the NHS each neighbourhood is consolidated around our GP practices who in turn work together, with community, voluntary and social care services in Primary Care Networks, offering integrated health and care services typically for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it (definitions of activity will be included in Terms of Reference as appropriate).

Neighbourhoods are part of our nine local Places. Our Places are our system's communities. They are the primary units for partnerships between NHS services, local authorities, charities, voluntary and community groups, all of whom work together to agree how to improve people's health and improve the quality of their health and care services.

The focus of the partnerships within our Places has moved away from simply treating ill health to a greater focus on preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment in addition to inequalities. The role of partners and Health and Wellbeing Boards as well as other place convenors are key to bringing partners together to achieve real and sustained improvements.

However in order to respond to the challenges we have within our region and the aims we have set, collectively, for our system we recognise that there are times when all partners need to work together on a wider footprint than the place, to combine resources, effort or attention to deliver a greater benefit. Such activity will be most critical in the following areas:

- to achieve a critical mass beyond local population level
- to achieve the best outcomes
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (i.e. complex, intractable problems).

3.2.1 How we are moving forward in Cheshire and Merseyside

3.2.1.1 Vision & Mission

We have worked together to develop a shared vision for health and care services across our region. Our aspiration is that all of our priorities, activities and initiatives support the delivery of this vision:

We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer.

The achievement of our vision will be supported by the delivery of our mission:

We will tackle health inequalities and improve the lives of our poorest fastest. We believe we can do this best by working in partnership.

3.2.1.2 Overarching aims of our Partnership

We have agreed a set of guiding principles that shape everything we do through our partnership. These principles are underpinned by our aims which themselves are derived from our vision and mission:

1. **Improve the health and wellbeing of local people**
2. **Shift from an illness based to a health & wellbeing model**
3. **Provide better joined up care, closer to home**

3.2.1.3 Values and Behaviours

We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our Place and of Cheshire and Merseyside

- We support each other and work collaboratively
- We act with honesty and integrity and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3.2.1.4 Active members of our communities

We recognise that a number of our partners consider themselves to be and act as *Anchor Institutions*. Through having sizeable assets that can be used to support local community wealth building and development *anchors* can advance the welfare of the populations they serve.

The Partnership takes its' and our partner's responsibilities and potential for social responsibility and social action seriously. Differing from what has preceded we hope and expect the Partnership, as a truly integrated care system, can impact on the wider determinants of health and care including in education, housing, business, industry, enterprise and ultimately the whole person approach to health and well-being. It is through this way of working that we expect to be able to have most impact on equity and health inequalities.

Furthermore, as a core part of its social responsibility, the Partnership is supporting organisations to develop Green Plans and meet new NHS Net Zero Carbon Plan targets. As a Social Value Accelerator Site, we're dedicated to embedding social value across anchor institutions, building capabilities across environmental, economic and social factors.

In progressing our aims and initiatives we will support and champion innovation and the use of data and technology to provide insight and guide our delivery and focus.

3.2.1.5 Delivering our objectives and outcomes

In delivering our aims we recognise that the Partnership needs to:

- Plan and establish our approach to financial and performance management
- Enhance integrated commissioning at Place/Borough and streamline it at system level
- Incorporate NHS providers through a Provider Collaborative using a peer leadership approach

- Respond to and embed the NHS Constitution and other statutory duties relevant to the partnership, for example, our shared commitment to quality of care and safeguarding

We anticipate our plans will be developed, reviewed and confirmed annually. The Partnership will set its priorities and area for collaboration and coordination together. From this activity we will identify a number of priority programmes, initiatives and priority investment areas. Such priorities will be guided by our vision and longer-term planning assumptions and commitments.

Our portfolio of programmes will be signed off by the Partnership Board following proposals being brought forward by the Partnership Coordination Group. They will be presented to and reviewed by the Partnership Assembly.

Our programmes and all Partnership activities will be outcome focussed. By working together, we expect to empower and enhance Place or neighbourhood activities and priorities through the opportunity for co-ordinated and combined action. Some recent examples of outcomes secured the Partnership activity include:

- Covid19 Testing & Vaccine collaboration resulting in delivery of regional mass testing and vaccination role out supporting all of our communities
- Pathology and Imaging improvement and efficiency supporting investment
- Digital and technology investments and development particularly supporting delivery through Covid 19 but also longer-term infrastructure needs.
- Corporate Collaboration at Scale, for example, in procurement delivering savings in both the actual cost of purchasing goods but also the investment required to support such activities and their resilience during the recent pandemic

We anticipate that Places, through which a significant number of partners will interact will similarly focus on and track outcomes.

3.2.1.6 Involving the public

We are committed to meaningful conversations with people and our communities and highly value the feedback that people share with us. This will primarily be through our existing organisations, utilising and supplementing our existing communication channels. Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions, together, about our health and care services.

Each of our organisations use a wide range of ways to involve the public. We will seek to supplement these activities, where appropriate, through any discreet work progressed by the Partnership using and linking with established Place channels.

Examples of this may include public, resident and patient reference groups, engagement events, participation in our Assembly or through our Board.

3.2.1.7 Voluntary and Community Sector

Cheshire & Merseyside is home to nearly 14,000 voluntary organisations, community groups and social enterprises working to tackle inequalities, and improve the lives of local people. The sector employs many but also supports and empowers thousands of volunteers and carers.

Our Voluntary, Community, Faith and Social Enterprise (VCFSE) sector is hugely important to the Partnership and is a major contributor to our communities having the resilience, capacity and social value to support us all in co-designing and delivering outcomes but also responding to and challenging inequalities within our communities. This coupled with the trust and expertise the sector brings to our system is why we consider it to be integral to our work.

3.3 Definitions and Interpretation

This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

3.4 Term

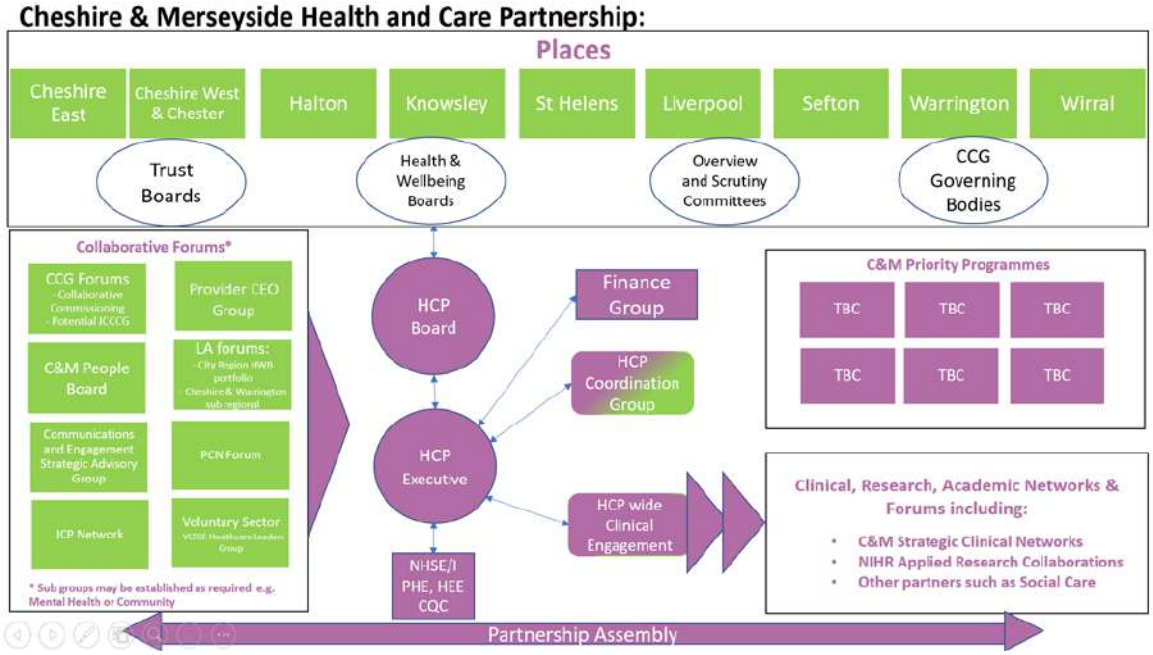
This Memorandum is a dynamic document and is intended to reflect where the partnership is at the date of adoption. As the system, collaboration and any responsibilities or delegations are developed or assumed this document will be reviewed and updated. When we become a full Integrated Care System the governance arrangements will be subject to review.

4. Partnership Governance

The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

The Partnership provides a mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.

A schematic of our governance and accountability relationships is provided at Annex 2**,** a summary of the roles and responsibilities of the Partnership Assembly, Partnership Board and Partnership Executive, Partnership Coordination Group and our relationship with collaborative forums is set out below. The terms of reference for each group are subject to review and development and will be added as an annex to this agreement following their agreement by the groups themselves and this governance structure.



4.1 Partnership Assembly

The representative body of the Partnership, bringing together the members of the Partnership akin to a shareholder AGM. The Partnership's representative or democratic council, without it there would be no systematic scrutiny of the Partnership Board & possibly narrower interests represented.

Provides the context in which the Board works and acts as the body of last recourse for the partnership. The Assembly:

- Provide a "democratic" forum for the Partnership
- Represents the wider C&M community
- Holds the Partnership Board to account

- Critiques the decision-making process
- Insist on transparency & blow the whistle as necessary
- Put the public good first
- Act as the conscience of the Partnership
- Acts as a “Community of Interest” in support of the Partnership’s work

The Assembly will meet on average three times a year and is chaired by the Partnership Chair.

The Assembly’s constituencies are detailed in Annex 5 and include all parties to this agreement (Annex A).

4.2 Partnership Board

The Partnership Board provides the formal leadership and authority of the Partnership. The Partnership Board is responsible for setting strategic direction. It provides oversight for all Partnership business, and a forum to make decisions together as Partners. It is chaired by the Partnership Chair

The Partnership Board:

- Acts as the governing body of the Partnership
- Sets the strategic framework of the Partnership & monitor performance against it; gives authority for expenditure & policy decisions where appropriate
- Holds the Partnership Executive to account
- Is Accountable to the Partnership Assembly.

The Partnership Board meets monthly.

Current proposed Board membership is detailed in Annex 6.

4.3 Partnership Coordination Group

The Partnership Coordination Group was initially established as an ad hoc operational group to coordinate the systems response to Covid-19. However the group has ongoing value as:

- A coordination forum across the partnership
- An informal, regular, communication channel and discussion point to support and influence pre work / thinking in advance of wider Partnership engagement

The co-ordination group meets twice monthly and is chaired by the Partnership Chief Officer

4.4 Partnership Executive

The Partnership Executive executes the strategic plan of the Partnership by delivering and helping Partners to deliver the vision and mission of the

Partnership. Accountable to the Partnership Board. It is chaired by the Partnership Chief Officer

The Partnership Executive focuses on:

- Strategic not operational issues.
- Creates & delivers plans to meet the Partnership's vision, mission & value
- Maintains oversight of programmes
- Provides the Partnership Board with information on key decisions
- Collects, collates & communicates data from across the Partnership
- Communicates simple, coherent messages from across the Partnership to stakeholders
- Advises on best practice across the Partnership

4.5 Finance Group

The Finance Group has been established to strengthen financial leadership, coordination and prioritisation across the Partnership. The Group makes proposals to the Partnership's decision-making structures on areas related to the Partnership's funding, system allocations and regional prioritisation. Financial leadership is built into each of our work programmes and groups, and the group provides financial advice to all of our programmes.

Where not already in place or available agreed Terms or References for each of the above described groups, or Boards will be developed by each group, discussed and circulated among interested parties before being put forward to the Partnership Board for approval.

It is envisaged that that such terms of reference will be finalised in Q4 of 20-21 and at that point form annexes of future versions of this Memorandum

4.6 Programme Governance

Strong governance and programme management arrangements are built into each of our programmes and workstreams. Each programme has a Senior Responsible Owner, typically a Chief Executive, Accountable Officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our Places and each relevant service sector.

Programmes provide regular updates to the Partnership Executive and Partnership Co-ordination Group.

Clinical leadership, contribution and participation is central to all of the work we do and is integrated into the way we work both through our governance, through participation but also through our Strategic Clinical Networks (the number and scope of these networks will respond to the priorities of our system) local forums and research structures.

Clinical leadership is built into each of our work programmes and governance groups, to be supplemented by our developing PCN Forum. Our Strategic Clinical Networks and our regional clinical, research and wider forums provide structures to place clinical advice central to all of our programmes.

The importance of recognising and addressing inequalities in the care we provide, the way we work and within our populations remains central to our purpose, our thinking and our priorities. Accordingly, we identify and prioritise addressing inequalities as a cross cutting theme through all of our work and our programmes.

4.7 Other governance

The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (e.g. commissioners, our providers and Councils) that support the way it works. These are described below.

4.7.1 Clinical Commissioning Groups

The nine CCGs in Cheshire and Merseyside are continuing to develop closer working arrangements within each of the nine Places that make up our Partnership.

The CCGs have established joint working arrangements. These arrangements allow for representatives of each CCG to meet to discuss and explore issues of common concern. The CCGs also have the opportunity, through formal delegation and prescribed governance steps, to establish a Joint Committee or Committee in Common, for formal collective decision making. Our CCGs are currently working through their approach to joint working which they will use to embed a shared agenda going forward.

4.7.2 Provider Collaborative

The nineteen NHS provider trusts in Cheshire and Merseyside already work together and collaborate across a variety of initiatives. They meet through an established CEO Group. However in order support our system in achieving our aims we expect the scope and outputs needed of this group to grow over time as our providers collectively plan and integrate care to meet the needs of our population.

Over time we expect the focus of this forum to:

- Deliver on NHS Constitutional requirements: 52 weeks wait, cancer treatment requirements and activity targets:
- Progress detailed planning – marshalling resource around priorities
- Tackle variation through transparent data and peer review
- Realise capacity utilisation - equalize and optimise access

- Target expert support for outlier organizations and specialties – deployed from region to ICS
- Promote innovation at scale – ICS owned

We recognise other networks and forums may exist or be established related to provider delivery, for example, in social care or community services.

4.7.3 Primary Care Network Forum

The Partnership is establishing a forum to bring together our system's Primary Care Networks (PCNs). PCNs bring primary and community services together to work at scale (as set out in the NHS Long Term Plan)

Bringing our Networks together periodically provides a tremendous opportunity to ensure there is a connection with our neighbourhoods, that the Partnership remains connected to and relevant to the front line but also to ensure that a clinical voice is even more prominently connected to our work, strategic planning and decision making.

The scope and frequency of this groups work will be defined in due course.

4.7.4 Integrated Care Partnership Network

The Partnership is establishing a network to bring together our emerging system place-based integrators.

Establishing this forum will support our emerging systems to share best practice, share learning and undertake shared, stepped implementation progress or integration.

The scope and frequency of this groups work will be defined in due course.

4.7.5 Cheshire and Merseyside People Board

The NHS People Plan sets a requirement for systems to develop a local People Board which will be accountable to the NHS North West Regional People Board. The Cheshire and Merseyside People Board (C&MPB) brings together health and care organisations and key stakeholders to provide strategic leadership to ensure the implementation of the People Plan and system wide workforce plans.

It is intended that the local People Board will provide a forum to:

- Monitor the delivery of the Cheshire and Merseyside People Plan targets and milestones
- Agree workforce transformation programmes
- Determine workforce development priorities and allocation and approval of funding accordingly
- Monitor performance of any workforce programmes

The Board meets on a quarterly basis. Membership is drawn from across the health and care sectors. Key NHS members from this group also participate in social care and Liverpool City Region workforce groups to maximise alignment and partnership collaboration.

4.7.6 Communications and Engagement Strategic Advisory Group

The Communications and Engagement Strategic Advisory Group provides leadership and co-ordination for communications and engagement across the Cheshire and Merseyside health and care system.

The group links with the Partnership's Co-ordination Group and aims to facilitate and secure alignment and connection between Partnership activities and those being undertaken in each partner organisation. The group provides leadership to the local communications and engagement community and shares local intelligence on sensitive or contentious issues,

The Group meets monthly. Membership is drawn from across health and care and includes wide, representative, local authority membership.

4.7.7 Local Council Leadership

Relationships between local councils and NHS organisations are well established in each of the nine places. The Partnership places great emphasis on these Place level connections and relationships. How the Partnership interacts with Place, secures intelligence and acts on feedback is and will be critical. The Partnership itself recognises it needs to develop its own relationships, avoid duplication and accordingly focusses primarily on the system level. We will continue to strengthen relationships in our current areas of focus:

- Liverpool City Region Health and Well-being Portfolio Holders
- Cheshire and Warrington sub regional Leaders' Board
- Local authority chief executives engage and collaborate with the Health and Care Partnership;
- Health and Wellbeing Board chairs collaboration
- Provision for Joint Health Overview and Scrutiny Committees as may be beneficial

4.7.8 Local Place Based Partnerships

Local partnership arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers working together in Primary Care Networks, to take responsibility for the cost and quality of care for the whole population.

Each of our Places has developed its own partnership arrangements to deliver the ambitions set out in its own Place Plan. As identified by NHSE/I these may take the form of or link with Place based Provider Collaboratives. Such ways of working reflect local priorities and relationships, but all provide a focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

We anticipate our local, place based, health and care partnerships will develop horizontally integrated networks to support seamless care for patients.

5. Mutual Accountability Arrangements

A single consistent approach for assurance and accountability[2] between Partners in Cheshire and Merseyside system wide matters will be applied through the governance structures and processes outlined in pages 12 through 17 above. Our mutual accountability framework is set out, in full, at Annex 4

Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health, including tackling inequalities where relevant to committed Partnership activities or delivery.

Our mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places wish to access support from the wider Partnership to ensure the effective management of financial and delivery risk.

As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Cheshire and Merseyside by, overtime, enacting streamlined oversight arrangements

5.1 Decision-Making and Resolving Disagreements

Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

5.2 Collective Decisions

There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision- making responsibilities.
- **Decisions delegated to collaborative forums** - some partners may from time to time delegate specific decisions to a collaborative forum, for example, a Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the relevant collaborative forum and not this Memorandum.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in annex 4 below.

[2] Within the NHS and extending to areas of committed Partnership or Place based activity or delivery

Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board will not act where it has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

The Partnership Board will aim to make decisions by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may be referred to the dispute resolution procedure on page 19 below and Annex 4 by any of the affected Partners for resolution.

In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

5.3 Dispute resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

Where necessary, Place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

The Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

6. National and regional support

To support Partnership development as an Integrated Care System there will be a process of aligning resources from NHS Arm's Length Bodies, such as some regional NHSE/I focus, to support delivery and establish an integrated single assurance and regulation approach.

National capability and capacity will be available to support C&M from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

7. Variations

This Memorandum, including the Schedules, may only be varied by the agreement of the Board after consultation with all Partners.

7.1 Charges and liabilities

Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a “Contributions Schedule” as may be developed by the Partnership through its Finance Forum.

Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

7.2 Information Sharing

The Partners will provide to each other all information that is reasonably required in order to achieve the objectives and take decisions on a Best for C&M basis.

The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

7.2.1 Confidential Information

Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner. It is the responsibility of the disclosing Partner to handle any relevant requests for information as may be disclosable under FOI legislation as such information is held in trust, only, via this agreement on behalf of the information asset owner to support delivery on their behalf via the Partnership.

To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

The Parties agree to ensure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

7.3 Additional Partners

If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

7.4 Signatures

This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document. For the document to have effect all Partners must have supported it.

The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

Schedule 1 - Definitions and Interpretation

Annex A – Parties to the Memorandum

Annex 1 – Applicability of Memorandum Elements

Annex 2 – Schematic of Governance and Accountability Arrangements

Annex 3 – Signatories to the Memorandum

Annex 4 – Mutual Accountability Framework

Annex 5 – Partnership Assembly Constituencies

Annex 6 – Partnership Board Membership

Annex 7 – Terms of Reference - will be added in due course

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm's Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, e.g. NHSE, NHSI, HEE, PHE
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England
GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Annex A
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better
HWB	Health and Wellbeing Board

ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision-making forum. It has delegated commissioning functions
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub-regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	A number of geographical areas which make up Cheshire and Merseyside, in which GP practices work together as Primary Care Networks, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people
NHS	National Health Service
NHSE	NHS England (formally the NHS Commissioning Board)
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS
NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Partners	The members of the Partnership under this Memorandum as set out in Annex A
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Assembly	The representative body of the Partnership, bringing together the members of the Partnership akin to a shareholder AGM. The Partnership's representative or democratic council,
Partnership Board	The senior governance group for the Partnership set up in accordance with pages 12-17
Partnership Executive	The team of officers, led by the Partnership Chief Officer, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the nine geographical districts that make up Cheshire and Merseyside, being Knowsley, Sefton, Liverpool City Region, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral. and "Place" shall be construed

	accordingly
Programmes	The C&M programme of work established to achieve each of the objectives agreed by the Partnership
STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
Transformation Fund	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	Shall have the meaning set out in pages 9 and 10

Annex A - Parties to the Memorandum

The members of the Cheshire and Merseyside Health and Care Partnership (the Partnership), and parties to this Memorandum, are:

Local Authorities

- Cheshire East Council
- Cheshire West and Chester Council
- Halton MBC
- Knowsley MBC
- Liverpool City Council
- Sefton MBC
- St Helens MBC
- Warrington Borough Council
- Wirral Council

NHS Commissioners

- NHS Cheshire CCG (Formerly Eastern, Western and South Cheshire and Vale Royal)
- NHS Halton
- NHS Knowsley
- NHS Liverpool
- NHS South Sefton
- NHS Southport and Formby
- NHS St Helens
- NHS Warrington
- NHS Wirral

NHS Service Providers

- Alder Hey Children's NHS FT
- Bridgewater Community Healthcare NHS FT
- Cheshire and Wirral Partnership NHS FT
- The Clatterbridge Cancer Centre NHS FT
- Countess of Chester Hospital NHS FT
- East Cheshire NHS Trust
- Liverpool Heart and Chest NHS FT
- Liverpool University Hospitals NHS FT
- Liverpool Women's NHS FT
- Mersey Care NHS FT
- The Mid Cheshire Hospitals NHS FT
- NW Ambulance Service NHS Trust
- NW Boroughs Partnership NHS FT
- St Helens and Knowsley Teaching Hospitals NHS Trust

- Southport and Ormskirk Hospital NHS Trust
- The Walton Centre NHS FT
- Warrington and Halton Hospitals NHS FT
- Wirral Community Health and Care NHS FT
- Wirral University Teaching Hospital NHS FT

Other Partners

- All PCNs in the Cheshire and Merseyside area
- Voluntary Sector North West
- Healthwatch in each of the Partnership's Places

As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and arrangements set out in this Memorandum.

Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

There are other partners who are not members and therefore not signatories to this memorandum. These include:

Heath Regulator and Oversight Bodies

- NHS England and NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission

Other Local Bodies

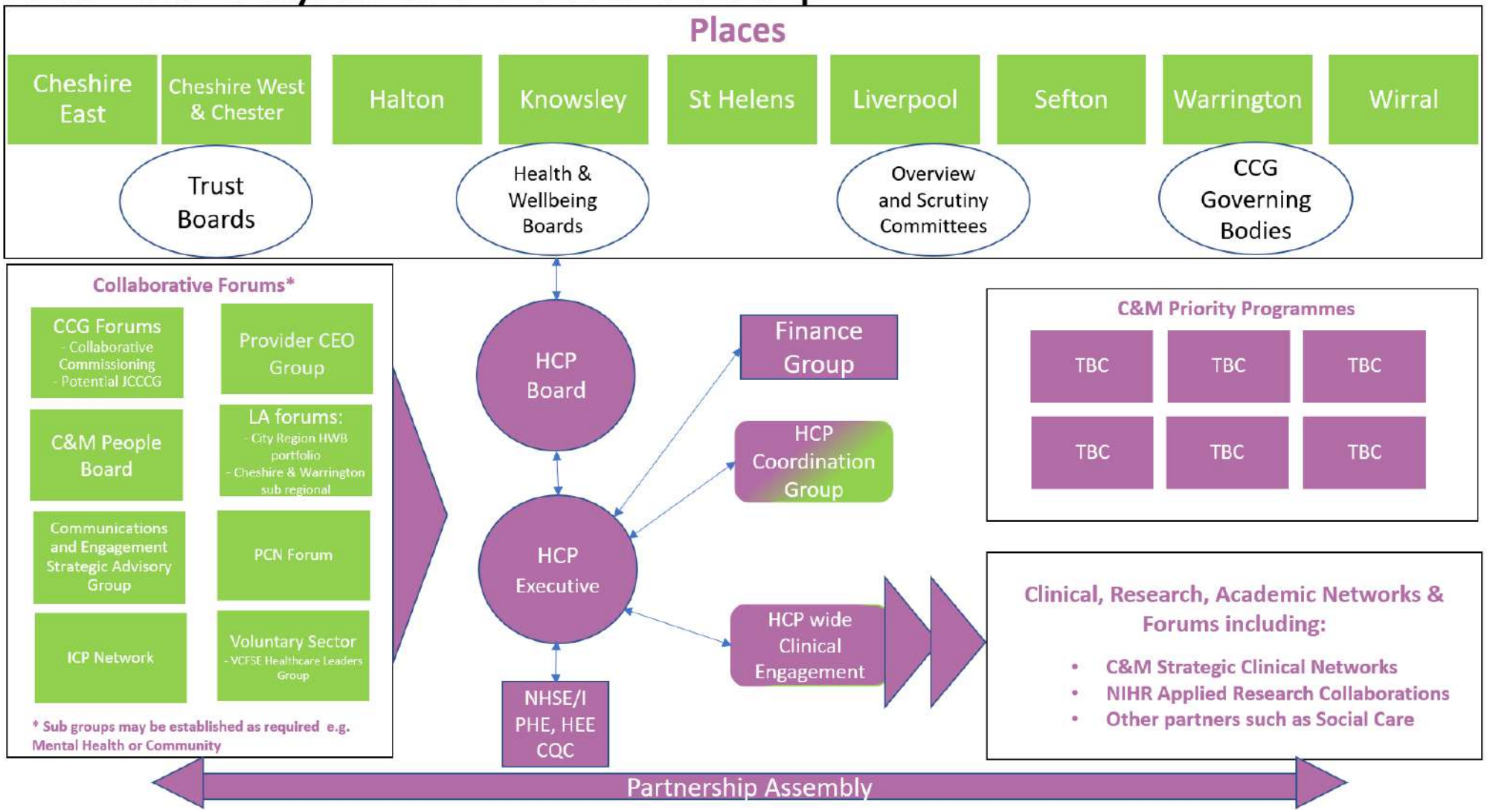
- Fire
- Police
- Probation
- Others, where relevant

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviours	✓	✓	✓	✓	✓	✓
Partnership aims	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financials: • Financial risk management • Allocation of capital and transformation	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

Annex 2 – Schematic of Governance and Accountability Arrangements

Cheshire & Merseyside Health and Care Partnership:



Annex 3 – Signatories to the Memorandum

Annex 4 – Mutual Accountability Arrangements

A single consistent approach for assurance and accountability[3] between Partners in Cheshire and Merseyside system wide matters will be applied through the governance structures and processes outlined in pages 12 through 17 above.

1. Current statutory requirements

NHS England and NHS Improvement were brought together to act as one organisation in 2019, but each retains its statutory responsibilities. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

We recognise that each non NHS partner has its own statutory and regulatory frameworks and requirements which are of equal importance and consideration. Some of these requirements may have greater relevance to the Partnership or Places than others. We envisage such arrangements will receive primary focus at a Place level e.g OFSTED.

2. Our model of mutual accountability

Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health including tackling inequalities where relevant to committed Partnership activities or delivery. As Partners we will:

- agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our collaborative groups to support any formally required decision making, engaging people and communities across our system; and

[3] Within the NHS and extending to areas of committed Partnership or Place based activity or delivery

- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

We anticipate as we develop over time, and when legislation or regulation requires, system oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

3. Progressing any action

We will prioritise work and the deployment of improvement support across the Partnership and agree recommendations for any action or interventions where relevant to committed Partnership activities or delivery. We envisage using our Partnership Co-ordination Group as the forum to agree recommendations on:

- Improvement or recovery plans;
- More detailed peer-review of specific plans;
- Commissioning expert external review;
- Co-ordination of any formal intervention and improvement support; and
- Agreement of any restrictions on access to discretionary funding and financial incentives.

For Places where financial performance is not consistent with plan, the Finance Group may make recommendations to the Partnership Co-ordination Group on a range of interventions.

4. The role of Places in accountability

This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

The Partnership and its constituent bodies recognise the statutory role and powers of Health Overview and Scrutiny arrangements

5. Implementation of agreed strategic actions

Our mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places wish to access support from the wider Partnership to ensure the effective management of financial and delivery risk.

6. National NHS Bodies oversight and escalation

As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Cheshire and Merseyside by, overtime, enacting streamlined oversight arrangements which will support the Partnership to:

- take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;

- Work with NHS England and NHS Improvement who will increasingly hold the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- Work with NHS England and NHS Improvement to agree where they will intervene in individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the Partnership and work with it to seek a resolution prior to making an intervention.

These arrangements will build upon the current Accountability Agreement in place between the Partnership and NHSE. We expect our current agreement to be reviewed which may result in a refresh.

7. Decision-Making and Resolving Disagreements

Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

8. Collective Decisions

There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision- making responsibilities.
- **Decisions delegated to collaborative forums** - some partners may from time to time delegate specific decisions to a collaborative forum, for example, a Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the relevant collaborative forum and not this Memorandum.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out below.

Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board will not act where it has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

The Partnership Board will aim to make decisions by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may be referred to the dispute resolution procedure on page 35 below by any of the affected Partners for resolution.

In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

9. Dispute resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

Where necessary, Place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

The Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

The key stages of the dispute resolution process are

I. The Partnership, working through the Partnership Executive, will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If the Executive cannot resolve the dispute within 30 days, the dispute should be referred to Partnership Chief Officer who will, likely, involve the Partnership Coordination Group.

II. The Co-ordination Group will consider the issues and, where necessary, make a recommendation based upon a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. The Partnership Executive will advise the affected Partners of its decision inwriting.

III. If the parties do not accept the decision, or Board cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by Partnership's Chief Officer. The facilitator will work with the

Partners to resolve the dispute in accordance with the terms of this Memorandum.

IV. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred back to the Partnership Board for final resolution based upon majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

Annex 5 – Partnership Assembly Constituencies

Organisations that represent constituencies within our Partnership Assembly above and beyond those listed as Parties to this agreement (Annex A):

Age UK Cheshire	Liverpool John Moores University
ANCS	University of Liverpool
Cheshire Fire and Rescue Service	Edge Hill University
Cheshire Police	Merseyside Fire and Rescue Service
Cheshire West Voluntary Action	Merseyside Police
Healthwatch Cheshire	CPS Mersey-Cheshire
Manchester Metropolitan University	NW Innovation Agency
Cheshire West Integrated Care Partnership	North West Ambulance Service
Cheshire Halton & Warrington Race & Equality Centre	Torus
The University of Chester	Voluntary Sector North West
Public Health England	Sefton CVS
Greater Manchester Health and Social Care Partnership	Venus Working Creatively with Young Women
Her Majesty's Prison and Probation Service	Together We're Better' - Staffordshire and Stoke on Trent STP
Citizens Advice Halton	Citizens Advice Warrington
Halton Housing	Fearnhead Cross Medical Centre
Halton & St Helens VCA	People First UK
Healthwatch	Right to Succeed
R-Health	Sovini
Lancashire and South Cumbria STP	VCFSE representatives
Lancashire Care	

This list may be extended through a simple process of proposition and agreement via the Partnership Board.

Annex 6 – Partnership Board Membership

i. A representative from each of our nine Local Authority areas within the ICS footprint.

ii. A CEO and a Chair representing acute providers

iii. A CEO and a Chair representing mental health and community providers

iv. A CEO and a Chair representing specialist providers

v. Two Primary Care Network representatives. Assumed elected or nominated via the Primary Care Network Forum

vi. A CCG Accountable Officer

vii. A CCG Clinical Chair

viii. A Public Health representative

ix. A VCSE representative

x. An NHSE/I representative

xi. From the Partnership, itself, it is proposed that the Chair, Chief Officer and up to 3 executive director posts will be full or voting members of the Board. Other directors will attend.

The above Partnership Board membership provides for the envisaged future form reflecting when the ICS has assumed statutory powers.

The Partnership is progressing dialogue with CCG's regarding representation, through 2021/22, reflecting an anticipated transition year.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date: 4th March 2021

Title	**Freedom to Speak Up Guardian Report – Quarters 2 & 3 2020/21**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	• Committee None • Group None • Other None

Executive Summary

The report provides an update on the progress of the role and plans for strengthening current speak up arrangements.

The report also highlights concerns raised with the Freedom to Speak Up Guardian.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations. There are a number of risks to having a culture where staff do not feel able to raise concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as reputational risk.
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations.
Action required by the Board	• To consider and note

The Walton Centre NHS Foundation Trust

Freedom to Speak Up Guardian Report
Quarters 2 and 3 2020/21

1. INTRODUCTION

1.1 The purpose of this paper is to provide the Board of Directors with assurance on the effective working of the Trust's Freedom to Speak Up arrangements.

1.2 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.

1.3 The Freedom to Speak Up Guardian (FTSUG) for the Trust is Julie Kane who is also the Quality Manager and works within the Corporate Nursing Team. The Executive Lead for raising concerns is Lisa Salter, Director of Nursing and Governance and the Non-Executive Lead for raising concerns is Seth Crofts.

1.4 The Trust's approach to developing and supporting a 'speak up' culture is essential to ensuring the organisation is well led. Staff who are encouraged and supported in raising concerns and know their concerns will be acted upon will have a positive impact on patient safety, promote good practice and ensure lessons are learnt.

2. LEADING BY EXAMPLE

2.1 There are two dedicated Freedom to Speak Up Champions within the Trust whose substantive posts are non-clinical. The Champions have received the NGO training and are named below:

- Tina Hughes - Medical Secretary
- Andrew Sharrock - Senior Business Intelligence Developer

The Champions role is promoted via the Walton Weekly, Team Brief and posters are displayed across the Trust which provides contact details for each of them.

3. AWARENESS RAISING

- Walton Weekly/Articles in Team Brief/Neuro Matters
- Separate email address freedomtospeakup@thewaltoncentre.nhs.uk
- Attendance and hosting Regional Meetings
- National Guardian Visit

- Undertakes Surveys
- Presented at Berwick Session
- Business cards attached to each payslip
- Drop-In Sessions scheduled throughout the year
- Holds 'speak up' events to promote the Guardian and Champions roles

The FTSUG has been co-ordinating staff swabbing since covid began and always asks when speaking to colleagues how things are and whether her input is required as FTSUG.

During covid the FTSUG has not attended team and departmental meetings due to social distancing, however, she works on site, has increased her visibility and attends the Trust safety huddle daily.

4. MONITORING

4.1 As part of ongoing monitoring the FTSUG became a member of the Strategic BAME Advisory Committee which was launched in October 2020.

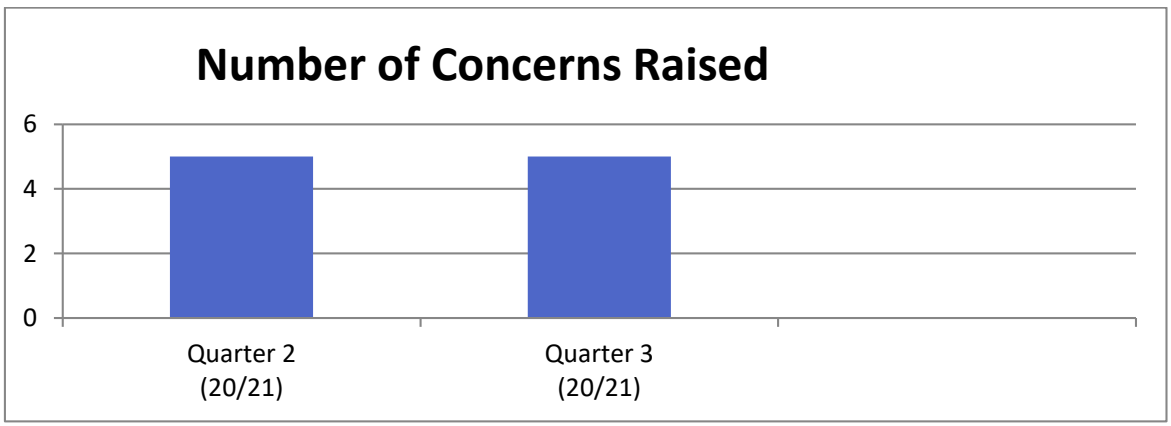
4.2 The NGO undertook a survey as to whether a guardian's ethnicity acts as a barrier to workers speaking up. The survey found that the guardian network is predominantly white, and other ethnicities continue to be under-represented when compared with the NHS workforce as a whole.

4.3 The NGO are commissioning research, to take place over quarter four in 2020/21, to shed light on whether the ethnicity of a guardian acts as a barrier to workers of other ethnicities speaking up. This work will include seeking opinions from workers and will be focused on a cross-section of organisations with a guardian.

There will be expressions of interest from guardians from all types of organisations and all ethnic backgrounds on this important piece of work. The NGO would particularly welcome expressions of interest from guardians from ethnic minorities.

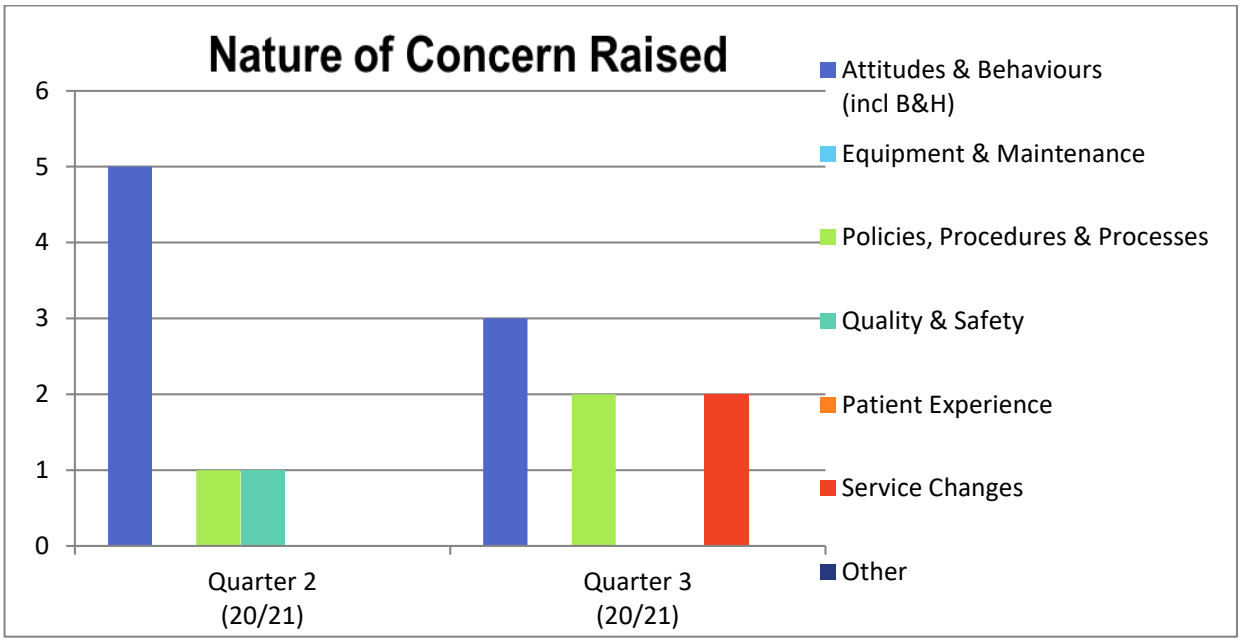
5. LOCAL ACTIVITY – Quarters Two and Three in 2020/21

5.1 The graph below indicates how many concerns have been raised during quarters two and three in 2020/21:



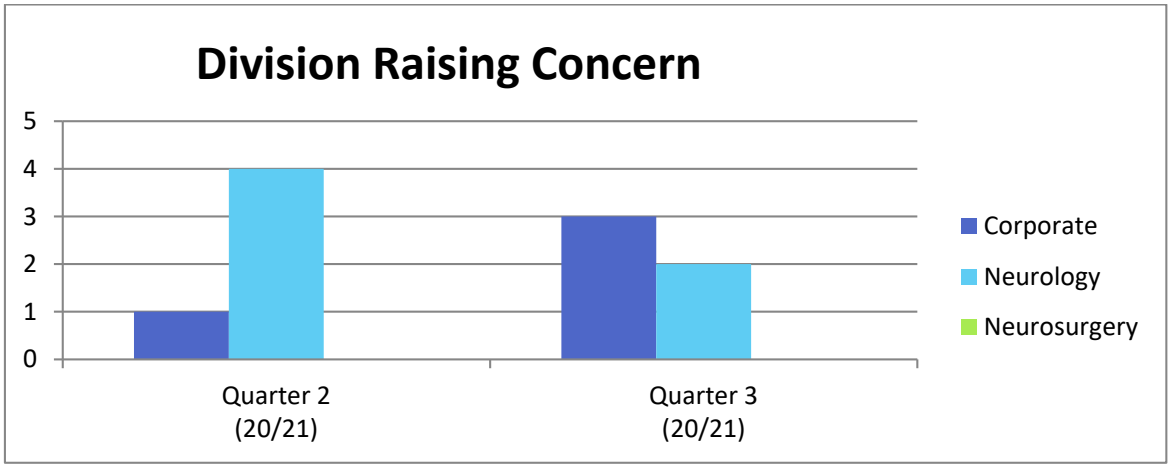
Note: Zero concerns were raised anonymously during 2020/21

5.2 The graph below indicates the nature of the concerns raised during quarters two and three in 2020/21:



Note: Some concerns raised have more than one element and are displayed across a number of categories

5.3 The graph below indicates the division raising the concerns during quarters two and three in 2020/21:



5.4 Throughout the year staff have met with the FTSUG not only to raise concerns but to seek advice which they found beneficial as the Guardian is independent and impartial. The role of the FTSUG/Champion is not to investigate a concern which has been raised or to mediate. Most concerns are resolved locally and by signposting individuals to appropriate personnel. However, further guidance regarding a specific issue is escalated immediately and links are made with the Executive/Non-Executive Leads for raising concerns and/or the Chief Executive.

5.5 The FTSUG continues to meet with the Non-Executive/Executive Leads for Raising Concerns to discuss concerns raised and review progress made. She meets with the Head of Business HR and HR Manager for Neurology monthly to discuss and review themes and provide progress against reviews which may have been undertaken.

Meetings are also scheduled quarterly with the Chair and Chief Executive to keep them appraised of activity.

5.6 The FTSUG has access to all Board members and the 'open door' approach within the Trust is extremely positive and encouraging should a concern need immediate attention/action.

6. SUBMISSIONS TO THE NATIONAL GUARDIAN'S OFFICE (NGO)

6.1 The NGO issued a minimum dataset for Trust's to assist with internal and external reporting. Each quarter the FTSUG submits a return to the NGO to enable benchmarking to be undertaken.

The information required is listed below:

- Number of cases raised within the quarter
- Number of cases including an element of patient safety/quality of care
- Number of cases including elements of bullying and harassment
- Number of incidents where the person speaking up may have suffered detriment
- Number of anonymised cases received

6.2 The total number of cases raised nationally with Freedom to Speak Up Guardians within NHS Trusts is as follows:

	2017/18	2018/19	2019/20
Quarter 1	1447	2348	3173
Quarter 2	1515	2604	3486
Quarter 3	1939	3600	4120
Quarter 4	2186	3406	5420
Total	**7087**	**11958**	**16199**

The figures above confirm more cases are being raised year on year which is extremely positive and shows a 32% increase in cases being raised in 2019/20 than in the previous year.

The figures submitted by the FTSUGs confirm 1 in 10 cases are reported as being raised to guardians anonymously which is concerning as these can sometimes be more difficult to investigate and difficult to provide feedback on. Equally, they can be an indicator that there is a general lack of trust or fear associated with speaking up. During 2020/21 no concerns were raised anonymously to the FTSUG which is very encouraging.

6.3 The Trust's FTSUG collects information from staff members who have raised concerns by asking the following questions:

- Given your experience, would you speak up again
- Please explain your above response

Respondents have confirmed they would speak up again and have given positive feedback. To date no negative feedback has been given. Some of the feedback received is below:

- ❖ Julie was reassuring and very supportive. She followed up the meeting and made sure I was okay
- ❖ Thankful to you for giving a passionate ear to my vows and resolving them for me on a priority basis
- ❖ I would speak up again as I feel confident my concerns have been taken seriously
- ❖ I am happy to say that there was a positive outcome and I would recommend that staff should feel able to speak up as it helped me
- ❖ Julie is someone independent and trustworthy, I would definitely speak up again if I needed to
- ❖ Could feel the difference within days and things improved out of nowhere
- ❖ Thanks for taking the time to listen to me. I would speak up again as help was given to me and the monitoring has continued
- ❖ I would definitely speak up again as the experience I had I felt completely listened to, treated with respect, and you are so friendly and approachable

7. NATIONAL GUARDIAN'S OFFICE UPDATES & REPORTING

7.1 The National Guardian's Office (NGO) carries out case reviews to identify learning and support improvements in the speaking up culture and arrangements in NHS trusts. These reviews have concentrated on cases where speaking up may not have been handled according to good practice.

Reviews can be triggered by referrals to the office from individuals. The office also has the discretion to accept referrals from other sources. The office is in the process of developing the way it decides what is reviewed. These changes seek to:

- Allow more workers to inform matters that are reviewed by the office, including workers who may face barriers to speaking up
- Ensure reviews undertaken by the office have the greatest impact on the greatest number of workers by focusing on areas of priority

Potential themes for review will be identified through use of a broad range of indicators, including:

- Staff engagement data (e.g. the NHS Staff Survey)
- Speaking up to:
  Freedom to Speak Up Guardians
  Professional and systems regulators
  Workers' representative bodies
  The National Guardian's Office

The NGO will launch this new process in 2021/22.

7.2 The North West Region appointed a Regional Liaison Lead (RLL) following a request from NHS England to the National Guardian's Office. The RLL is supporting the implementation of the guardian role in primary care organisations and developing an integrated approach to speak up across primary and secondary care boundaries.

7.3 The FTSUG continues to attend the regional meetings, remotely, throughout the year to keep appraised of national guidance, plans going forward and to share views and learn lessons from her peers.

8. Training

8.1 The NGO has launched the first module of a Freedom to Speak Up e-learning package for all healthcare workers.

'Speak Up, Listen Up, Follow Up' was developed in association with Health Education England and has been divided into three modules to explain what speaking up is.

The first module, 'Speak Up', is core training for all healthcare workers, including volunteers and students. The e-learning module is undertaken once and takes approximately 45 minutes to complete which includes watching a video. The FTSUG is working with the Training and Development Team to look at how best to launch this training module and agree when would be the best time to do this within the Trust.

9. NEXT STEPS AND ACTIONS

9.1 The Freedom to Speak Up Guardian, Champions, Executive and Non-Executive Leads will continue to promote the role, encourage speaking up and support staff engagement sessions.

9.2 Ensure future collaborative working takes place across the Trust.

9.3 Once the intranet site has been redesigned the FTSUG will ensure current information is readily available and accessible.

9.4 Continue to work with other organisations to review, discuss and support speaking up.

10. RECOMMENDATIONS

10.1 The Board are asked to receive and note the report and the Freedom to Speak Up arrangements in place within the Trust.

Report to the Board of Directors
Date: 4th March 2021

Title	**Board of Directors - Cycle of Business 2021-22**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	Content reviewed by individual Executive Directors

Executive Summary

A draft Cycle of Business 2021/22 for the Board of Directors is included for reference at Annex A. The Cycle of Business sets out core agenda items for Board meetings throughout the year and facilitates effective and efficient planning for the preparation and submission of reports for consideration by the Board.

The content of the Cycle of Business is consistent with the approach adopted for the current year but incorporates amendments to schedule review of the IPC Board Assurance Framework in June 2021, which had been identified in the Board Action Log, and formal review of progress against the Trust's Strategy in July 2021. Board members should note that delivery of the Cycle of Business may be impaired by the prevailing situation relating to the Covid-19 pandemic and agendas may be 'streamlined' to facilitate an appropriate operational focus. This risk will be mitigated as far as is practicable through use of a Consent Agenda approach and the Corporate Secretary will maintain a log of any deferred items to ensure Board consideration at a later date.

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Cycle of Business should ensure that the Board of Directors discharges its responsibilities in a timely manner and thereby mitigates the risk of breaching legal and/or regulatory requirements.
Action required by the Board	The Board of Directors is recommended to: a) approve the Cycle of Business 2021/22 as presented at Annex A.

BOARD CYCLE OF BUSINESS 2021-2022	Purpose	Lead	Assurance /Oversight Committee	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Standing Items															
Welcome and apologies		Chair		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Minutes of previous meeting		Chair		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Matters Arising Action Log		Chair		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Chair and CEO Report		CEO		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Patient Story		DON		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Strategy (Updates provided by bi-annual review and relevant annual reports)															
Trust Strategy 2018 - 2023		DoOS					✓								
Quality & Safety															
Quarterly Governance Report (includes complaints, SI's, H&S)		DoN	QC		✓				✓		✓			✓	
Mortality and Morbidity Report		MD	QC			✓				✓				✓	
Complaints and Patient Experience Annual Report		DoN	QC				✓			✓					
Guardian of Safe Working Quarterly Report		MD	QC			✓			✓			✓			✓
Freedom to Speak Up Guardian Report		DON							✓		✓				✓
Nurse Staffing - Bi-Annual Acuity Review		DON				✓					✓				
Nursing Revalidation Report (Annual)		DoN			✓				✓						
Medical Revalidation Report (Annual)		MD					✓								
Research, Development & Innovation Annual Report		DW&I	QC												
Safeguarding Annual Report		DoN	QC			✓									
Infection Prevention & Control Annual Report		DoN	QC	✓											
Medicines Management (including AO for Controlled Drugs) Annual Report		MD	QC		✓				✓						
Performance															
Integrated Performance Report		CEO	All	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Staff Survey Results		DoW&I	N/A												✓
Staff Survey Action Plan		DoW&I	BPC			✓									
National Inpatients Survey		DoN	QC			✓									
Regulatory, Guidance or Contractual															
Annual Audit Letter		DOF	AC			✓									
Annual Governance Statement		Co Sec	AC			✓									
Annual Report and Accounts		DOF	AC			✓									
Chairs Annual Review of Fit and Proper Persons		Co Sec			✓										
Charitable Funds Annual Report & Accounts		DOF	WCC									✓			
Equality Diversity & Inclusion Annual Report		DoW&I				✓									
ERIC Return		DoOS	BPC			✓									
EPRR Core Assurance Self-Assessment		DoOS	BPC								✓				
IPC Board Assurance Framework		DoN	QC			✓									
Major Incident Plan		DoOS	BPC				✓								
Medical Education Annual Report		MD	RIME						✓						
Mixed Sex Accomodation; Annual Statement of Compliance		DON	QC	✓											
Modern Slavery Act Statement		DoN	N/A								✓				
Operational Plan		DoOS	BPC	✓											

Quality Account Priorities		DoN	QC											✓	
Quality Account		DoN				✓									
Provider Licence Self Certification (G6, FT4,)		Co Sec	Audit			✓									
Register of Interests		Co Sec	Audit		✓										
SIRO Report		DOF					✓								
Sustainable Development Management Plan		DoOS	BPC			✓									
Workforce Race Equality Standard		DW&I	N/A						✓						
Workforce Disability Equality Standard		DW&I	N/A						✓						
Governance															
Annual Budget (including capital programme and CIP) - Draft		DoF										✓			
Annual Budget (including capital programme and CIP) - Final		DoF													✓
Board Assurance Framework		Co Sec		✓			✓			✓					
Board Cycle of Business & Development Programme		Co Sec													✓
Board Effectiveness Review (Part 2)		DoW&I				✓									
Register of the Seal		Co Sec	Trust Board	✓							✓				
Risk Appetite Statement (Links to Risk Management Strategy)		DON													✓
Standing Financial Instructions, Scheme of Reservation and Delegation		DoF	Audit								✓				✓
Constitution & Standing Orders		Co Sec													✓
Committees of the Board															
Audit Committee Chairs Assurance Report		Audit Chair			✓	✓			✓		✓			✓	
Audit Committee Annual Report and effectivness review		Co Sec			✓										
Business Performance Committee Chairs Assurance Report		Com Chair		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Business Performance Committee Annual Report and effectiveness review		Co Sec			✓										
Charity Committee Chairs Assurance Report		Com Chair													
Neuroscience Programme Board Chairs Report		CEO		✓										✓	
Neuroscience Programme Board Annual Report		CEO			✓										
Quality Committee Chairs Assurance Report		Com Chair		✓	✓	✓	✓		✓	✓	✓	✓		✓	
Quality Committee Annual Report and effectiveness review		Co Sec			✓										
RIME Committee Chairs Assurance Report		Com Chair		✓		✓			✓	✓		✓		✓	
RIME Committee Annual Report and effectiveness review		Co Sec			✓										

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 March 2021

Report Title	**Chair's Assurance Report – BPC 23 February 2021**
Sponsoring Director	David Topliffe – Chair of Business Performance Committee
Author (s)	Jan Ross, Director of Operations and Strategy
Purpose of Paper:	
The Business Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Business Performance Committee held on 23 February 2021.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Operational Performance Recovery plan to be developed and presented at the next meeting which aims to incorporate an appropriate staff recovery plan.
- The current financial arrangements to continue to for Q1 21/22 and possibly Q2. An exercise is being undertaken looking at exit run rates for 20/21 to calculate what the Q1 block income payments will be.
- The proposal of the commercial strategy being a subject for a forthcoming board development session.
- The procurement of multiple capital items with short lead time to maximise capital spend before 20/21 year end.

The meeting consisted of a slimmed down agenda, specific proposals presented for information or approval alongside a consent agenda.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Integrated Performance Report

Operations – The Trust had seen a decline in activity and average wait was below target and there had been some deterioration in the 52 week performance. A Recovery Plan was being drawn up and that would be presented to the Committee at the March meeting.

Workforce – Recruitment had continued over the past year and the first virtual recruitment day had recently taken place with 15 applicants shortlisted and 5 offers returned. Sickness was currently 5% with total staff unavailable at 7.5%. Staff who were shielding were continued to be monitored and a shift in staff unavailable was not expected to drop until shielding came to an end. An update was given on the vaccination programme and the commencement of the second dose. An area of concern was around PDRs and Appraisals and the work around improving this was detailed.

Work going forward would be on incorporating staff health and wellbeing into the recovery plan and what the key priorities would be and how staff could feel supported.

Finance – At M10 the Trust reported an in month £90k deficit against a planned deficit of £158k. The Committee were asked to note that M10 forecast is £0.6m surplus so an improvement of £1.1m from the January forecast – this was due to improvements seen in both M9 and M10. There was an income under performance of £297k in month and expenditure in month underspend of £365k.

Capital of £281k was incurred in M10 which was £96k above plan and £2,534k underspent YTD. A large proportion of spend will be incurred later in the year. Cash remained in a healthy position with the balance at the end of January at £41.3m.

The current financial arrangements would continue for at least Q1 of 21/22. An exercise is being undertaken looking at exist run rates for 20/21 to calculate what the Q1 block income payments would be.

b) Estates Return Information Collection (ERIC) Annual Report

The Committee received a briefing document based on the annual ERIC providing an overview of what ERIC is and the main drivers behind the data collection. The report compared the Trust data submitted for 2019/20 against peer trusts with similar sized estates based on gross internal area. The Estates Manager updated that this was the first report produced of this kind and although there had been some learning from the statistical analysis there was the problem around how data was interpreted by peers and the difficulty in getting direct comparisons.

Discussion took place around:

- How the ERIC data feeds into NHSI Model Hospital and what processes are in place to view these metrics for a more broader focus around use of resources;
- Benchmarking with other trusts and the recent contact with Queens Square, London, in order to use that trust as a comparator for a number of different services; and
- The need to have a form of benchmarking in place that would meet the expectations of NHSI when a use of resources assessment is looked at in a Well Led Review.

c) Communication, Engagement and commercial Update

The Committee received the update from the Head of Commercial Engagement and Marketing and were informed on the commercial and innovation work that was relatively new to the Trust. It was considered that discussion around the Trust's commercial strategy be a subject for wider discussion at BPC going forward. Projects currently in place were detailed as well as initiatives coming through. The work of the Communication Team both internally and externally was referenced with Covid 19 dominating both activities. The website development was a project that continued to take up a lot of work for the team however the commencement in post of a Communications and Marketing manager next month was welcomed.

The Committee discussed at length the commercial agenda and how the trust was probably behind the curve on this but going forward would need to think less about commissioner income streams and explore more areas of commercialisation and return on investment. It was considered to be a potential agenda for a board development session.

d) Terms of Reference - Staff Partnership Committee

The annual review of the Terms of Reference were approved. It was noted there were no major changes.

e) Capital Programme Update

The Committee were updated that the planned 20/21 capital spend had progressively increased to £7m funded by an 'original' system allocated budget of £4m plus a range of other central budget allocations which have been progressively granted capital, mainly late in the year.

Where capital projects were funded through PDC, these could not continue beyond March as this funding could not be carried forward. Projects funded internally would need to spend up to allotted allocations or the pressure would be carried forward into 2021/22.

Further support has now been given to spend up to a total of £8.7m provided justified projects can be completed by end of March. Spend phasing has therefore ended up disproportionally skewed to year end (c. £6.5m in Q4).

An opportunity has arisen to take on an additional neurosurgery service. The related capex could be implemented in 21/22 and to 'create headroom' in the anticipated 21/22 capital budget, other planned 21/22 items with short lead times are being urgently brought forward to procure in 20/21. The support to 'overspend' by £1.7m in 20/21 as noted above relates to this. Achieving this significant amount of expenditure in a short time scale involves intense focus and aligned action across the organisation.

The Committee discussed how to approve any items before the next meeting on 23 March. It was agreed rather than Chair's action, any business cases would be emailed to voting members of the Committee to gain overall approval before final decisions / authorisations were made.

f) Items presented under Consent Agenda

Four Chair's Reports from sub groups that had taken place were received and noted.

3.0 Progress against the Committee's annual work plan

The Committee continued to follow its annual work plan this month. Some deferred items from the January meeting were put on the agenda. Some deferred items required rescheduling on the cycle of business for 2021-22.