NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 4th May 2023

Agenda and Papers

Excellence in Neuroscience

The Walton Centre
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
Thursday 4 May 2023
Boardroom
09:30 – 13.15

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Staff Story (v)	Chief Nurse	N/A
2	09.50	Welcome and Apologies (v)	Chair	N/A
3	09.55	Declaration of Interests (v)	Chair	Note
4	10.00	Minutes and actions of meetings held on: • 6 April 2023 (d)	Chair	Approve
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive	Note
6	10.20	Quality Substrategy (d)	Interim Chief Nurse	Approval
7	10.40	Trust Brand Narrative (d)	Chief Executive	Approval
8	10.55	NHS Digital Maturity Assessment (d) *Justin Griffiths- Chief Digital Information Officer*	Chief People Officer	Approval
9	11.05	NHS Prevention Pledge Update (d) *Rachel Saunderson – Innovation Manager*	Chief People Officer	Assurance
10	11.15	External Well Led Review Report (d)	Chief Executive	Assurance
GOVERNANCE				
11	11.25	Aintree Site Joint Committee (d) • Chair's Assurance Report - 26 April 2023 • Terms of Reference	Medical Director	Assurance Approve
11.35 BREAK				
PERFORMANCE & FINANCE				
12	11.45	Integrated Performance Report (d)	Chief Executive Officer	Assurance
13	11.50	Business Performance Committee (d): • Chair's Assurance Report – 25 April 2023	Committee Chair	Assurance
14	12.05	Quality Committee (d): • Chair's Assurance Report – 20 April 2023	Committee Chair	Assurance
15	12.20	Annual Plan 2023/24 Update (v)	Chief Finance Officer	Assurance
QUALITY & SAFETY				
16	12.25	Guardian of Safe Working Report – to January 2023 (d)	Medical Director	Assurance

Item	Time	Item	Owner	Purpose
17	12.30	Freedom to Speak Up Guardian Report Q4 2022/23 (d) *Julie Kane, Freedom to Speak up Guardian*	Interim Chief Nurse	Assurance
COMMITTEE CHAIR'S ASSURANCE REPORTS/ TERMS OF REFERENCE				
18	12.40	Audit Committee – 18 April 2023 (d) • Terms of Reference (d)	Committee Chair	Assurance/ Approve
19	12.50	The Walton Centre Charity Committee - 21 April 2023 (d)	Committee Chair	Assurance
20	12.55	Remuneration Committee – 24 April 2023 (d) • Terms of Reference (d)	Committee Chair	Assurance/ Approve
21	13.00	Business Performance Committee Terms of Reference (ToR)	Committee Chair	Approve
22	13.05	Quality Committee Terms of Reference (ToR)	Committee Chair	Approve
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Nursing Revalidation Annual Report 2022/23 (d) • ED&I Annual Report 2022/23 (d)				
CONCLUDING BUSINESS				
23	13.10	Any Other Business (v)	Chair	
24	13.15	Review of Meeting (v)	Chair	Note

Date and Time of Next Meeting: 9.30am, 1 June 2023, Boardroom, The Walton Centre

UNCONFIRMED

Minutes of the Public Trust Board Meeting
Board Room
6 April 2023

Present:

Su Rai (SR)	Deputy Chair and Senior Independent Director/ Acting Chair
Irene Afful (IA)	Non-Executive Director (via Teams)
Mike Burns (MB)	Chief Financial Officer
Mike Gibney (MG)	Chief People Officer
Karen Heslop (KH)	Non-Executive Director
Paul May (PM)	Non-Executive Director (not present for item 12-14)
Andy Nicolson (AN)	Medical Director
Morag Olsen (MO)	Interim Chief Nurse
Jan Ross (JR)	Chief Executive Officer
David Topliffe (DT)	Non-Executive Director
Lindsey Vlasman (LV)	Chief Operating Officer
Ray Walker (RW)	Non-Executive Director

In attendance:

Jennifer Ezeogu	Deputy Corporate Secretary
Mike Duffy (MD)	Head of Risk *(items 11 & 16)*
Jane Mullin (JM)	Deputy Chief People Office *(items 2&15)*
John O'Sullivan (JO)	Investors in People Assessor *(item 2 only)*
Lisa Judge (LJ)	Head of Patient & Family Experience *(item 1 only)*

Observers

Amanda Chesterton	Staff Governor: Clinical
Daniel Feldman	Healthcare Partnership Manager - Cheshire and Merseyside
Belinda Shaw	Public Governor: Merseyside
Melanie Worthington	Partnership Governor
Elaine Vaile	Communications and Marketing Manager

Apologies:

Max Steinberg (MS)	Chair
Katharine Dowson (KD)	Corporate Secretary
Lisa Salter	Chief Nurse

1 Patient Story

1.1 The patient story was from a patient with learning disabilities was non-verbal and was admitted via referral from the Accident and Emergency (A&E) Unit at Liverpool University Hospitals NHS Foundation Trust (LUHFT). The patient had suffered intermittent seizures, and their physical and learning disability had impacted their ability to communicate the severity of their illness.

1.2 The patient's sister highlighted that the patient was always distressed by the sight of hospitals and ambulances, and this had affected the patient's transfer in the first instance. The Safeguarding Team worked with the patient's sister to develop a plan to help mitigate the risk of the patient being distressed and make the environment more conducive for the

patient. The patient was successfully admitted into the Trust and made comfortable while all the tests and blood work were successfully carried out.

1.3 The patient's sister emphasised the need for clinical staff, who were experienced in managing people with learning disabilities at A&E.

1.4 PM thanked the patient's sister for presenting her story and asked what the Trust could do to help support people with learning disabilities at A&Es and improve the process. The patient's sister said that the issue needed to be highlighted to start a debate particularly around the bridge from paediatric to adult services for people with learning disabilities and she would be happy to support this.

1.5 MO advised that there were ongoing discussions about specialist learning disability nursing provision within the Trust.

1.6 SR asked if there were any areas the Trust could have acted differently. The patient's sister stated that the Trust was organised and helpful in planning from the point of transfer and throughout the patient's stay in the hospital.

1.7 AN noted that the Trust would continue to raise awareness in primary care and other pathways for people with learning disabilities and epilepsy and this could influence the whole system as others could learn from the process.

The Board thanked the patient's sister for sharing the story.

2 Investors in People Report

2.1 JM presented the Investors in People report and highlighted that the Trust maintained its Gold accreditation in the Investors in People assessment, which took place in January 2023, and was on course to achieving Platinum because the Trust continuously demonstrated a solid commitment to improvement. The next full review of the 'we invest in people' standard would be November 2023. A meeting would be held in April with the Trust's Investors in People Assessor to agree on the next steps towards achieving Platinum status.

2.2 MG highlighted that the Trust was the only one in the region with gold accreditation. An action plan had been developed to make progress on the areas of focus identified in the assessment report to enable the Trust to achieve Platinum status.

2.3 PM asked about the potential risks if the Trust attained Platinum accreditation. JS highlighted that it would put the Trust in the spotlight but that the methodology for achieving the Platinum status was based on evidence gathered from a broader scope for the past three years, which spanned across operational, business and people and how the Trust performed against this.

3 Welcome and apologies

3.1 Apologies were noted as above. SR chaired the meeting in the absence of the Chair and welcomed everyone to the meeting.

4 Declarations of interest

4.1 MG notified the Board of a loyalty interest due to his partner having started in post as the Company Secretary at Clatterbridge Cancer Centre NHS Foundation Trust. The interest had been recorded in the register of interests.

4.2 PM notified the Board of his appointment to the Board of Trustees of Fletchers Foundation. The interest would be recorded on the register before the next Board meeting.

4.3 IA notified the Board of her appointment to the Board of Trustees of Fletchers Foundation. The interest would be recorded on the register before the next Board meeting.

4.4 No declarations of interest were made in relation to the agenda.

5 Minutes of the meetings held on 2 February 2023 and 2 March 2023

2 February 2023

5.1 Paragraph 5.7 – Alan Stokes to be corrected to Alan Stubbs.

5.2 Paragraph 11.3 – the first and third sentences were amended from "The Trust was projected to have an end of year financial surplus of circa £1m…... The full Cost Improvement Plan (CIP) had been met." to read "The Trust was projected to have an end of year *over performance on its planned surplus by £1m*. …… The full Cost Improvement Plan (CIP) had been *identified*."

5.3 Paragraph 11.5 – the first sentence was amended from "NED-RW commented that 64% of the CIP for 2022/23 was non-recurrent which was not as good a figure as planned." to read "NED-RW commented that 64% of the CIP for 2022/23 was *recurrent* which was not as good a figure as planned."

5.4 Paragraph 13.2 – National to be added in front of Guardian's Guidance for Board Members.

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

2 March 2023

5.6 The following changes were proposed and agreed:

5.7 Paragraph 6.7 – DT requested that the following text was added to the end of the paragraph "DT stressed that the TOR of the executive-led digital steering group should be updated to reflect the wider scope involved in overseeing the implementation of the Digital Substrategy and the group would require appropriate involvement across the directorates".

5.8 Paragraph 7.3 – the second sentence was amended from "DT noted the need for it to be overseen by an executive lead." to read "DT noted the need for it to be overseen by *a new sub-group*."

5.9 Paragraph 9.7 – the first sentence was amended from "KH highlighted that there were a high number of amber shifts compared to green and sought clarity on the discrepancies." to read "*KH sought clarity on why there were many amber shifts (particularly on Chavasse ward) when it had been reported that they were fully established."*

5.10 Paragraph 10.2 – Manpower in the first sentence to be replaced with resource.

5.11 Paragraph 13.2 – the first sentence was amended to attribute the comment to the MD not MB.

5.12 Paragraph 13.4 – Addition of Audit in front of Committee in the first sentence.

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

Action Tracker
There was one outstanding action which was updated and agreed as completed.

6 Chair & Chief Executive's Report

6.1 SR gave the Chair's update on behalf of MS and advised that the first meeting of the Aintree Joint Site Committee meeting was held on 6 March 2023 where MS was appointed Chair for the first six months. MS attended a meeting hosted for the Chairs of Cheshire and Merseyside Acute Specialist Trust (CMAST), the Chair's meeting for Combined North-West System leaders, and a dinner hosted by the University of Liverpool for NHS Trust CEOs, Chairs and their senior team with JR and AN. The Board met for a development session held on 9 March 2023, and the Council of Governors met on 13 March.

6.2 JR gave an update on the planned junior doctors' strike, due to start from 06.59am on Tuesday, 11 April 2023, until 06.59am on Saturday, 15 April 2023 and advised that there were plans in place to mitigate and manage the situation to ensure that core services were delivered, and patient care was maintained; this would be managed through command and control. JR highlighted that the strike action was likely to lead to lots of elective cancellations.

6.3 IA asked if there were expectations for the Trust to provide mutual aid during the junior doctor's strike. JR noted that although there were currently no requests for mutual aid, the Trust would be in touch with the system and be on standby to offer mutual assistance where needed whilst bearing in mind the Trust's capacity when the requests were made.

6.4 IA applauded the "Veteran Aware" accreditation awarded to the Trust and inquired about what had inspired the idea. JR responded that it arose through common interest around what the Trust could do to align with the best practice and what was obtainable at other Trusts.

6.5 IA asked if the Trust was exploring gaining accreditations around Autism Awareness. JR stated that the Trust was willing to explore avenues to improve patient experience both from an access point of view and at a clinical level.

The Board noted the Chair and Chief Executive reports.

7 Trust Strategy 2022-25 Quarterly Update

7.1 AN gave a quarterly update on the Trust Strategy 2022-25 and stated that good progress had been recorded against the priorities set out in Q4. The new priorities for Q1 were outlined and AN noted that each of the key objectives for Q1 were mapped against strategic aims. Quarterly progress on each priority would be brought to Board and the strategic key performance indicators (KPI) would be refined. AN highlighted that it was agreed at the Executive Team meeting that a dashboard would be developed with the Business Intelligence Team to prioritise and monitor the KPIs.

7.2 SR welcomed the report and the introduction of quarterly updates to the Council of Governors. SR enquired when the KPIs would be available to the Board. AN responded

that there was ongoing work to finalise it by May, and the KPIs could then be included in the Q1 report.

7.3 SR asked if any challenges were envisaged towards delivering the outlined priorities. AN stated that these were likely to be due to external factors; the Trust had the right plan to monitor and manage partnerships to help deliver on the set priorities.

The Board noted the Trust Strategy Quarterly Update.

8 Finance and Commercial Development Substrategy

8.1 MB presented the Finance and Commercial Substrategy and advised that it had been to the Executive Team and the Business Performance Committee (BPC). The underlying vision was to improve productivity, maximise resource use, and develop market opportunities to deliver the best value for the Trust, the public and the wider system. These would be achieved through maintenance and improvement of financial performance, productivity improvement within the organisation, maximising opportunities in the procurement of capital, goods and services and carrying out market data assessment to better understand and develop areas of opportunity.

8.2 MB highlighted that the potential changes to income flow and increments in the Quality Improvement Plan (QIP) could be a challenge to delivery of the of the Substrategy. SR suggested that consideration should be given to documenting the business cases to support the use of the high cash reserves held by the Trust if the Trust was permitted to use the cash reserves freely. The Trust could use the cash reserves efficiently and effectively to benefit patients and the wider system, but is restricted in this respect due to regional and national guidelines. This would potentially support the rationale for holding higher levels of cash, in the event of this being challenged.

8.3 MB added that there were also opportunities, for example through the hosting of Health Procurement Liverpool. This could be expanded to other parties to create opportunities for greater economies of scale and improved value.

8.4 MB noted there was a detailed work plan to back up the delivery of the Substrategy. The delivery of the Substrategy would be managed through BPC and shared with the Executive Team and the Hospital Management Group (HMG).

8.5 SR questioned the plans to mitigate the highlighted risks and improve financial awareness. MB noted that the report addressed the cultural issues and suggests that the Trust improve and increase education around financial behaviour and its implications. JR stated that the Trust had the right spending culture and would continue educating and exploring opportunities to improve financial awareness.

The Board approved Finance and Commercial Development Substrategy.

9 Board Assurance Framework Q4 2022/23 and Closure

9.1 JR presented the Q4 closure report for the 2022/23 Board Assurance Framework (BAF) and highlighted that it remained based on the principal strategic risks approved by the Board on 5 May 2022. JR stated that the risk score assigned to BAF003 Systems Finance had reduced from 9 to 6 given the end of year position, and this had been endorsed at BPC.

The Board approved the closure of the 2022/23 Board Assurance Framework.

10 Principal Risks 2023/24

10.1 JR presented the principal risks for 2023/24 and noted that twelve principal risks to achieving the Trust's strategic ambitions had been agreed in consultation with Board members. The Digital risk had been reworded to reflect the change in focus from digital aspirant delivery to the delivery of the digital Substrategy following discussions at the Board Development Day in March and a new risk score and appetite would be assigned to the Digital risk through the Q1 review process.

The Board agreed and approved the proposed Principal Risks.

11 Risk Appetite Statement

11.1 MD presented the Risk Appetite Statement for 2023/24 and stated it would be incorporated within the Risk Management Framework and reviewed by the Board on an annual basis.

11.2 JR noted that there was no risk appetite against BAF012 Digital on the table although it was referenced in the statement as CAUTIOUS. SR and DT commented that the Board had an ambitious appetite towards the digital agenda given the amount of resources and improvements the Trust had carried out to improve the digital agenda and drive innovation. The Board agreed that the digital agenda and risk appetite for BAF012 Digital be raised to MODERATE from CAUTIOUS.

11.3 SR queried if the risk appetite in the statement relating to BAF005 People could be raised from cautious because the Board had evidence to demonstrate what had been done to retain good people, providing the right environment and culture; the Trust was an ambitious organisation and all of this had to be reflected. JR acknowledged that the Trust was doing a lot of work to do things differently to stay ahead, and the Trust could demonstrate that it had an open appetite for the people agenda. The Board agreed that the people agenda and risk appetite for BAF005 People be raised to OPEN from CAUTIOUS.

11.4 DT suggested raising the risk appetite statement for BAF007 Estates, Facilities and Sustainability to MODERATE from CAUTIOUS. MB concurred that the Trust had efficiently managed its capital spends and would continue to push the boundaries to do better, and a moderate appetite better reflects all the work that had been done and is currently ongoing. The Board agreed that the risk appetite for BAF007 Estates, Facilities and Sustainability be raised to MODERATE from CAUTIOUS.

The Board approved the Risk Appetite Statement for 2023/24 subject to the agreed changes.

12 Integrated Performance Report

12.1 JR noted that there had been a few challenges in infection prevention and control in February. The Trust had recorded high performance in cancer standards and diagnostics and improved its referral to treatment waits and activity restoration. JR informed that Board Committees had undertaken the check and challenge of the Integrated Performance Report (IPR), and the Chairs of the relevant Committee would present this as part of their assurance reports.

13 Business Performance Committee

13.1 DT, as Chair of the Business Performance Committee (BPC), highlighted that the overall number of long waiters within the Trust had reduced, the average waits from Referral to

Treatment (RTT) had also improved slightly. Capital spends remained behind plan, but assurance had been given at the Committee that the end-of-year plan would be achieved. There had been improvements in the number of appointments not attended, sickness levels had reduced slightly by 6.3%, and vacancy levels remained low.

13.2 Work was ongoing to improve the compliance levels for appraisal and training, and the 2023/24 financial operational plan continued to adapt within the context of the wider system challenges. The reported income and expenditure monthly position was a £0.7m surplus in February. The end of year forecast was now £4.6m which was £1.7m better than planned.

13.3 DT highlighted that the Committee had recommended to the Board that Audit Committee and BPC put more productivity improvement programmes and processes in place to help deliver on the required QIP given the forecasted challenges in next year's finance and operation plan.

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

14 Quality Committee

14.1 RW, as Chair of the Quality Committee highlighted a potential gap in the sepsis screening process had been identified. However, the Committee was assured that a plan was in place to improve the position and that a progress report would be received at a future meeting. There had been an increase in complaints mostly around appointments, and the Committee was putting greater focus on ensuring that similar complaints were prevented.

14.2 The Trust had exceeded its trajectory for E.Coli and MSSA for the year, and there were ongoing discussions about how to address this. Mutual aid had been agreed on for spinal patients from Robert Jones and Agnes Hunt Hospital and operational discussions were ongoing to accept the patient referrals.

14.3 The Committee had considered the Quality Substrategy and advised that further work needed be done to ensure the comprehensive engagement of clinical staff. Some of the concerns around safeguarding adults had been addressed.

14.4 RW stated that the Committee had now met in its new format for a number of meetings and it was enabling better conversations with positive contributions from members.

14.5 SR asked whether some of the items in the report were more advice than assurance as the full details were not included to ascertain if the Committee were received the right assurance. RW responded that the committee had received partial assurance in many areas, but there were mechanisms in place to address and improve on them, and the Committee had systems in place to challenge and receive assurance that work was ongoing to improve on the areas of limited assurance.

14.6 SR advised that the Board had adopted the standard terminologies used in the key issues reports, particularly assurance, advise and alerts, to ensure that the correct information had been captured. The Key Issues reports should represent a balanced view of achievements and challenges considered by committees. Where there are challenges, the report should reflect clear actions that are being taken to obtain assurance together with timescales.

14.7 IA stated that the Quality Committee carried out the right check and challenges and sought assurance, requesting plans in areas of low performance.

14.8 SR queried why the complaints level had risen and asked what had been done to reduce this and prevent similar complaints from arising. MO noted that complaints had gone up nationally, and the Team had interrogated the complaints and had tried to narrow down the issues to see what area had the highest complaints. A report on that would be presented at the next Quality committee meeting.

14.9 MO stated that the Senior Nursing Team had begun listening events with staff, and there was also a weekly 'Join Jan' event to listen to staff and get feedback. The feedback from both sessions were reported to the Executive Team for detailed discussion to ensure the right mechanisms were in place to attend to and reduce complaints. In addition, the Trust had a volunteer and safety meeting with specialised commissioners and had a meeting with the Care Quality Commission (CQC) to demonstrate how efficiently the Trust was listening and managing complaints.

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

15 Staff Survey Results.

15.1 JM presented the NHS national staff survey results for 2022/23 and noted that it was based on the NHS People Promises. The Trust had increased the response rate by 1% in comparison to last year. The Trust had scored higher than average in all elements of the NHS People Promise except for 'we are always learning', where the Trust scored average, but this was an improvement from last year's score. The Trust scored best for 'we work flexibly' and scored higher in nine of the fifteen areas that made up the sub-scores of the people promise.

15.2 The Workforce Race Equality Scheme (WRES) has identified that 533 white staff responded to the survey, and only 53 staff from other ethnic groups responded. Some of the comments received indicated that the Allied Health professionals felt that their roles were undervalued. Some responses also highlighted the staffing level pressures and low feedback on concerns raised.

15.3 RW questioned the Trust's ambition to improve the participation of more staff in the survey significantly and implement the feedback received from the survey. JM noted that the Trust was doing its best to deliver on the feedback received but highlighted that the timeframe between when the survey results are released, and the next survey was too short hence limiting the implementation of feedback before another survey cycle.

15.4 KH queried if the decline in the WRES result was due to the Trust not having an Equality, Diversity, and Inclusion (ED&I) lead in post and what work had been done to improve the experience of staff from the minority ethnic groups in the Trust. JM stated that the Team was working to recruit an ED&I lead for the post by 24 April 2023, and the race network for staff had been re-established to encourage improvement and better participation.

15.5 MG commented that there was a need to boost education around the survey and assure staff that the survey was conducted independently and that their responses were anonymous and not identifiable. JR suggested that the company that conducted the survey be invited in to educate staff about the independence of the survey and reassure staff that their responses were unidentifiable and anonymous.

15.6 SR questioned if there was an action plan in place to improve participation. JM responded that an action plan had been developed and several groups established that cut across race, disability, and other areas to push the agenda forward and improve participation within the Trust.

The Board noted the Staff Survey results and the assurance given.

16 Violence and Aggression Strategy Update

16.1 MD presented the violence and aggression strategy and highlighted that the Trust had successfully recruited into the Personal Safety lead post in February 2023 and had developed a work plan to deliver the Trust's Violence Prevention and Reduction Strategy in line with the national violence prevention and reduction standards.

16.2 MD highlighted that the violence and reduction work plan and the new violence and aggression report would be monitored quarterly by the Health, Safety and Security Group. The aim for this plan was to have compliance with 33 out of the 42 national violence prevention and reduction standards as the Trust was currently compliant with 21. The anticipated completion dates of all the remaining non-compliant criteria were identified within the work plan.

16.3 RW asked if the Trust provided accreditation and training for staff around violence and aggression. MD responded that the Trust did not offer accreditation as part of the training, but the Training offered was certified and met the national level requirement. The new Personal and Safety Lead was certified and trained up to the Prevention and Management of Violence and Aggression (PMVA) level, and the Trust conducts annual PMVA and individualised training for staff.

The Board noted the Violence and Aggression Strategy Update.

17 Health Inequalities Committee Proposal

17.1 JR presented the Health Inequalities Committee proposal which was a review of the Strategic BAME (Black, Asian, Minority Ethnic) Advisory Committee to provide oversight over all aspects of health inequalities in line with the national focus on reducing health inequalities.

17.2 The proposal had been developed and agreed upon after consultation with the SBAC committee members, regular attendees, and internal stakeholders. The proposal suggested a widening of the remit of SBAC to include other protected characteristics, ED&I and also health inequalities and social value work under formal Board Committee with delegated responsibilities from the Board.

17.3 DT agreed to the proposed review but disagreed with paragraph 17 that stated that the BPC agenda was stretched. He stated that it was unnecessary to suggest the total removal of the issues around people from the ambit of BPC and move to a new committee. He stressed that having different elements of the people agenda covered by other committees was acceptable.

17.4 IA suggested that the name of the proposed committee be reviewed to be more inclusive to reflect its objectives and the work done. JR stated that due consultation would be carried out in the next SBAC meeting to come up with other proposed names for the committee.

The Board approved the Health Inequalities Committee Proposal subject to the changes identified.

18 Neuroscience Programme Board Chair's Report

18.1 AN reported on the Neuroscience Programme Board meeting held on 16 March 2023 and highlighted that the Cheshire and Mersey Rehabilitation Network review had not progressed as planned with the Clinical Commissioning Group, and discussions were ongoing with the Integrated Care Board (ICB) on the best way forward.

The Board noted the Neuroscience Programme Board Chair's Report.

19 Research, Innovation and Medical Education Committee Chair's Report

19.1 PM presented the Research, Innovation and Medical Education Chair's report and highlighted that since the in-depth review last summer, the effectiveness of the committee meeting had improved.

19.2 The Chair and NEDs had visited the Neuroscience Research Centre (NRC) and engaged with staff on the value of supporting research and how to harness the benefits of the University Hospital Association (UHA) membership. The Medical Education Development Manager was undertaking the process of commencing scoping work to understand better how to best maximise the opportunities of the UHA membership.

The Board noted the Research, Innovation and Medical Education Committee Chair's Report.

20 Strategic Black, Asian and Minority Ethnic Advisory Committee Chair's Report

20.1 JR reported on the Strategic Black, Asian and Minority Ethnic Advisory Committee (SBAC) meeting held on 13 March 2023 and highlighted that the meeting was primarily focused on the health Inequalities Committee proposal and drafting of the proposed terms of reference (ToR).

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

21 Remuneration Committee Chair's Report

21.1 SR presented the Remuneration Committee chair's report for the meeting held on 9 March 2023 and highlighted that it was agreed by the committee that there would be no increment in the Executive Directors' pay other than any recommendations made by NHS England regarding the cost-of-living increases.

The Board noted the Remuneration Committee Chair's report.

22 Consent Agenda

22.1 The Board agreed on the following actions in relation to the Consent Agenda

- **Quality Account Priorities –** noted.
- **Mixed Sex Accommodation: Annual Statement of Compliance –** noted.
- **Report on the Use of Trust Seal –** noted.

23 Any Other Business

There was no further business to be discussed.

24 **Review of Meeting**

Those present agreed that the Board debate was robust and well-challenged particularly around the IPR. Items were presented in a timely way, and the patient story helped highlight areas for improvement for people with learning disabilities. Progress on the Trust Strategy priorities had been welcomed.

The meeting closed at 13.35

Date and time of next meeting Thursday, 4 May 2023 at 09:30 Boardroom

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

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	Chief Executive's Report
Executive Lead	Jan Ross, Chief Executive
Author (s)	Jan Ross, Chief Executive
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Industrial action has been called for by the RCN from 8pm on 30 April to 8pm on 2 May 2023. At the time of writing this report, the Secretary of State was challenging the mandate in court on the grounds that the strike action should expire at midnight on 1 May 2023.
- The second Aintree/ Walton Joint site committee meeting took place in April. The Terms of Reference were agreed and a proposed governance structure was circulated and will be shared with Trust Board. The main focus is now to develop a workplan that will support delivery of the clinical services review recommendations.
- Saffron Cordery, Deputy Chief Executive of NHS Providers, visited the Trust on 20 April and opened the new staff well-being hub.
- The Trust delivered above plan for its Income & Expenditure (I&E) for the financial year in line with the ICS requirements to support the wider system. Capital expenditure for the full year was £10.1m, which was £182k below plan.

Next Steps

This paper is intended for information purposes.

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

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

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Chief Executive's Report

National Updates

1. **Industrial Action:**
   Industrial action has been called for by the Royal College of Nursing (RCN) from 8pm on 30 April to 8pm on 2 May 2023. At the time of writing this report, the Secretary of State was challenging the mandate in court on the grounds that the strike action should expire at midnight on 1 May 2023. The dates selected are particularly challenging as they include a bank holiday on the Monday and coincide with industrial action from teaching unions on the Tuesday. The main concern for The Walton Centre (TWC), is that no derogations have been agreed for critical care and we therefore have increased staffing risk in this area which is a patient safety concern, all mitigation will be in place and the Trust continues to work closely with the RCN on concerns.

2. The Society of Radiographers has announced that its members have voted to reject the NHS pay rise and intend to conduct a ballot during May.

3. **Hewitt Report**
   In November, the Rt Hon Patricia Hewitt, chair of NHS Norfolk and Waveney integrated care board (ICB) and deputy chair of the integrated care partnership (ICP), was commissioned by the chancellor to lead a review into the role and powers of integrated care systems (ICSs) and maximise the opportunities they bring to improve population health and wellbeing. The final report was published in April.

4. There is recognition throughout the report of the issues hindering progress and placing unhelpful burdens on system players. The report recognises that without investment, workforce and leadership development, recurrent and multi-year funding, reduction of duplicative or unnecessary data requests, and effective planning (centrally and locally), systems will be unable to achieve their potential.

5. The report makes the case for reducing the number of national targets to give local leaders the 'time and space' to lead. Hewitt suggests that there should be no more than ten national priorities, and that local priorities should be treated with equal weight. High performing ICSs should have fewer national targets – it recommends establishing an initial cohort of 10 "high accountability and responsibility partnerships" (HARPs). The report clearly explains the fundamental need to join up health and social care in numerous ways, and the challenges of doing so. It also emphasises the need to shift the focus to prevention and health improvement, including through more joined up central government, an increase in prevention spending, and a focus on inequalities and discrimination. The review recognises the importance of collaboration and co-design as drivers of improvement.

6. The report aims to set out clearly the responsibilities and accountabilities of the different players in systems locally, regionally, and nationally. The report emphasises the need for improvement support to be the focus of most intervention, espousing a 'one team' approach to system development and oversight although ICBs are positioned as system overseers, rather than equal partners of trusts. On finance and capital, Hewitt recommends reviewing the entire NHS capital regime, reducing the use of short-term funding pots, and learn from good practice (including internationally) around payment model.

7. The full briefing is available from the Corporate Secretary.

8. **NHS75**
   On 5 July 2023, the NHS will mark 75 years of service. We will be celebrating this milestone and plans are underway to ensure all staff get the opportunity to join in. NHSE has established a separate communication page with branding and ideas to support trusts to get involved.

Cheshire & Merseyside Integrated Care System (ICS)

9. The second joint site committee meeting took place in April. The Terms of Reference were agreed and a proposed governance structure was circulated and will be shared with Trust Board. The main focus is now to develop a workplan that will support delivery of the clinical services review recommendations.

10. The focus of the Integrated Care Board (ICB) for the past month has been planning. The system has been visited by the national team to support the current Cheshire and Merseyside (C&M) plan.

11. The C&M system has also had a national 'discharge' visit which included several site visits as well as presentations and data reviews. The system is currently awaiting feedback.

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

12. Nina Russell is taking up the role of Programme Director for Efficiency at Scale with effect from 1 May 2023. Nina is a qualified accountant and experienced senior operational manager with almost 20 years' experience in the NHS. Nina has had previous roles in C&M, Nina supported the Hospital Cell as part of the Covid-19 response and has previously been the C&M Right Care Delivery Partner.

13. Nina is currently Director of Transformation at Southport and Ormskirk Hospital NHS Trust and has been supporting with the stabilisation of fragile services and the collaboration with St Helens & Knowsley Hospitals Trust.

Trust Update

14. On 20 April, we welcomed Saffron Cordery, Deputy CEO of NHS Providers to the Walton Centre. Dr Nicolson presented the Trust strategy, Mr Brodbelt spoke on the brain tumour pathway; Mr Olubajo presented on the major trauma network; Mr Farah talked about innovative work around MR-guided focused ultrasound; our Chief People Officer Mike Gibney provided an update on our work around social responsibility and Dr Bhojak showed Saffron around our radiology department. It was a very positive visit and supported our agenda to raise the profile of the Walton Centre.

15. While Saffron was here, she officially opened our new Staff Wellbeing Hub, which is located at the front of the hospital's main building, opposite the front stairwell. The health and wellbeing of our staff has been a key priority for me and is dedicated to the memory of our colleague Jean Blevin, who passed away in 2020. Jean was passionate about staff health and wellbeing, her contribution in this area was invaluable so it felt fitting to dedicate this space to her memory.

16. The Wellbeing Hub provides staff with a safe space to collect their thoughts and find out what health and wellbeing activities. We will also be using the space to hold events and drop-in sessions that we run as part of our Walton wellbeing programme.

17. The draft Well led report produced by 'consultone' has been circulated to all Trust Board members. The aim of the review was to assess the leadership and governance of the Trust, it is a very positive report that gives us some keys areas of focus.

18. On the 26 April, the Trust held its annual Sutcliffe-Kerr lecture. This year's event was held at the spine Liverpool and had Professor Giovanna Mallucci, principal investigator Altos Labs Cambridge Institute of science as its guest speaker. The event was well attended and a great success.

Business as Usual

19. **Finance:**
    The Trust delivered above plan for its Income & Expenditure (I&E) for the financial year in line with the ICS requirements to support the wider system. The improved performance against plan was driven in the main by the agreed final Welsh contract being above plan, increased activity relating to the Isle of Man, higher interest receivable and higher Health Education England (HEE) income than planned, along with non-recurrent vacancy savings in year. Elective Recovery Fund was paid in line with plan. Cost Improvement Plan (CIP) was fully delivered, albeit through a higher level of non-recurrent CIP than planned and through measures such as increased interest rates and increased Isle of Man activity. The improved position enabled the Trust to access higher capital funding (c£450k) next year.

20. Capital expenditure for the full year was £10.1m, which was £182k below plan. This underspend was due to the Trust receiving additional cancer funding for an ultrasound that was already in the plan and was agreed could be underspent in advance with the ICS. Heating and pipework, Digital Aspirant schemes and radiology and neurosurgery form the majority of the capital spend.

21. Planning for 2023/24 continues after the previous Trust submission of a £2.4m surplus given the overall ICS position was still a significant deficit. Trusts with plans with a significant deficit have since faced further scrutiny from regional and national bodies. Meetings are still ongoing with Liverpool PLACE Finance Directors and Chief Executives to review what further could be done to improve the overall position, so the plan remains draft currently. It includes £7.5m of CIP which will be a major challenge to deliver in 2023/24.

22. The first submission of the 2022/23 accounts will be made to C&M ICB on 27 April followed by a submission to NHS England on 4 May. The Trust's external auditors, Grant Thornton, will be carrying out their audit of the 2022/23 financial accounts throughout May will the aim of completing the audit by June.

23. **Operations and Performance**
    Performance remains on track for cancers and diagnostics, long waits have now been completed for 104 weeks and 78 weeks. The trust is now focusing on patients who have waited 52 weeks.

24. Mutual aid requests continue via the Digital Mutual Aid Systems. Requests have been asked for spinal support from Robert Jones and Agnes Hunt, Stoke and Salford; both the clinical and operational teams are working through these requests.

25. The Trust continues to deliver cancer and diagnostic performance.

26. **EPRR**
    Meetings have now commenced for the planning of the Eurovision Event in Liverpool and the arrangements for emergency services and support throughout the system are currently being finalised.

27. **Estates and Facilities**
    The trust received the results from the PLACE inspection that was undertaken in October 2022, several areas have seen decline with an action plan now in place. It is important to note that the inspection took place prior to the new ISS contract and national cleaning standards, the meal changes, and the estates cycle of capital work throughout the trust. A mini-PLACE inspection is due to take place in June 2023.

28. The ERIC Collection is now live for submissions and will remain open until July 2023, for the trust to start submitting their data.

Recommendation

To note

Author: Jan Ross, Chief Executive Officer
Date: 27 April 2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
4th May 2023

Report Title	Quality Substrategy 2023-2026
Executive Lead	Morag Olsen, Interim Chief Nurse
Author (s)	Nicola Martin, Deputy Chief Nurse
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Development of the new Quality Substrategy 2023-2026, ensuring alignment to the strategic ambitions outlined in the new Trust Strategy 2022-2025.
- Changes have been made to the format and structure of the sub-strategy to reflect the organisations strategic structure.
- The Quality Substrategy is being shared with the Board for approval.

Next Steps

- To incorporate feedback
- Communications Team to put the substrategy into the agreed format in line with all other substrategies.
- To share final version with each division for them to develop their divisional delivery workplan.

Related Trust Strategic Ambitions and Themes	**Impact**		
Quality of Care	Quality	Compliance	Not Applicable

Strategic Risks

001 Quality Patient Care	004 Leadership Development	002 Collaborative Pathways

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Hospital Management Group (HMG)	17/4/23	Nicola Martin	Nil
Quality Committee	21/4/23	Nicola Martin	Minor amendments

Quality Sub Strategy 2023-2026

Executive Summary

1. In line with the revised Trust Strategy launched in September 2022, and the closure of the Quality Strategy 2019-2024. A new Quality Substrategy has been developed to ensure alignment to the strategic ambitions outlined in the Trust Strategy 2022-2025.

2. The Substrategy comprises: -

    - Introduction
    - What Quality means to The Walton Centre
    - Key achievements 2022/23
    - What is patient family centred care
    - Building capability to deliver the sub-strategy
    - How does quality support the Trust's strategic ambitions?
    - Priorities
    - Implementation and monitoring
    - Conclusion

3. The Communications Team do need to transfer the Substrategy to the agreed format of all Substrategies once approved.

Conclusion

4. In line with the new Trust Strategy 2022-2025 a new Quality Substrategy has been developed and is being shared with the Board for approval.

5. The divisions will create delivery workplans once final draft is received.

Recommendation

The Board is asked to note and approve the Quality Substrategy for 2023-2026.

Author(s): Nicola Martin, Deputy Chief Nurse
Morag Olsen, Interim Chief Nurse

Date: 21 April 2023

Appendix 1

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Sub-Strategy
2023 to 2026

Introduction

The Walton Centre is the only standalone specialist neurosciences NHS Trust providing a high-quality, integrated, and multidisciplinary service to Merseyside, Cheshire, North Wales, the Isle of Man and parts of Lancashire and Greater Manchester – serving a population of 3.5 million people.
The Walton Centre provides comprehensive neurology, neurosurgery, spinal, pain management and rehabilitation services, and our three-year strategy sets out how we will continue to deliver excellent clinical outcomes and patient experience with our team of dedicated, specialist staff. We recognise the specific exceptional additional risk and challenges that Central Nervous System disorders pose to patients and families and this recognition is inbuilt within the culture of the trust and within all the staff do.

At The Walton Centre, we place our patients and their families at the heart of everything we do, with a primary focus on patient and family centred care. We are a national leader, providing a world-class service in diagnosing and treating injuries and illnesses affecting the brain, spine and peripheral nerves and muscles.

The Trust aims to innovate, build, and standardise to deliver high quality, safe and effective care that provides patients, families, and carers with the best experience. Our 'hub and spoke' clinical model means we have satellite clinics in multiple sites across our region, enabling patients to be seen closer to home by the most appropriate specialist.

This sub-strategy outlines our goals for the following three years and our commitment to continuously improve quality for patients, families and communities we serve. Quality encompasses such a wide variety of care delivery, and this sub-strategy sets out clearly our ambitions. We believe it is important to be open and transparent about our plans and recognise quality in all its facets, for patients, their families and our staff. Our patients expect a quality service and so should their family members and carers. We see ourselves as visitors in a patient's journey and we endeavour to deliver quality healthcare and encourage a high level of engagement and communication with families and carers.

We believe that staff must be supported to deliver outstanding care. Our values and behaviours are set out in the 'Walton Way' and underpins our strategy. This sub-strategy is aligned to the Trust quality accounts, quality improvements (QI) and the five CQC domains: Safe, Caring, Responsive, Effective and Well Led – key indicators that enable us to measure our success.

All Trust employees have a responsibility to deliver "Excellence in Neuroscience" which is continually monitored and documented as part of annual appraisals. Implementation of this sub-strategy is supported by the Executive Directors and Divisional Triumvirates (comprising Divisional Director, Divisional Nurse Director and Divisional Clinical Director), including clinical and operational leaders as well as the Transformation Team, Finance, HR and IT support.

What quality means to The Walton Centre.

The Walton Centre defines quality as "Excellence in Neuroscience" within the context of its mission. This superiority is incorporated into the patient and family-centred care we provide, ensuring that we achieve and surpass our clinical goals for the benefit of patients. Although we have metrics for quality indicators, we think it is equally critical to collect patient and family feedback regarding their experiences so this can be used to drive improvements.

Patient and Family Centred Care (PFCC) and feedback regarding experience is very important to us. This sub-strategy will focus on PFCC feedback, as research shows that by achieving PFCC, quality care and satisfaction increases.

Governance is a key part of how quality is managed. The NHS Patient Safety incident response framework has been published and the implementation plan will ensure we will focus on continuously improving the safety culture. The Walton Centre has incorporated the points from this document into the sub-strategy.

We plan to continue evaluating and analysing decisions made in the interests of patients, and continue to engage with patients, families, our staff and external stakeholders to ensure we are meeting the needs of all.

The Trust is committed to delivering outstanding care for patients and monitors quality and safety daily. Safety is reviewed each morning at the Trust safety huddle meeting, which allows all staff (regardless of role and seniority) to escalate any concerns relating to patient, visitor or staff safety. This forum allows staff to act swiftly, address issues and reduce risks.

To ensure compliance with the Care Quality Commission (CQC) registration regulations, each regulation is part of a planned schedule of reviews, which works alongside internal quality inspections. The clinical area accreditation scheme, CARES (communicate, assess, respect, experience and safety) Quality Review is an example of how standards of care can be assessed. The evaluation is structured around 15 standards, and the results are examined and shared with the Trust Board. The objective is to further improve patient experiences and care, and the results will be shared outside each clinical area.

What our staff said about quality?

What is Patient & Family Centred Care

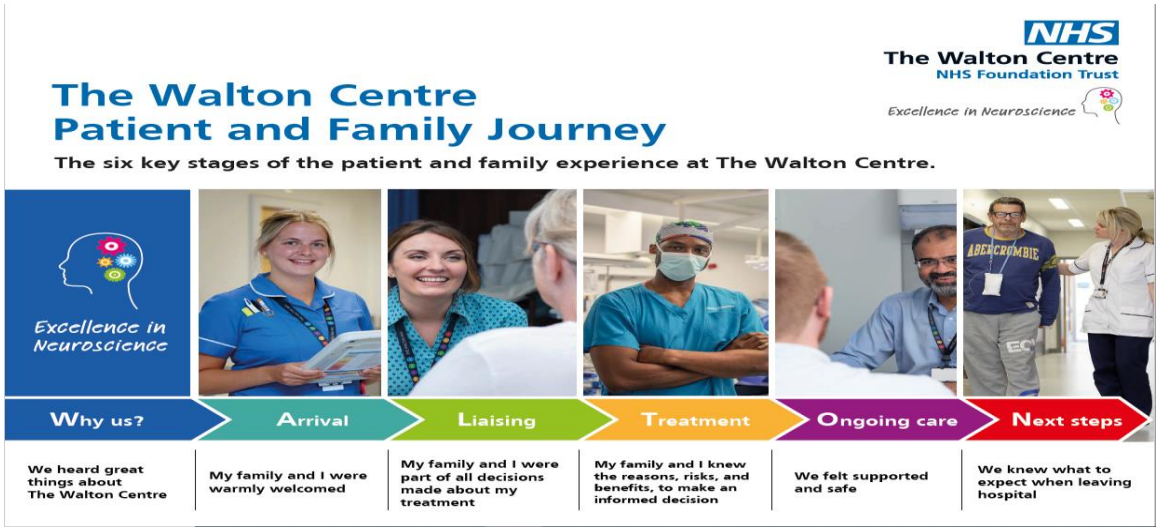
Patients and families are at the heart of everything we do at The Walton Centre. Our aim is that all patients and families receive outstanding care and have an excellent experience when they require our services. Their voice is central to how we monitor performance and identify ways in which we can improve.

PFCC is an approach to the planning, delivering and monitoring care that is based on mutually beneficial relationships between staff, patients and families. The central focus is on staff working in partnership with patients and families in all aspects of care. Research by the Institute for PFCC has shown that this approach leads to better health outcomes, improved experience of care, better staff satisfaction and a more effective use of resources. Our staff are proud of the care they provide and PFCC provides a valuable way in which we can align excellent patient and family experience with excellent staff experience.

At The Walton Centre, we have adopted a structured approach to implementing PFCC. It will be incorporated into our governance structure and a PFCC Champions Group comprising clinical and non-clinical staff from across the organisation will be introduced. The Group will identify and monitor ways in which we can improve patient and family experience and will be a sub-group of the Patient Experience Group, which in turn reports to the Quality Committee. The aim of this group of staff is to take forward work identified by the Patient Experience Group in addition to discussing ideas with patients and their families.

An essential element of our approach is embedding methods that enable us to understand what it is like for patients and families to use our services. We do this through ‘soft’ indicators such as engagement events with patients and families, patient and family stories, patient and family shadowing and Executive ‘walkabouts’ in wards and departments.

Through feedback, the Trust developed a shared vision for the ideal patient and family experience at The Walton Centre. The ‘Six WALTON Steps’ highlight our vision of an excellent Patient and Family Journey at The Walton Centre.



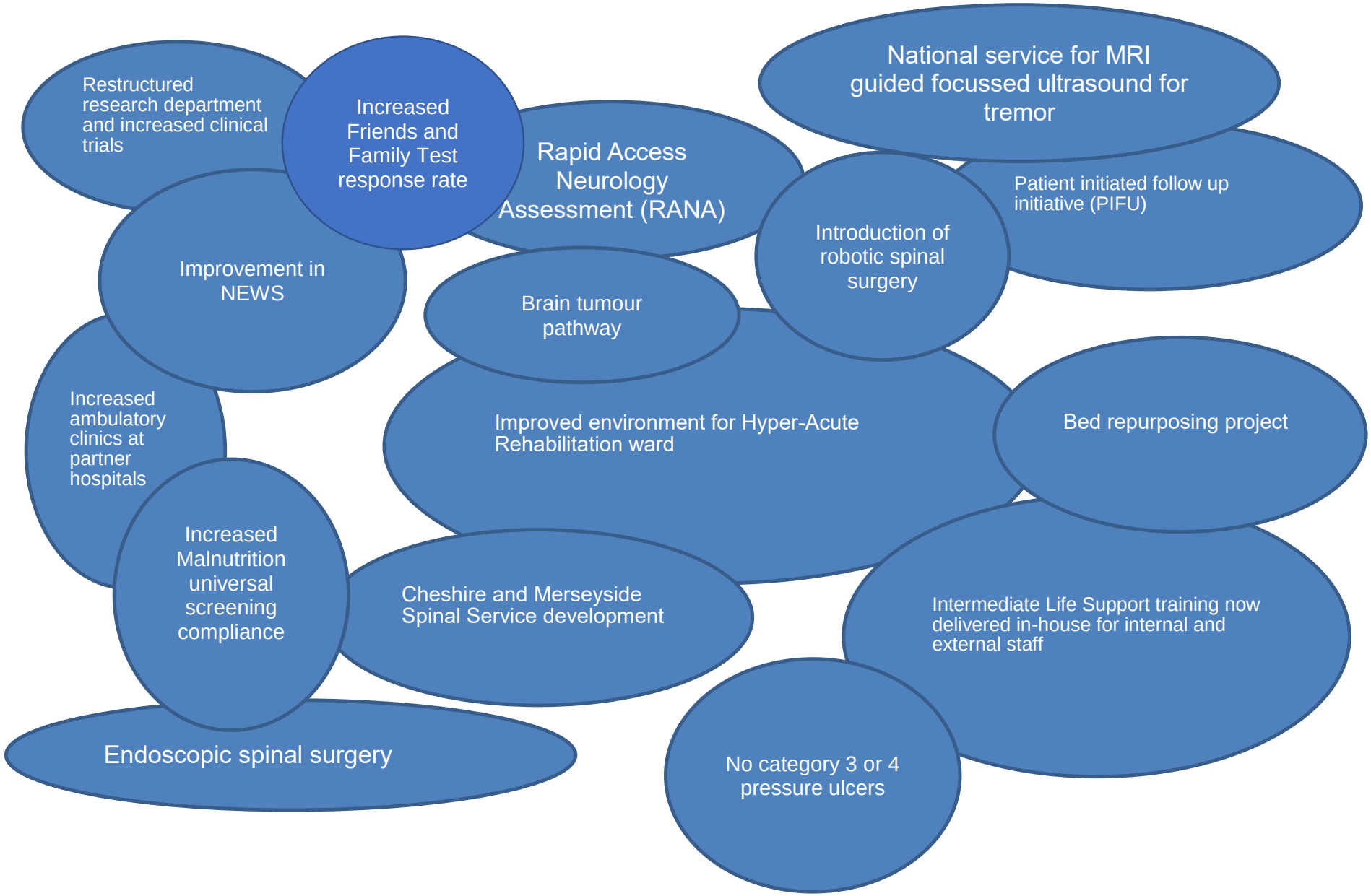
Building capability to deliver the sub-strategy

We recognise that our people are key to delivering quality throughout the Trust. We therefore must make sure that we are training and supporting our people to make improvements continuously as well as carrying out their day-to-day roles. Together, with the Transformation Team, we want to implement new ways of working systems and services with transparent measurement to track progress. We have therefore decided to adopt a standardised approach to quality improvement (QI) to make this possible. The 6'I's of Improvement is designed to encourage and support our people by providing them with the tools they need to make sustained improvements. We believe this will be one of the long-term drivers to delivery of this sub-strategy. We want this to stimulate energy for learning and development in improvement methodology and ensure that change becomes the way of doing things at the Trust.

As well as defined workstreams, we will identify individual QI projects through a robust process of clinical service reviews, thematic reviews, self-referral by staff and patient and family feedback. Using the 6'I's of Improvement, our teams will be empowered to plan, test, implement and share best practice, underpinning the 'Six WALTON Steps'.

Recognising the importance of culture on the implementation of successful QI programmes, we will embed training programmes grown out of our values and behaviours, we will develop a culture of sharing ideas and learning, celebrating success and developing new perspectives. All quality initiatives or projects will demonstrate how they will support delivery of the sub-strategy before being initiated.

Our quality achievements and highlights 2022/2023



The Quality Sub-Strategy is one of the seven enabling strategies underpinning the Trust's strategy 2022-25. It is based on the Trust's five strategic ambitions:

The Trust's five strategic ambitions and seven enabling strategies are represented in the diagram below.

10. Priorities

Priority 1 – SAFE

We will reduce mortality and harm by:-

Focusing on our safety culture is central to ensuring we provide high quality care. We believe unlocking the knowledge, experience and ideas of our staff will be key to achieving the aims set out within this strategy.

It takes genuine dedication from every member of our team, all the way up to our board, to create a culture where openness, transparency, and a true patient-centred approach is visible. We want a culture of open learning because it is necessary for sharing safety-related discoveries and for embedding and maintaining change that enhances care.

What are our key aims?
We will achieve a year on year reduction in patient harm
We will work collaboratively to provide the best environment to support delivery of safe care.
We will embed the new Patient Safety Incident Response Framework
We will continue to evolve effective Risk Management and robust governance throughout the organisation by embedding a culture of learning.
We will provide access to appropriate skills, equipment and resource
We will us clinical evidence and best practice standards to achieve and drive improvements.

Priority 2 – Effectiveness

We will improve the clinical outcomes for all patients presenting with neurological symptoms and for those with long term conditions.

We strive for excellence in outcomes for our patients at all times, We strongly believe that we can always learn and improve by collecting clinical outcome data for all interventions, learning from audit and utilising research and innovation to enhance our services.

What are our key aims?

We will improve access to the most appropriate clinician at the right time

We will work collaboratively to improve the patient outcomes.

We will increase our focus on audit and research to enable continuous learning and improvement.

As a centre of excellence, we will actively share information locally, nationally, and internationally to enhance patient outcomes.

Priority 3 – Caring- Patient, Carer and Family experience

We will support, listen, respect and involve patients, carers and families in striving for the best quality services.

At The Walton Centre everyone prioritises safety, and leaders cultivate an environment that is open to collaboration to enhance our patients, carers, and families experience.

We will make sure that every patient and carer has easy access to provide feedback about their experience receiving treatment, that they feel heard, and that it is easy to see that the feedback has resulted in action.

Care and treatment will be received in a safe environment, and we will continuously strive to improve what our patients can see, do, hear and feel during their stay or visit.

What are our key aims?
We will increase shared decision making with patients, carers and families.
We will increase patient representation at Trust groups.
We will provide patients, families and carers with the optimum digital healthcare information to suit their needs.
We will focus on the delivery of Patient and Family Centred Care agenda resulting in improved patient experience.
We will ensure that we provide an equitable service for all of our patients

Priority 4 – Responsive through Continuous Improvement

We will reduce variation in care for our patients in the region by adopting a culture of continuous improvement

Patient and carer experience is positive when staff listen, give care that is compassionate, involves patients in decision making and provides them with good emotional support.

We will make sure that every patient and carer has easy access to provide feedback about their experience receiving treatment, that they feel heard, and that it is easy to see that the feedback has resulted in action.

Care and treatment will be received in a safe environment, and we will continuously strive to improve what our patients can see, do, hear and feel during their stay or visit.

What are our key aims?

- We will embed evidence-based practice and nationally recognised benchmarking information to support continuous innovation.
- We will deliver our transformation and innovation agenda
- We will provide a culture that facilitates continuous improvement, through learning
- We will continue to deliver all access targets
- We will improve training and education in neurological conditions to health care provision across the region.

11. Implementation and Monitoring

This Sub-Strategy will be approved by the Quality Committee. The Chief Nurse, and Medical Director as the executive leads for quality will monitor the requirements and progress of this Sub-Strategy. A quarterly report will be presented to Quality Committee on progress and achievement of goals as set out in the objectives above.
Each Division will have a developed comprehensive Divisional delivery workplan, which will be formally reviewed through the Divisional Governance Meetings. At these meetings, the Divisions will be expected to report on progress and position of their quality delivery workplan.

12. Conclusion

This quality sub strategy builds on the processes already in place for supporting and delivering quality. It ensures a positive focus is maintained and considers the Trust Strategy, underpinning Strategies and Frameworks, in turn supporting the achievement of the Trusts ambitions.

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	The Walton Centre Brand Narrative
Executive Lead	Jan Ross, Chief Executive
Author (s)	Elaine Vaile, Head of Communications and Marketing
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Work has been ongoing to refresh and reinvigorate our brand
- One of the first steps of this process has been the development of a brand narrative
- The final narrative reflects feedback from Board, and senior staff and encapsulates a combination of ambition, patient focus and our values

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

- Following approval of the brand narrative, next steps will include developing a messaging framework as part of the brand development refresh and work, which includes work on the visual identity and the name of the Trust

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

The Walton Centre Brand Narrative

Executive summary

1. As part of the Communications and Marketing Substrategy, work has been ongoing to refresh and reinvigorate our brand, working with our Board and senior staff across the organisation, to provide us with a more distinctive and recognisable brand identity.

2. One of the first steps of this process has been the development of a brand narrative which would work both internally and externally and would be used to inform all levels of marketing and communications across the Trust.

3. Working with an external agency, we have carried out a piece of work, involving stakeholders from across the organisation, which has now come to conclusion for presentation to Board.

Background and analysis

4. Following senior stakeholder interviews, draft narratives were developed and tested through Board and further staff interviews – both clinical and non-clinical staff.

5. From these interviews and testing, short, medium and long narratives were developed. These will be used as key messaging in communications across the Trust.

6. Key feedback, as included on the presentation included:
    - Build our reputation as a leader
    - Should be inclusive of all staff, not just medical
    - Significant concerns around negative connotations of ‘life-changing’ in a medical context
    - Perception of ‘life-changing’ as a positive, in the sense of a deeply meaningful experience

7. The final narrative reflects feedback from Board, and senior staff and encapsulates a combination of ambition, patient focus and our values.

8. The end of line narrative is important, and the subject of debate. Following new options, it was decided to retain ‘Excellence in neuroscience’ which is already embedded in our brand, and logo lockup.

Conclusion

9. Following approval of the brand narrative, next steps will include developing a messaging framework as part of the brand development refresh and work, which includes work on the visual identity and the name of the Trust.

Recommendation

- To approve

Author: Elaine Vaile
Date: 26 April 2023

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre Brand narrative

Elaine Vaile
Head of Communications and Marketing

www.thewaltoncentre.nhs.uk

The brief

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- The complexity and chaos of today's world requires a strong and clear brand to connect the competing needs of employees, patients and general society
- We wanted to refresh and reinvigorate our brand and profile, to provide us with a more distinctive and recognisable brand identity
- The first step was the creation of a brand narrative which would work both internally and externally and would be used to inform all levels of marketing and communications across the Trust

The aims

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

- A brand narrative which would:
  - Act as the north star for The Walton Centre
  - Inform everything we do and how we communicate internally and externally
  - Be a rallying cry for employees, unifying and inspiring our people

- Short, medium and long versions would be produced that can be used as key messaging in communications

What a brand narrative is not

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- An entire brand

- It will not transform our brand in a click of the fingers
- It is a narrative, a thread which will run through everything we produce and write
- It is the hidden part of the brand, but the essential first building block

- But shouldn’t be mixed up with things that look pretty, or how we then need to execute the narrative

Process

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Senior stakeholder interviews
- Draft narratives development
- Board workshops
- Further staff interviews to test directions
- Development of final short, medium and long narratives

Testing feedback

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

'Neuroscience' is sufficient as a catch-all term' but it needs to be explained for a lay audience

Build our reputation as a leader

Should be inclusive of all staff, not just medical

Playing a guiding role for peers is critical, especially in the context of the NHS

'Leaders in neuroscience' narrative feels too narrow and lofty – research and teaching over patients.

Fit with Walton Way values

Perception of 'life-changing' as a positive, in the sense of a deeply meaningful experience

Need to see something about research

Significant concerns around negative connotations of 'life-changing' in a medical context

Final narrative

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre is the UK's only specialist hospital trust for neurology and neurosurgery. We're leading the way by delivering meaningful patient outcomes, developing groundbreaking innovations and providing exceptional teaching across neurology, neurosurgery, spinal, pain management and rehabilitation services.

What unifies us is how much we care about our patients, their families, and our people. Everybody at The Walton Centre is working towards the same mission: to deliver life-changing treatment and care.

We see it as our responsibility to advance neuroscience by leading clinical research and collaborating with our peers, with openness and respect to drive forward change.

At The Walton Centre, we're proud to have a culture of dignity and excellence, where every individual is inspired by the important role we play in improving lives.

The end line

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- The end-line of the narrative is important
- It offers a concluding statement and ties all of the themes together
- Whilst the ‘life-changing neuroscience’ rated positively by some stakeholders in feedback, it also had a high level of dissatisfaction, particularly amongst clinical staff
  - Eg, Life-changing is losing a leg, having a terminal illness, a diagnosis which changes your life
- It is proposed therefore to retain ‘Excellence in neuroscience’ which is already embedded in our brand

Next steps

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Messaging framework
  - Key messages for audiences including patients, staff, students, researchers etc. This messaging can be lifted and used in applications such as the website, social media, job descriptions, patient comms etc

- Visual identity
  - Within the parameters of the NHS brand guidelines, explore how to bring the narrative to life visually. This would be applied throughout the hospital itself, on owned digital channels and in printed materials

- Brand film
  - Including footage of real staff, researchers and patients, to use both internally and externally and to engage donor audiences

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	NHS Digital Maturity Assessment
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Justin Griffiths, Chief Digital Information Officer
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Initial draft submission completed.
- National Peer review chose Alder Hey. That was completed along with Liverpool Heart and Chest submission.
- NHSE/McKinsey data analysts/ICB Digital team/Specialist Trusts CIOs Peer review session completed.
- Cheshire and Mersey overall What Good Looks Like capabilities scores one of highest in NHS and best on Northwest region
- The Walton Centre "What Good Looks Like" capabilities scores were all above national average bar 1 area equal with national average and 1 area below relating to lack of Patient Portal.
- Been approved at Executive Group and Business Performance Committee with full questions and answers in appendix.

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

- To be approved for submission
- To be submitted May 14th 2023
- To arrange Trust Board session with NHS England to contextualise data across Cheshire and Mersey region and NHS England.
- Create local GAP report into moving up the Digital Maturity Assessment.as appendix to Digital Sub Strategy

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executives Meeting	19 April 2023	J Griffiths, CDIO	Agreed, requested summarised version to go to board

Business Performance Committee	25 April 2023	J Griffiths, CDIO	Reviewed.

NHS Digital Maturity Assessment

Executive Summary

1. In September 2021, NHS England launched The What Good Looks Like (WGLL) framework. The framework draws on local learning to build on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely.

2. As part of the levelling up agenda, to support ICS in their digital transformation journey. NHS England appointed McKinsey to develop a Digital Maturity Assessment Programme to help providers and systems to understand their current state of digital and data maturity as part of the Long-Term Plan strategic aims for digital transformation.

3. The data and insight from the assessment are key to providing evidence-based planning and investment in digital transformation as part of the levelling up agenda and identifying opportunities to ensure resilience in existing digital infrastructure.

4. The Walton Centre has gone through a nationally selected peer review with Alder Hey (inc Liverpool Heart and Chest) and then a further peer session with NHSE, McKinsey, ICB and Specialist Trusts.

Background and Analysis

5. The initial draft submission happened in March 2023 and the organisation peer reviewed itself against Alder Hey (HIMSS Digital Maturity level 7) and Liverpool Heart and Chest (HIMSS Digital Maturity level 6) and the results were comparable to the HIMSS scores as Walton Centre is HIMSS Digital Maturity level 5.

6. From the initial data from the submission; Cheshire and Mersey overall What Good Looks Like capabilities score was 2.9 compared to the NHS average of 2.4 and Cheshire and Mersey ICS is the highest of the Northwest Integrated Care Systems (Greater Manchester and Lancashire & South Cumbria)

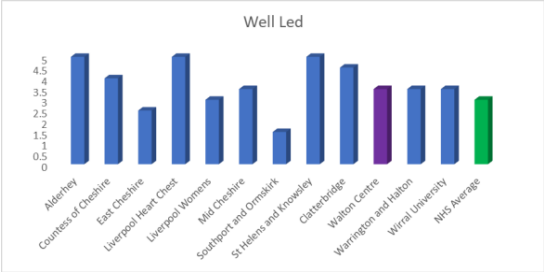
The 'What Good Looks Like' framework has 7 success measures:

- Well led
- Ensure smart foundations
- Safe practice
- Support people
- Empower citizens
- Improve care
- Healthy populations

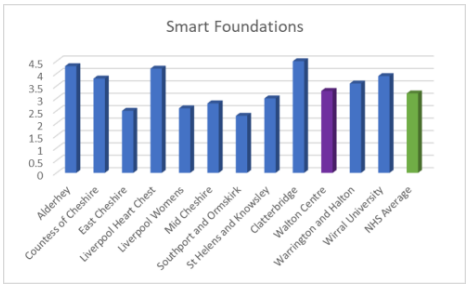
7. The Walton Centre scored above national average in all What Good Looks Like capabilities apart from the 'Healthy populations' capability which was equal to NHS average and 'Empower citizen' which was below national average; which further supports the case for the Walton Centre to be included in the national Patient Engagement Portal programme which it is currently excluded from as a specialist Trust. This would increase the Digital maturity scores in both capabilities to above national average.

8. The table below shows high level overview of questions within pillars and the Walton score against regional Trusts and National average.

For leadership pillar (WGLL Pillar 1)	**The leadership pillar (WGLL Pillar 1) question on digital** leadership focuses both on board representation and having a strategy. How did you assess your maturity if you have a clear strategy but no board membership?



For electronic patient record (EPR) maturity (WGLL Pillar 2).	Does your organisaton have different EPR systems (e.g., for outpatient vs. inpatient care)? If so, how would the EPR maturity response y indicated vary based on that? How may that be reconciled? Does your maturity assessment represent the EPR system that has the grea maturity? To what extent was there a difference between % of patient records digitised vs. their level of integration in the system? How was integra interpreted? How did you reconcile that with the question in interoperability on WGLL Pillar Improve Care? How may that change the EP maturity assessment? How was user experience of EPR judged? How might that change the EPR maturity assessment?



Conclusion

9. The appendix shows the initial submission of the Digital Maturity Assessment.

10. Following a peer review session with NHSE, McKinsey, ICB and specialist acute providers The Walton Centre wasn't classed as an outlier in any areas and scores seemed to reflect the current status when discussed against assessment controls. WCFT CDIO requested if NHSE/McKinsey could develop a Trust Board Session as some of the areas required contextualising beyond what was in the questions as was apparent in the session, NHSE said they agreed and would talk to their delivery partners to do this.

11. There is potentially a couple of changes upwards by single points that need to be discussed with radiology (use of AI) and regionally around validity of using e-roster as workforce evidence; although this was discusses as a possible change of question (splitting workforce, assets) in version 2 which is currently being developed.

12. There is more narrative to be added around Data Security and Protection Toolkit scores to further support Cyber awareness and compliance in Smart Foundations section

13. The full Digital Maturity Assessment will be available via Freedom of Information requests in June following NHSE Board sign off.

14. The Walton Centre submission has gone to the Executive committee and Business Performance Committee and is now being presented to Trust Board prior to final submission by May 14th.

Recommendation

- To approve for submission.

Author: Justin Griffiths
Date: April 2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	NHS Prevention Pledge Update Report
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Rachel Saunderson, Innovation Manager Jane Mullin, Deputy Chief People Officer
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- The Cheshire and Merseyside Prevention Pledge supports NHS provider trusts to take a place-based approach to improving population health
- In 2022, the Trust developed its Prevention Pledge action plan in line with the 14 Prevention Pledge core commitments
- The report overviews the progress made to date

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

- Continue to progress work aligned to the 14 'core commitments'
- Continue to report progress through the Regional Community of Practice
- Participate in additional sessions to develop work in line with health inequalities and working at place agendas

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

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

006 Prevention & Inequalities	010 Innovative Culture	Not Applicable

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

NHS Prevention Pledge Update Report

Executive Summary

1 The Prevention Pledge consists of a set of commitments which NHS organisations pledge support to achieve action on improving population health with a specific focus on prevention measures, for the benefit of staff, patients and the wider community. Prevention Pledge is one of the delivery action plans that underpin the Trust's People Sub-strategy and will report into the newly formed Anchor Institution Group the inaugural meeting of which was held on the 18 April 2023.

2 The report overviews the progress made to date against the 14 core commitments.

Background

3 It is widely acknowledged that prevention measures are needed at scale to help address the gaps identified by the NHS Five Year Forward View, the NHS Long Term Plan, and the NHS Phase 3 COVID response requirements, all of which prioritise a renewed focus on prevention.

4 The Cheshire and Merseyside Population Health Framework has been developed to support delivery of the prevention challenge across the sub-region at the request of the Cheshire and Merseyside Health and Care Partnership (HCP). In supporting NHS provider trusts to take a place-based approach, the HCP's Population Health Board is now in the process of accelerating initial work carried out by Public Health Agency Health Equalities Group (HEG) to develop and roll out an NHS Prevention Pledge for the sub-region to strengthen and increase population-level prevention priorities.

5 The Prevention Pledge is a framework underpinned by 14 'core commitments' that NHS providers are expected to work towards as a means of formally adopting the Pledge. The commitments have been developed through extensive consultation with representatives from provider trusts, NHSE&I, local authority public health teams, Public Health England, and third sector organisations. Each of the 14 commitments are to feature within a Trust's action plan for adopting the Pledge, along with additional prevention commitments bespoke to the Trust. The 14 'core commitments' fall under the following themes:

- Organisational and cultural change; primacy of prevention within governance structures
- Workforce development; quality improvement; workplace health & wellbeing
- Brief advice and making every contact count (MECC)
- Promoting healthier lifestyles for patients/visitors – catering, smoke-free and active environments
- Embedding social value, sustainability and anchor institution practices
- Using Marmot principles to address health inequalities
- Signing up to the NHS Mental Health & Suicide Prevention Concordat

6 In 2022, the Trust developed its Prevention Pledge action plan in line with the core commitments with update reports provided to Trust Board the last being in October 2022. Work is progressed internally under the social innovation agenda through the Deputy Directors' Forum and is monitored via the Trust's newly formed Anchor Institution Group. External accountability and delivery are monitored through bi-monthly updates to the regional Community of Practice (**Appendix 1**).

7 The Trust's 2022/23 Progress Report outlines that out of the 14 commitments, 4 have been completed, 9 are in progress and 2 are unable to be progressed at this time. Commitment 11b – increased public access to fresh drinking water on NHS sites is unable to be progressed due to infection control concerns and commitment 13 – sign up to the Prevention Concordat for Better Mental Health for All is unable to be advanced as awaiting national framework to be launched. It

should be noted that no NHS trusts are able to progress these commitments at this time. The full report is included in **Appendix 2**.

Conclusion

8 The Cheshire and Merseyside Prevention Pledge supports NHS provider trusts to take a place-based approach to improve the health and wellbeing of staff, patients and the wider community with a specific focus on prevention measures. It is also one of the 3 delivery workstreams for the Regional Anchor Institution Charter that the Trust signed up in July 2022 alongside Social Value and Sustainability.

Recommendation

9 The Trust Board is asked to note the progress made to date and support the continued work against the remaining commitments.

Author: Rachel Saunderson and Jane Mullin
Date: 19/04/23

Appendix 1 – The Walton Centre's Prevention Pledge Community of Practice Update, March 2023

Appendix 2 – The Walton Centre's Progress Report for 2022/23 inclusive of updated action plan and January 2023 KPI Report

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

NHS Prevention Pledge Update

C&M NHS Prevention Pledge Community of Practice Meeting on 21/03/23

Jane Mullin, Deputy Chief People Officer

Commitments Overview

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Trust action plan developed for all 14 commitments out of which:
  - 4 actions completed
  - 9 actions progressing
  - 2 actions currently unable to progress: 11b – increased public access to fresh drinking water on NHS sites due to infection control concerns and 13 – sign up to national Prevention Concordat for Better Mental Health for All framework
- Update report and action plan shared with Executive Team on 15/03/23
- Prevention Pledge is one of the delivery action plans that underpin the Trust's People Sub-strategy 2022-25
- The Trust has formed an Anchor Institution Group which will oversee the delivery of the Prevention Pledge commitment along with the Social Value Charter and the Trust's Sustainability Plan. The first meeting is being held on 18/04/23
- Prevention Pledge is cited on the Trust's Prevention and Inequalities Board Assurance Framework (BAF) Risk: ***'If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population.'*** The BAF reports into Executive Team and Trust Board on a quarterly basis. It will also feed into the newly formed Trust Board sub-committee – Health Inequalities Committee the purpose of which is to:
  - Provide assurance that improving health inequalities is embedded as part of the core delivery of good quality, responsive healthcare
  - ensure that the ongoing strategic approach to social value, fairness, equality, diversity and inclusion is robust, timely, actively promotes inclusion and is based on effective community engagement

Key Actions Over Last 3 Months

The Walton Centre NHS Foundation Trust

Access to Exercise and Wellbeing Programme

The aim of the programme is to expand the offer of exercise and wellbeing therapies for patients with long-term neurological conditions and their carers, located in Chester and North Wales through Neuro Therapy Centre, Greenbank Sports Academy and Brio Leisure. Key updates:

Excellence in Neuroscience

- Patient representatives identified for the Programme Steering Group
- Project Manager appointed
- Progress being made in all areas of the project plan in line with delivery timeline
- Health and Wellbeing Coach (based at Neuro Therapy Centre) vacancy going through shortlisting
- Health and Wellbeing Coach (based at Greenbank) support secured from South Liverpool Primary Care Network
- Research protocols in development for full service and FES evaluation and will be submitted to ethics in the coming weeks
- Patient referral portal has been developed and currently going through Information Governance
- Expressions of interest have been received for the FES cycle training in response to initial communication materials
- Session with Nurse Specialists at TWC held on 08/03/23 to raise awareness of the programme and identify potential barriers for referral
- Official Communication finalised and working on broader communication strategy
- Toolkit being developed to aid understanding of how to set up an Access to Exercise Programme for people with neurological conditions

Key Actions Over Last 3 Months

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Rapid Access to Neurological Assessment (RANA)

- Developed by clinicians at The Walton Centre, provides Emergency Department clinicians with direct access to expert neurologists when patients visit Emergency Departments with neurological signs and symptoms
- Model endorsed by Association of British Neurologists, aligned with GIRFT recommendations for acute neurological care and aligned with the requirements of the new specialist training curricular
- The service provides:
  - Direct, rapid access to a dedicated RANA Neurological Registrar at The Walton Centre to discuss patients presenting to local EDs with an acute Neurological sign or symptom
  - Daily ambulatory assessment capacity, both onsite at The Walton Centre and at satellite sites for patients that have been discussed with, and accepted by, the identified RANA Consultant / Registrar
  - Ring-fenced diagnostic capacity at The Walton Centre to support a rapid diagnosis and management plan

- Initially, the service started in February 2021 to support the system as part of The Walton Centre's mutual aid offer during the COVID-19 pandemic. On average the service supported15 patients per month for the last 12 months. However, January 2023 saw an increase to 30 patients with a further increase see in February 2023 to 50 patients.

Further information available via: https://www.thewaltoncentre.nhs.uk/pathways.htm

Commitment 9 Update - CURE

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- Discussions ongoing with LUHFT to collaborate with their tobacco dependence treatment service
- The CURE Project is a comprehensive secondary care treatment programme for tobacco dependency. At its heart is systematically identifying all active smokers admitted to secondary care and immediately offering nicotine replacement therapy and other medications, as well as specialist support, for the duration of the patient's hospital stay and support to stay smokefree after discharge. Work is in progress to develop the CURE model:
  - The Trust is working as a collaborative with LUHFT regarding advice and support and referral to community services for inpatients that smoke
  - Larger piece of work to be undertaken to identify how to record patients that smoke and of those who requires advice and support to quit. Currently recorded on nursing admission document
  - Two submissions have been made to HEE on the number inpatients that smoke.
- The Trust also has guidelines for staff on using Nicotine replacement products for patients and a patient information leaflet which will be updated to include VAPE products

THE CURE PROJECT
CURING TOBACCO ADDICTION IN CHESHIRE AND MERSEYSIDE

The Walton Centre
NHS Foundation Trust

Cheshire & Merseyside NHS Prevention Pledge:

Phase 1 and 2 Trusts: Progress Report for 2022/23

NHS Prevention Pledge Executive Lead for The Walton Centre:

Exec Lead: Dr Andrew Nicolson, Medical Director and Deputy CEO

Operational Lead: Jane Mullin, Deputy Chief People Officer

Project Lead: Rachel Saunderson, Innovation Manager

March 2023

1. NHS Prevention Pledge, Governance and Implementation

The Prevention Pledge consists of a set of commitments whereby NHS organisations pledge support to achieve action on improving population health with a specific focus on prevention measures, for the benefit of staff, patients and the wider community. A number of 'strategic core commitments' have been considered in line with commitments in the NHS Long-Term Plan, sub-regional prevention priorities and in particular the Cheshire & Merseyside Population Health Framework. The strategic core commitments have been drafted to align with a range of NHS Provider Trusts, offering the opportunity for different providers to adopt the Cheshire & Merseyside Prevention Pledge.

As the Trust emerged from the COVID-19 pandemic, there was a need to revise the Trust's strategy and supporting strategies as they were no longer fit for purpose. In September 2022, the Trust's Strategy for 2022-25 was launched which reflects the pace of change in the NHS and the infrastructure changes brought about by the Health and Social Care Bill 2021, primarily the formation of Integrated Care System and the implementation of Integrated Care Boards.

The delivery of the Prevention Pledge commitments translate across all five strategic ambitions outlined in the Trust's Strategy: Education, Training and Learning, Research and Innovation, Leadership, Collaboration and Social Responsibility and its action plan is one of the delivery plans that underpins the Trust's People Sub-strategy (one of the seven 'enabling' sub-strategies of the Trust Strategy).

The Medical Director/Deputy Chief Executive Officer is the Trust Executive Lead for the Prevention Pledge. The Trust has established a group of Deputies to implement and monitor its adoption, this includes, finance, human resources, nursing, strategy and the Deputy Medical Director which works closely with the Divisional Directors. Project Manager support is provided by the Trust's Innovation Manager with a number of the objectives being achieved through the Trust's social innovation agenda.

The Prevention Pledge is support by the Trust's Chief Executive Officer and quarterly updates are provided to the Executive Team and the Board of Directors (See **Appendix 1.1 – 1.2** for Prevention Pledge Update Report, March 2023). In response to the Trust signing up to the Regional Anchor Institutions Charter, an Anchor Institutions Group has been formed with the purpose to monitor and oversee the delivery of the workstreams within the Trust's Social Responsibility and Innovation (social) strategic ambitions in line with the Anchor Institution principals and priorities i.e. Prevention Pledge, Social Value and Sustainability (Net Zero Plan). The Group will be chaired by the Trust's Chief People Officer and reports into the Executive Team. The inaugural meeting of the Group is scheduled for the 18 April 2023.

2. Reflection of Achievements of Prevent Pledge Commitments for 2022/23

The Trust has developed an action plan to deliver against all 14 commitments. Key achievements for 2022/23 are outlined below:

1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC) and making 'prevention everybody's business'.

- Trust People Sub-strategy approved by Trust Board in February 2023
- Divisional update meetings held with Divisional Directors to link business planning and development process
- Trust Health and Wellbeing Strategy approved by Trust Board in June 2022 and Health and Wellbeing is one of the Strategic Implementation Plans that underpins the People Sub-strategy
- Wellbeing Non-Executive Director for the Trust identified
- Location of Wellbeing Hub identified. In the process of being refurbished and identifying services

2.Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.

- Quality impact assessments completed for all project activity

3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities & deliver local priorities and prevention ambitions set out within the NHS Long Term Plan & in COVID recovery plans.

- The Trust is an active member of the Access to Exercise and Wellbeing Programme the aim of which is to expand the offer of exercise and wellbeing therapies for patients with long-term neurological conditions and their carers, located in Chester and North Wales through Neuro Therapy Centre, Greenbank Sports Academy and Brio Leisure including opening up the access to Functional Electrical Stimulation (FES) cycle training. Funding for the Initiative was secured through National Lottery funding
- Rapid Access to Neurological Assessment (RANA) was developed by clinicians at The Walton Centre and provides Emergency Department clinicians with direct access to expert neurologists when patients visit Emergency Departments with neurological signs and symptoms. The model is endorsed by Association of British Neurologists and aligned with GIRFT recommendations for acute neurological care and the requirements of the new specialist training curricular. The service is fully operational and utilisation has increased following open access

4.Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.

- Number of patients seen via the RANA pathway has continually increased with 340 patients seen to date
- Number of advice sessions provided by Allied Health Professionals via the RANA pathway to date is 16

5. Establish key anchor practices that contribute to a successful application for the Cheshire & Merseyside Social Value Award; to positively impact on the wider determinants of health & the climate 'health' emergency when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.

- In February 2023, coinciding with National Apprenticeship Week, the Trust's Training and Development Team held a Workplace Safari for students from local schools, showcasing clinical and non-clinical roles in the NHS. 16 schools from across the 6 boroughs of the City were invited to participate with approximately 20 pupils from each. The schools involved included those providing educational support to pupils with special education needs and disabilities (SEND)

- Everton Legacy Scheme MoU signed off by the Executive Team to commit the Trust to being a partner for phases two and three of the scheme which includes a Health Zone development which will be a purpose-built health and social care facility for residents living in one of the most deprived areas of the city and beyond. Initial scoping of services that could be provided by the Trust via the Health Zone development has been undertaken
- The Trust signed up to the C&M HCP Anchor Institutions Charter launched in July 2022 which will be delivered via the Prevention Pledge, Social Value and Sustainability Workstreams
- The Trust signed the C&M HCP Social Value Charter in May 2022. Application for Social Value Award and Quality Mark Level 1 in progress. The Trust also signed up as an early adopter site of the C&M ICB TOMs Framework and is participated in workshops to design the regional framework and identify metrics for inclusion in the areas of jobs, growth, social, environment and innovation
- The Trust became a Founding member of Liverpool Citizens to enable a realistic dialogue with the people that it serves in line with the health inequality agenda. Pre-founding Assembly held in November 2022. Trust Core Group established and undertaking Community Leadership training in support of listening campaign to be held later in the year. Trust ED&I champions identified to join the Core Group and support the listening campaign
- Since April 2022, a total of 8 apprenticeships have commenced in the Trust: 7 were existing staff and 1 was recruited to the organisation as an apprentice

6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.

- MECC training modules were mandated by the Trust which saw as of January 2023, 93% compliance for Brief Encounters and 91% compliance for Motivating Change

7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building & to reduce impact on GP consultation rates, A&E attendance, hospital stays & re-admission, medication use, and social care.

- St Helens Health Coaches Service developed for patients with long-term conditions
- Enhanced triage consultant pilot benefits being realised. Further expansion planned to support all incoming general neurology referrals to receive enhanced triage
- The Shiny Mind App is an alternative option for staff to improve accessibility to psychological support. Functions include mediation, stress reduction, nursing life packs and gratitude board. The App was re-launched in December 2022 along with new a new version for Nurses, Midwives and Healthcare Support Workers developed for Nurses by Nurses. Initial feedback showed that 94% of nurses felt the App made them feel better, 51% felt it improved confidence and 100% of users wished to continue using it

8.Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental well-being.

- MECC training modules were mandated by the Trust which saw as of January 2023, 93% compliance for Brief Encounters and 91% compliance for Motivating Change

9.Ensure a smoke-free environment, linked to support to stop smoking for patients and staff who need it.

- Collaborating with LUHFT on their tobaccos dependence treatment service – CURE, in terms of advice and support as well as referral to community services for inpatients who smoke
- The Trust has also developed guidelines for staff on using Nicotine replacement products for patients and a patient information leaflet which is being updated to include VAPE products

10.Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental well-being.

- Trust Wellbeing Strategy launched in June 2022
- 20-minute Health Check/MOTs are offered to all staff free of charge and includes blood pressure check, total cholesterol, blood glucose, height, weight and BMI, waist measurements, body fat percentage and visceral fat score and an exercise behaviour questions
- Monthly health and wellbeing staff bulletins advising on all aspects of wellbeing: mental, physical, social, workplace and financial commenced in August 2022
- Introduced 'Wellbeing Wednesdays' when a wellbeing stand is located in a variety of areas across the Trust for staff to access wellbeing support and advice
- Continuing to roll out the Mental Health First Aiders programme
- Wellbeing hub in the process of being refurbished and identifying services
- Health and wellbeing junior doctor survey undertaken Oct/November 2022
- Cost-of-living support initiatives to support staff e.g. hardship vouchers, information on food banks, food pantries, community growers and food support organisations across the region

11a. Review food and drink provision across all our NHS buildings, facilities and providers in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.

- New Bistro opened in the Main Centre and the Trust continues to work with contractors to identify healthy options

11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.

- The Trust has proposed to have freshwater fountain points across the Trust however, work is currently ongoing to address infection control concerns

12.Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.

- The Walton Centre purchased 10 bikes for staff for a year to enable staff to access free of charge
- The Trust is working with LUHFT as secured funding from Cycling UK to host Dr Bike maintenance sessions for staff
- Working with LUHFT and identified a space on Aintree site and have staff who physical activity teachers to provide classes back on site
- 'Walk Walton' asked supporters of the Trust to walk 100,000 steps during the month of May in 2022 to help raise funds to support the Trust's Home from Home relatives' accommodation
- The Trust took over financial leadership of the North West Games to enable the event to continue to be held and participated in the autumn 2022 event
- Wellbeing Balance Scorecard approved at Business Performance Committee in January 2023 which has indicators for the areas of absence, wellbeing pulse, health checks and wellbeing engagement

13.Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.

- Unable to sign up to the Prevention Concordat as waiting publication of national framework
- The Trust continued to roll out its Mental Health First Aider programme
- NHS England REACT training was included in the Trust internal leadership programme for existing and aspiring leaders, Building Rapport. The REACT training aims to equip managers to hold supportive and compassionate mental health and wellbeing conversations

14. Monitor the progress of the pledge against all commitments and to publishing the results of our progress at regular intervals.

- Quarterly updates are provided to the Executive Team and the Board of Directors (See **Appendix 1.1 – 1.2** for Prevention Pledge Update Report, March 2023)
- In response to the Trust signing up to the Regional Anchor Institutions Charter, it has formed an Anchor Institutions Group the purpose of which is to monitor and oversee the delivery of the workstreams in line with the Anchor Institution principals and priorities i.e. Prevention Pledge, Social Value and Sustainability (Net Zero Plan). The Group will be chaired by the Trust's Chief People Officer and reports into the Executive Team. The inaugural meeting of the Group is scheduled for the 18 April 2023.

A review of progress made against Prevention Pledge commitment KPIs was undertaken in Q4, 2022/23 and reported to the Community of Practice and Health Inequalities Group. The submission has been included in **Appendix 2**.

3. Reducing Health Inequalities

Health inequalities is a key priority for the Trust and relates to all five of the organisation's strategic ambitions identified in the Trust Strategy 2023-25 e.g. Education, Training and Learning, Research and Innovation, Leadership, Collaboration and Social Responsibility. It will be measured by the strategy being outcome based looking at areas of evaluation to the Marmot principles. Developments during 2022/23 include:

- Equality, Diversity and Inclusion Leads identified for the @race, LGBTQ+ and disability groups with staff networks relaunched
- Board Assurance Framework (BAF) Strategic risks have been developed in line with the five strategic ambitions of the Trust set out in the Trust Strategy 2023-25 one of which is the Prevention and Inequalities risk "*If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population."* BAF risks comprising of mitigation and corrective action measures, are reviewed on a quarterly basis and reported through the Executive Team, relevant sub-committees of the Trust Board and the Board of Directors itself
- Following an effectiveness review of the Trust's Strategic Black Asian & Minority Ethnic (BAME) Advisory Committee (SBAC), there is a proposal for its remit to be widened to cover all aspects of Equality, Diversity and Inclusion and for a formal Health Inequalities Committee to be established which would be a sub-committee of the Trust Board. If established, the Anchor Institutions Group would report into the Committee. Options are currently being reviewed by the Executive Team.

Some neurological conditions may exacerbate health inequality by impacting on employment opportunities and independence. It is vital therefore that the Trust understands these issues which may be specific to people with neurological conditions by engaging with patient groups and addressing their needs in a personalised way.

The Trust will continue to work collaboratively with the acute trusts across the region through the Cheshire and Merseyside Acute and Specialist Provider Collaborative (CMAST), developing more integrated ways of working by standardising pathways and interventions and new services to improve healthcare delivery for our population.

The Trust will continue its work to deliver against the 14 commitments of the Prevention Pledge which will feed into the strategic ambitions of the organisation. Also, linking with organisations outside of the health service to explore interventions which may benefit people with long-term neurological conditions e.g. Sports England on access to exercise, and measures to prevent neurological trauma e.g. head injury prevention measures, promotion of the wearing of cycle helmets.

Appendices

Appendix 1.1 and 1.2: Prevention Pledge Update Report for Executive Team Meeting, March 2023, inclusive of updated action tracker

Appendix 2: Prevention Pledge Action Plan KPI Report, January 2023

The Walton Centre NHS Foundation Trust

Prevention Pledge Action Tracker

Element	Outcome	Status	Progress	Upcoming Actions	Action Owner	Completion Date	Metric	Update	KPI Impact Data
Programme Set Up	Executive sponsor in place		Andy Nicolson, Deputy CEO identified as Executive Lead	Action Tracker to be presented to Trust Board in March 2022	AN	01/01/22	N/A	Complete	
Programme Set Up	Working Group in place		Deputy Directors identified as working group	Monthly meetings for working group (last Tuesday in the month)	JM	01/02/22	Group TOR	Complete	
Programme Set Up	Prevention Pledge Plan outlining actions and completion dates		Plan created	Plan to be shared with Executive Directors	Working group (WG)	01/02/22	Agreed plan	Complete	
Programme Set Up	Governance structure established		Plan agreed with CEO	Meetings arranged to ensure progress is being made	WG	01/01/22	Agreed plan	Complete	
PP - Systems & Environmental	1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC) and making 'prevention everybody's business'.		Well-being and prevention incorporated into refreshed Trust Strategy Neurosciences Board Linked to HCP- acute, social care & community sectors all involved Refreshed Well-being strategy for staff NED appointed as Board Wellbeing Guardian	To be approved at SPC/LNC	JR JM	31/03/22	Refreshed strategies and associated action plans	People Substrategy approved by Board in February 2023	
							Meeting with Divisional Directors to embed prevention in all service developments All new service plans to have prevention as an integral aspect of the development	Neurology Division updated Meetings with Divisional Director to link to business planning and development process completed	
							Number of staff participating in H&W activities	H&WB Strategy approved by Board June 22 and Wellbeing NED identified	
							Opening of Wellbeing Hub	Wellbeing hub opened on the 23/04/23 and provides a safe space for staff to collect their thoughts and find out what health and wellbeing activities are available as well as attend wellbeing event and drop-in sessions. Although staff focussed can be used for patients.	
PP - Systems & Environmental	2. Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.		Service Transformation Team in place- staff training to support leadership & building ideas Patient experience training – specific to teams/wards Single/joint procurement portal	Continued review of projects at Transformation Board	LV	On going	Action plans	QIA agreed and completed for all projects	

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PP - Systems & Environmental	3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities & deliver local priorities and prevention ambitions set out within the NHS Long Term Plan & in COVID recovery plans		Involvement in a number of place-based strategies and interventions designed at reducing inequalities in line with NHS Long Term Plan / COVID recovery	Consider prevention work in the community re head injury and helmets	SN	31/12/22		Visit made by Consultant Neurosurgeon to local school – need to look at how to include into job plans.	
					SN	Ongoing	TBC	LUFHT made new consultant appointment leading on frailty and trauma. Contact will be made to progress when in post.	
				Work with local acute Trust re back pain/injury	JR	Ongoing	TBC	Collaboration with LUHFT – discussions ongoing regarding integration of services and review of pathways. Exploring use of new Pain suite/theatre space at Broadgreen Hospital.	
				Leading on the collaboration of pain services across North Merseyside linking in with the medicines optimisation project	JR	Ongoing	Action plans	Pain collaborative workstream is ongoing to review integrated pain pathways between Tier 3, 2 & 1 – collaborative working between trusts aiming for a single Pain Service for the region to deliver community, secondary and tertiary care. The Pain Management Programme at the Walton Centre aims to reduce opioid dependency, leading to financial and clinical benefits, including a reduction in A&E attendances, hospital admissions, reduced drug costs (GPs), reduced GP attendances and reduction in diagnostics.	
				In line with the above working with Sports England on improving access to exercise for patients with LTC. This is also in partnership with the Neuro Therapy Centre	JR	01/01/25	Outcome measure from the evaluation undertaken by University of Sheffield	Neurotherapy Treatment Centre evaluation of the Access to Exercise Programme the aim of which was to support and sustain people with neurological conditions into an active lifestyle. NTC successful in being awarded national lottery funds for a 3-year project to enable physical and mental wellbeing support to be provided to patients in the Chester area win the community – Reaching Communities project. The Trust is a member of the steering group. St Helens Place – health coaching for access to exercise and psychological support	N/A as research evaluation currently going through ethics approval.
				Work with local acute Trust re cancer patients	SH	Ongoing	Links to transformation plan	Whiston Cancer Services – emergency brain pathway pilot is ongoing with plans in place to roll out across the region, discussions have been held with Arrowe Park and LUHFT.	

				Work with Local acute Trusts to support patients neurological care and treatment closer to home	JD	Ongoing	Outcome of RANA and acute neurology pilot Integrated Neurology Nurse Specialist (INNS) Service providing community clinics (23 across Cheshire and Merseyside) and home visits for Motor Neurone Disease, Multiple Sclerosis, Epilepsy and Parkinson's Disease. Also, provide education to professionals, patients and care homes.	RANA is operational and utilisation has significantly increased following open access. Service established	Dec 2021/22 the INNS team provided 863 home visits 3100 community clinic appointments. The patients also have access to Nurse advice lines with 11 per week being provided at the moment.
PP - Systems & Environmental	4. Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.		Integrated Neurology Nurses RANA	Continue pathway work commenced in covid re stroke prevention/early presentation Develop role of AHP's in providing advice linking to other neurological care pathways	JD JD	31/03/22 30/09/22	Number of patients treated via RANA pathway- baseline information May 2022 Number of advice session provided by AHP's- baseline information May 2022	2nd phase of RANA commenced on 25/11/22 with opening of day case ward	Number of patients treated via RANA pathway to date is 340. Number of advice sessions provided by AHPs via RANA pathway to date is 16.
PP - Systems & Environmental	5. Increase social value by establishing anchor practices, that positively impact on the wider determinants of health & the climate 'health' emergency, when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.		Emphasis of Trust's social responsibility as an anchor institution within draft Trust strategy, for approval in 2021. Involvement in a number of place-based strategies and interventions demonstrating the Trust's commitment to its social responsibility.	Collaborative procurement service across a number of specialist Trusts	HW	31/03/22	Service in place	completed	
				Promote the Trust as an employer to local schools	JM	31/03/22	Number of visits to schools over the year- baseline information May 2022, number of events attended.	Work on-going with Liverpool City Region Careers Hub	Workplace Safari being hosted by The Walton Centre in February 2023. 16 schools from across the 6 boroughs of the City will be participating with approximately 20 pupils from each. The schools involved include those providing educational support to pupils with special education needs and disabilities (SEND). A member of the Therapies team has contacted a local school and is working directly with them to raise awareness of Allied Health Professions available
				Consider employing local community as a priority	JM	31/03/22	Monitor local recruitment	Baseline information of staff living in most deprived wards. Working to widen local access to recruitment opportunities via Liverpool Citizens partnerships.	None to report at this time. Applicable roles are being shared through networks.

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				Active partner in the Everton Minds programme	JR/RS	31/03/22	Participation in programmes Baseline information -May 2022	Trust is a partner in the development of the Health Zone Development - a purpose-built health and social care facility. Part of the Goodison Park legacy. Trust specification developed and submitted. Currently exploring models of ownership and legal implications/restrictions. Key Updates: • Strategic Development Framework being developed • Key investors identified and proceeding to formal tender process • Regular meetings being held between Everton Minds and Everton Exec Team to drive momentum and ensure project is active in next 6-12 months • Update partnership MoU being progressed by partners • Consensus from health partner meeting was for EitC to own and manage the Health Zone	The Trust has signed off the Everton Legacy Scheme MoU to commit to being a partner for phases two and three of the scheme. Initial scoping of services that could be provided via the Health Zone development has been undertaken which include the following services: • Outpatients: ○ Neurology ○ Neurosurgery ○ Pain ○ Physio ○ Occupational Health ○ Neuropsychiatry ○ Neuropsychology ○ Rehabilitation • Nurse led services • Immersive technology • Gait lab • Simulation in Rehabilitation, Neuropsychiatry, Neuropsychology
				Anchor Institutions Charter	RS	15/07/22	May 2022 application completed.	C&M HCP Anchor Institutions Charter launched in July 2022. Trust signed up to Charter on 15/07/22. Will be delivered through Social Value, Sustainability and Prevention Pledge initiatives.	Inaugural meeting of the Trust's Anchor Institution Group held on the 18/04/22 to oversee the delivery of the 3 identified workstreams and will report into the Executive Team.
				Apply for Social Value Award	RS	31/03/22	Success with application -May 2022 commitment made	Trust has signed the C&M HCP Social Value Charter in May 2022. Application for Social Value Award and Quality Mark Level 1 in progress. Initial scoping of Trust activity mapped against the 8 themed areas. Currently mapping activity via partners and developing pledges and metrics. Also exploring data capture system options e.g. TOMs Framework	The Trust has signed up as an early adopter site of the C&M ICB TOMs Framework which provides a consistent set or metrics across partner organisations for the following themes: • Jobs: promote local skills and employment • Growth: supporting growth of responsible regional business • Social: healthier, safer and more resilient communities • Environment: decarbonising and safeguarding our world • Innovation: promoting social innovation Portal goes live end of April 2023 and working through internal process with identified leads.

				Participation in Liverpool Citizens Alliance	JM/ RS	31/03/22	Involvement in alliance baseline information	Trust committed to being a founding member- relationship being developed. Trust core group members identified, and training allocated. Pre-founding Assembly held on 30/11/22. The Trust is leading on the recruitment for the role of Community Organiser for the alliance inclusive of psychometric support. Focussing on progressing from pre-founding to founding stage with official launch and listening campaign commencing in September 2023.	Pre-founding assembly outcomes: • Exceeded attendance target of 150 with 220 people attending • All 15 founding organisations formally committed to the alliance and expressions of interest from other organisations are currently being followed up The Trust's Core Group membership currently stands at 11 members with Trust-wide representation including HR, Staff Side, Staff Governor, nursing, AHP, Clinical Division. Exec and project leads named and Board and NED champions identified ED&I champions identified to join Core Group and support listening campaign in spring 2023.
				Widening of the apprenticeship programme	JM	31/03/22	2022- number of apprentices in post.	• Since April 2022, 3 staff members have started an apprenticeship to date with a further 4 to start in the coming weeks • The Trust has employed one direct apprentice • Plans for 2022/23 are to recruit for another TNA programme and recruit 5 HCAs and to review Bands 2-4 admin vacancies and work closely with managers to support them to see if the vacancies can be turned into apprenticeships	A total of 8 apprenticeships have commenced: 7 were existing staff and 1 was recruited in as an apprentice
				Step into Health Programme	JM	01/04/23	The programme connects skilled candidates from across the Armed Forces community with employers and new opportunities in the NHS. The aim is for NHS organisations to benefit from the transferable skills and values that Armed Forces community members bring to the workplace.	In April 2023, the Trust made the pledge to the programme therefore making a public commitment to support the recruitment of member of the Armed Forces community into the NHS.	N/A at this time as the Trust only signed up to the pledge in April 2023.
PP- Brief Intervention / MECC / Social Prescribing	6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.		MECC training package	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process	NM	30/09/22	Number of staff trained Number of new staff inductions that include mandatory MECC training at a basic competency level	MECC e-learning modules mandated.	As of April 2023 compliance of MECC e-learning is: MECC Brief encounters – 91% MECC Motivating Change – 90%

PP- Brief Intervention / MECC / Social Prescribing	7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building & to reduce impact on GP consultation rates, A&E attendance, hospital stays & re-admission, medication use, and social care.		E-Consent	Following a small successful trial, a wider scale pilot has been agreed for 12 months to incorporate an electronic consent process into our processes. There is a clinical medical record risk currently for patients who consent off-site (such as satellite clinics) as the paper form needs to be transported across sites by the clinical teams. There is also a current risk for patients who are consented in clinic as from a medicolegal point of view, there is no 'thinking time' for the patient to consent to all of the risks.	RP	01/04/24	Benefits have been identified as follows: • Decrease clinic overruns • Increased quality of time with the patient in clinic • Reduce the need for subsequent FU clinics to consent patients prior to their operation • Decrease the risk of paper forms going 'missing' or being lost • Improve information governance processes • Increase RTT performance • Increase patients 'readiness' for surgery • Decrease medicolegal risks • Improve patient experience and understanding of their surgical procedure • Reduced paper waste, therefore a more sustainable solution	No further update available at this time as pilot just been agreed.	N/A at this time.
			Patient & family centred care steering group to inform holistic approach	In partnership with the voluntary sector supporting the implementation of the Health Coaches for patients with LTC	SN	30/06/22	Length of Stay baseline May 2022	St Helens Health Coaches service development	
			Best supportive care pilot with Whiston for cancer patients					Whiston Cancer Services – emergency brain pathway pilot is ongoing with plans in place to roll out across the region, discussions have been held with Arrowe Park and LUHFT.	
			Enhanced triage					Enhance triage consultant pilot benefits being realised and expansion planned to support all incoming general neurology referrals receiving an enhanced triage.	
			Nursing advice lines					Nurse advice lines ongoing and established - completed	
			Social prescribing	Via the Wellbeing sub-group with Liverpool City Council to consider the use of shinyminds resilience app in social prescribing	JM	April 2022	Implementation and use of app May 2022 Zero users	Shiny Mind is an alternative option for staff to improve accessibility to psychological support. Functions include mediation, stress reduction, nursing life packs and gratitude board. Relaunch of the Shiny Minds App was re-launched in December 2022 along with new App version for Nurses, Midwives and Healthcare Support Workers developed for Nurses by Nurses. The Trust continues to promote the App to Nursing staff across the Organisation	Initial feedback from staff shows that: • 94% of nurses felt Shiny Mind made them feel better • 51% felt using that App improved confidence • 100%of App users wished to continue using the App.

PP- Brief Intervention / MECC / Social Prescribing	8. Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental wellbeing.		MECC training Internal communications i.e. Walton Weekly, posters etc Staff wellbeing advocates	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process Wellbeing advocates being identified across the Trust in line with the Trust's Wellbeing Strategy	NM JM	30/09/22 Ongoing	Number of staff trained/participating in training Number of patients receiving a MECC contact Number of new staff inductions that include mandatory MECC training at a basic competency level	MECC e-learning modules mandated. Meeting being held with IT to progress capturing number of patients receiving MECC Relaunch of MECC Moments not undertaken – in the process of identifying the MECC lead for the Trust to take this forward.	As of April 2023 compliance of MECC e-learning is: MECC Brief encounters – 91% MECC Motivating Change – 90% Trust has 10 member of staff who have committed to be wellbeing advocates and invited to attend monthly meetings and receive regular communications.
PP - Health & Well-being for Staff, Patients & Visitors	9.Ensure a smoke-free environment, linked to support to stop smoking for patients and staff who need it		Smoke free site Smoking cessation support in place		JM	31/12/22	Smoke-free policy in place and actions related to policy complete. Further education planned for staff	Discussions ongoing with LUFT to collaborate with their tobacco dependence treatment service . Work is in progress to develop the CURE model: • The Trust is working as a collaborative with LUHFT regarding advice and support and referral to community services for inpatients that smoke • The Trust has guidelines for staff on using Nicotine replacement products for patients and a patient information leaflet which will be updated to include VAPE products • Larger piece of work to be undertaken to identify how to record patients that smoke and of those who requires advice and support to quit. Currently recorded on nursing admission document • Two submissions have been made to HEE on the number inpatients that smoke.	SLA now agreed with LUHFT and will operate from 1st May 2023 to 31 March 2026. The aim of the service is to provide a high-quality inpatient and staff smoking support service
PP - Health & Well-being for Staff, Patients & Visitors	10. Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental wellbeing		Staff well-being programme Trained MHFA across the Trust Internal communications i.e. Walton Weekly, posters etc	Review of staff experience action plan at sub-Board level Review staff rest facilities Respond to staff need re wellbeing	JM	Quarterly 28/02/22 28/02/22	Reduction in staff absence May 2022 data Reduction in the number of staff leaving May 2022 data the Trust Improving number of staff recommend the Trust as a place to work and receive treatment Pulse Survey- April 20220 data	Completed – now reports directly to Trust Board • The Trust has mental health first aiders within each departmental area across the Trust. Will look to collate feedback themes to inform future work • Monthly Wellbeing Wednesday commenced August 2022 • MHFA programme is continuing with a new cohort being trained on the 12&20 Jan 2022. • Wellbeing hub opened on the 23/04/23 and provides a safe space for staff to collect their thoughts and find out what health	

								and wellbeing activities are available as well as attend wellbeing event and drop in sessions. Although staff focussed can be used for patients. • Funding has been secured to enable MOTs to be offered to the remaining 1300 staff who have not yet taken up the offer over the next 12 months • Cost of Living support i.e. additional bread and milk in staff areas, 200 £25 Asda vouchers purchased and distributed via line managers and staff side • Exploring Real Living Wage • Working in partnership with LUHFT to offer a joint wellbeing resource for staff including smoking cessation, running group and exercise classes.	
				Launch of new Wellbeing Strategy	JM	28/02/22		Wellbeing strategy launched and in process of being implemented.	
				Monthly wellbeing newsletter	JM	28/02/22		Regular monthly newsletter covering all aspects of wellbeing including financial	
				Introduction of ambassadors for the Trust's resilience app	JM	28/02/22		New nursing version of ShinyMind app launched – co-created with the NHS with nurses, midwives and HCAs	Initial feedback from staff shows that: • 94% of nurses felt Shiny Mind made them feel better • 51% felt using that App improved confidence • 100%of App users wished to continue using the App.
PP - Health & Well-being for Staff, Patients & Visitors	11a. Review food and drink provision across all our NHS buildings, facilities and providers in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.		New catering contract from 1st April 2022	As part of new provision to audit staff and public food provision on site to identify opportunities to further the availability of healthy food and drink	LV	01/04/22	Percentage of drink lines stocked which are sugar free, including energy drinks, fruit juices and milk-based drinks Percentage of pre-packed sandwiches and other savoury pre-packed meals available contain 400kcal or less per serving and don't exceed 5g fat per 100g Need to get baseline data from ISS	New Bistro open in Main Centre and continue to work with contractor to identify healthier options.	
PP - Health & Well-being for Staff, Patients & Visitors	11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.		All staff members provided with re-usable drink bottle Fresh water fountains available in staff areas	Audit to be undertaken of current facilities on site	JM	31/12/22	Water points across the Trust	Work ongoing to address infection control concerns - Infection control issues still not resolved	
PP - Health & Well-being for Staff, Patients & Visitors	12. Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients and visitors to be physically		Some physical activity promotion to staff, including the offer of subsidised gym membership sessions	Audit of staff physical activity Work with MSP to promote physical activity	JM	31/03/22	Proportion of staff participating in regular physical activity	• The Trust has purchased 10 bikes for staff for a year so free to staff • The Trust is working with LUHFT as secured funding from Cycling	

	active both on and off site and in line with active travel and sustainable management plans.		and the invitation to take place in the NHS games. Aligned with initiatives at local government Charity events- Hope Mountain Hike, virtual London marathon					UK to host Dr Bike maintenance sessions for staff. • Working with LUHFT and identified a space on Aintree site and have staff who physical activity teachers to provide classes back on site • Walk Walton during May 2022 • LUHFT timetable of physical activity classes now advertised across the Trust	
						On going	Wellbeing survey baseline Nov 2022	The Trust is working with Merseyside Sports Partners to undertake wellbeing survey in early 2023. The Trust took over financial leadership of the NW Games to enable the event to be held.	Wellbeing survey to take place in Spring 2023
						On going	May 2022 baseline info	Wellbeing Balance Scorecard has been devised and was shared with Business Performance Committee in January 2023.	Indicators have been developed for the following areas: • Absence • Wellbeing pulse • Health Checks • Wellbeing Engagement See Appendix A.
						On going	Participating in Autumn 2022 games	The Trust participated in the NHS NW games and will participate in 2023 games. It also continues to support the games by managing the finances	
PP - Health & Well-being for Staff, Patients & Visitors	13. Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.			Paper to be produced outlining the requirements of the Prevention Concordat and the benefits to the Trust to implement the Strategy	JM		Number of staff who have participated in training provided Baseline data May 2022- not commenced	• National framework due to be launched end of 2022/early 2023 • A further cohort of MHFA trained. • NHSE REACT has been included in Building Rapport internal leadership programme for all line managers.	
PP- Governance	14. Monitor the progress of the pledge against all commitments and to publish the results of our progress at regular intervals.		Action plan	Review with Executive team	All DD	Quarterly	RAG rated action plan to be reviewed at Board	Reports into Trust Board every 6 months with the last update taken in October 2022. Next update due May 2023.	

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Appendix A

Walton Hospital NHS Trust Performance Scorecard					**Number of staff**	1400			
					Date: October 2022				
ABSENCE	**QI**	**Q2**	**YTD**		**HEALTH CHECKS**	**Jan**	**Feb**		**YTD**
(ESRData)					*(Health check Data)*				
Total number days absence					Total number health check days	4	4		0
Number of people currently absent					Number of people attended	67	56		123
Average number of days absent per person					Percent of staff screened	5%	4%		**9%**
Average number of days absent pp (excluding LTS)					% high risk - blood pressure	15%	23%		**19%**
Total number days LTS absence					% high risk - cholesterol	3%	4%		**3%**
Number of people LTS					% high risk - waist	42%	36%		**56%**
% of staff < 7 days absence					% high risk - body fat	42%	36%		**56%**
Mental health related absence days					% high risk - sleep	39%	45%		**47%**
Work related stress related absence days					% high risk - energy	33%	36%		**35%**
Musculoskeletal absence days					% high risk - glucose	1%	2%		**2%**
Seasonal flu/virus days					% high risk -exercise	16%	25%		**20%**
Covid absence days					% referred to GP	19%	21%		**20%**
Long term covid days					% high risk - finances	x	x		**x**
					% high risk - smoke	x	x		**x**
					% high risk - alcohol	x	x		**x**
					% would recommend to colleague	83%	85%		**84%**
WELLBEING PULSE	**QI**	**Q2**	**YTD**		**WELLBENG ENGAGEMENT**	**QI**	**Q2**		**YTD**
(PulsesurveyData)					*(WellbeingData)*				
Organisation practically supporting wellbeing	59.8%		**59.8%**		Newsletter opens	0	490		**490**
Teams supporting each other	77.2%		**77.2%**		Wellbeing Wednesday days deliverd	4	4		**4**
Anxiety level	31%		**31%**		MHF Staff trained	28	14		**32**
Positvity rating overall	58%		**58%**		MHF awareness	249	19		**44**
Look forward to going to work	54%		**54%**		Workshops	x	x		**x**
Had a management conversation about wellbeing	x		**x**		Wellbeing champlons	9	0		**9**
I found the wellbeing converation supportive	x		**x**						

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Prevention Pledge Key Performance Impact Data Update – January 2023

Element	Outcome	Metric	Update	KPI Impact Data
PP - Systems & Environmental	4. Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.	Number of patients treated via RANA pathway-baseline information May 2022	2nd phase of RANA commenced on 25/11/22 with opening of day case ward	Number of patients treated on via RANA pathway to date is 340.
		Number of advice session provided by AHP's-baseline information May 2022	Work progressing with Clinical Divisions	Number of advice sessions provided by AHPs via RANA pathway to date is 16.
PP - Systems & Environmental	5. Increase social value by establishing anchor practices, that positively impact on the wider determinants of health & the climate 'health' emergency, when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.	Number of school events attended/hosted.	Work on-going with Liverpool City Region Careers Hub	Workplace Safari being hosted by The Walton Centre in February 2023. 16 schools from across the 6 boroughs of the City will be participating with approximately 20 pupils from each. The schools involved include those providing educational support to pupils with special education needs and disabilities (SEND).
		Participation in programmes Baseline information -May 2022	Trust is a partner in the development of the Health Zone Development - a purpose-built health and social care facility. Part of the Goodison Park legacy. Trust specification developed and submitted. Currently exploring models of ownership and legal implications/restrictions. Key Updates: • Strategic Development Framework being developed • Key investors identified and proceeding to formal tender process • Regular meetings being held between Everton Minds and Everton Exec Team to drive momentum and ensure project is active in next 6-12 months • Update partnership MoU being progressed by partners • Consensus from health partner meeting was for EitC to own and manage the Health Zone	The Trust has signed off the Everton Legacy Scheme MoU to commit to being a partner for phases two and three of the scheme. Initial scoping of services that could provided via the Health Zone development has been undertaken which include the following services: • Outpatients: o Neurology o Neurosurgery o Pain o Physio o Occupational Health o Neuropsychiatry o Neuropsychology o Rehabilitation • Nurse led services • Immersive technology • Gait lab • Simulation in Rehabilitation, Neuropsychiatry, Neuropsychology
		Success with application - May 2022 commitment made	Trust has signed the C&M HCP Social Value Charter in May 2022. Application for Social Value Award and Quality Mark Level 1 in progress. Initial scoping of Trust activity mapped against the 8 themed areas. Currently mapping activity via partners and developing pledges and metrics. Also exploring data capture system options e.g. TOMs	The Trust has signed up as an early adopter site of the C&M ICB TOMs and is participating in workshops to design the regional framework and identify metrics for the following themes: • Jobs: promote local skills and employment • Growth: supporting growth of responsible regional business • Social: healthier, safer and more resilient communities • Environment: decarbonising and safeguarding our world • Innovation: promoting social innovation Implementation is set for April 2023.

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		Involvement in alliance baseline information May	Trust has committed to being a founder member-relationship being developed. Trust core group members identified and training allocated. Pre-founding Assembly held on 30/11/22.	Pre-founding assembly outcomes: • Exceeded attendance target of 150 with 220 people attending • All 15 founding organisations formally committed to the alliance and expressions of interest from other organisations are currently being followed up The Trust's Core Group membership currently stands at 11 members with Trust-wide representation including HR, Staff Side, Staff Governor, nursing, AHP, Clinical Division. Exec and project leads named and Board and NED champions identified ED&I champions identified to join Core Group and support listening campaign in spring 2023.
		Number of apprentices in post.	• Since April 2022, 3 staff members have started an apprenticeship to date with a further 4 to start in the coming weeks • The Trust has employed one direct apprentice • Plans for 2022/23 are to recruit for another TNA programme and recruit 5 HCAs and to review Bands 2-4 admin vacancies and work closely with managers to support them to see if the vacancies can be turned into apprenticeships	A total of 8 apprenticeships have commenced: 7 were existing staff and 1 was recruited in as an apprentice
PP- Brief Intervention / MECC / Social Prescribing	6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being. 7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building & to reduce impact on GP consultation rates, A&E attendance, hospital stays & re-admission, medication use, and social care.	Number of staff trained including new staff inductions that include mandatory MECC training at a basic competency level		As of January 2023 compliance of MECC e-learning is: MECC Brief encounters – 93% (1315/1419 staff) MECC Motivating Change – 91% (988/1082 staff)
PP- Brief Intervention / MECC / Social Prescribing		Implementation and use of App May 2022 Zero users	Shiny Mind is an alternative option for staff to improve accessibility to psychological support. Functions include mediation, stress reduction, nursing life packs and gratitude board. Relaunch of the Shiny Minds App was re-launched in December 2022 along with new App version for Nurses, Midwives and Healthcare Support Workers developed for Nurses by Nurses.	Initial feedback from staff shows that: • 94%of nurses felt Shiny Mind made them feel better • 51% felt using that App improved confidence • 100%of App users wished to continue using the App.

PP- Brief Intervention / MECC / Social Prescribing	8. Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental wellbeing.	Number of staff trained including new staff inductions that include mandatory MECC training at a basic competency level		As of January 2023 compliance of MECC e-learning is: MECC Brief encounters – 93% (1315/1419 staff) MECC Motivating Change – 91% (988/1082 staff)
PP - Health & Well-being for Staff, Patients & Visitors	12. Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.	May 2022 baseline info	Trust developed Wellbeing Balance Scorecard to measure indicators in the following areas: • Absence • Wellbeing Pulse • Health Checks • Wellbeing Engagement	Please see **Appendix A** for specific metrics.

The Walton Centre NHS Foundation Trust

Appendix A

Walton Hospital NHS Trust Performance Scorecard					Number of staff	1400			
					Date: October 2022				
ABSENCE	**Q1**	**Q2**	**YTD**		**HEALTH CHECKS**	**Jan**	**Feb**		**YTD**
(ESRData)					*(Health check Data)*				
Total number days absence					Total number health check days	4	4		0
Number of people currently absent					Number of people attended	67	56		123
Average number of days absent per person					Percent of staff screened	5%	4%		**9%**
Average number of days absent pp (excluding LTS)					% high risk - blood pressure	15%	23%		**19%**
Total number days LTS absence					% high risk - cholesterol	3%	4%		**3%**
Number of people LTS					% high risk - waist	42%	36%		**56%**
% of staff < 7 days absence					% high risk - body fat	42%	36%		**56%**
Mental health related absence days					% high risk - sleep	39%	45%		**47%**
Work related stress related absence days					% high risk - energy	33%	36%		**35%**
Musculoskeletal absence days					% high risk - glucose	1%	2%		**2%**
Seasonal flu/virus days					% high risk -exercise	16%	25%		**20%**
Covid absence days					% referred to GP	19%	21%		**20%**
Long term covid days					% high risk - finances	x	x		**x**
					% high risk - smoke	x	x		**x**
					% high risk - alcohol	x	x		**x**
					% would recommend to colleague	83%	85%		**84%**
WELLBEING PULSE	**Q1**	**Q2**	**YTD**		**WELLBENG ENGAGEMENT**	**Q1**	**Q2**		**YTD**
(PulsesurveyData)					*(WellbeingData)*				
Organisation practically supporting wellbeing	59.8%		**59.8%**		Newsletter opens	0	490		**490**
Teams supporting each other	77.2%		**77.2%**		Wellbeing Wednesday days deliverd	4	4		**4**
Anxiety level	31%		**31%**		MHF Staff trained	28	14		**32**
Positvity rating overall	58%		**58%**		MHF awareness	249	19		**44**
Look forward to going to work	54%		**54%**		Workshops	x	x		**x**
Had a management conversation about wellbeing	x		**x**		Wellbeing champlons	9	0		**9**
I found the wellbeing converation supportive	x		**x**						

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	External Well Led Review – Final Report
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Final well led report has been received
- Number of areas of positive feedback and some areas with recommendations for improvement

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

- Develop an action plan to be monitored by the Executive Team
- Update report to Board in six months on actions taken in response to the recommendations

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Board Development Day	24 April 2023	Jan Ross, Chief Executive	Findings presented and agreed, minor changes to be made ahead of Board.

External Well Led Review – Final Report

Executive Summary

1. The Trust recognises the summary provided of the Trust in the report and welcomes its findings and areas highlighted of good practice. The top five strengths identified were:
   - Culture (family feel, open and friendly)
   - Pride in the Trust
   - Staff Communications
   - Increasing visibility and connectivity with stakeholders
   - Self Awareness

2. The areas identified for improvement are not unexpected and work is already underway in many of these areas to make changes as recommended. The top five areas for focus are:
   - Research
   - Digital and Business Intelligence
   - Strengthening accountability and performance management
   - Socialisation of the Trust Strategy – more focus on the 'how'
   - Culture of modesty

3. The Trust will now take this work forward through a targeted action plan and report back to the Board in six months.

Well Led Framework

4. The boards of NHS Trust (providers) are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care.

5. In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries. Rather than assessing current performance, these Well Led reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance. The NHS has a Well Led Framework[1] which was issued in 2017 and which align with the CQC well-led framework which has recently been revised.

6. The Trust had not undergone a review against any aspects of the framework since 2018 and the guidance recommends that these should be repeated at least every five years. The Board therefore undertook a self-assessment against the framework in 2022 as preparation before commissioning an externally facilitated, developmental review of leadership and governance using the well-led framework.

7. Between January and March the assessment team observed all the major Board meetings and Committees, Council of Governors and divisional governance meetings. Interviews were conducted with the Board and senior managers and a series of focus groups held with patients, Governors and staff. Surveys were also sent out to key external stakeholders.

[1] https://www.england.nhs.uk/wp-content/uploads/2020/08/Well-led_guidance_June_2017.pdf

8. The report (Appendix 1) was initially fed back to the Board at a recent Board Development Day and comments from this session have been taken into account in this final report.

Findings and Next Steps

9. The report is structured around the eight quality statements in the CQC well-led framework and for each statement good practice has been identified, findings described and areas for further developmental focus identified.

10. An action plan will be compiled to pick up areas for development and this will work will be led by the Corporate Secretary with the Executive Team as part of the continual improvement cycle. A report on progress will be presented back to the Board in September.

11. The report will also be shared with Governors and senior managers.

Recommendation

- To note and accept the findings of the report and agree the next steps.

Author: Katharine Dowson, Corporate Secretary
Date: 26 April 2023

Appendix 1 – Well Led Framework External Assessment Report

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Well-Led developmental review

The Walton Centre NHS Foundation Trust

March 2023

Introduction

The aim of this review was to assess the leadership and governance of the Trust as described in the developmental reviews of leadership and governance using the well-led framework: guidance for NHS Trusts and NHS foundation Trusts dated June 2017 and identify developmental actions to inform further targeted development work by the Trust to secure and sustain the Trust's future performance as part of continuous improvement.

We undertook the review in line with the recently revised CQC well-led framework (dated January 2023) and considered existing and planned practice against the five domains of the framework with particular focus on the Well Led domain:

1. Safe
2. Effective
3. Caring
4. Responsive
5. Well Led

Within the well-led domain there are eight quality statements, with our report being structured around those quality statements. For each quality statement, we have detailed existing good practice within the Trust, our findings and areas for further developmental focus.

Comparison of the previous well-led Key Lines of Enquiry (KLOEs) and the revised well-led quality statements shows close alignment between the old and new albeit with an additional emphasis on environmental sustainability and increased focus on matters such as workforce diversity (shown at diagram 1 below).

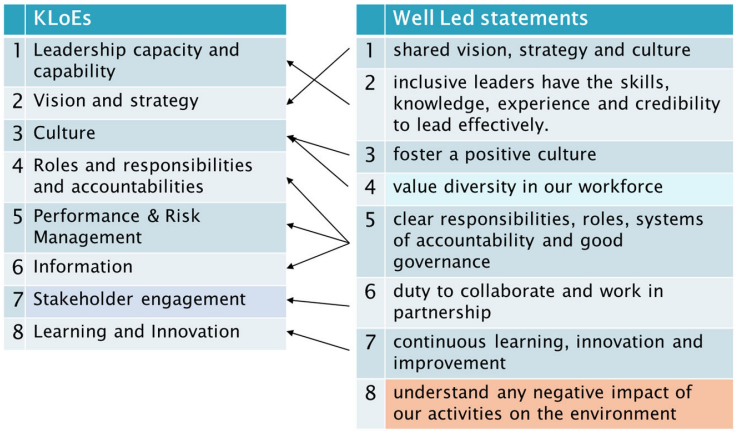


Diagram 1: Well-led KLOEs and quality statements

We engaged extensively with the Trust during the conducting of the review. We found staff to be welcoming, professional and courteous. We have no doubt that staff engaged in the process with the sole intention of providing positive and constructive feedback to support the Trust in its improvement journey. We would like to place on record our thanks for the time given over by staff to support the review and the way in which staff conducted themselves.

Contents

Overview – summary of findings

Shared direction and culture

We found a strong and positive culture within the Trust, which was described as being open, friendly and supportive. This view was reflected in our interactions with Trust personnel, external stakeholders and also our review of documentation including staff surveys. In addition, there is clearly a strong sense of pride in the Trust.

The Trust has recently refreshed its strategy, setting out its five strategic ambitions within an easy to read and succinct strategy. The strategy places patients at the heart of it and sets out clear success statements against each ambition to help the reader understand what will be different. We also noted the recent refresh of the Trust's enabling strategies including digital, estates and workforce strategies. We have noted that the board discussed strategic reporting metrics in January 2023 and whilst we have not seen evidence of these being reported as yet, we are confident that this is due to the timing of our review. The Trust now needs to focus on effective socialisation of the strategy and its enabling strategies into the Trust and externally.

Capable, compassionate and inclusive leaders

We heard evidence of an open, visible, and caring board who are perceived to genuinely listen and act on what they hear. We saw numerous examples of evidence of board focus on patients and staff and corporate governance being delivered in clear alignment with Trust values and expected behaviours.

We observed some good and effective challenge during our meeting observations from engaged and curious non-executives who challenge in a supportive way. The overall effectiveness of what is some good challenge would be strengthened by improving the follow through of actions and their impact. Also, we note the tendency to invite contributions from non-executives at board meetings which can create a less than effective unitary board approach and impact on the profile and contributions of executives.

We heard many positive comments regarding the visibility of Trust leadership and the approachability of board members. We also heard positive comments regarding the breadth of staff communications and engagement opportunities that ensure accessibility to leaders and understanding of the wider picture.

We heard positively about the Walton Way and the Trust's embedded values. However, we also heard that operational pressures have meant that the focus on this is not what it was during the pandemic with a need to refocus efforts on the Trust values.

We recognise as a small specialist Trust the enduring capacity issues of what is a relatively small executive team. Not wanting to be disrespectful in any way to the historic achievements of this team who have delivered well, including through the pandemic, it would be remiss of us not to comment on the sustainability of continuing to do so at the required pace. It is important to recognise the current operational, workforce and financial challenges alongside the need for ever greater partnership working and collaboration. This includes the need for increasing engagement in digitisation of the NHS and having the required skills and experience to not only deliver this but also to ensure that the Trust generates the available benefit from it.

Freedom to Speak Up

In the section above we referenced the Trust's culture which was commented on positively by staff. This was recognised in their ability to speak up and raise concerns if they felt it necessary and feel safe in the knowledge that these would be received in a positive manner and responded to accordingly. We also noted the positive trade union relationships that exist which further support

the positivity regarding the Trust's approach to receiving feedback.

We have noted the number of Freedom To Speak Up (FTSU) Champions who support the FTSU Guardian and the ambition to have champions in all areas. The governance and reporting arrangements that surround the FTSU process also appear effective and allow good visibility of the FTSU Guardian with a number of board members on a regular basis. We were informed that the FTSU Guardian normally presents their report at board meetings to allow all board members to engage directly with the process although we noted that this has not occurred recently.

Workforce equality, diversity and inclusion

The Trust has a strong focus on Equality, Diversity and Inclusion (ED&I) which is visible from the top of the organisation via the Chief Executive and Chair and is also evidenced by the creation of the Strategic BAME Committee during the pandemic and now its widening remit.

We note that the Strategic BAME Committee is currently reviewing its purpose with the clear intention to encompass wider aspects of ED&I including health inequalities. We noted positively the recent reporting of health inequality data using the Index of Multiple Deprivation (IMD) data at the committee which places the Trust at the leading edge of trusts considering such matters. Whilst it is early in its approach and maturity, the Trust is clearly on an exploratory journey in terms of harnessing the data and understanding the benefits it might derive from the presentation of such material.

As part of the review of the Strategic BAME Committee we note the relaunching of the staff network groups and reporting arrangements into the committee alongside improved connectivity for network chairs into board.

We heard about issues being escalated to the Trust from its recent international nurse recruits. We note positively the Trust's response to this including the commissioning of an external review by an expert in this area and organising a board level discussion to explore matters with an external speaker. We understand that this has led to an action plan being implemented including increased training and awareness for all staff regarding unconscious bias sessions and the use of inclusive language and civility.

We also note that the Trust has been awarded Gold status in the Investors in People award and its ambition to achieve Platinum status, which is a reflection of the high level of focus that the Trust gives to staff related matters.

Governance, management and sustainability

The Trust has a comprehensive governance framework in place with examples of good governance practices. We can see evidence of recent improvements and new reporting arrangements have been introduced at the Council of Governors, board and committee meetings which demonstrate improved governance and conduct of business. Overall, there is strong evidence of strengthening governance and a positive direction of travel at the Trust. Inevitably there are areas for further improvement and we have sought to identify these within our review, including the need for a more fundamental review of the approach to clinical governance and its reporting arrangements into Quality Committee.

We would also suggest that there are opportunities to formalise and strengthen performance management and accountability within the Trust. Current arrangements were described to us as 'very gentle' and 'very kind' and we noted an informal approach, in part brought about by the small scale of the Trust and the 'family feel' that was constantly referenced to us. Improvements in performance management are not just cultural in our view, with opportunities to strengthen analytical capabilities to provide more insightful reports that support improvement based discussions.

Whilst noting the need to improve information provision we recognise that the Trust is a member of the Digital Aspirant Programme and is recognised as being in the top 20% of NHS organisations for the digital maturity of its Electronic Patient Record (EPR). This along with other investments and ambitions within the Trust's Digital Strategy provide a level of confidence that the Trust recognises the need to be a digitally enabled organisation in order to thrive in the future. However, senior digital leadership at board level is lacking and there is a question as to whether the Trust currently has the capacity and capability to offer a coherent digital strategy that maximises the added value of existing and impending investments. Put simply, the supply of systems and software alone without the necessary investment in human factors and analytical capabilities will not maximise the benefits that can be derived from the Trust's Digital Strategy. The current Digital Strategy excludes information and analytics and does not appear to sufficiently recognise the importance of human factors.

We noted recent improvements in the Trust's risk management processes, which are being driven by a proactive Governance and Risk Team. Risk reporting and profile of discussions is strong at senior levels with the Trust recognising that operational risk management is still work in progress. In addition, there is recognition that the Trust needs to do more to better understand and operationalise its risk appetite to ensure that this is a regular feature in both discussions and decision making.

Partnerships and communities

The Trust benefits from having excellent relations with many of its stakeholders. As an example, governors are passionate advocates of the Trust. We also heard and saw evidence of strong partnership working with the Trust offering mutual aid to system partners during the pandemic and also actively supporting the short term disruption caused by the Liverpool University Hospitals NHS Foundation Trust's move to its new premises. Support has continued and has seen permanent changes in pathway referrals and delivery including spinal and the rapid access neurology assessment service.

Feedback from stakeholders suggests that whilst the Trust does enjoy strong relations with system partners, and especially with commissioning partners, there is a need to continue to build positive relations with provider trust partners and the newly formed Integrated Care Board (ICB). That is not to say that relations are poor, just that they are less mature relative to the long standing and strong relations with commissioners. The changing system working landscape requires all trusts to focus on building such relationships.

We noticed a desire and emergent plans to also embrace the Trust's anchor institution role and build relationships with civic partners to support wider social value initiatives including 'knives down, gloves up', 'building Liverpool Citizens' and the Civic Forum.

The positive feedback from stakeholders often referenced a small cohort of individuals including the Chair and Chief Executive as one would expect. There is a need, as system working and collaboration matures, to ensure that the wider board is sighted on engagement activities and feedback including receipt of qualitative feedback from stakeholders including patients and carers, staff and external partners. This will allow board members an improved ability to triangulate quantitative data with qualitative data.

Learning, improvement and innovation

We noted during our review a renewed focus from the Trust on its research activities with a view to increasing the Trust profile in this area and the level of research activity undertaken. This is central to delivery of one of the Trust's strategic ambitions. Focus to date has centred around the award of University Hospital status and improving links with the University of Liverpool. We did, however, note the absorption of the existing Research Strategy into the newly refreshed People Strategy and the potential reduction in profile and focus that this may cause. As a stated strategic ambition, the Trust may wish to be bolder and more explicit regarding its renewed focus in this area along with

the perceived benefits that this will deliver.

The Trust has recently developed it's 6i quality improvement methodology and is in the process of rolling this out during our review. The timings of our review was such that we could not evidence the impact of this as yet. We are also aware that the Trust is considering pooling its project management resources into a Project Management Office (PMO) to help oversee the large scale transformation projects in theatres and outpatients which will support delivery of significant productivity and efficiency benefits. Beyond this we also heard about a renewed focus and early post pandemic discussions regarding re-energising the Trust's approach to innovation. Taken together there is much to be positive about regarding the Trust's recent focus on improvement and innovation. To help maximise the value of these separate strands it is important that the Trust seeks to understand the relationship between them and how it will harness the added value of ensuring close alignment of them.

In terms of learning and investing in its staff, we heard that the Trust has recently developed, and is rolling out, a number of leadership courses aimed particularly at middle and first line management. This increased leadership development offer was recognised by staff we engaged with who described the Trust's leadership development programme as 'emergent'.

Environmental sustainability – sustainable development

We have noted the collaborative approach adopted by the Trust when developing its Sustainability Plan including the baseline exercise conducted with the Carbon Trust. We also note the involvement of the Trust in a number of other collaborative arrangements surrounding sustainability including the Liverpool Carbon Collective and the Liverpool Cycling Alliance.

We noted that oversight of the delivery of the plan resides with the Business Performance Committee although reporting into the committee has been sporadic and lacking in clear measurable objectives and measures against which the committee can effectively oversee delivery in the first 12 months of the plan delivery timeline.

Detailed findings

Well Led Quality Statement 1: Shared direction and culture

'*We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these'*.

Strengths	Development areas
• Refreshed strategy and suite of enabling strategies • Board push for strategic ambition KPIs • 'pride', 'friendly', 'family feel' • Open and honest culture with staff, patients, and the wider community at its core • Walton Way – embedded values	• Oversight of strategy delivery • Socialisation of strategy • Breadth of People Strategy content • 'Build out' of how in delivery plans • Culture of modesty

- We recognise that the Trust has recently refreshed its strategy in late 2022 and has five strategic themes: Education, Training and Learning, Research and Innovation, Leadership, Collaboration, and Social Responsibility. We also noted positively the inclusion of the 'how we will know we have succeeded' section (i.e. critical success factors) within each ambition to help the reader understand what this means for patients, staff and stakeholders.
- We heard positive feedback from staff regarding the Trust's engagement process in relation to developing its new strategy. Staff feel that they can recognise their inputs and have helped to shape the outcome. However, this was not universal, with some staff suggesting there is still more to do in socialising the strategy. Equally, other stakeholders felt that in their view they were presented with advanced plans and were invited to ask questions but felt that they were not able to influence the shaping of the strategy. Feedback also suggested that patient engagement in the development of the strategy was limited.
- We heard more mixed views from governors about engagement in the refresh of the Trust strategy and supporting plans. Some governors acknowledged the opportunity to engage while others thought that engagement came 'too late in the day'. However, we were informed that governors were engaged at a formative stage and were engaged with on a number of occasions including a governors focus group, governor advisory committee meetings and presentation of the draft strategy at two CoG meetings. Linked to this, as part of the development of the supporting plan, the Trust's standing financial instructions (para 3) states that the Chief Executive will submit to the Board of Directors and to the Council of Governors the annual operational plan. We are not aware that this has happened. While the approach to planning varies considerably in Trusts and how this is discharged with governors, it is suggested that the Trust should review how it engages with governors on the development of its plans to ensure members' interests are considered.
- The strategy itself is relatively high level and what matters most to staff is its day to day impact on both them and patients. Whilst overall staff were generally aware of the strategy, feedback suggests that there is an opportunity to strengthen feedback regarding delivery in terms of 'how' the Trust will deliver its strategy and what this means for short term priorities and focus for services. It is important to ensure there is a clear communication plan to cascade the understanding of strategy and the board's vision for the future to all stakeholders recognising the need for alternative, non-digital channels of communication too as not all staff have regular access to a computer whilst at work.
- We note that there are seven enabling 'sub-strategies' that underpin delivery of the Trust's strategy, namely, Quality, People, Estates, facilities and sustainability, Finance and commercial development, Communications and marketing, Charity, and Digital.

- We noted that whilst the Trust strategy has Research and Innovation as a separate and distinct strategic objective there is no separate enabling strategy that underpins this with it forming part of the People Strategy. The lack of a separate enabling strategy may impact on the perceived profile and focus of research and innovation within the Trust. We note that this is also the case for ED&I which could also be adversely impacted by the perception of a reduced profile.
- It is recognised that the enabling strategies that underpin the overall Trust strategy were at various stages of refresh during our review including the Digital Strategy being presented to the board in March 2023. We understand that the Trust plan is to have all enabling strategies which support the refreshed Trust strategy in place by March 2023.
- We noted good pushback from non-executives regarding the draft format of the People Strategy. It is important that the board (and its committees) retain ownership of the Trust's strategy including enabling strategies.
- We were informed of the establishment of a 'strategic PMO' which will monitor implementation of the enabling strategies. At the time of approving the Trust strategy, the metrics for monitoring successful delivery of the strategic objectives were not in place and it was noted that this was challenged by non-executives although the response indicated that some objectives did not lend themselves easily to being monitored which is of concern.
- We note that there was a board discussion regarding the monitoring of strategic objective metrics in January 2023 to agree a suite of metrics to allow board oversight with the intention to report performance on a quarterly basis to board.
- There was recognition that operational business plans are in place and support the delivery of the Trust objectives but these require a level of transformational change beyond what the Trust has previously delivered. It is noted that there are transformational skills within the Trust, with a number of staff having been trained in the Trust's quality improvement methodology, however operational pressures mean that time to devote to such matters is challenged. There is concern amongst leaders that the Trust will not have the capacity to transform and will continue to work in its old established ways. As it was said to us "*business as usual takes up all of the headspace*".
- Following the refresh of the strategy where board spent quality time focusing on this there is a need to maintain an appropriate balance of strategy and operational focus at board. We note the structure of the board agenda allows for a balance of strategic and operational items however review of this indicates an opportunity to strengthen board oversight over the delivery of the enabling and Trust strategic objectives.
- We heard repeated reference to staff having pride in the Trust and what it delivers in terms of exceptional clinical outcomes.
- We heard from staff that the Trust is a good place to work and that staff generally feel well supported. There were a number of references to the size of the Trust meaning that people know each other, bringing a 'family' and 'friendly' feel with a positive, open culture. Honesty was another way that staff described the culture at the organisation.
- The Chief Executive was considered to be very open and transparent and staff felt like they could raise issues and be confident that these would be listened to.
- Patients and carers described the clinical care provided in very positive terms. They praised the staff for their skill, professionalism, compassion, and how they communicate with patients and families, keeping them well informed. They described being made to 'feel at home'.
- We heard that the Trust has a relatively stable workforce, with many staff remaining at the Trust for long periods of time. This reflects well on the Trust in terms of its culture. We heard mention of 'the Walton way', predominantly from a positive perspective in relation to culture. However, we also heard that this can make some staff reluctant to embrace change and adapt to new ways of working, particularly when colleagues have little experience of working elsewhere. There was perceived to be greater enthusiasm for change and new ideas amongst leadership.
- We also heard about a 'culture of modesty' from both internal and external stakeholders. Whilst those stakeholders recognised the historic understanding of this there was also felt to be an opportunity to create a new narrative that better supports partnership and collaborative working and better promotes and demonstrates the worth of small, specialist trusts within the system.
- We note that Trust board was presented with an initial health inequalities dashboard report at its

October 2022 meeting. The report presented initial analysis undertaken on health inequalities to measure outcomes and also to understand workforce inequality. Moving forward, regular oversight of the dashboard and any associated actions that arise from its reporting will be overseen by the Strategic BAME Committee.

Recommendations

1.	As part of the roll out of the Trust refreshed strategy and suite of enabling strategies the Trust should ensure that the new strategic framework is well socialised with staff and stakeholders (including governors) including sufficient detail of implementation plans to make the strategies meaningful to all.
2.	The Trust should ensure that it retains appropriate oversight over the delivery of the refreshed strategic ambitions and enabling strategies.
3.	The Trust should review its approach of incorporating numerous strategic elements within the People Strategy in terms of appropriateness of profile and oversight.

Well Led Quality Statement 2: Capable, compassionate and inclusive leaders

'*We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty*'.

Strengths	Development areas
• Visible and prominent values • Compassionate leaders • Leadership visibility and approachability • Experienced, engaged and curious NEDs • Staff engagement • Strong staff wellbeing focus	• Re-energise Trust value focus • Unitary board approach • Executive capacity / succession planning • Digital leadership • Divisional autonomy

- We heard and observed throughout our review that there is compassionate leadership both in terms of the workforce and patients. We consistently heard that the Trust places its people at the heart of what it does and heard about a wide range of wellbeing support and care towards staff. We heard about the importance of the culture and values across our interviews, staff focus groups and observations of meetings. We did also hear staff say consistently that they felt the focus on the values had dwindled in the face of operational pressures and that they did not feel as though they were at the forefront of management's minds in the same way that they used to be. It is important that the Trust listens to this and takes note of this although we would add that in our experience the Trust displays embedded values.
- The values are visible on the board documentation reinforcing the values being at the heart of what the Trust does.
- At the observed board meeting the board received a direct account from a patient's family member about their experience. It was a very positive story carrying high praise for the way the patient and family had been supported and the difference it had made. Comments from board members showed empathy and respect as well as a willingness to learn. Questions were asked by non-executives about what aspects could be improved. At the end of the meeting there was a request from the board for stories where things have gone wrong to understand first-hand the issues that can affect care.
- Through our work we gathered evidence about patients and carers having direct contact with the Chief Executive, either to raise concerns (by email which elicited quick responses), to write a letter of thanks, or through her presence on wards and interacting with patients. This is a positive in terms of modelling a caring attitude towards patients and being responsive and open as an organisation. However, we also heard about a lack of confidence in the formal complaints/feedback system and the benefits of having the opportunity to be able to raise matters with people who respond and can effect change where required. The Trust needs to be mindful that the informal mechanisms do not become established 'workarounds' for Trust formal processes. We have made further reference to this under Quality Statement 7 later in the report.
- We heard positive comments about the Trust's approach to staff communications with multiple channels in operation to provide effective communication and also offer two way engagement opportunities. These included the 'Walton Weekly' newsletter, modernising notice boards and social media including weekly executive blogs. In addition, there are monthly communications including a wellbeing newsletter and team brief along with an opportunity to engage with the Chief Executive via 'Join Jan'. We also heard about the Trust's use of the 'you said, we did' style of communication and TEA (talk, engage, action) rounds to support greater staff engagement.
- The Trust Chair was also recognised for their visibility within the Trust and speaking and listening to staff.
- We heard about board members involvement in walkarounds to engage with patients, carers and staff to help triangulate written assurances. We also observed evidence of this triangulation being

brought into non-executive challenges at board and committee meetings.

- We are also aware that the Trust was awarded a Gold standard Investors In People award, has a monthly employee of the month scheme and annual award ceremony alongside more informal 'thank you' cards which are issued to staff who receive nominations from colleagues.
- Staff described a "phenomenal" staff wellbeing offer and evidence was shared with us of staff participating in the available activities albeit recognising the time constraints due to operational pressures. The Trust performs well in this area as indicated by the staff survey results where it scores above average in this domain. We heard that the Trust has had the wellbeing of its staff as a priority since 2013. We heard many examples including sports teams such as netball and football. We heard about the prominence of financial wellbeing to support staff with examples such as subsidised white goods and ASDA vouchers for staff. We heard about Walton Wednesday and support around mental health with Mental Health First Aiders.
- We also heard that the Trust has recently identified space for a wellbeing hub in the main building which will further help raise the profile and uptake of staff wellbeing offers.
- We heard that the Trust had recently developed a formal induction process for non-executive directors and received positive comments from those who had experienced the new approach.
- We heard about how non-executives are buddied with an executive colleague to help build relations and understanding around the board table.
- We heard about and observed a strong set of experienced non-executives with a diverse range of backgrounds. The executive group has a blend of experienced executives and fresh eyes/new perspective which is positive who were described as being open and supportive.
- The Trust has undertaken a skills assessment of the board in 2022. Feedback from board members demonstrated belief that there is an appropriate balance of skills and experience amongst non-executive directors although a number of interviewees referenced that the board would benefit from having greater digital expertise amongst its ranks.
- We also note that the board undertook personality profiling in 2022 which showed an overall preference for extraversion and having a co-operative and compassionate personality. Highlights identified that conscientiousness and following procedures are less important and a more spontaneous, expedient approach is likely to be taken by the board.
- We note the presence of a board development programme which incorporates a combination of internal and externally facilitated sessions. These sessions appear well balanced and include discussion regarding the above psychometric profiling along with skills acquisition such as cyber security and branding. We also note the planned session in June 2023 regarding horizon scanning which is positive.
- The Trust has strengthened its diversity following the recent non-executive recruitment process. We heard that the Trust is considering further strengthening the board through the appointment of associate non-executive directors which many also afford an opportunity to further consider strengthening any perceived skills shortages.
- We heard and observed for ourselves the use of humour at leadership meetings which can be a positive trait and help instil a team feel to proceedings. As with most things in life, there is a need for an appropriate balance and over use of humour can lead to a familiarity and informal feel to proceedings which on occasions require a level of discipline and meeting protocol to reinforce accountability. An example of possible focus for the Trust would be to ensure that there are clear outcomes from discussions and agreed actions which then form part of an action log and are followed through in terms of delivery and evidenced impact.
- Trust governors are supported by the Trust to discharge their role both in terms of training and induction.
- We also heard about the visibility of executives including departmental visits and some executives also undertaking operational shifts. The executive open door policy and visibility was seen as both a positive and also a potential block in relation to the level of perceived authority and devolved management by divisional management teams. There was some sense that at times executives can 'reach in' to operational matters in a supportive way but nonetheless this is seen as potentially eroding operational authority and accountability. In a small Trust and one so compact as The Walton Centre it is not surprising that executives are so visible but there is a need to remain

mindful of adopting a coaching style approach and allow divisional management to flourish. Senior leaders who had experience of working in similar roles in other trusts were especially noticeable of the difference for understandable reasons. One respondee summed up the sentiment well in their statement “there is a balance to be achieved between visibility and involvement”.

- Our observations of committees and our interviews showed alignment with Trust values and the stated culture. At committee meetings we observed an openness with questions being asked borne out of interest and curiosity for the subject matter. Challenge was conducted in a constructive and thoughtful way demonstrating the values being lived. At our observation of the Strategic BAME Committee we noted that the Chief Executive’s approach as chair embodied the values throughout the meeting with her approach being inclusive, welcoming encouraging different views and providing time and space for discussion.
- Participation and engagement across all committees was high particularly from non-executives. At times it felt that the executives were in attendance to respond to this non-executive challenge and there could have been more active executive participation in the discussions as part of the unitary board.
- We observed compassionate and passionate executive leadership in the Trust which is positive. However, care must be given to ensure that this individual passion does not overspill into being perceived as directive rather than collegiate behaviour. The benefit of having diverse teams is that differing views and opinions ensure that a rounded and informed discussion is held prior to concluding an agenda item. To not facilitate such contributions risks diluting the quality of discussions and subsequent decision making.
- We heard that the new Chair and Chief Executive had both brought a number of positives to the operation of the board including improved focus, improvements in paper quality and improved purpose of papers in addition to improvements in the relationship between board and committees. It was also noted by many the positive impact that the new Company Secretary had brought to board and wider governance processes.
- The executive team is a relatively small team and as such has to share executive level responsibilities including strategy and digital portfolios. This also means possible senior level experience gaps in knowledge and understanding as well as having the capacity to focus on these matters. Of particular concern is digital given the Trust’s membership of the Digital Aspirant Programme and the need for significant focus and investment in this area to deliver the requirements of a digital enabled NHS service in the future.
- A patient story is shared at each Quality Committee. At our observed meeting of the committee, discussion on how staff receive recognition for any positive story was discussed. We heard that the acting Chief Nurse writes a thank you card to the staff involved and that the team and individuals are mentioned in the regular safety huddles.

Recommendations

4.	The Trust should consider ways in which it can effectively re-energise the Trust’s focus on its embedded values.
5.	The Trust should consider how it increases the contribution from executives at board and committee meetings and create more of a unitary board feel to proceedings.
6.	The Trust should consider ways in which it can create additional executive/senior level capacity given the forward agenda i.e., digital leadership, and also look to develop effective succession planning arrangements below executive level.
7.	The Trust should consider ways in which to create more formal divisional autonomy arrangements and generate effective accountability.

Well Led Quality Statement 3: Freedom to speak up

'We foster a positive culture where people feel that they can speak up and that their voice will be heard'.

Strengths	Development areas
• Open and honest culture • Staff confident to raise concerns • FTSU engagement and governance arrangements • Trade union relations	• FTSU visibility to all board members • CQC safe staffing whistleblowing incidents

- The majority of feedback supports that the Trust values are well socialised and lived by staff. However, it was recognised that this was not universal and the continuous journey of communication, reinforcement and enforcement needs to continue but interviewees were confident that where pockets of poor culture exist, such as that shown with the international recruits, the Trust is swift at dealing with it. The most recent annual staff survey results support the view that the Trust is effective at dealing with such issues when they arise.
- We note that the Trust undertakes quarterly staff Pulse surveys which is seeing an increased uptake and upward trend in feedback scores
- We heard about the non-executive programme of departmental visits including back office functions.
- The Freedom to Speak Up Guardian (FTSU Guardian) provides a report to the board on a quarterly basis with the executive sponsor being the Chief Nurse. Overall board engagement was described as good with the FTSU Guardian meeting with the non-executive sponsor and the executive director on a monthly basis. We understand from our interviews that the FTSU Guardian also meets with the Chief Executive and Trust Chair on a quarterly basis. Furthermore, we were informed that there are monthly meetings with the FTSU Guardian and the HR function. We heard that the FTSU Guardian can also raise issues outside of these regular meetings should the need arise.
- We heard about the regular meetings between the non-executive FTSU champion and the Trust FTSU Guardian. We also heard about how the non-executive FTSU champion also, on occasions, accompanies the FTSU Guardian on their walkarounds including a night shift.
- As described in Quality Statement 2, we heard how the executive team hold TEA (Talk, Engage, Action) talks so that staff can meet the team.
- We heard that how to access the FTSU Guardian is well signposted within the Trust, that staff feel confident in raising concerns and that that there are no negative consequences from speaking up. We heard that the Trust is considering placing QR codes in staff breakout areas to facilitate ease of contact with the FTSU Guardian which is positive.
- We heard that whilst the FTSU Guardian is not a full time role as in many Trusts we also recognise the size and scale of the Trust makes this an unreasonable proposition. In addition, we heard that there are 12 Freedom to Speak Up Champions across the Trust with the aim to have a Champion in each area.
- We note that for the most recent FTSU report at board, the Deputy Chief Nurse, who was deputising for the Chief Nurse, presented the Freedom to Speak Up Guardian report at board due to the absence of the FTSU Guardian.
- We noted that there had been two whistleblowing concerns raised directly to the Care Quality Commission (CQC) regarding staffing levels and skills mix. These referrals appear to have been made despite the Trust internal processes being in place which raises concerns as to why those raising concerns did not access the Trust internal processes.
- We heard examples of the Trust taking action in response to a rise in issues being raised and reported by BAME staff and a correlation with the increase in recruitment of international nurses. This led to an external review being undertaken and an invitation to an external speaker to attend and talk about work in this area.

- We heard that there are various routes for staff to raise concerns and it was positive to see that the staff focus groups included trade union representatives. We heard that there is an excellent relationship between the Trust and its trade unions. We heard that there is an open culture and staff can raise issues and speak up to management and feel that they will be heard.

Recommendations

8.	The Trust should ensure that the FTSU Guardian is available to present their own papers at board meetings to increase their visibility and connection with all board members.

Well Led Quality Statement 4: Workforce equality, diversity and inclusion

'We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us'.

Strengths	Development areas
• Evidence of focus on ED&I matters including wider health inequalities • Strategic BAME Committee and widening remit • Response to international nurse reports of incidents • IIP Gold award status • Staff Survey results positive overall	• Appraisal and mandatory training compliance • Estate constraints inhibit ease of confidential discussions

- Whilst feedback suggested that the Trust is 'behind the curve' in relation to ED&I, there was recognition and evidence that progress is being made in this important area and is now a focus for the Trust. This includes the development of divisional ED&I plans and a focus on these at divisional governance meetings.
- We were informed that whilst there was provision for an ED&I lead this position is vacant and has been for some time which has impacted on the pace of movement of EDI ambition. The post is currently being covered by two part time postholders.
- We noted that protected characteristic staff networks are in place within the Trust including a Strategic BAME Committee which was established during the pandemic and reports directly into Trust board. While the advisory group has no formal powers or duties, and is currently established as an information sharing forum, the Trust is currently considering its future role including extending its remit to include all protected characteristics and health inequalities. Indeed, at the observed Strategic BAME Committee meeting discussion took place around the terminology of 'BAME' and whether this should be changed as the term is not necessarily viewed in a positive light. We did not observe any defensiveness to the raising of this, with the point leading to an open conversation that demonstrated compassion and empathy and led to an action for the committee to review terminology and find alternative language where appropriate.
- The Strategic BAME Committee agreed at its March 2023 meeting, and as part of the governance review, that the staff networks would have a direct route into this committee and therefore direct access to the board ensuring that their messages are not diluted. It was agreed also that the committee would receive a report from each staff network chair into this committee as part of the direct feed into board.
- Our observation of a Strategic BAME Committee meeting demonstrated an inclusive culture throughout the meeting with diverse views and opinions encouraged, welcomed, and considered.
- At the observed Strategic BAME Committee, health inequalities data was presented utilising the Index of Multiple Deprivation (IMD) and whether there is a link to accessibility of services. The report contained comprehensive data including follow up, inpatient and outpatient service data including Did Not Attends and waiting list and admissions rates using the IMD lens. In our experience, many trusts are still at the stage of talking about the need for this and not yet presenting the data. The next step for the Trust is to consider how to use this information and how to present findings in a more concise way to enable purposeful discussion at this group and identification of themes, learning and actions that lead to impact.
- We also saw additional examples at the observed meeting of the committee exploring additional data and expanding its area of discussion and focus. This included a staff heatmap in relation to ED&I across different staffing levels within the Trust. It was acknowledged that whilst it is positive to produce such material this needed further development to provide appropriate analysis of the data including themes which can lead to more meaningful discussions and agreed actions.
- The Trust has been successful in its international nurse recruitment drive. The Trust has introduced a pastoral care nurse to support the international nurses although we understand that

this is a non-recurrent post which ends at the end of March 2023.

- We heard from various sources that there was a spike in bullying and harassment cases relating to the Trust's international nurses. We heard how the Trust was open to the feedback and curious to understand the drivers of this. The organisation took steps by inviting some leaders in the field of ED&I to undertake a review, notably Clive Lewis and an NHS Chief Executive, Owen Williams. The learning is now being developed into an action plan which includes staff training including unconscious bias sessions and the use of inclusive language and civility.
- Beyond protected characteristics and in consideration of wider inclusion matters, we heard from governors about difficulties digesting information due to dyslexia. It is important that governors and other stakeholders are supported wherever possible in their interactions with the Trust in order to maximise the value of such activities.
- We heard that the quality of the Trust's estate is an issue for staff and adversely impacts on their ability to hold confidential discussions. We heard that there is limited provision to meet in a private or confidential space for a conversation which makes it difficult for staff to access trade union representatives, talk to their manager about their wellbeing and/or personal issues or raise any concerns confidentially. We did hear that a Wellbeing Hub is being created which was seen as a positive step but that this is different to the issues raised around the lack of available space for one to one conversations.
- The experience of staff in accessing information is mixed and we heard from staff that there are not enough computers compared to the number of staff. This can create an issue as it means some people are not able to access the information and communication that the Trust shares in a timely way.
- We heard that there is a 24 hour helpline with support available for staff at all times including those who are working out of hours or night.
- The Trust's key workforce indicators show a mixed picture with both appraisals and mandatory training below target based on the Integrated Performance Report (IPR) reviewed at the January Business and Performance Committee meeting. The report makes reference to the figures and targeted chasing in relation to appraisals but includes no narrative regarding an improvement plan or indication of the improvement trajectory. In terms of mandatory training the report did not include any further narrative on this subject.
- The Trust has achieved gold status in Investors in People and is aspiring to reach platinum which is an indicator of its focus and care for staff.
- The NHS staff survey results were published on 9th March 2023 and we have accessed these as part of our review. The Trust's response rate of 42% is lower than the median at 52%. In summary, the results are positive with all but one of the People Promise elements scoring above average. We note that in one element: 'we work flexibly', the Trust scores the best in the benchmarking group. The Trust is not ranked as worst for any of these key nine themes although 'we are always learning' scores the relative lowest in that it scores the same as average at 5.7.
- There are a few key highlights based on our findings during the review; appraisals scores low at 4.6 and is reflective of performance reported within the Integrated Performance Report. The theme of discrimination and the view shared that the Trust has been proactive and taken steps to address this, reflects in the survey in that the number of staff saying they have personally experienced discrimination at work from their manager/team leader or colleagues has reduced from 8.5% in 2021 to 6.4% in 2022. This is still higher than 2018, 2019 and 2020 but does demonstrate that it is moving in the right direction and is more than a 2% reduction.

Recommendations

9.	The Trust should focus more effort on improving its appraisal and mandatory training performance in line with agreed Trust targets.
10.	Whilst we recognise the Trust's estates constraints and lack of meeting rooms, the Trust should consider how it can better support the above recommendation by providing increased access to suitable rooms to hold 1:1 confidential discussions.

Well Led Quality Statement 5: Governance, management and sustainability

'We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate'.

Strengths	Development areas
• Strong evidence of effective board and committee governance arrangements • Digital Aspirant Programme member and digital focus • Data quality (in general) and kitemark usage • Proactive Governance and Risk team driving risk management improvements • Risk profile at senior levels	• Member engagement • Data led, insightful reporting to enhance scrutiny and understanding of performance • Effectiveness of accountability and performance management arrangements • Strengthen clinical governance arrangements • Digital/ Information leadership and realising the added value from investments • Risk appetite application • Audit Committee role in oversight of risk management

Governance

Council of Governors

- The Council of Governors consists of 17 public, four staff and 12 appointed members. This includes more stakeholder governors than is observed in many trusts. Whilst active engagement of key stakeholders on the council is valuable, the quoracy on the council has been reduced owing to a number of vacancies. A review of the constitution is planned following the publication of the new NHS code of governance, and the Trust may wish to take this opportunity to review the composition, and size, of its Council.
- The governors we spoke to understand their statutory roles to hold the non-executive to account for the performance of the board and to represent the views of members and the public.
- The Council undertook its first effectiveness review last year. The review identified areas for improvement including strengthening reporting to enable the Council to effectively hold the non-executives to account and to strengthen opportunities for membership engagement. From the documentary review, it is positive to note that reports are now provided by non-executive committee chairs in the form of an advise/alert/assure format. Whilst there is some limited evidence from the minutes that the governors are holding the non-executives to account, the change in reporting should better support the governors in their role. We were also told that there is now time available for governors to question the non-executive directors at the Council meetings.
- Governors acknowledge that their role in representing interests of the members and the public remains 'work in progress', with opportunities to actively engage with members to be explored. The Council of Governors approved the membership strategic implementation plan (membership strategy) in July 2022, the implementation plan is structured around the three aims of maintain, communicate, and engage, with progress monitored by the membership and engagement committee.
- It was evident from reviewing the minutes that challenges are made by the governors, which have not always been fully responded to. Governors need to develop confidence to pursue a challenge if a response does not provide an adequate response. For example, at the June 2022 Council meeting there was a challenge in relation to cancelled operations and the impact on patients. The Trust response was that it seeks to reinstate any operations the next day. There was no further

challenge or follow up as to how assurance is obtained whether this is the case. At the September 2022 Council meeting there was a governor challenge in respect of how the Trust planned to ensure that community voices would be heard during the next stage of the strategy delivery. It was explained that the Trust would be working with external colleagues whose involvement would be crucial. Whilst it was stated that progress would be reported back to the Council, no formal action was captured, and the review team has not seen evidence that this occurred.

Board and committees

- Our review of board agendas noted an appropriate range of agenda items and time given over to strategic matters as well as operational focus. We also noted positively the close alignment of presentation of the Integrated Performance Report and the chairs assurance reports for the relevant committees and the use of the consent agenda approach for items for noting.
- In our meeting observations we noted engaged non-executives who were well-prepared and contributed with purposeful challenge.
- We noted good examples of challenge from non-executives occurring at board and committee meetings. However, the minutes and action log capture few formal actions arising from these challenges, with many interactions seemingly being resolved in the meeting. The board should remain conscious to the difference of being assured as opposed to reassured and seek evidence to support statements and suppositions wherever appropriate.
- We noted the longstanding challenge regarding staff appraisal rates and the deteriorating performance of mandatory training achievement. We did not note a corresponding effective escalation of board and/or executive challenge to these matters.
- At our observed board meeting we noted the tendency to invite only the non-executives only to comment on agenda items. Whilst not intentional, this could be impacting on the perceived balance of the unitary board and reducing executive contribution around the board table. Our views were borne out in interviewees where board members expressed a desire to hear more executive contribution and challenge in discussions.
- We noted the use of shorter private board agendas which appears to support the view that the Trust conducts its business at its public board meetings wherever possible with private agenda items being restricted to matters of confidentiality and more strategic ‘free range’ conversations. We did however note a number of agenda items where the rationale for a private discussion was unclear, including a presentation of the Referral to Treatment / Average Wait Update Report.
- We noted that recent structural changes at committee level has reduced the number of non-board member attendees at committee meetings. This is a positive move and should ensure that committees remain suitably assurance based and focused on strategic and material operational matters. We had noted through our review of meeting minutes that the board and in particular committees can stray into operational detail, in part driven by poorly structured and unfocussed papers. However, we have noted improvements in paper quality in more recent board reporting, albeit with some way still to go, and this along with the revised attendance arrangements should support improved governance.
- We understand that the Trust has recently reviewed and updated the board and committee cycle of business to provide effective oversight in accordance with the terms of reference for each forum.
- The Trust undertook effectiveness reviews of the board and each committee in 2021/22. One theme that was identified as an area for improvement was the quality of papers. Whilst improvements have been made in relation to reporting at the board and its committees, it remains work in progress to extend and embed the improvement to all meetings. From our observed meetings there remains room to improve the consistency of papers which were not always clear regarding their purpose and what was expected from the forum. In addition, reports should clearly describe the evidence base for any assurance provided.
- We noted the comprehensive approach to the Trust’s well led self-assessment exercise in June 2022. The Trust reviewed evidence in support of each key line of enquiry and sub-enquiry and RAG rated itself against the criteria paying particular attention to the Trust’s ability to evidence compliance. Our review of the results noted a conservative and self-aware approach being adopted with no sense of optimism bias in the outcome.

- We heard and could observe that there have been ongoing governance including recent changes to the committees including membership and a review of each terms of reference. The changes around attendance at committee level led us to observe effective committees with appropriate attendance from other colleagues for specific agenda items and areas of expertise such as the Chief Pharmacist at the Quality Committee. It enabled purposeful and concise discussion on this item. We also noted the discipline at the beginning and the end of the observed Quality Committee where changes to the committee operation were referenced, members were informed that there would be time at the end of the meeting to hear views about what had worked/not worked well. This did happen at the end of the meeting and in an inclusive way with the Chair ensuring everyone had an opportunity to share their views.
- Through our review of documentation and observation of committee meetings we noted good cross committee working arrangements including referral of relevant agenda items to each other for consideration.
- We also noted the common practice of undertaking a review of the meeting as part of the end of meeting discipline which is positive although we noted a universal positive feel to these discussions with no evidenced suggestions for improvement being captured.
- We note that there is regular attendance at Audit Committee by the Chief Nurse and Chief Financial Officer. Other executives are expected to attend as required depending upon the agenda and assurance rating given to the internal audit reports. Lead executives are expected to attend where a limited assurance rating is given.
- We note that the Audit Committee retain sign off and oversight over the clinical audit plan. The committee also receives the preceding years clinical audit annual report for review. Review of the Audit Committee minutes show that the 2022/23 clinical audit plan was signed off by Audit Committee in July 2022, some four months into the year. We also note that the Quality Committee has a role in oversight of the clinical audit plan and receives regular updates throughout the year. It is unclear what benefit the Trust gains from the Audit Committee signing off the clinical audit plan as opposed to the Quality Committee whose membership and reporting appears better suited to this role.
- We understand that the Audit Committee review the principal risks on an annual basis. Beyond the annual review of the risks it is unclear how else the Audit Committee discharges its duty in relation to oversight of the effectiveness of the Trust's risk management arrangements. This was also queried by committee members as part of their latest committee effectiveness self-assessment.
- We noted from our review of Audit Committee minutes non-executives reminded executives of the importance of timely responses to implementing audit recommendations. This includes concerns regarding the timeliness of the Trusts implementation of cyber security audit recommendations.
- We noted that the 2021/22 Head of Internal Audit opinion was one of substantial assurance that there was a good system of internal control designed to meet organisational objectives and these controls were being consistently applied. We also note the unqualified external audit opinion in relation to the 2021/22 accounts.
- We noted the wide remit of the Business Performance Committee which covers operational performance, finance, workforce and organisational development, estates, commercial and digital issues. This results in a busy agenda and a tight schedule to cover the required ground within the time allotted which impacts on the frequency of reporting and how long is set aside for each agenda item. In addition, and related to the wide remit of the group, we note that there are 11 sub-groups that report into the committee. This further adds to the time pressures and raises concerns over how little time is afforded to the receipt of assurance from these sub-groups. For instance it is not uncommon for c5-10 minutes to be allotted on the agenda for the cumulative sub-group updates.
- The broad agenda and time constraints are recognised by the committee with a paper being presented to the July 2022 Business Performance Committee meeting setting out some helpful suggestions as to how the committee can be more effective.
- Despite the wide coverage and obvious overlap of operational, workforce and quality discussions we note the lack of clinical membership of the committee. In our view this potentially promulgates

separation of such discussions whereby quality is seen as separate to business matters.

- We also note that due to the wide coverage of the Business Performance Committee that it has oversight responsibility for the majority of the Trust's principal risks.
- A number of interviewees expressed concern regarding the future financial challenges facing the Trust and wider NHS. It was recognised that historically under the payment by results funding regime the Trust has been able to utilise growth to help meet its financial challenges whereas now the focus has to be much more on productivity and cost out measures. As part of this, we noted the non-recurrent element of the current years Cost Improvement Programme (CIP) and the need to increase the level of recurrent cost savings and efficiencies going forward.
- We note that the Trust is planning to deliver recurrent savings in 2023/24 via two cross Trust flow related schemes: theatre productivity and outpatient productivity.
- It is recognised by the Trust that it needs to be more data led and use data to better understand operational and financial performance. The Trust recognises that it can make greater use of the Model Health System, Right Care, Getting It Right First Time (GIRFT) reports, and wider benchmarking reports alongside more insightful internal reporting to better understand its cost base and relative efficiencies. The use of data at consultant level is also being considered to understand the post pandemic productivity challenge.
- We noted the series of submissions of materially changing draft operating and financial plans to the ICB without the board having the opportunity to formally discuss and approve these changes in principle due to board and committee meeting timings. Whilst we note the intention to engage the board prior to final submission to the ICB there is a concern that by that stage assumptions become 'baked in' and wider system plans and submissions will already incorporate the latest draft Trust submissions. Therefore at that stage of deliberations it will be difficult for the board to demonstrate full and genuine ownership of the operating and financial plans over which they will be held to account for delivery.
- The future operational and financial challenges are seen as a fundamental change in the environment and one where the Trust needs to ensure that not only are its performance management and accountability arrangements strong but also its analytical and transformational change capabilities are also well developed.
- Regarding the financial management culture within the Trust we also noted within the July 2022 Audit Committee minutes that fewer than half of all invoices were accompanied by a purchase order. This is at odds with many trusts who operate a 'no purchase order, no pay' policy approach to enforcing the use of purchase order discipline within the Trust.
- Clinical governance is a recognised area of some concern for the Trust. We recognise that the absence of the Chief Nurse, temporary stepping up of the deputy, and the recent appointment of an interim Chief Nurse will not have helped the situation. We understand from the Chief Executive that clinical governance will be a priority in the immediate term and we would concur with this.
- The reports presented at the Quality Committee we observed in January 2023 appeared incomplete in some instances and lacking in effective quality assurance. The committee noted the current acting up arrangements and consequent workload and were empathetic with the deputy Chief Nurse. Nonetheless, this poses a risk to the Trust at this time including the transitional period whilst the interim appointment becomes embedded. We observed numerous examples where the content of the report led to non-executives having to seek assurance due to report shortfalls. . Examples included an increase in complaints which were rated as red. There was significant discussion and challenge around the increase in upheld cases versus the reduction of complaints not upheld. The response provided was one of reassurance rather than assurance and more about information relating to ward processes than responding the questions posed or agreeing appropriate actions and follow up at committee. Equally, the discussion on tissue viability provided minimal assurance with non-executives querying if the report was suggesting a direct link between a rise in pressure ulcers and unsafe staffing levels. This led to cross-reference to other papers that highlighted that staffing levels were improving and that this appeared to be contradictory. This example encapsulates the current (as at January 2023) risk around clinical governance with an observed lack of confidence being exhibited by committee members in what was being reported and therefore what assurance can be obtained.

- At the same observed committee meeting the committee received a report on Infection Prevention Control providing an update and assurance on the improvement and action plan. The submitted report was not approved by the committee. This report should not have been on the agenda or discussed until the report deficiencies were addressed including clarity of the purpose for presentation at the committee.
- We note the volume of sub-groups reporting into Quality Committee and the need to streamline and improve reporting and escalation into the committee. We noted in our observation of the Neurosurgery governance meeting that one of the agenda items included what to include in the chair's report to Quality Committee. This appears to indicate a direct reporting line from divisions into a board committee without executive oversight and input. This suggests a level of operational detail which may not be relevant to the committee and potential lack of executive ownership of what is being reported into the committee.
- Overall, the Chair and members of the Quality Committee are sighted on the gaps that exist in terms of the committee function and wider clinical governance process which is a positive. We noted appropriate challenge and questioning along with support and recognition of the improvements in governance to date. The Trust needs to continue to focus on this area as a priority to be able to demonstrate that effective governance is in place including clinical audits, identification of themes around incidents, analysis of complaints and expert analysis of risks alongside mitigation and ownership.

Executive / operational level

- Our review of Executive Committee minutes and agendas identified a largely appropriate range of agenda items including preparation and feedback from board and committee meetings, review and approval of business cases in line with the Scheme of Delegation and preparation of team brief as examples. We saw minimal referral to achievement of strategic objectives although we recognise that for the period under review the Trust refreshed its strategy and was in the process of refreshing and/or developing its enabling strategies. Going forward, we understand that implementation of the Trust's strategic objectives will be subject to quarterly reporting to board and therefore we expect this to feature at Executive Committee.
- We heard that the system of performance management and accountability within the Trust could be strengthened with the current Trust approach being described as "very gentle" and "very kind" with a tendency to tolerate slippage in delivery. This gives some cause for concern given the future operational and financial delivery challenges. We heard that whilst many staff are driven to deliver by their own personal accountability, this is not robustly or systematically reinforced through the Trust's accountability framework both at divisional and corporate functions. Implementation of more robust arrangements would also provide an opportunity for divisions and corporate areas to demonstrate their successes
- In addition, some feedback suggested that senior leaders felt that they were more held to account by the non-executives at committee meetings as opposed to executives via operational performance review meetings.
- We heard that there are weekly performance meetings but these are only attended by operational and financial executives and not clinical or workforce executives with a corresponding focus on those matters. The Trust should consider wider executive attendance to facilitate more rounded discussions across all aspects of performance.
- In addition to the weekly operational and finance meetings there are more formal six monthly divisional review meetings held which include all executives. These meetings are supported by a standardised set of template slides to help steer discussions. The template slides provide the opportunity for divisions to bring local issues to management attention. In addition to the divisional performance reviews, divisions present their risk registers to Executive Committee on a bi-monthly basis. Looking ahead at the future challenges there may be a need to review the accountability arrangements and determine if the current narrowly focussed weekly meetings and wider six monthly meetings provide sufficient opportunity to hold divisions to account for delivery.
- We note the recent implementation of the Hospital Management Group as part of the governance restructure. Review of its terms of reference states that it is chaired by the Chief Executive,

provides oversight of the implementation of Trust strategies and objectives, reviews business cases and provides assurance to the executive team that effective performance management arrangements ensure delivery of the Trust's plans and operational targets. We also noted a recent review of the purpose of the meeting and revision to membership to try to streamline attendance, improve efficiency and facilitate two way engagement as opposed to information sharing. Review of the minutes demonstrate an operational focus with little time spent on oversight of strategic objective implementation despite the explicit reference to this within the terms of reference. Meeting notes record minimal discussion with the majority of agenda items marked as 'noted' including the IPR which is identified as being for information rather than discussion or assurance. Equally, at the meeting we observed there was limited evidence of generation of actions. It was not always clear from the papers why the papers had been brought to the meeting. There were references to papers having been discussed elsewhere, but whilst the reports referred to actions, they did not consistently describe what they are.

- Review of the Neurosurgery management meeting papers prior to the meeting observation demonstrated a number of performance concerns. The observed discussions did not focus on these concerns nor seek assurance over rectification actions. Departmental feedback at this meeting was a mixture of written and verbal updates. For some areas that provided verbal updates, the content was relatively detailed in nature including reference to progress against action plans which would have benefitted from having a written paper for members to read in advance which would have allowed members to come to the meeting better prepared. Equally, some of the verbal updates appeared unstructured and unfocussed and would have benefitted from greater forethought regarding the purpose of the meeting and the required outcomes from the update.
- We noted in our observed operational level meetings that the absence of a key individual often meant that the agenda item was deferred to the next meeting. This inevitably causes delays and can weaken oversight of key matters, with one example being a safeguarding item being deferred. The Trust should set out clear arrangements regarding the expectation of deputies or others to present and own paper content in the absence of key individuals.

Digital

- The Digital Strategy was presented to the March 2023 Trust board meeting. Ongoing oversight of delivery will be reported regularly through the Digital Strategy Group to Business Performance Committee via the monthly Digital Update.
- The Digital Strategy references that the Trust is in the top 20% of NHS organisations in terms of digital maturity, following achievement of Healthcare Information and Management Systems Society (HIMSS) Stage 5 for the maturity of the in-house developed Electronic Patient Record (EPR) system.
- We understand that IT and Information report into different executive leads with the potential for them to be seen as distinctly separate entities and potentially unaligned in terms of their strategic objectives. This in part is reflected within the newly adopted Digital Strategy which states that it does not cover data and intelligence systems and services (such as business intelligence platforms, tools and services, performance reporting and data quality). There appears to be opportunity to increase the connectivity of digital and information under a single executive leadership to help drive the agenda forward and ensure that the Trust realises the full benefits from its digital investment.
- Whilst the Digital Strategy reflects a very positive picture, feedback suggests that the lived experience is markedly different. IT was referenced as a challenge and the top priority to be improved. The IT team was described as 'disconnected' from the organisation and interviewees referenced inadequate provision of computers for the number of people needing them and a reduction in IT support. Beyond IT issues interviewees also made reference to the adequate availability of information but that staff cannot easily access it.

Information

- We are aware of Trust investment in Power BI which has provided the Trust with an improved

ability to create dashboards and that this has driven demand for more information. However, capacity constraints within the department, including vacancies, have constrained the Trust's ability to service the demand.

- Staff feedback suggested that generally information systems were deemed adequate with the main concerns being system inter-operability and timeliness of information. We heard from multiple sources frustration regarding disparate IT systems and the lack of interoperability between them which is causing operational inefficiencies and potential risks. The presence of such disparate systems coupled with the absence of a data warehouse means that it is also quite labour intensive to populate performance dashboards with the latest information.
- We understand that there are Business Intelligence business partner arrangements in place, one post is currently vacant although it is expected to be filled in April 2023.
- From our discussions and review of documentation the Trust has limited triangulation of metrics across its performance dashboards and in effect reports performance one dimensionally. We understand that there are no existing plans to increase the level of triangulated metric reporting or the use of co-joined leading and lagging indicators to improve the interpretation of performance reports.
- Overall, we found good evidence of the Trust and non-executives in particular seeking benchmarking information to triangulate performance and/or seek assurances over current performance.
- The Trust received a substantial assurance from internal audit on the self-assessment rating of the data security and protection toolkit, with moderate assurance received against the ten national data guardian standards.
- In our interactions with the Trust, feedback highlighted the robustness of statutory and mandatory training performance reporting with many interviewees having little confidence in the current processes.
- We noted many examples of non-executives helping to 'shape' report content including requesting performance metrics to be reinstated that had been discontinued. One such example relates to statutory and mandatory training whereby non-executives sought further detail below the high level aggregate performance to understand which courses were compliant/non-compliant and whether this put patients at risk.
- Review of the integrated performance report identified good use of statistical process control style reporting which encourages trend based reporting. We also noted positively the use of a data quality 'kitemark' to assure readers over the quality of data being reported and the triangulation of safe staffing and quality metrics. The finance section in particular offers a good range of performance information including balance sheet, cashflow, capex and cost improvements. The report also contains a helpful RAG based, point in time, overview section although this section could be further improved to help signpost to board and committee the key matters for focus. We noted a lack of narrative offering both context on performance and assurance over any mitigating actions where the Trust is not compliant with target. Equally there is no forecast to help the reader understand when performance is expected to be back on track. These issues were also identified to the Trust in June 2022 during its externally facilitated well led self-assessment exercise.
- Interviewees recognised and we would concur that the Trust needs to be more data led and to 'get under the data' to explore drivers of performance and provide greater insight to management.
- The quality of papers has recently improved but remain variable with opportunities for further improvement. It was recognised that this was an ongoing journey with the need to refresh expectations and address development areas. More specifically, the purpose of the paper and the provision of assurance was found to be lacking at times. For example at the Business and Performance Committee a paper was presented on sickness absence rates for Healthcare Support Workers. The paper concluded that the sickness absence rate was higher compared to other staff groups and anxiety and stress is the most dominant factor. However, there was no detail included about next steps other than an assurance that it would continue to be monitored. In short, the paper only provided narrative rather than either assurance or identification of a risk and what is being done to mitigate the risk or try to solve it. The paper led to non-executives asking operational level questions because of the lack of clarity on the purpose of the paper and why the

committee had originally has asked for this. It was not an effective use of time as the report shortfalls led to a lengthy discussion around benchmarking and associated challenges although we did note that perseverance by non-executives eventually led to an agreed action.

Risk management

- Review of the Internal Audit plan for 2022/23 shows a risk based plan in place that demonstrates clear linkage to the Trust's risk profile. The plan includes explicit mapping of the three year forward plan to the Trust's principal risks and shows that across the three year timeframe the majority of the Trust's existing risk areas will be subject to an audit with the most notable exception being the research and education risks.
- As part of the strategy refresh, the board has spent time reviewing its principal risks and risk appetite. In addition, we note that principal risks are allocated to committees for oversight in line with good practice. We also noted committee oversight of allocated principal risks being exercised effectively with a good profile of risk discussion including at the end of meeting reflection.
- We understand that the board reviewed its principal risks at a board development session in April 2022 to ensure alignment with the new Trust strategy. Each of the principal risks is assigned to a lead executive and to a committee of the board for oversight. We found evidence of risk-based discussions at board and most committee meetings.
- The Trust has a Risk Management Policy that is in date and includes key responsibilities, methodology and process, and risk reporting. A new Risk Management Strategy has been recently developed and was approved by the board. It sets out an ambition to integrate risk management into core business and decision-making processes, and to enhance the tools, techniques and knowledge of risk across the Trust.
- One of the objectives in the Risk Management Strategy is to define the organisation's risk appetite. The strategy describes what is meant by risk appetite and tolerance, but does not include the board's risk appetite statement, nor does the Risk Management Policy.
- We understand that the board assigned a risk appetite for each of the principal risks set out in the Board Assurance Framework (BAF), however, it is not clear how the risk appetite levels are taken into account in setting target risk levels. For example, the cyber security risk is the only one that has been assigned a risk appetite of 'averse', yet it does not have the lowest risk target score. Operational performance, quality and leadership risks all have the same 'cautious' risk appetite, however, their target risk scores range from 4 to 12. It is recognised by the Trust that the approach to risk appetite needs clarifying with consideration given to how the board communicates and operationalises its risk appetite into the organisation. We have not included a specific recommendation regarding this as we are clear that the objective is already captured and approved by the board as part of the Risk Management Strategy. Indeed, we note that the Trust stated in its 2021/22 Annual Governance Statement that it will embed its evaluation of risk appetite more closely to its principal risks in 2022/23.
- Our review of key risk documents highlighted a lack of documented clarity regarding the ownership of risk management. The Scheme of Reservation and Delegation states that the Chief Operating Officer is responsible for the Risk Management Strategy and ensuring there is a programme of risk management, however, in practice we understand that this is under the Chief Nurse's portfolio. The Risk Management Policy focusses on the responsibilities of the Chief Nurse, Deputy Chief Nurse and Chief Financial Officer, whereas the latest Annual Governance Statement summarises responsibilities of key officers in relation to different categories of risk, including the Chief Financial Officer, Chief People Officer, Chief Nurse, Medical Director and Chief Operating Officer.
- We also noted that the Risk Management Policy does not make reference to the Audit Committee, which should be responsible for scrutinising 'the organisation's overarching framework of governance, risk and control' (NHS Audit Committee Handbook).
- Indeed, we observed a degree of confusion regarding the role of the Audit Committee in relation to the new Risk Management Strategy. When the new strategy was presented to the Audit Committee, the cover sheet was marked for approval but on the agenda for assurance. The next steps within the paper stated that an annual report would be provided to the Quality Committee, however, this was changed during the meeting to the Audit Committee. Our view is that it is

appropriate for the Audit Committee to review the key risk management documents prior to approval by the board, and to receive an annual report about the effectiveness of the Trust's risk management arrangements, including progress on implementing the Risk Management Strategy. This would also be in keeping with the Audit Committee's terms of reference which reference 'assisting the board of directors in its oversight of risk management and the effectiveness of internal control'. The Trust should consider reviewing ownership and responsibilities associated with risk to ensure they are represented consistently across all relevant documents.

- The format of the Board Assurance Framework (BAF) is relatively clear and includes most of the key information we would expect. Whilst there is focus on describing the impact/consequences of the principal risks materialising, there is a lack of information relating to the causes of each risk. Causes are an important aspect of risk articulation and should be incorporated as they inform the assessment of the likelihood of risks occurring and assist with the identification of controls and actions required to address the drivers of risk. Furthermore, the BAF could be further strengthened by assisting the reader to understand the relevance of assurances in relation to individual controls, the strength of each assurance, and the alignment between proposed actions and control/assurance gaps. It is clear that the board does use the BAF to help support risk-based discussions, however, the aforementioned refinements would enhance its value as an assurance tool.
- In terms of presenting the BAF and taking ownership of the individual principal risks in meetings, in our experience it is best practice for the accountable executive to lead at committee meetings and the Chief Executive at board. This provides greater clarity about ownership and accountability in relation to the management of the risks and reinforces the point that the Corporate Secretary is only responsible for the methodology, coordination and reporting of the BAF but not it's content.
- We heard that risk management was a concern for the Trust and this has been a focus for the new Head of Risk and Governance appointed in 2022. They have been instrumental in cleansing old risks of operational risk registers and undertaking a systematic review of the Trusts' approach to risk management which has helped raise the profile of risk within the Trust at an operational level. This is still work in progress with operational areas still tending to report issues as risks but this is now recognised and we saw evidence of challenge regarding this matter during our observed meetings.
- The Governance and Risk team has been reinvigorated in the last 12 months and a key focus has been to ensure all risks have action plans and assurance and control gaps have been identified. The way that risk registers have been reported includes information to facilitate the understanding of existing controls and further actions planned to manage the risks, and we found evidence of review at executive team and committee meetings. We understand that the team has recently redesigned risk register reports for committees. We were provided with an example that was presented to the Quality Committee and found it to be more thematic and analytical than previous reports, using evidence from analysis of incidents to inform risk profiles. We also noted development of the Trust's in-house information system, Minerva, to provide risk dashboards which will help further focus discussions on the management of risk and agreed actions. All these developments indicate a positive direction of travel in relation to risk management which is supported by a proactive Governance and Risk Team.

Recommendations

11.	The Trust should continue to support governors to discharge their statutory duty to represent members.
12.	The Trust should consider its approach to digital and information leadership to maximise the benefit from its investments and ensure an aligned approach to secure greater value from its analytical and reporting capabilities to better scrutinise performance and help deliver current and future productivity and efficiency challenges.
13.	The Trust should review the effectiveness of the Quality Committee in terms of the sub-group structure and effectiveness of reporting to support required improvements.
14.	The Trust should consider reviewing its accountability and performance management arrangements to better formalise and improve accountability to support delivery of

	required targets via suitably devolved arrangements.
15.	The Trust should consider how it demonstrates fulfilment of the Audit Committees role in overseeing the effectiveness of risk management arrangements.
16.	The Trust should consider ways to operationalise its risk appetite approach and improve alignment with target risk scores and risk-based discussions and decision making.

Well Led Quality Statement 6: Partnerships and communities

'We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement'.

Strengths	Development areas
• Positive relations between Trust and governors • Strong external stakeholder relations • Mutual aid / partnership working • 'Home from Home' facility • Anchor Institute contribution to social value	• Trust external profile / culture of modesty • Board level engagement with stakeholders • Continue to build ICB and CMAST relations • Patient feedback and involvement

- We note that within the Trust's refreshed strategy one of the five Trust strategic objectives is collaboration.
- We noted some excellent relations with those external partners we engaged with who see the Trust as open and responsive both at a local issue level and also as a wider system partner. Indeed, one external partner stated that they found the organisation to be an outstanding partner and could not find any area that they felt could be improved.
- It was observed that relationships with commissioners, especially specialist commissioning, is excellent too and seen as being stronger than those with Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST). We note the impending shift of specialist commissioning arrangements in 2024/25 into the Integrated Care Board and the corresponding need to ensure that those relationships continue to build positively.
- External stakeholders also referenced the positive way in which the Trust has engaged with the Liverpool Clinical Service Review.
- We heard lots of evidence of proactive offering of mutual aid support to wider system partners during the pandemic which has continued to date. Examples provided include collaboration with system partners for the spinal pathway, brain tumour pathway and rapid access neurology assessment service which is supporting partner trusts through admission avoidance and shorter length of stays. Further examples include the implementation of a joint stroke consultant rota including thrombectomy and the introduction of a pain management service. In addition, we were told that mutual aid was provided to the neighbouring trust in terms of offering nurses and providing beds.
- It was noted that the Trust took on the provision of the spinal service despite knowing that this would challenge the Trusts 78 week wait position and reporting which is demonstration of a Trust that can do the right thing for patients whilst at the same time recognising the adverse challenges that this brings on the Trust.
- The Trust hosts a joint procurement team, which serves the specialist trusts in Liverpool. This enables the trusts to harness the benefits of collective buying scale of economies and share the costs of this function. This is a positive example of both partnership working and of reducing costs.
- We heard of the increasing recognition within the Trust of the need to proactively demonstrate the value that niche specialist trusts bring to the system. The need to actively promote the Trust and its perceived value to the system appears to be at odds with the historic culture of the Trust with interviewees stating that the Trust has had a 'culture of modesty' and consciously not promoted its successes for fear of being seen as being in a privileged position. This is despite the Trust undertaking some leading edge innovation including a ground-breaking new surgical robotic navigation system, and treatment of Essential Tremor using Focused Ultrasound. A number of interviewees felt that the profile of the Trust was lower when compared to other specialist trusts in Liverpool.
- Interviewees referenced the need for greater board level engagement and feedback with external

stakeholders recognising the increasing system working, the clinical services review outcomes and the Trust's role in being an anchor institution in the city.

- From our interactions with the Trust we noted some concerns regarding the current status of the third party contracts register and in particular concerns regarding how up to date some of the service level agreements are.
- The governors we engaged with held the Trust in high esteem. As referenced in the previous section, the Trust and governors are aware of the need to strengthen the membership engagement role of governors to help them meet their statutory duties. We also noted commentary from governors suggesting that the Trust could do more to engage with patients and communities (see comment around strategy development under statement 1).
- A number of specific references were made by governors in terms of building stronger relationships with the third sector to develop links with relevant bodies and groups for the benefit of patients after they have had treatment at the Trust. We have included them here for completeness although we would highlight that we have not been able to triangulate the need for this. Feedback included the need for improved signposting to support groups and charities to help raise the profile of post treatment support. There was also reference for the need to strengthen links with Alder Hey Children's NHS Foundation Trust in order to improve the transition between children's and adult services.
- We note that patient stories are a regular feature at both Trust board and at Quality Committee meetings along with reporting of Friends and Family Test (FFT) feedback and complaints. Beyond this there is an opportunity to strengthen the provision of qualitative feedback at board and committee level from patients, staff and stakeholders.
- We noted the use of posters to report FFT feedback in wards and departments.
- We noted the charity funded eight bedded 'home from home' facility to allow families to remain close to patients recognising the benefit to patients of having loved ones close by and also to support those loved ones during the episode of care. This facility is of particular benefit to those families from further afield, recognising the significant geographical area that the Trust covers.
- We note that in addition to the annual staff survey, the Trust engages with the national quarterly staff pulse survey. To date, the response is not at the same level as the annual survey although we understand that the Trust is focussing on improving this.
- We note that protected characteristic staff networks are in place who appear active and engaged in pursuing their aims and objectives. Whilst we noted earlier in the report the apparent need to strengthen the connection between these networks and the ED&I team, there are also opportunities for the board to engage these networks more directly via its review of the governance arrangements surrounding the Strategic BAME Committee.
- We noted the Trust's participation in 'Building Liverpool Citizens' which is a social value initiative across the city of Liverpool.
- We heard about the Trusts involvement in the 'Weapons down, Gloves up' initiative across the wider Liverpool community which demonstrates an ambition to be part of the wider system and be involved in public health issues beyond the immediate boundaries of the Trust. The Chair's leadership is prominent in the area of civic involvement and engagement and this can be seen through the desire get involved in new areas such as the Civic Forum.
- The Trust had signed up to the Social Value Charter and work towards the Social Value Quality Mark accreditation is underway.

Recommendations

17.	The Trust should consider ways in which the Trust can continue to proactively raise its profile and demonstrate the wider added value that the Trust offers to system partners.
18.	The Trust should consider ways in which the Trust board increases the voice of its stakeholders (qualitative feedback) at board and committee level.

Well Led Quality Statement 7: Learning, improvement and innovation

'We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research'.

Strengths	Development areas
• Roll out of 6i quality improvement methodology • Number of existing QI trained personnel • Daily safety huddles/ weekly safety meetings • CARES ward accreditation scheme • Patient Experience Group membership and involvement • Growing strategic focus on research	• Clinical audit follow through into lessons learned and embedded practice • Emergent leadership development • Research profile and activity level • Alignment of QI, innovation and transformation to add greatest value • Opportunities exist to strengthen lessons learned and dissemination of learning

Learning

- Learning opportunities would be enhanced by the provision of greater analysis within papers to bring insight to board and committee discussions rather than merely reporting performance. This is also true of quality reports where the primary focus of papers appears to be compliance against timelines and volume of instances rather than the learning and changes in practice that these have brought about.
- Observation of divisional management meetings indicated an appropriate range of agenda items are discussed however the focus on quality governance matters appears to be more on compliance with timescales and numbers of incidents as opposed to learning and improving, driven as referenced above by the focus of current reporting.
- We heard about the daily safety huddles that take place each morning and is an opportunity for staff of all disciplines to raise concerns.
- We noted the weekly meetings that are held between divisions and the Head of Patient Experience. Lessons learnt from patient feedback are discussed at these weekly safety meetings and also disseminated through regular bulletins. We also heard that there are opportunities to strengthen learning lessons from implementing regular post-project evaluations for all change projects including non-clinical and also wider learning from outside of the Trust.
- Feedback was more positive surrounding the arrangements for learning from clinical incidents and dissemination of key messages. Staff referenced alerts and communications that are shared internally and externally where relevant, including informing work with commissioners.
- We noted the use of the complaints tracker to track outstanding learning actions from complaints which are only closed following receipt of evidence of the action being implemented. Once closed we would expect to see a more formal link with clinical audit, or other tools, to check embeddedness of those actions at an appropriate point in the future.
- Staff spoke about a shift away from feeling criticised or blamed for incidents to one of learning. However, we noted that the outcomes from the mock CQC review identified that not all areas were able to articulate lessons learned from complaints or incidents. In addition, not all staff were able to explain what had happened once an incident had been reported i.e. the absence of an effective feedback loop.
- Culturally we noted that end to end ownership of complaints resides with the central patient experience team who provide active support to divisions to respond to complaints in an appropriate and timely manner and also ensure learning actions are implemented. The Trust may wish to explore how it shifts ownership of complaints to the divisions with the central team facilitating co-ordination.
- Examples were provided to us where patients and carers felt the need to bypass the Trust

complaint process and escalate matters directly to the Chief Executive. They felt this was necessary as there was a lack of tailored follow-up in response to complaints, or they felt that it was unclear about what action was being taken in response to the complaint.

- Patient experience reports are presented bi-monthly to Executive Committee and reported quarterly to Quality Committee. In addition there is an annual report reported into Trust board via Quality Committee. We heard that the intention is that patient experience reports will also be presented quarterly into the Hospital Management Group.
- We note that the Patient Experience Manager attends divisional risk and governance meetings albeit on a differentiated basis, monthly into Neurology and quarterly in Surgery.
- We heard about how patients and carers are involved in nurse inductions including providing a patient/carer view of their experiences at the Trust and what good patient experience looks like.
- Leadership development in the Trust was described as 'emergent'.
- We note that the leadership development courses on offer include coaching and mentoring. We were told that the intention is for all managers to partake in a five day programme including building rapport. We understand that the second cohort completed the course in December 2022.
- We understand that the Trust is also rolling out a deputy director training programme which includes action learning sets and the first cohort of this course is just commencing.
- We were also informed that many of the external leadership development courses are part funded via charitable funds which helps to reduce the self-paying element.
- We note that the Trust utilises well the NHS apprenticeship scheme to help 'grow your own' workforce.

Continuous improvement

- We understand that the Trust is looking to potentially introduce a Project Management Office and centralise its service transformation resources together to create greater capacity to support implementation of productivity improvements. This increased capacity should support delivery of the two main focuses for service transformation in 2023/24: those being theatre and outpatient productivity.
- We noted the current lack of a standardised quality improvement methodology being routinely utilised within the Trust. We understand that the Trust has developed it's 6i approach as its improvement methodology going forward and we were informed that the Trust is currently rolling this out.
- Some concerns were raised with us regarding whether service changes and improvements are sustained. We would expect to see the clinical audit function supporting the provision of assurance over embeddedness of service changes.
- We note that the Trust has a broad ranging clinical audit programme which includes national and local areas for audit. We note the Trust prioritisation approach including the adoption of a 1-5 scale to reflect the prioritisation of each audit with national 'must do' audits rated as 1 and local, low priority audits rated as 5. We noted the full programme of audits including 40 Trust wide audits including the national audits and 119 further, more locally identified, audits. What was less clear was how the local audits are identified with no clear 'driver' of the audit to help inform the reader as to the provenance of the audit and whether it links to Trust identified concerns from incidents, complaints etc or local clinical determination.
- We noted evidence of discussion of clinical audit plans at divisional management meetings. However, it appears that once an audit has been completed there is an opportunity to strengthen the focus given to the implementation and impact of any proposed recommendations from the findings or the need to re-audit in the future to test embeddedness of the proposed changes.
- We noted a relatively large number of outstanding and abandoned clinical audits due to the lack of responses from services. Outstanding audits included NICE guidance assessments.
- Review of clinical audit documents show that the specimen acceptance policy audit showed 74% of requests missing essential information with the learning action being to implement an electronic order communication system. There was no discussion or actions relating to the immediate short term fix or risks that such low compliance may cause or enforcement of adherence of basic essential requirements for clinicians. Whilst we can appreciate the benefits an electronic order

system might bring; the implementation of an electronic system is potentially treating the symptom not the cause.

- We note that within the 2021/22 Quality Account there were two quality priorities that were not achieved and one quality priority that had been partially achieved.
- We heard about the Communicate, Assess, Respect, Experience and Safety (CARES) ward accreditation reviews which is an internal quality assurance assessment. Our understanding is that the Quality Manager, an executive and a member of the Governance and Risk team conduct on the spot observations and review of documentation (including patient documentation), checking for up to date records/assessment. Wards are awarded an assessment which helps determine the frequency of reassessment. Those wards awarded Gold status are reassessed in 12 months, Silver status every 6 months and Bronze status every 3 months.
- The Patient Experience Group's membership which meets quarterly includes governors, Healthwatch members, representatives from brain charities and operational representatives from both divisions in addition to the patient experience team and corporate nursing representatives.
- We noted the Neurosciences Programme Board which has a number of patient representatives on it, which is chaired by the Medical Director. We also noted the inclusion of patient representatives on PLACE assessments within the Trust. PLACE assessments also include volunteers, many of whom are ex-patients. We also noted the inclusion of patients in the redesign of Jefferson Ward and the Road to Recovery Programme.
- Examples of improvements brought about from patient feedback includes the introduction of the library trolley, devices to enable streaming services on ward areas, birthday visits including a card and present and noise at night sleep well packs which include toiletries and single use earphones.
- We noted the ongoing challenge in relation to the Trust's achievement of its appraisal rate target. It is important that staff receive a timely and high quality appraisal and this should be seen as part of the Trust's staff retention focus.
- We noted that the Trust's internal auditors undertook a review of the Trust's exit interview process. Report feedback indicated opportunities for improvement with regards to controls for the analysis and reporting of exit interview responses, monitoring of uptake and implementation of actions.

Research and innovation

- We noted the recent granting of university hospital status in October 2022 and membership of the University Hospitals Association which links in with the research and innovation strategic objective.
- We also heard about the increasing relationship with the University of Liverpool and the intention for the development of a joint research strategy.
- In 2020, the Trust procured an external review of its research portfolio recognising the need to improve the profile, volume and impact of the Trust's research activities. The review recommended re-structuring of the department and investment. We note that the Trust has also recently appointed a non-executive with research experience and an interim research lead which demonstrates further commitment to this. Overall, we would agree that the Trust's research activities and overall standing in the Trust are not commensurate with the Trust's status as the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services.
- We note that the executive lead for research is the Chief People Officer, not the Medical Director, which is unusual.
- We heard about the lack of clarity regarding research costs and benefits and we were told that oversight of managing consultant job planning inputs for those with research PAs is less than effective.
- As noted earlier in this report, the new People Strategy, presented for final approval at the February 2023 board meeting incorporates research and innovation. The addition of research into the People Strategy appears to be a late decision as the draft version presented to the Research, Innovation and Medical Education Committee (RIMEC) in December 2022 incorporated innovation and medical education but excluded research, which had a separate strategy dated 2019-24. The final version of the People Strategy presented to board includes two additional lines related to

research that have been added to the research and innovation section.

- A Research Strategy implementation update report was presented to the RIMEC in December 2022 alongside the draft People Strategy. The update acknowledged that the Trust's Research Strategy needed to be reviewed to take account of the research landscape post pandemic and to align with the new Trust Strategy. The paper gave no clarity about how or when this would take place, however, the subsequent committee action log notes this as complete through its incorporation into the People Strategy. We did note, however, that a research strategic implementation plan is in development, although we have not found reference to a timeline for this.
- We are not clear about the rationale for incorporating research and innovation into the People Strategy. We understand that people and culture are important for successful delivery of all the strategic objectives, but there seems to be a lost opportunity to create a vision, ambition and sense of momentum for research that will inspire Trust staff and relevant external partners and maximise the Trust's unique position as a specialist hospital.
- From our observation of the RIMEC it still seems to be developing its focus and approach. The agenda consisted mainly of items marked to inform. The meeting overran due to lengthy discussions seeking clarity about a number of matters, including how to make best use of the University Hospital Association, resourcing, required investment and financial reporting. There was a lot of detailed information provided, much of it verbally through discussion, giving an overall impression of complexity and challenges without clear recommendations and few specific next steps.
- Feedback suggested a perceived a shift in ambition around innovation. The RIMEC was referenced in the hope it would aid clinical engagement and clarify funding arrangements. Feedback also suggested opportunities exist to align service improvement and quality improvement. Structurally, quality improvement, transformation and innovation were seen as separate strands, but participants recognised that the newly forming Project Management Office provided an opportunity to bring these current disparate parts together.

Recommendations

19.	The Trust should consider ways in which it can increase the added value from its clinical audit activities in terms of follow through of lessons learned, impact and embeddedness of changes.
20.	The Trust should consider ways in which it can strengthen the focus on learning lessons and dissemination of these lessons across the Trust including patient feedback, clinical audit and other sources of feedback as well as the more well established learning from incidents.
21.	The Trust should continue to focus on increasing the research profile and level of activity within the Trust commensurate with being a national specialist Trust.
22.	The Trust should consider as part of the roll out of the 6i quality improvement methodology how this best aligns and provides value into the Trust's transformation and innovation activities.

Well Led Quality Statement 8: Environmental sustainability – sustainable development

'We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same'.

Strengths	Development areas
• External collaboration in developing the Sustainability Plan	• Governance and oversight of plan delivery

- A draft Sustainability Plan 2022-25 was presented to the Trust board in December 2021 in order to gain approval to submit to NHSE in January 2022. We noted from the accompanying report that an action plan was being developed to measure the delivery of the plan with timeframes and Trust leads being identified.
- We note that the Trust received feedback from NHSE in May 2022 on its draft Sustainability Plan which was reported into the June 2022 Business Performance Committee meeting. The June 2022 update paper to the committee states that the Trust is working through the recommendations and forming an internal action plan. It appears therefore that some six months since the original draft plan was submitted to the committee they remained unsighted on the Trust's action plan to deliver the Sustainability Plan. We do note that the Business Performance Committee was scheduled to receive a Sustainability Plan update at its January 2023 meeting for which we do not have the papers and therefore we assume that the committee is now sighted on this.
- In terms of governance of the Sustainability Plan we understand that implementation of the plan will be delivered by the Trust Sustainability Project Group which reports into the Business Performance Committee. Review of the Business Performance Committee's annual workplan identifies that following the NHSE feedback report presented at the June 2022 committee meeting the next scheduled update was scheduled for January 2023. This appears to indicate that an update containing an action plan for approval will be presented to the committee c12 months following the presentation of the original draft plan.
- We also note the absence of the Trust Sustainability Group as an identified sub-group of the committee per the supplied annual workplan and consequently the committee is not routinely sighted on progress from the group. As referenced earlier in the report, the breadth of coverage of the Business Performance Committee requires infrequent updates from sub groups and other reports to avoid over population of the committee's agenda. This impacts on the timeliness and frequency of oversight arrangements by the committee.
- In September 2022, we note that the same update paper that was presented to the June 2022 Business Performance Committee was also presented to the board under the consent agenda section of the meeting.
- We note that the feedback from NHSE regarding the Trust's Sustainability Plan was largely positive and in particular reference was made to the collaborative arrangements that the Trust participated in when drawing up its plan. This includes work with the Carbon Trust, the Liverpool Carbon Collective, and the Liverpool Cycling Alliance.
- Key improvements that were suggested by NHSE include the identification of a board level lead for the Green Plan, the inclusion of clear and measurable objectives to enhance oversight of deliverability of the plan, assignment of specific actions and measures for adaptation planning, to continue to explore opportunities for external funding support and ensure environmental considerations are part of the business planning process.
- The conclusion in the report to the Business Performance Committee and board was that 'the team are currently working through the recommendations and forming an internal action plan to progress the work that can be taken internally within the Sustainability group'. No specifics are included about the next steps or timelines and as it was under the consent agenda, there was no discussion of the report by the board.
- We noted that the recently appointed Associate Director of Operations will be leading the work on

Sustainability with the Chief Operating Officer being the board level representative.

- In addition to the three-year Green Plan, NHSE guidance sets the expectation that each Trust formally review and update their plans annually and for delivery progress to be reported annually to the Trust board. From the documentation supplied to us we have not been able to evidence that the board has adequate visibility of the net zero agenda, nor confirm that actions plans are well developed or that the governance arrangements are functioning as stated in the Sustainability Plan.

Recommendations

23.	The Trust should consider the appropriateness of the governance and oversight arrangements surrounding delivery of the Trust's Sustainability Plan.

Other considerations

We have included below other observations that have emerged during the course of our review which, whilst not central to the main feedback, are worthy of mention in supporting the Trust in terms of its overall governance improvements. These have not formed part of our recommendations but are included for completeness.

- The operation of the action log in meetings appears a little 'clunky' at times and might benefit from prior population of the update section in advance of the meeting to aid review and the efficient running of meetings.
- We observed some lengthy presentations of papers at meetings. More could be done to ensure that introductions are succinct and focus on the cover sheet (i.e., why is the paper here, what are the key issues, what does the presenter want the forum to do with the paper).
- We noted a number of examples where the chair of the forum did not seek explicit agreement to the recommendation of the paper. Whilst agreement was assumed on a number of those occasions it might be useful for the minute taker to be able to minute explicit agreement to each decision or recommendation.
- The Trust board has a comprehensive forward plan. The board has a scheme of reservation and delegation which was approved by the board in November 2022. There are a number of policies that it has retained authority for approval which do not appear on the board forward plan e.g. FTSU, health, safety and welfare and learning from deaths. The Trust should include these on the board's forward plan if it is the intention to reserve policy approval in these areas.
- It is not clear from the documentary review how the views of the governors are obtained in relation to compliance with the declarations made by the board regarding compliance with provider licence conditions. The Trust may wish to consider how the views of the governors are obtained. The governors may benefit from a development session on the self-certification to understand how they should be holding non-executive directors to account regarding compliance with the provider licence conditions.
- Council of Governor minutes should distinguish between governors (members of the council) and others who are invited to attend the meeting.
- The Council of Governors is responsible for approving the appointment of non-executive directors, following recommendation of the nominations committee. It is noted that recent practice has been to include information on the performance of the shortlisted candidates including whether they were appointable or not. We would suggest that it is not appropriate to report this in the part 1 (public) CoG and is perhaps better reported in part 2 (private).
- We would suggest that the explanatory material that precedes the Board Assurance Framework should be appended to the paper instead. In addition, attention should be given to the RAG system used through the Board Assurance Framework in relation to risk scores as there appears to be an inconsistent approach being applied.
- We noted the tendency on cover sheets to tick the assurance boxes even when the paper is not for assurance. This could give the impression of assurance being provided when in fact it is not.
- We note within the Audit Committee minutes that the Financial Accountant is a regular attendee at each meeting. The terms of reference for this committee include a list of regular attendees and the Financial Accountant is not identified as a required regular attendee.
- In our review of committee minutes we noted a high proportion of 'to follow' papers relative to similar reviews. This was particularly prevalent at the Business Performance Committee.
- We noted numerous examples of slippage in action dates with minimal recourse or challenge. It is important that realistic timelines are agreed from the outset and where

slippage occurs the reasons and impacts of each instance is understood. We also noted a tendency sometimes to close actions when the course of action has been agreed as opposed to when it is actually actioned.

- We noted thew absence of both finance and workforce representation at the October 2022 Hospital Management Group and resultingly a lack of discussion regarding those aspects of the integrated performance report. It is important that attendance by deputies is clarified if key personnel are unable to attend.

Recommendations

1.	As part of the roll out of the Trust refreshed strategy and suite of enabling strategies the Trust should ensure that the new strategic framework is well socialised with staff and stakeholders (including governors) including sufficient detail of implementation plans to make the strategies meaningful to all.
2.	The Trust should ensure that it retains appropriate oversight over the delivery of the refreshed strategic ambitions and enabling strategies.
3.	The Trust should review its approach of incorporating numerous strategic elements within the People Strategy in terms of appropriateness of profile and oversight.
4.	The Trust should consider ways in which it can effectively re-energise the Trust's focus on its embedded values.
5.	The Trust should consider how it increases the contribution from executives at board and committee meetings and create more of a unitary board feel to proceedings.
6.	The Trust should consider ways in which it can create additional executive/senior level capacity given the forward agenda i.e., digital leadership, and also look to develop effective succession planning arrangements below executive level.
7.	The Trust should consider ways in which to create more formal divisional autonomy arrangements and generate effective accountability.
8.	The Trust should ensure that the FTSU Guardian is available to present their own papers at board meetings to increase their visibility and connection with all board members.
9.	The Trust should focus more effort on improving its appraisal and mandatory training performance in line with agreed Trust targets.
10.	Whilst we recognise the Trust's estates constraints and lack of meeting rooms, the Trust should consider how it can better support the above recommendation by providing increased access to suitable rooms to hold 1:1 confidential discussions.
11.	The Trust should continue to support governors to discharge their statutory duty to represent members.
12.	The Trust should consider its approach to digital and information leadership to maximise the benefit from its investments and ensure an aligned approach to secure greater value from its analytical and reporting capabilities to better scrutinise performance and help deliver current and future productivity and efficiency challenges.
13.	The Trust should review the effectiveness of the Quality Committee in terms of the sub-group structure and effectiveness of reporting to support required improvements.
14.	The Trust should consider reviewing its accountability and performance management arrangements to better formalise and improve accountability to support delivery of required targets via suitably devolved arrangements.
15.	The Trust should consider how it demonstrates fulfilment of the Audit Committees role in overseeing the effectiveness of risk management arrangements.
16.	The Trust should consider ways to operationalise its risk appetite approach and improve alignment with target risk scores and risk-based discussions and decision making.
17.	The Trust should consider ways in which the Trust can continue to proactively raise its profile and demonstrate the wider added value that the Trust offers to system partners.
18.	The Trust should consider ways in which the Trust board increases the voice of its stakeholders (qualitative feedback) at board and committee level.
19.	The Trust should consider ways in which it can increase the added value from its clinical audit activities in terms of follow through of lessons learned, impact and embeddedness of changes.
20.	The Trust should consider ways in which it can strengthen the focus on learning

	lessons and dissemination of these lessons across the Trust including patient feedback, clinical audit and other sources of feedback as well as the more well established learning from incidents.
21.	The Trust should continue to focus on increasing the research profile and level of activity within the Trust commensurate with being a national specialist Trust.
22.	The Trust should consider as part of the roll out of the 6i quality improvement methodology how this best aligns and provides value into the Trust's transformation and innovation activities.
23.	The Trust should consider ways in which it can increase the added value from its clinical audit activities in terms of follow through of lessons learned, impact and embeddedness of changes.

Appendix 1 – Engagement Schedule

Interviews

Name	Role	Organisation
Max Steinberg CBE	Chair	The Walton Centre NHS FT
Su Rai	Deputy Chair (Chair of Audit Committee)	The Walton Centre NHS FT
Karen Heslop	Non-Executive Director	The Walton Centre NHS FT
David Topliffe	Non-Executive Director (Chair of Business Performance Committee)	The Walton Centre NHS FT
Paul May	Non-Executive Director (Chair of Research, Innovation and Medical Education Committee)	The Walton Centre NHS FT
Ray Walker	Non-Executive Director (Chair of Quality Committee)	The Walton Centre NHS FT
Irene Afful	Non-Executive Director	The Walton Centre NHS FT
Jan Ross	Chief Executive	The Walton Centre NHS FT
Dr Andy Nicolson	Deputy CEO and Medical Director	The Walton Centre NHS FT
Nicky Martin	Interim Chief Nurse	The Walton Centre NHS FT
Mike Burns	Chief Financial Officer	The Walton Centre NHS FT
Mike Gibney	Chief People Officer	The Walton Centre NHS FT
Lindsay Vlasman	Chief Operating Officer	The Walton Centre NHS FT
Katharine Dowson	Company Secretary	The Walton Centre NHS FT
John Taylor	Lead Governor	The Walton Centre NHS FT
Julie Kane	Freedom To Speak Up Guardian	The Walton Centre NHS FT
Lisa Judge	Head of Patient and Family Experience	The Walton Centre NHS FT
Andrew Sharrock	Head of Information and Business Intelligence	The Walton Centre NHS FT
Gemma Nanson	Head of Neurosciences Research Centre	The Walton Centre NHS FT
Mike Duffy,	Head of Patient Safety and Risk	The Walton Centre NHS FT
Andrew Bibby	Regional Director of Health and Justice and Specialised Commissioning	NHSE Specialised Commissioning
Fiona Lemmens	Deputy Medical Director,	Cheshire & Mersey ICB
Graham Irwin	Chief Executive	Cheshire & Mersey ICB
Louise Kenny	Executive Pro-Vice-Chancellor	University of Liverpool
James Sumner	Chief Executive	Liverpool University Hospitals NHS Foundation Trust
Annette Morris	Director of Neurosciences	Betsi Cadwaladr University Health Board

Focus Groups

Name	Date
Council of Governors	3rd March 2023
Divisional Management	10th February 2023 3rd March 2023
Staff focus	14th February 2023 15th February 2023
Patient Focus	15th February 2023

Meeting observations

Forum	Date
Board of Directors	2nd February 2023
Council of Governors	14th March 2023
Audit Committee	7th February 2023
Quality Committee	19th January 2023
Business Performance Committee	24th January 2023
Research, Innovation and Medical Education Committee	21st March 2023
Executive Committee (or similar)	15th February 2023
Hospital Management Group	20th February 2023
Neurology risk and governance meeting	14th February 2023
Neurosurgery risk and governance meeting	8th February 2023
Strategic BAME Advisory Committee	13th March 2023
Corporate Risk & Governance meeting	21st February 2023

Surveys

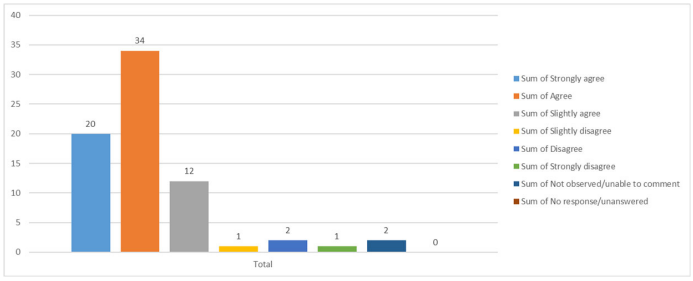
Stakeholder Group	Number of responses
Board members	12
Senior Leaders	8
External Stakeholders	9

Appendix 2 - Survey results

Trust board members and attendees

Leadership

The below chart shows the total aggregate number of responses across each answer option for all of the Leadership domain survey questions for Trust board members and attendees.



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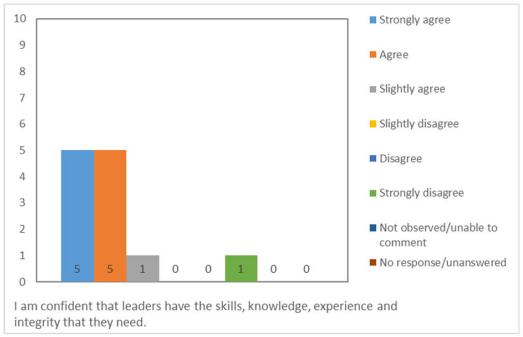
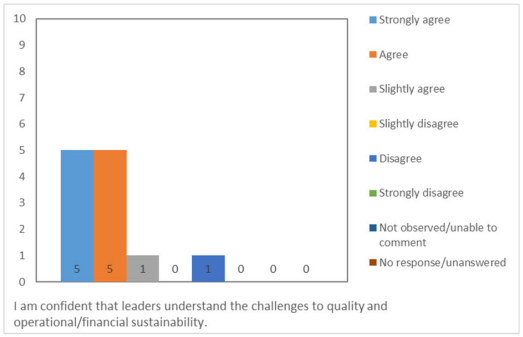
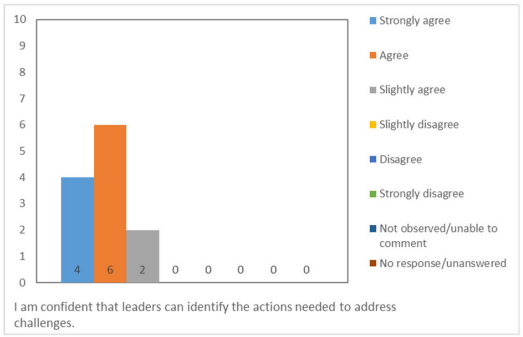
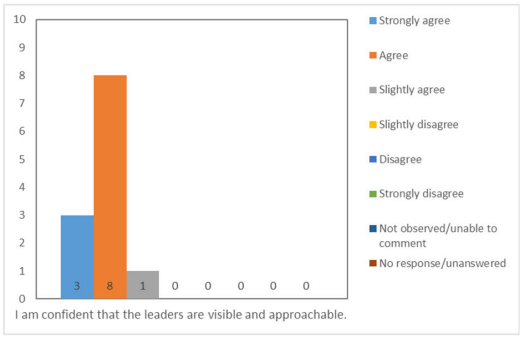
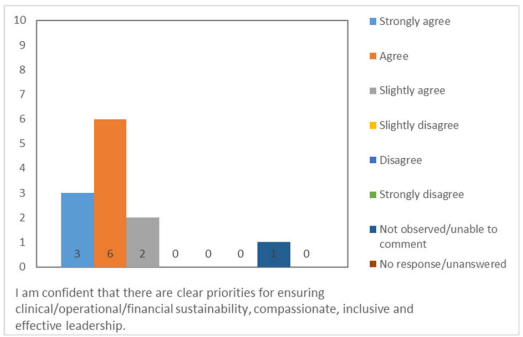
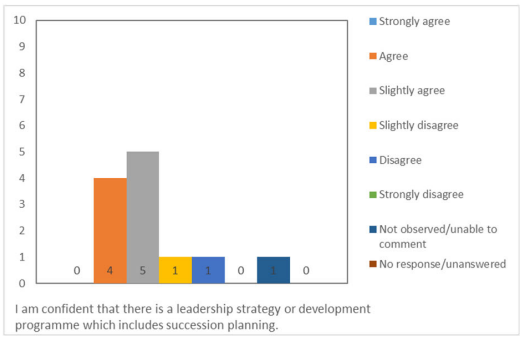






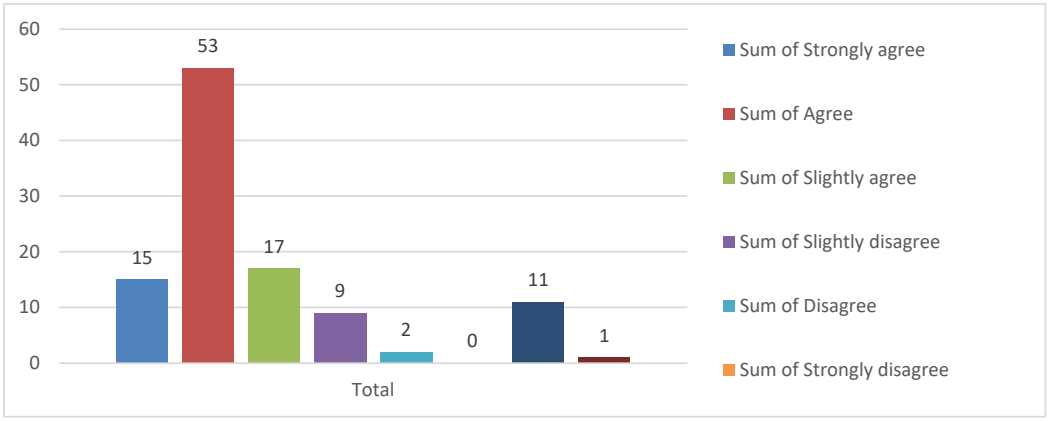


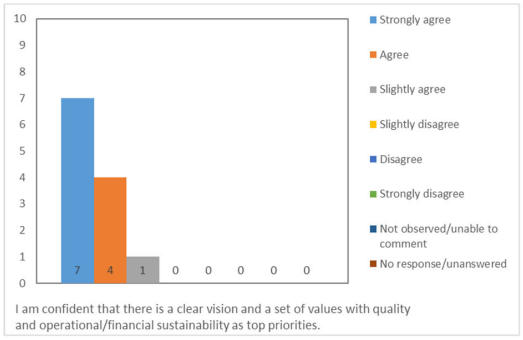


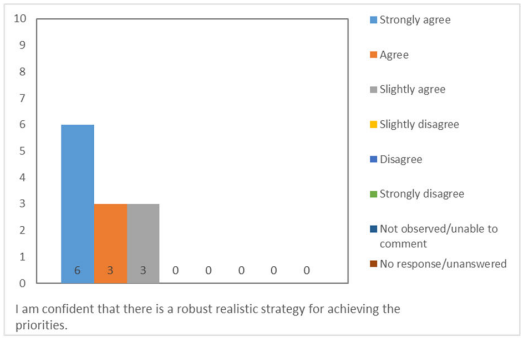


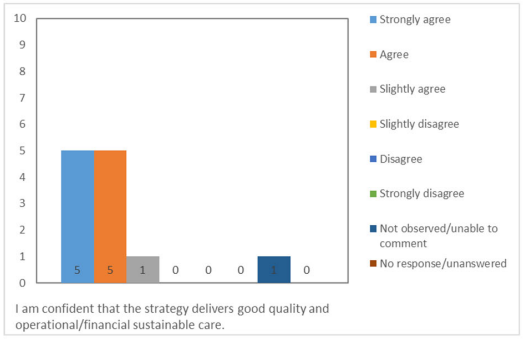
Strategy

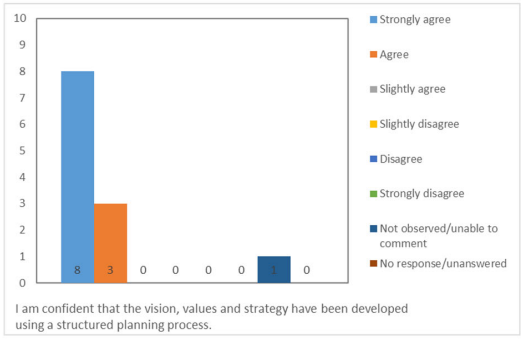
The below chart shows the total aggregate number of responses across each answer option for all of the Strategy domain survey questions for Trust board members and attendees.

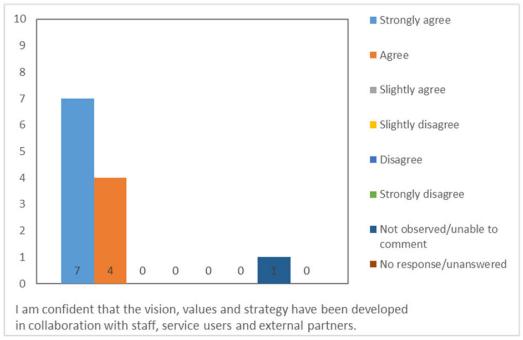


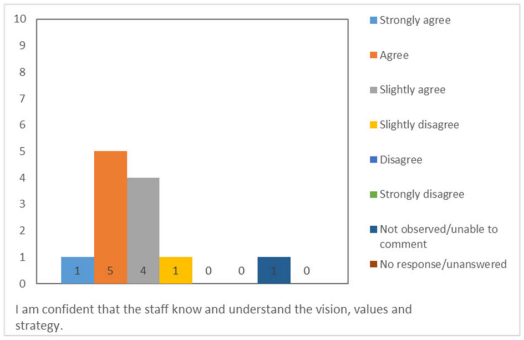


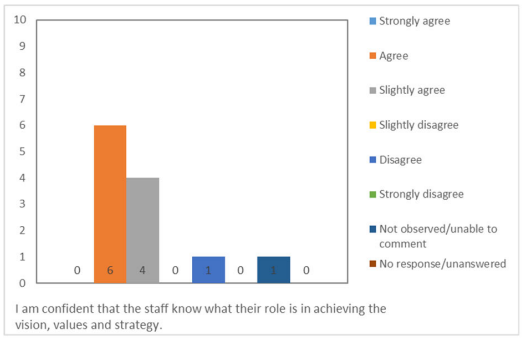


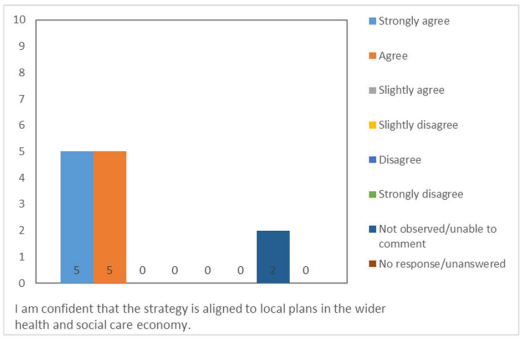


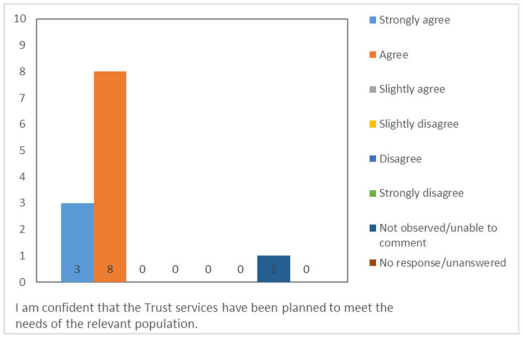


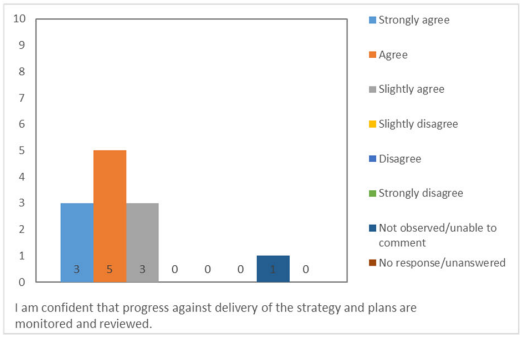






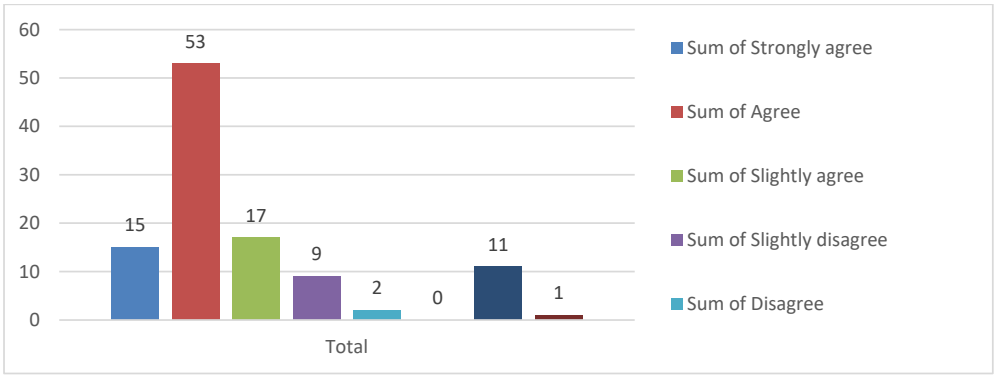




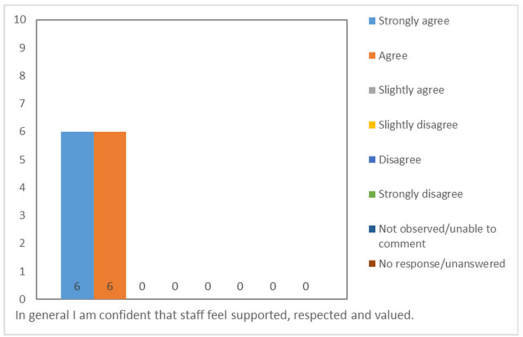


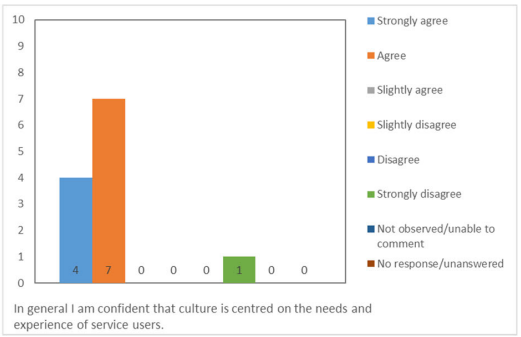
Culture

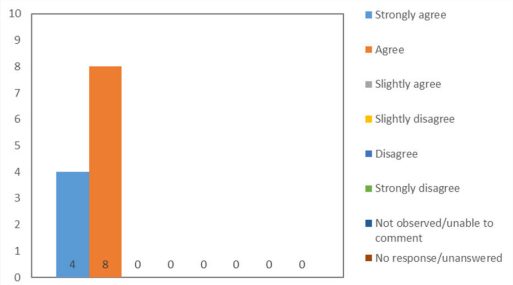
The below chart shows the total aggregate number of responses across each answer option for all of the Culture domain survey questions for Trust board members and attendees.



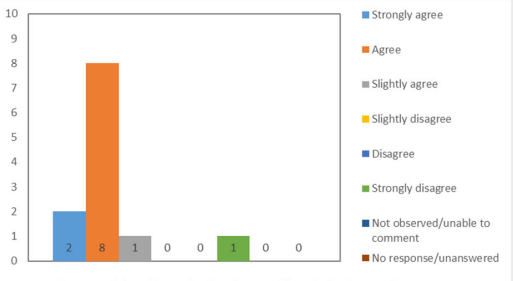
Individual question responses:



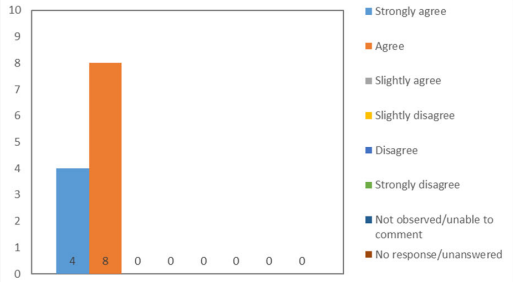




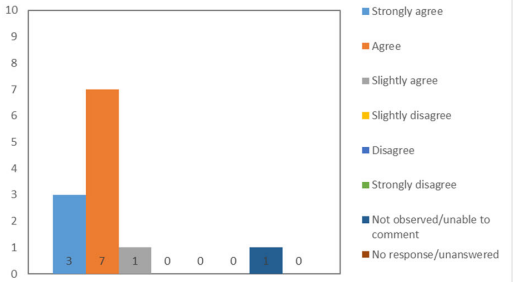
In general I am confident that staff feel positive and proud to work in the Trust.



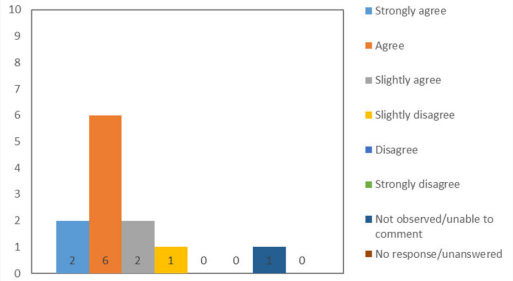
In general I am confident that action is taken to address behaviour and performance that it inconsistent with the vision and values, regardless of seniority.



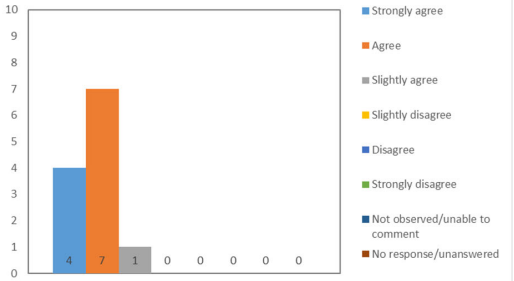
In general I am confident that the culture encourages openness and honesty at all levels of the Trust.



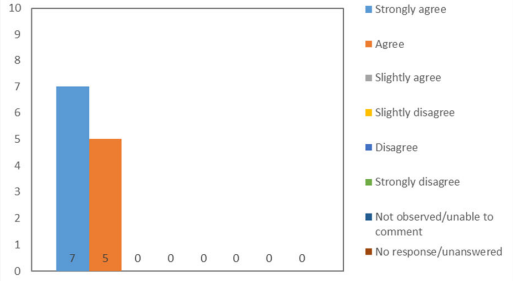
In general I am confident that leaders and staff are able to raise concerns without fear of retribution.



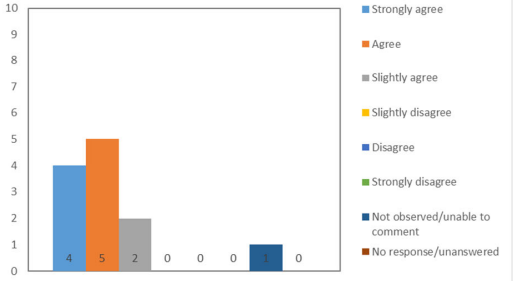
In general I am confident that appropriate learning and action takes place as a result of concerns raised.



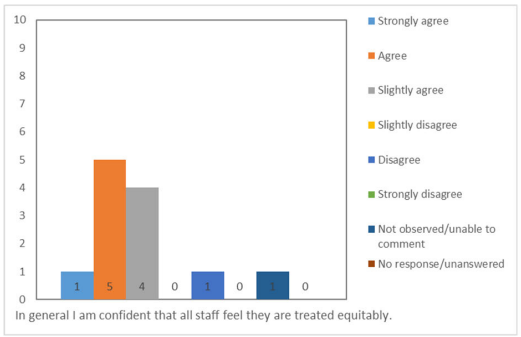
In general I am confident that there are mechanisms in place for all staff to receive the development they need.

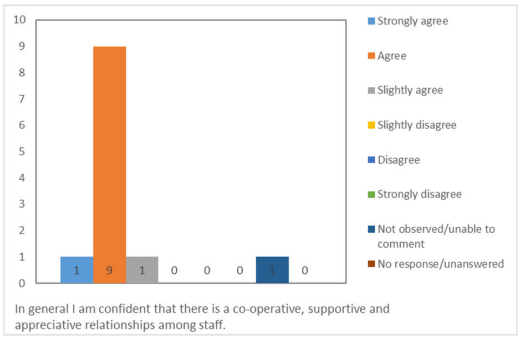


In general I am confident that there is a strong emphasis on safety and well-being of staff.



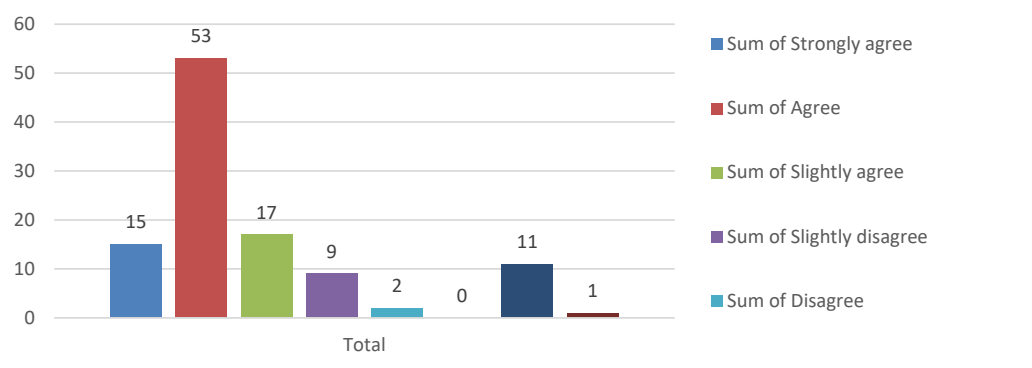
In general I am confident that equality and diversity are promoted within and beyond the Trust.



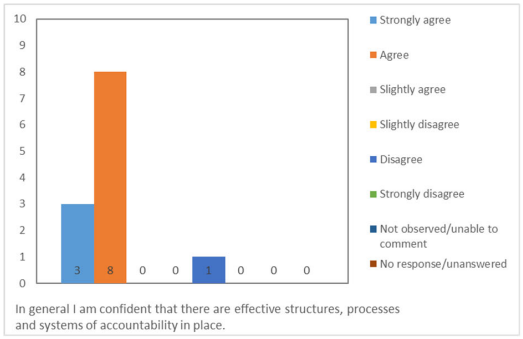


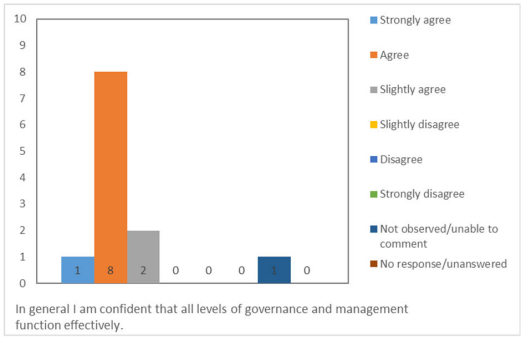
Roles

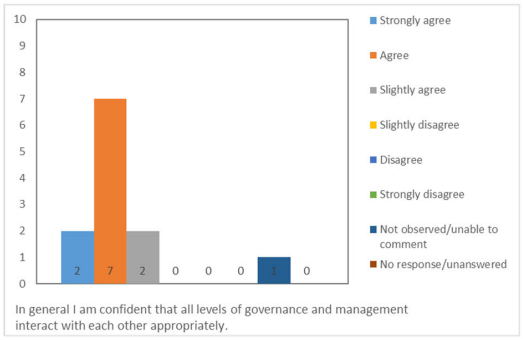
The below chart shows the total aggregate number of responses across each answer option for all of the Roles and Responsibilities domain survey questions for Trust board members and attendees.

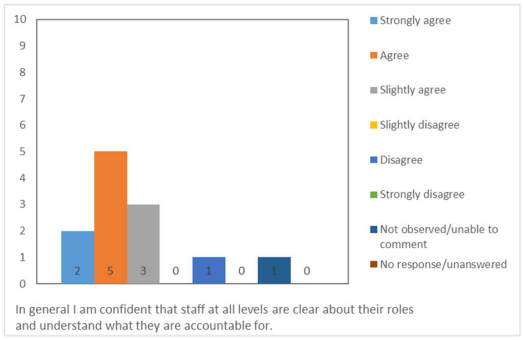


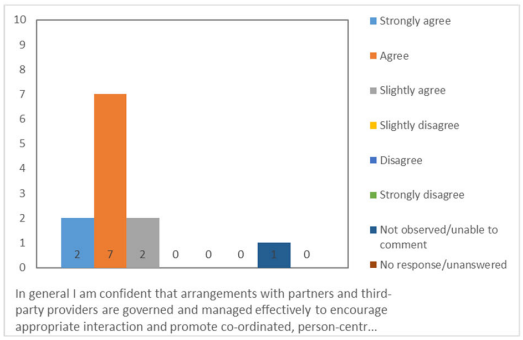
Individual question responses:





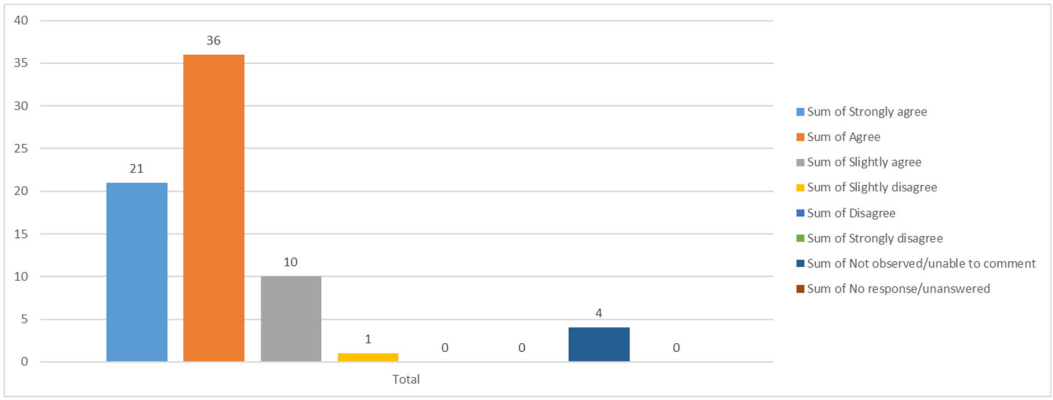




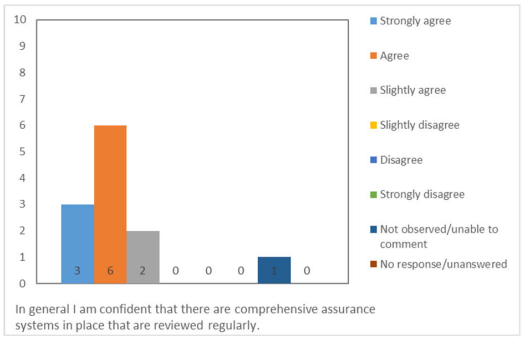


Risk & Performance

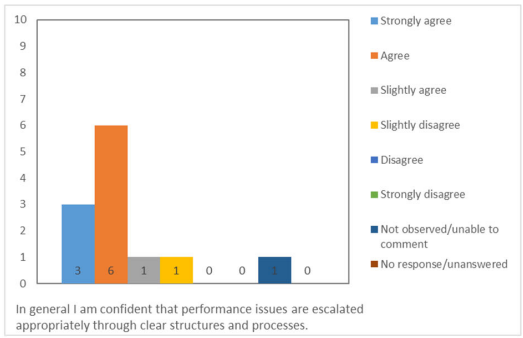
The below chart shows the total aggregate number of responses across each answer option for all of the Risk and Performance domain survey questions for Trust board members and attendees.



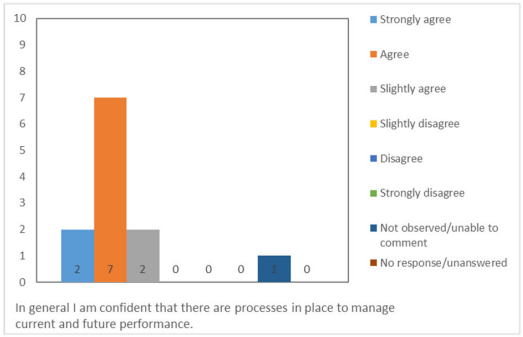
Individual question responses:



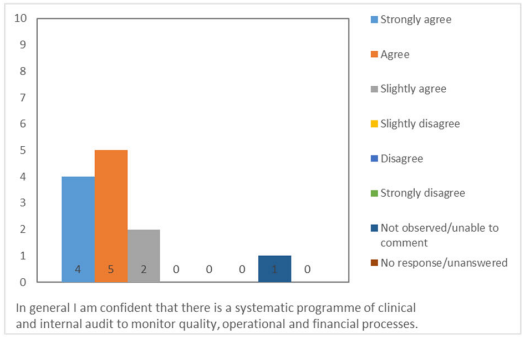
In general I am confident that there are comprehensive assurance systems in place that are reviewed regularly.



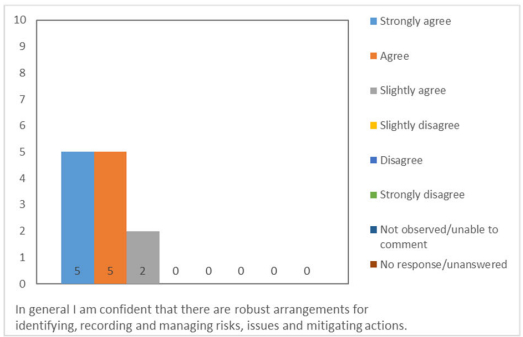
In general I am confident that performance issues are escalated appropriately through clear structures and processes.



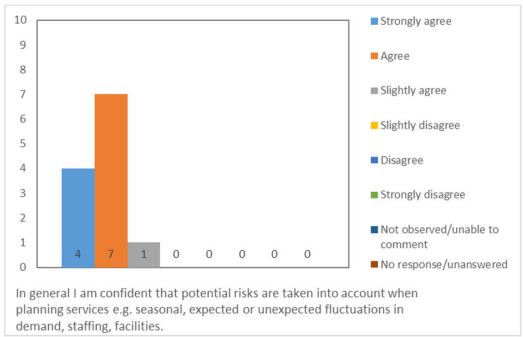
In general I am confident that there are processes in place to manage current and future performance.



In general I am confident that there is a systematic programme of clinical and internal audit to monitor quality, operational and financial processes.



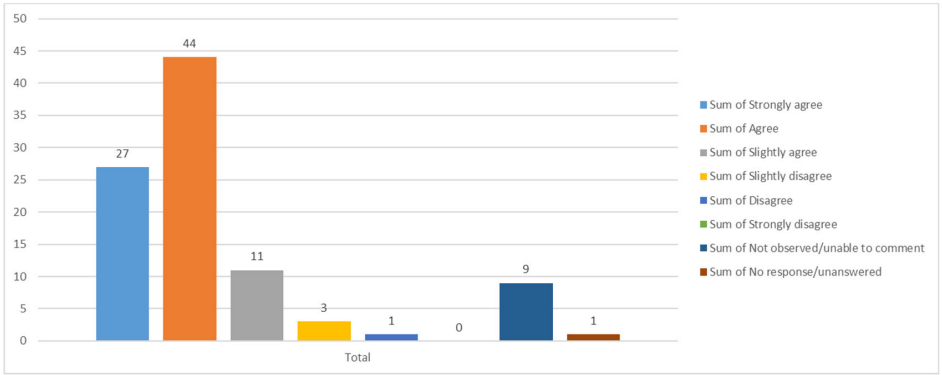
In general I am confident that there are robust arrangements for identifying, recording and managing risks, issues and mitigating actions.



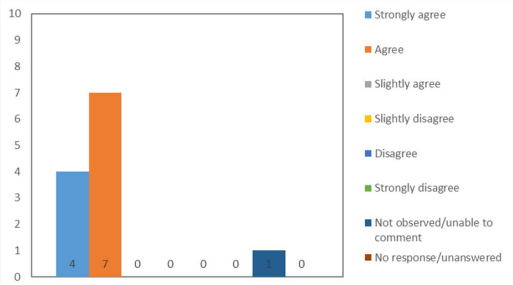
In general I am confident that potential risks are taken into account when planning services e.g. seasonal, expected or unexpected fluctuations in demand, staffing, facilities.

Information

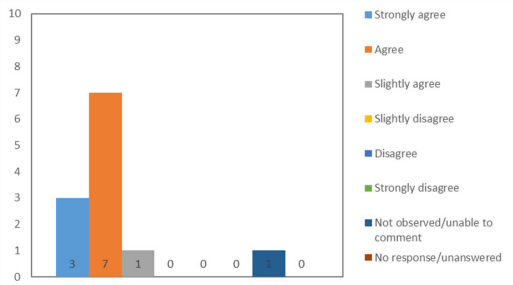
The below chart shows the total aggregate number of responses across each answer option for all of the Information domain survey questions for Trust board members and attendees.



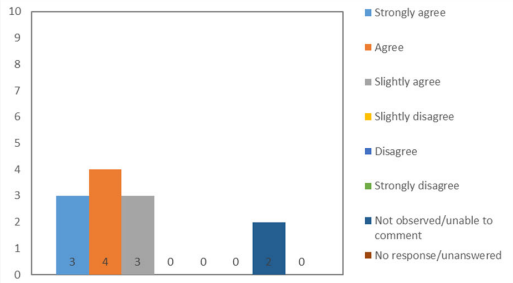
Individual question responses:



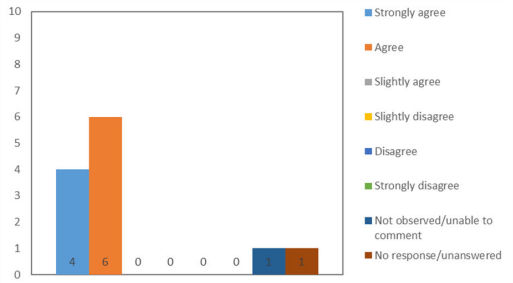
In general I am confident that there is sufficient information provided on quality, operations and finance to understand performance.



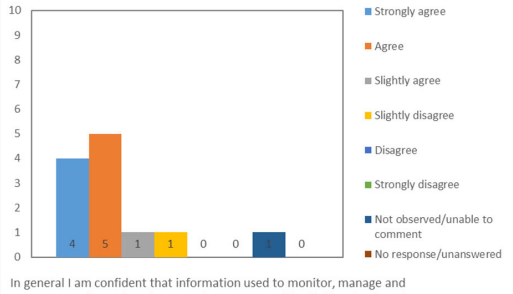
In general I am confident that quality and operational/financial sustainability receive sufficient coverage in relevant meetings at all levels.



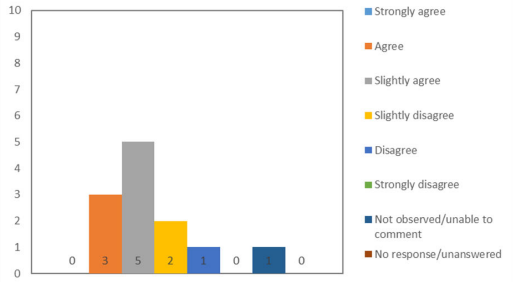
In general I am confident that all staff have access to information and can challenge it appropriately.



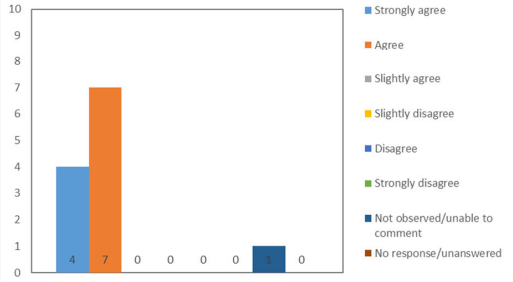
In general I am confident that there are clear and robust service performance measures that are regularly reported and monitored.



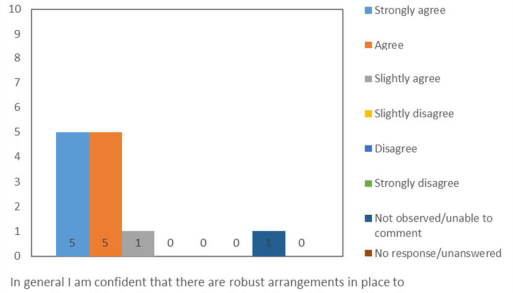
In general I am confident that information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.



In general I am confident that information technology systems are used effectively to monitor and improve the quality of care.



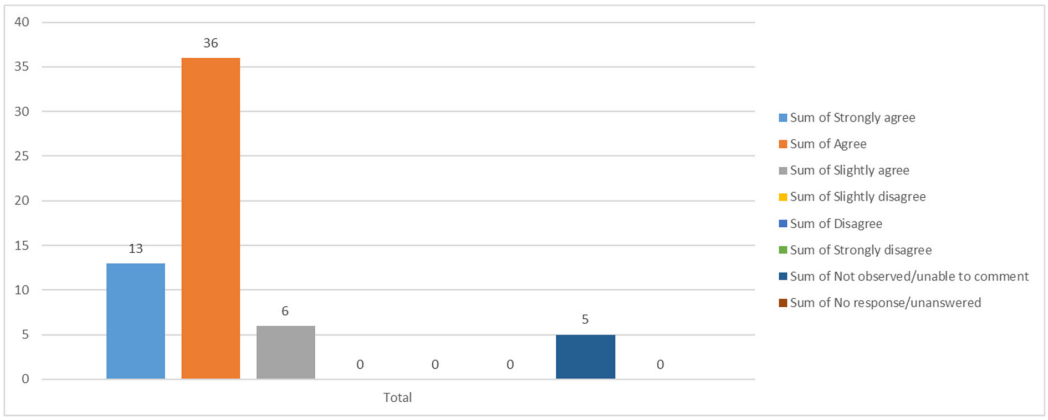
In general I am confident that there are effective arrangements to ensure that data or notifications are submitted to external bodies as required.

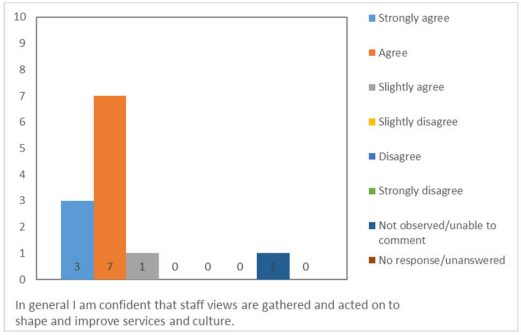


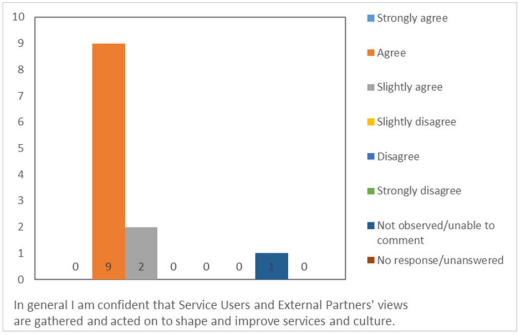
In general I am confident that there are robust arrangements in place to ensure the availability, integrity and confidentiality of data, records and data management systems.

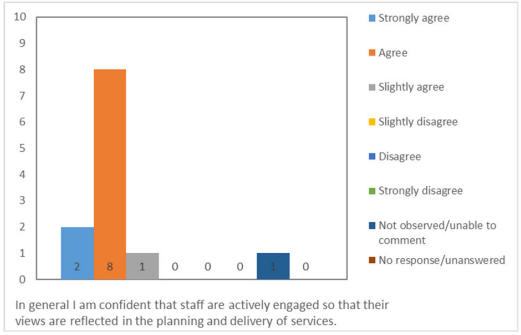
Engagement

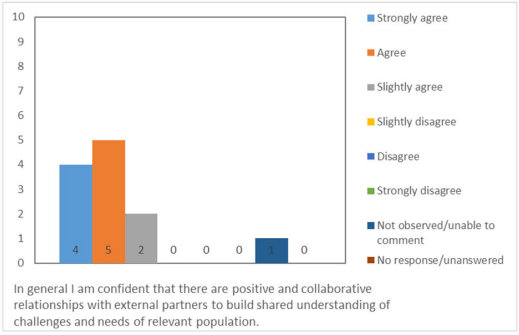
The below chart shows the total aggregate number of responses across each answer option for all of the Engagement domain survey questions for Trust board members and attendees.

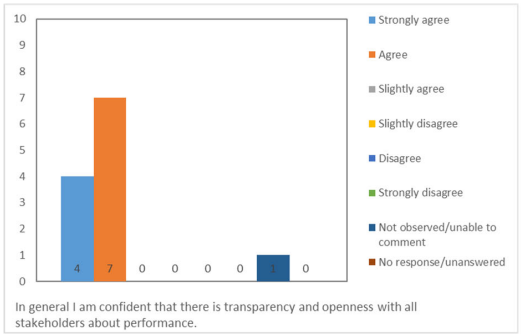






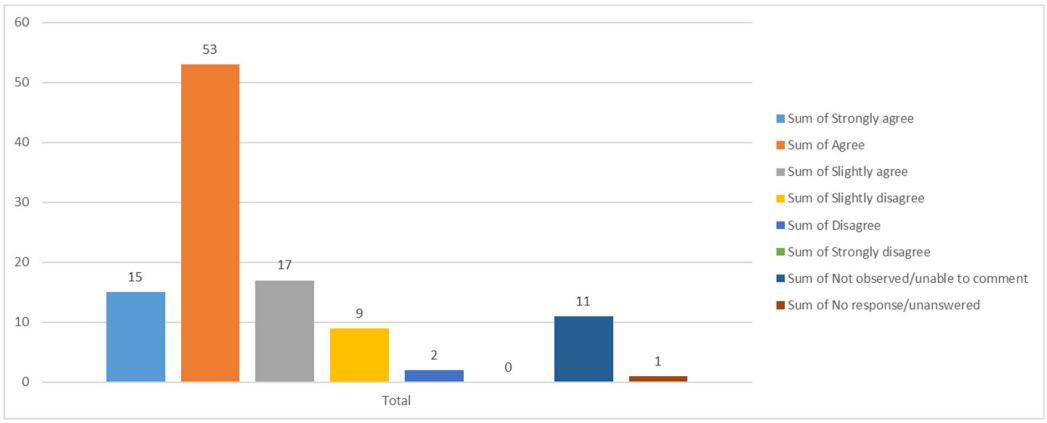


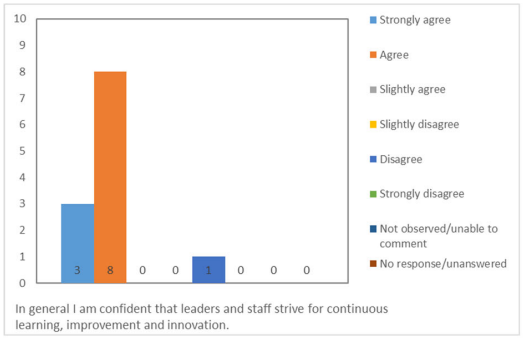


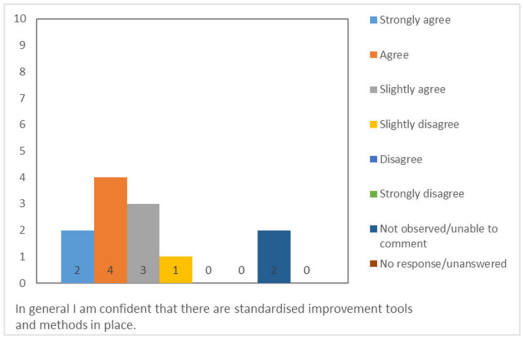


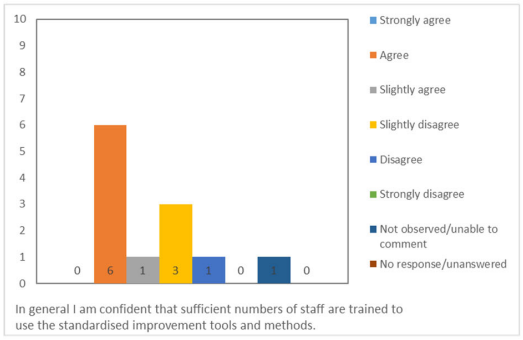
Learning

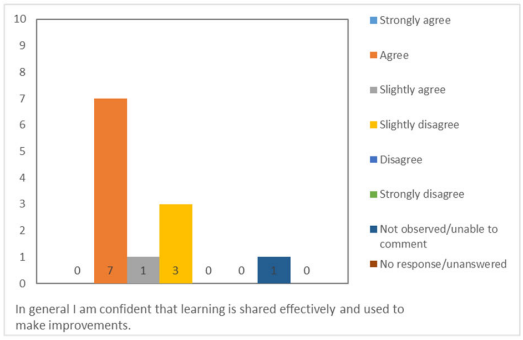
The below chart shows the total aggregate number of responses across each answer option for all of the Learning domain survey questions for Trust board members and attendees.

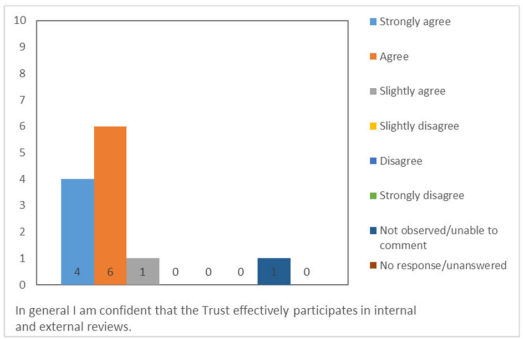


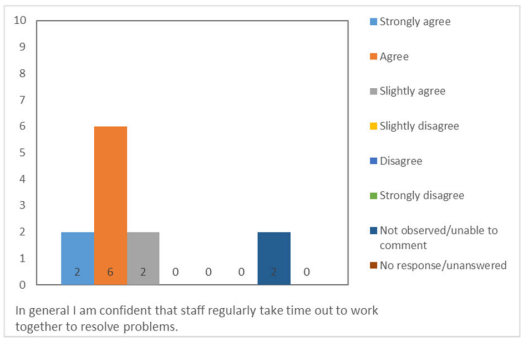


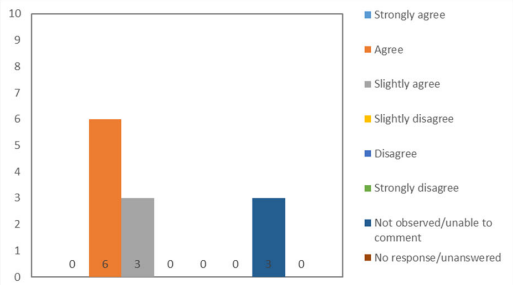




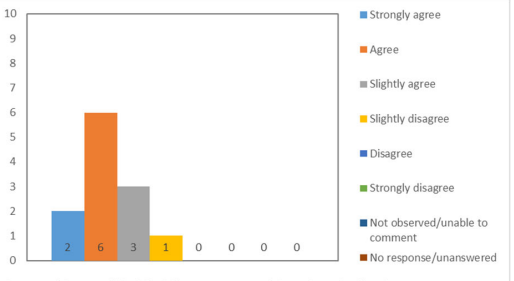




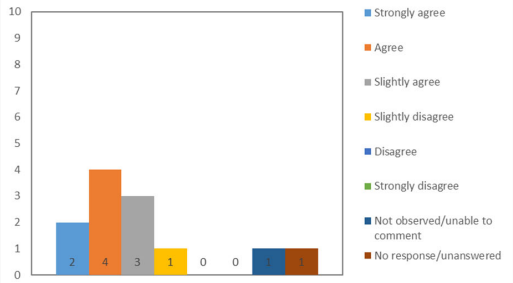




In general I am confident that staff regularly take time out to review individual and team objectives, processes and performance.



In general I am confident that there are appropriate systems in place to support improvement and innovation work e.g. objectives and rewards for staff, data systems.

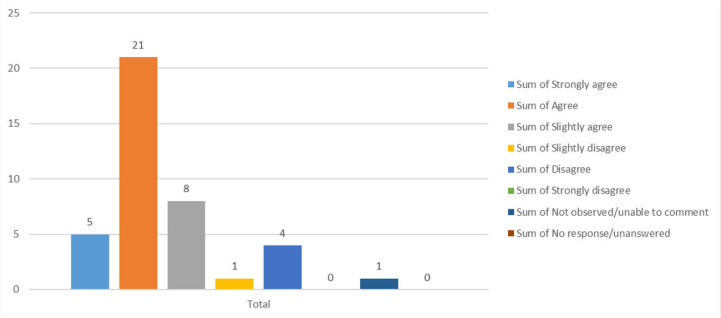


In general I am confident that there are processes in place to evaluate and share the results of improvement work.

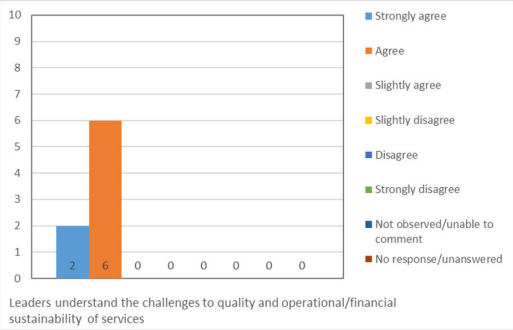
Senior Leadership Team

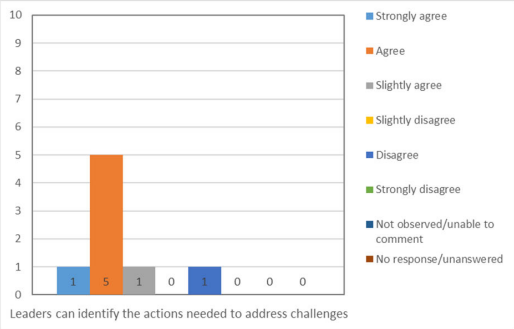
Leadership

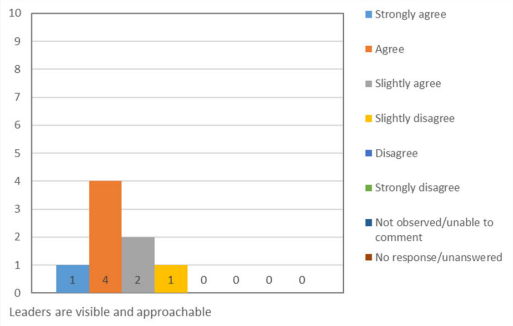
The below chart shows the total aggregate number of responses across each answer option for all of the Leadership domain survey questions for the Senior Leadership Team.

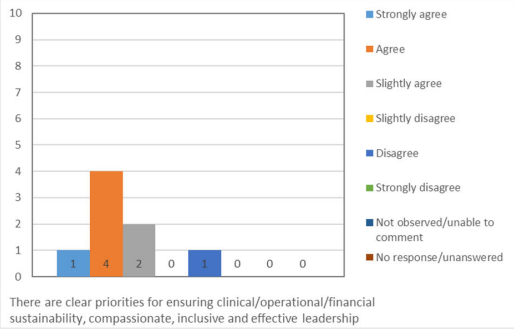


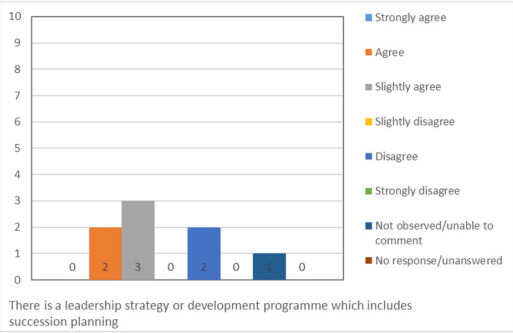
Individual question responses:





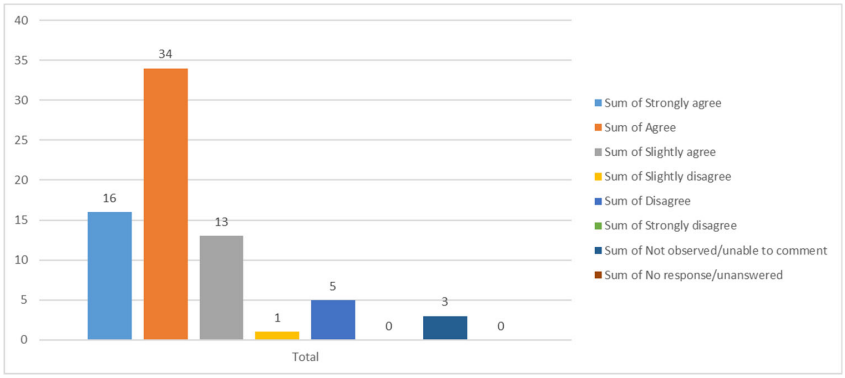




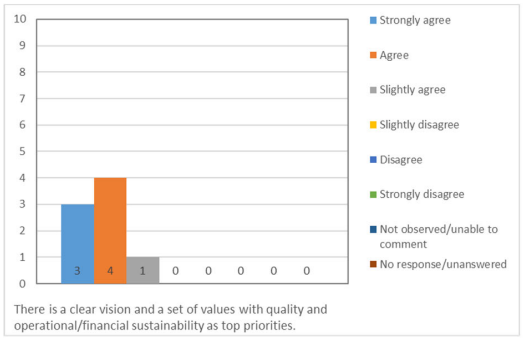


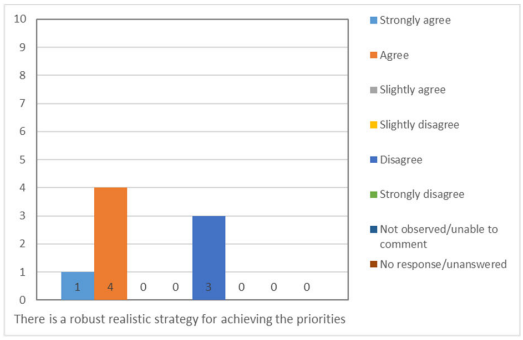
Strategy

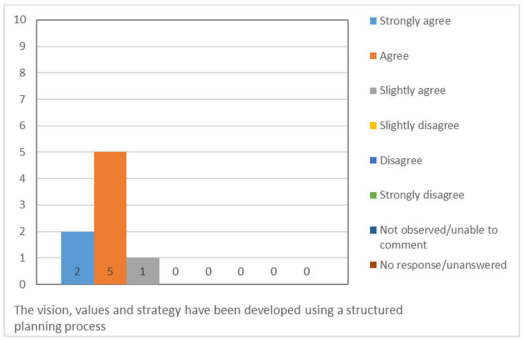
The below chart shows the total aggregate number of responses across each answer option for all of the Strategy domain survey questions for the Senior Leadership Team.

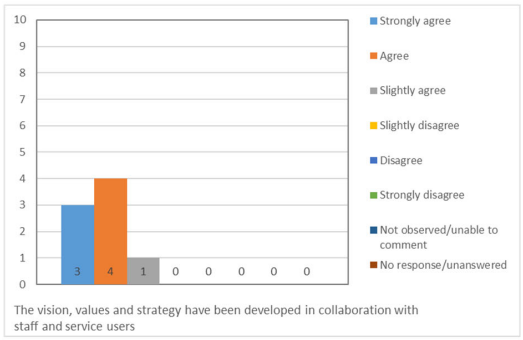


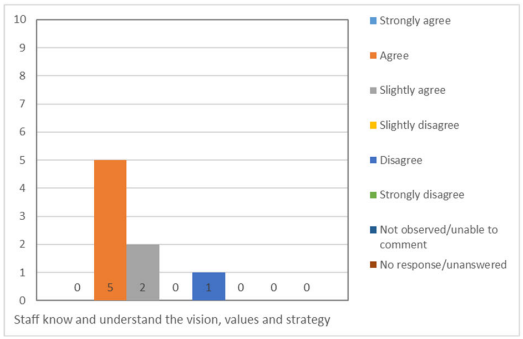
Individual question responses:

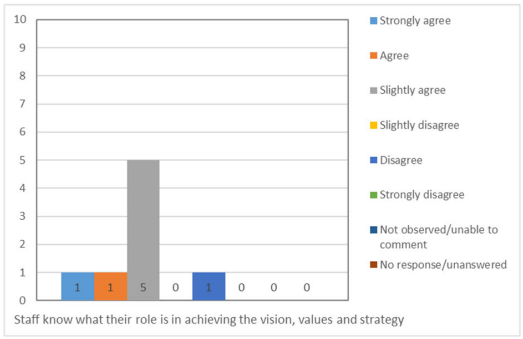


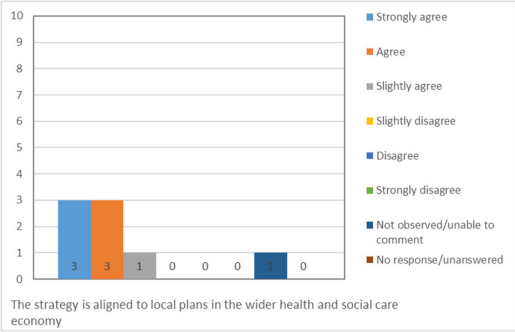


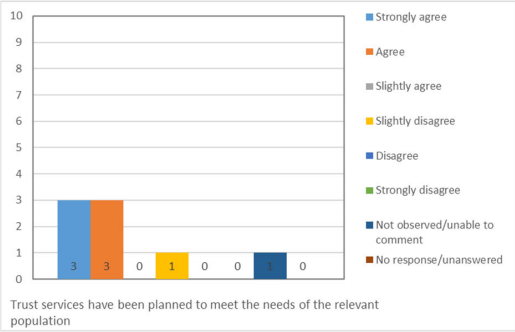


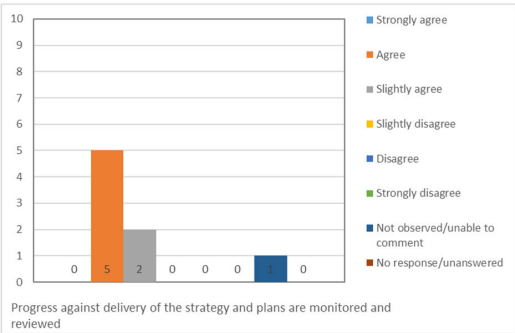






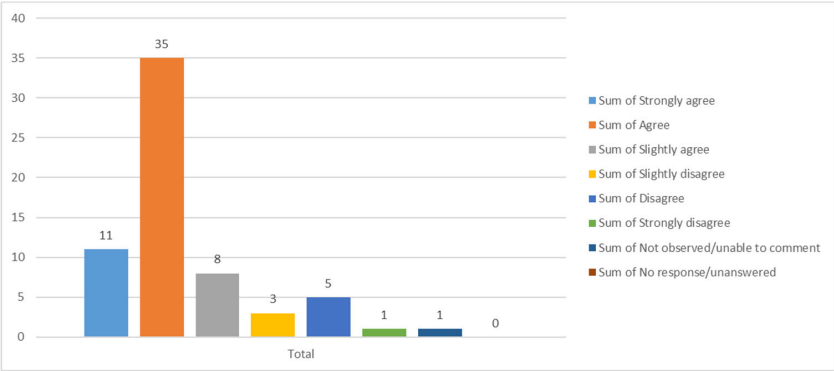




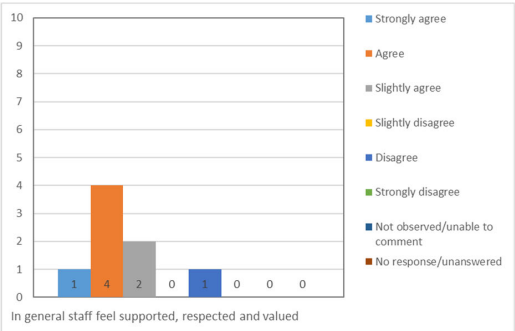


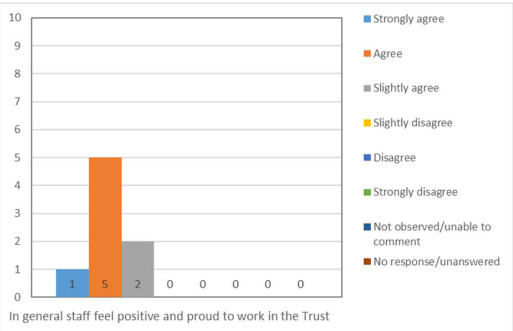
Culture

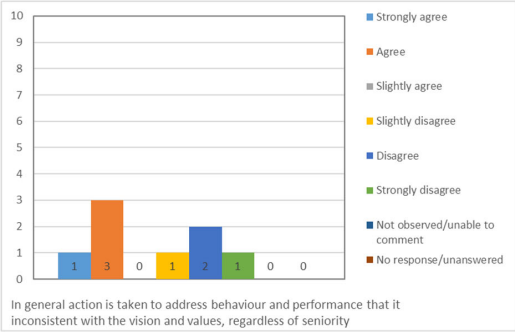
The below chart shows the total aggregate number of responses across each answer option for all of the Culture domain survey questions for the Senior Leadership Team.



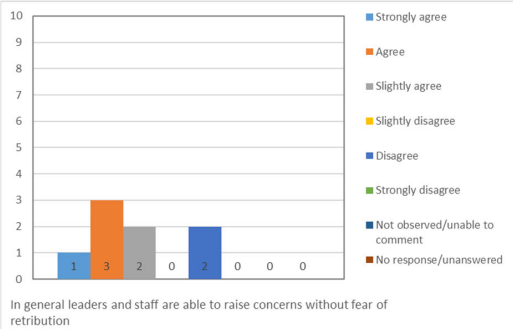
Individual question responses:



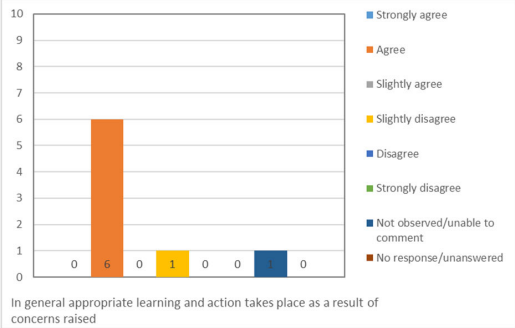




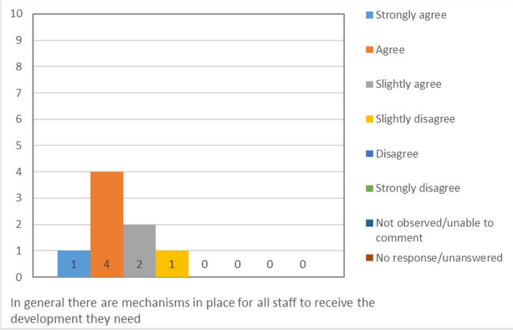
In general action is taken to address behaviour and performance that it inconsistent with the vision and values, regardless of seniority



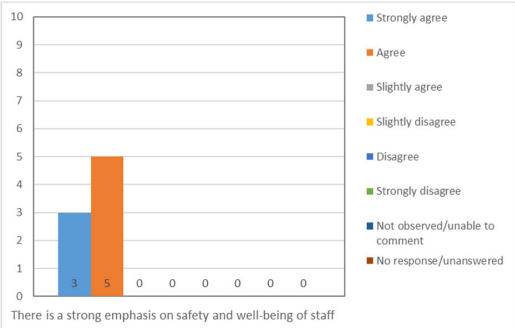
In general leaders and staff are able to raise concerns without fear of retribution



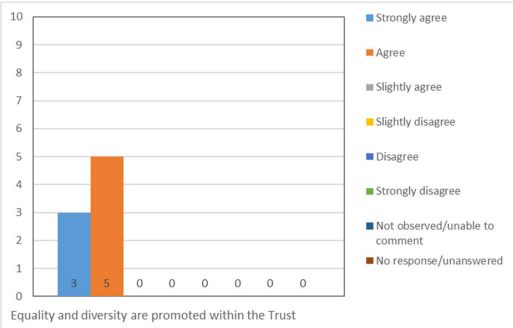
In general appropriate learning and action takes place as a result of concerns raised



In general there are mechanisms in place for all staff to receive the development they need



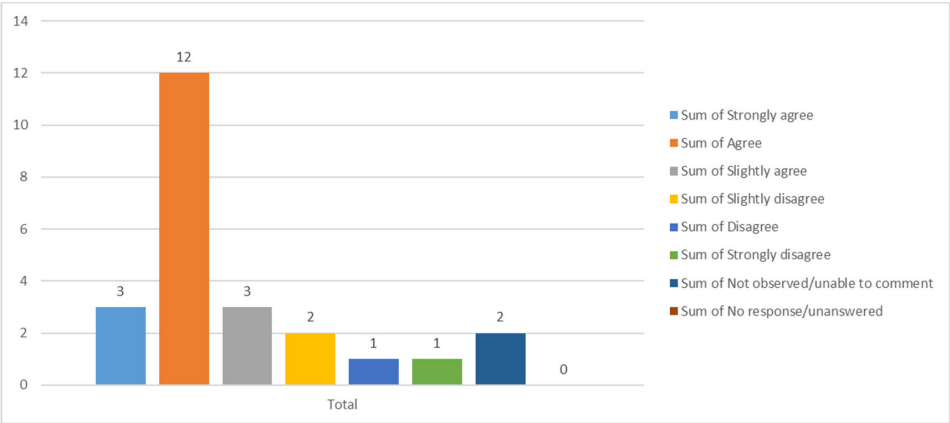
There is a strong emphasis on safety and well-being of staff



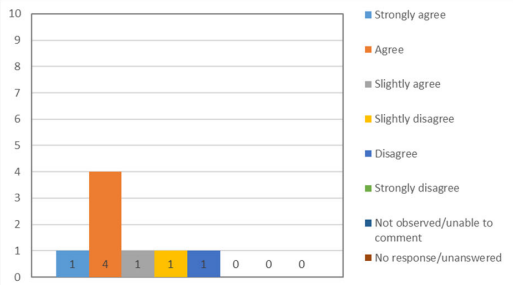
Equality and diversity are promoted within the Trust

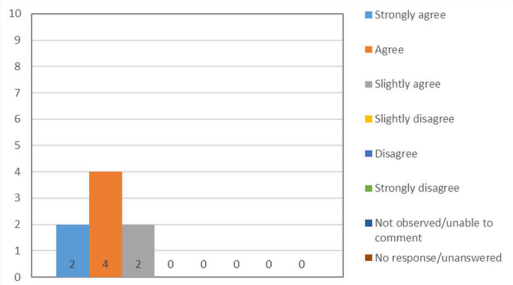
Roles

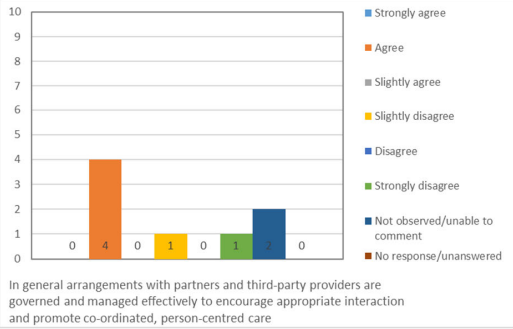
The below chart shows the total aggregate number of responses across each answer option for all of the Roles and Responsibilities domain survey questions for the Senior Leadership Team.



Individual question responses:

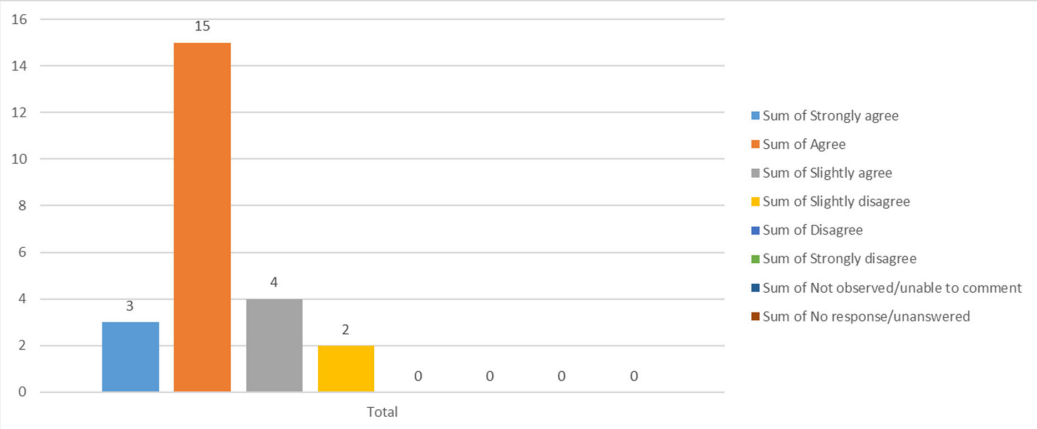




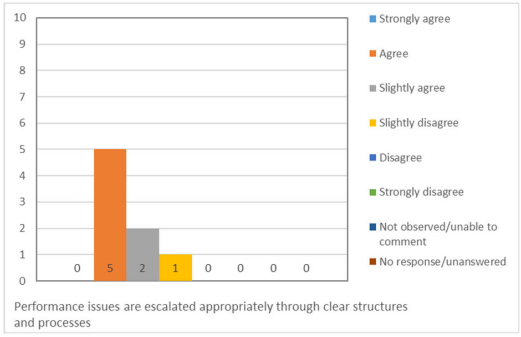


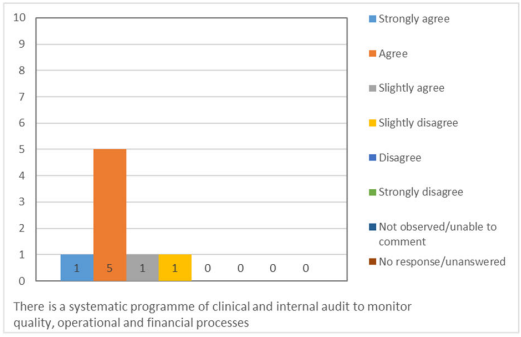
Risk & Performance

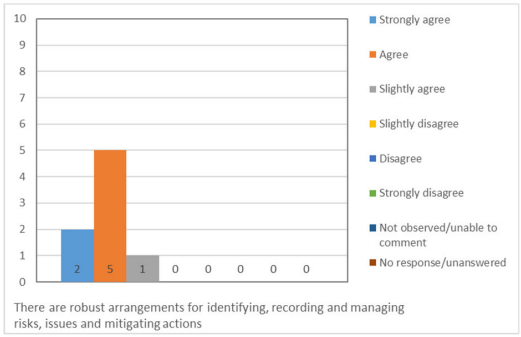
The below chart shows the total aggregate number of responses across each answer option for all of the Risk and Performance domain survey questions for the Senior Leadership Team.



Individual question responses:

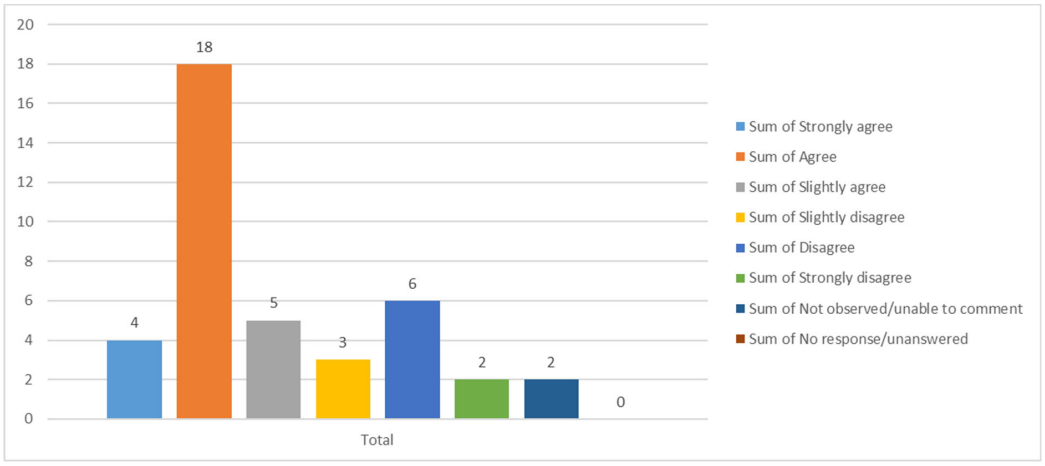




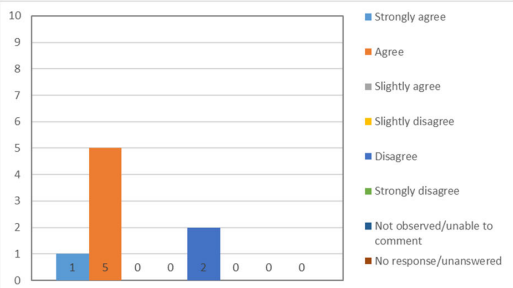


Information

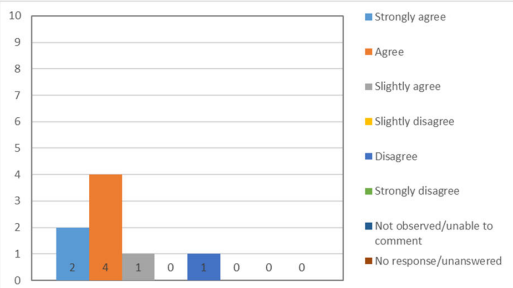
The below chart shows the total aggregate number of responses across each answer option for all of the Information domain survey questions for the Senior Leadership Team.



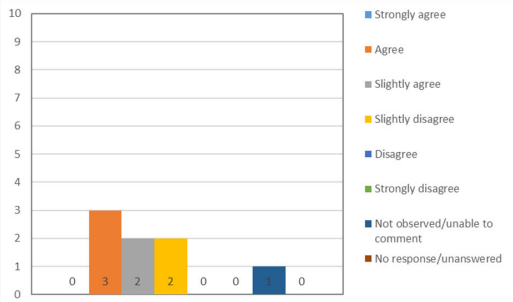
Individual question responses:



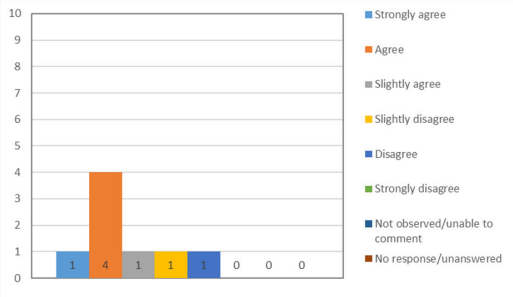
There is sufficient information provided on quality, operations and finance to understand performance



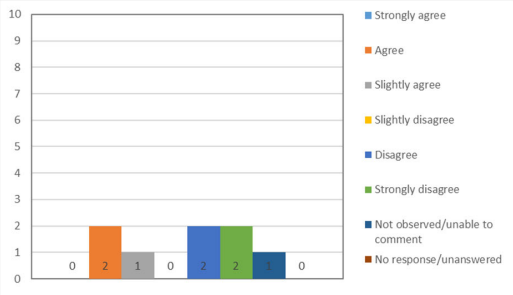
Quality and operational/financial sustainability of services receive sufficient coverage in relevant meetings at all levels



All staff have access to information and can challenge it appropriately



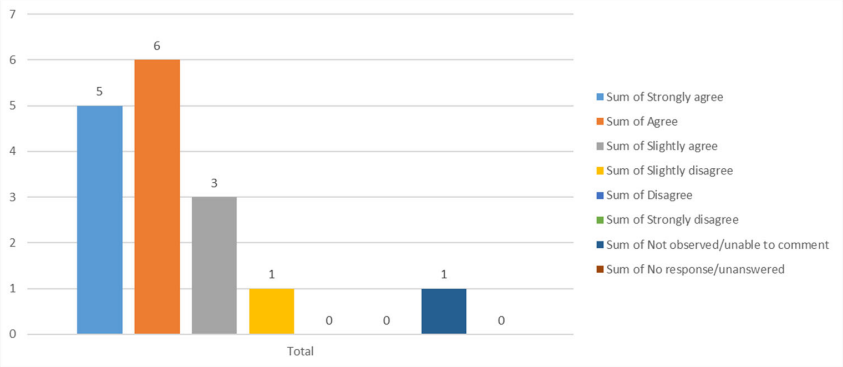
Information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant



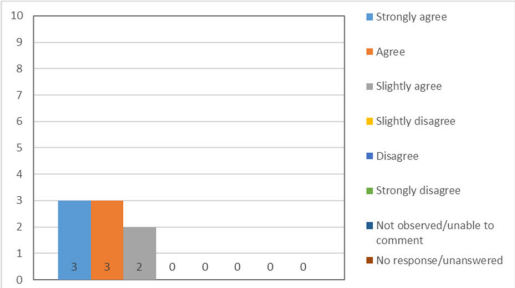
Information technology systems are used effectively to monitor and improve the quality of care

Engagement

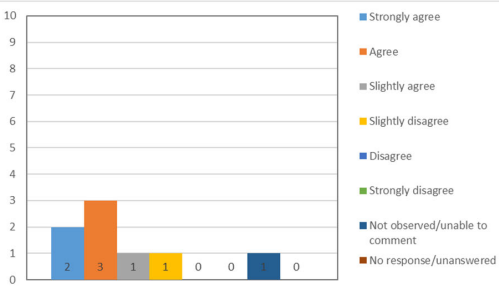
The below chart shows the total aggregate number of responses across each answer option for all of the Engagement domain survey questions for the Senior Leadership Team.



Individual question responses:



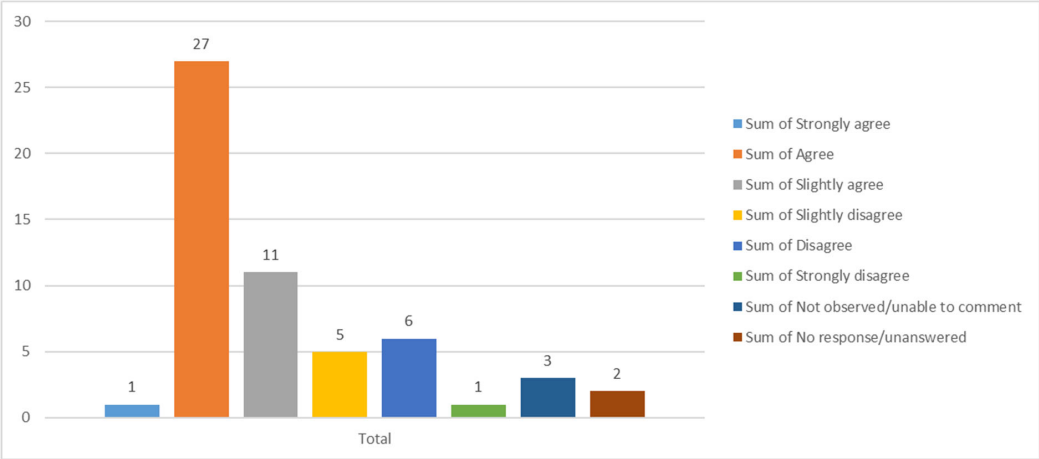
Staff views are gathered and acted on to shape and improve services and culture



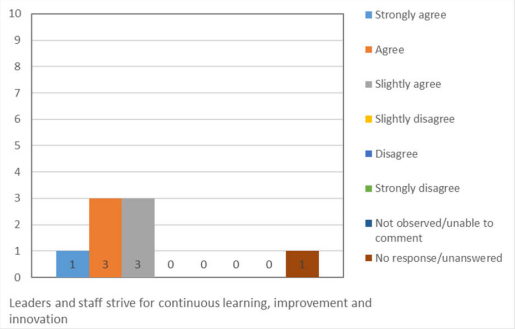
Service Users and External Partners' views are gathered and acted on to shape and improve services and culture

Learning

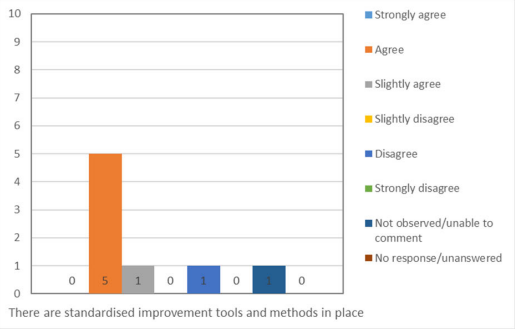
The below chart shows the total aggregate number of responses across each answer option for all of the Learning domain survey questions for the Senior Leadership Team.



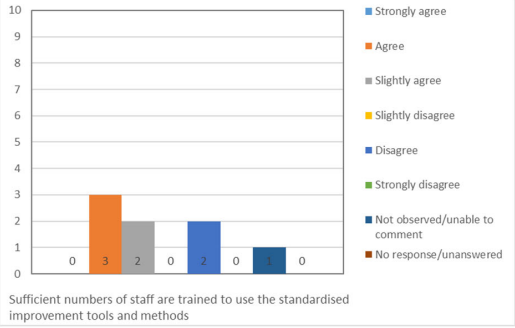
Individual question responses:



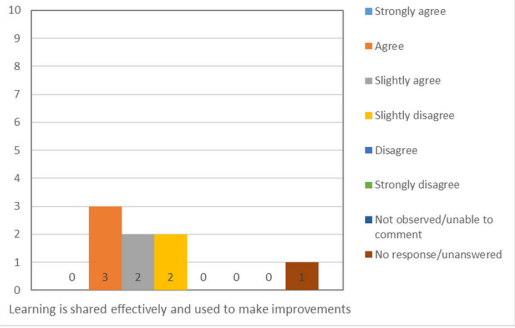
Leaders and staff strive for continuous learning, improvement and innovation



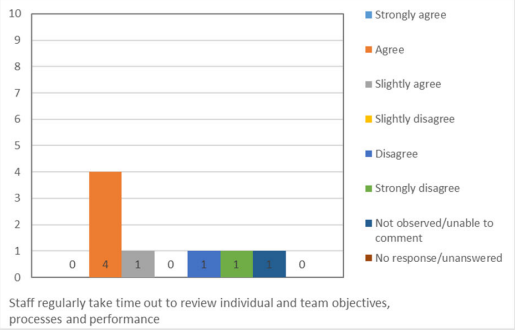
There are standardised improvement tools and methods in place



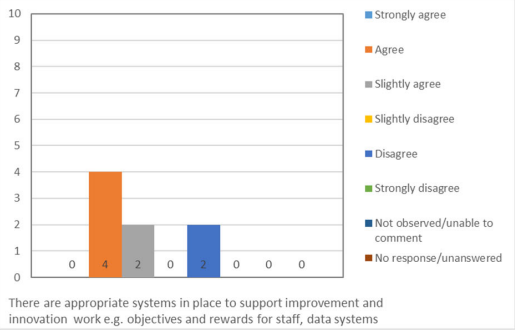
Sufficient numbers of staff are trained to use the standardised improvement tools and methods



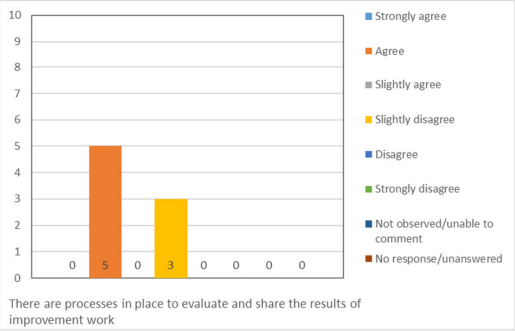
Learning is shared effectively and used to make improvements



Staff regularly take time out to review individual and team objectives, processes and performance



There are appropriate systems in place to support improvement and innovation work e.g. objectives and rewards for staff, data systems

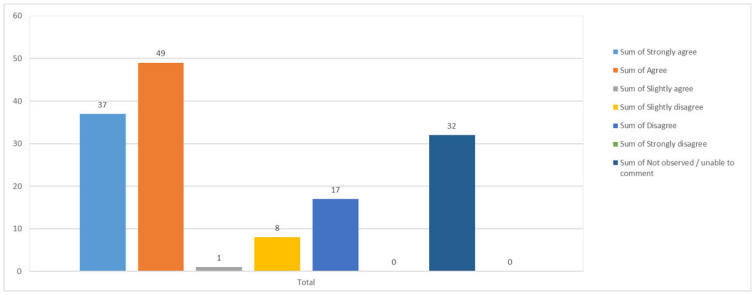


There are processes in place to evaluate and share the results of improvement work

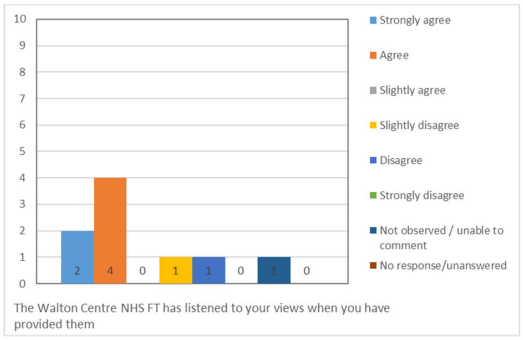
External stakeholders

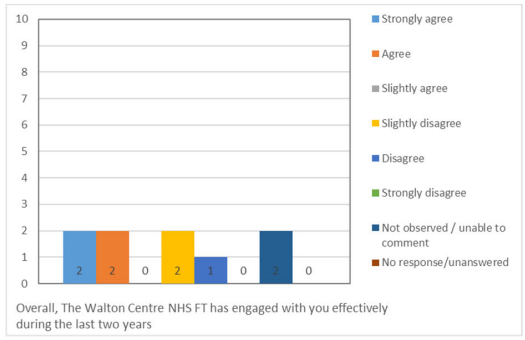
Engagement

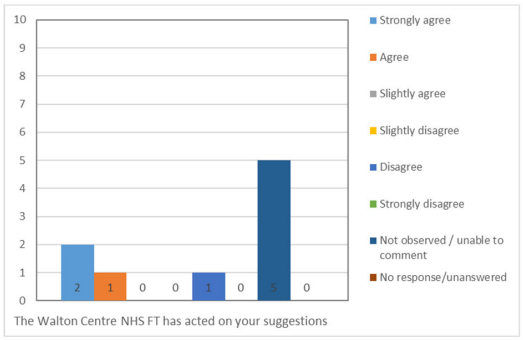
The below chart shows the total aggregate number of responses across each answer option for all of the Engagement domain survey questions for external stakeholders.

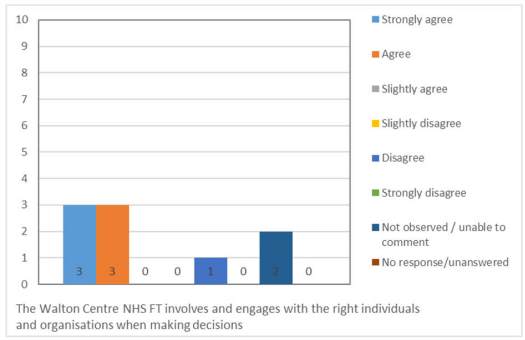


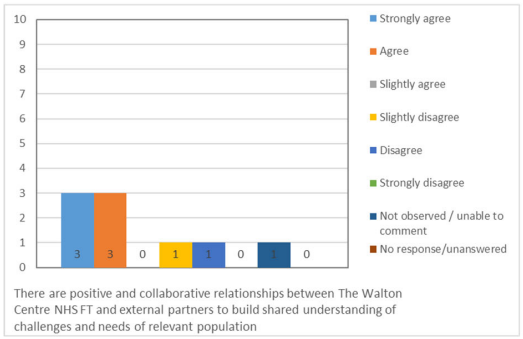
Individual question responses:

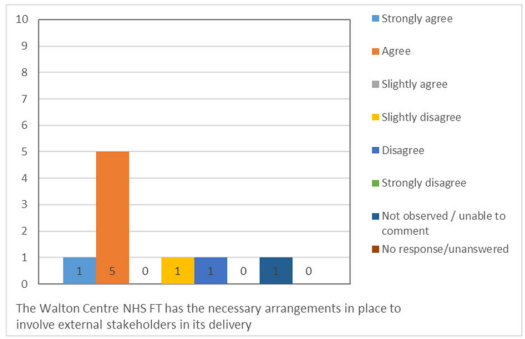


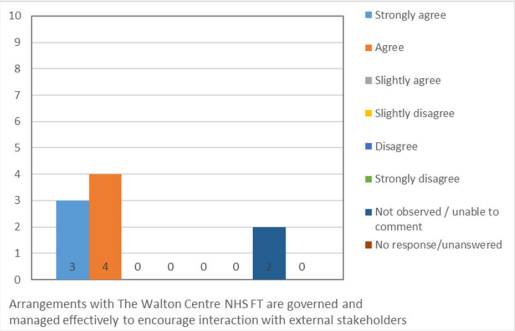




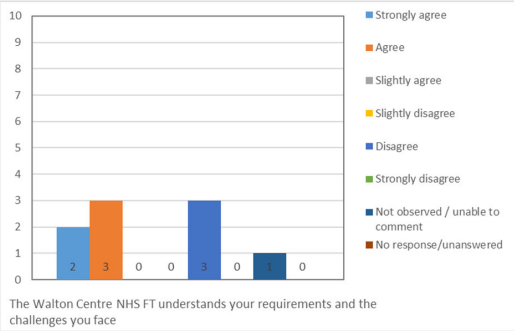




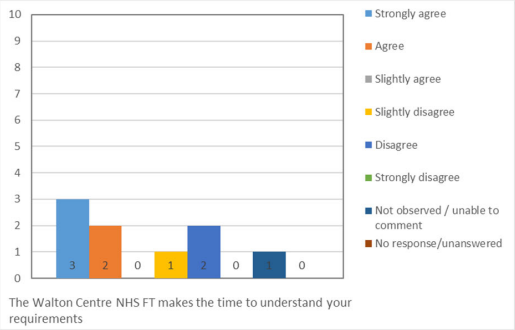




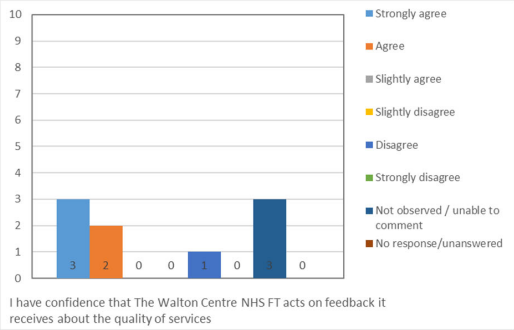
Arrangements with The Walton Centre NHS FT are governed and managed effectively to encourage interaction with external stakeholders



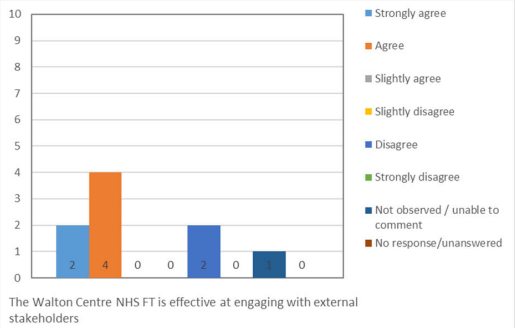
The Walton Centre NHS FT understands your requirements and the challenges you face



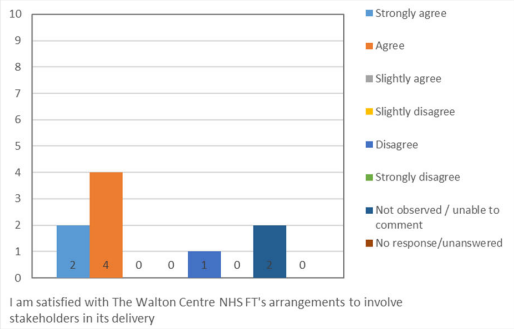
The Walton Centre NHS FT makes the time to understand your requirements



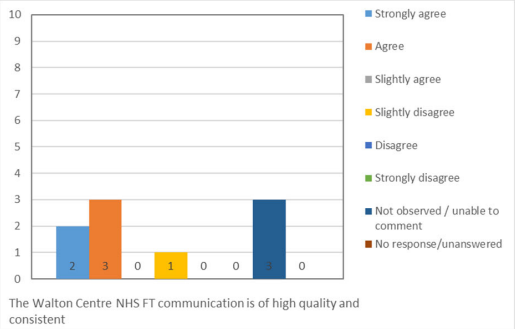
I have confidence that The Walton Centre NHS FT acts on feedback it receives about the quality of services



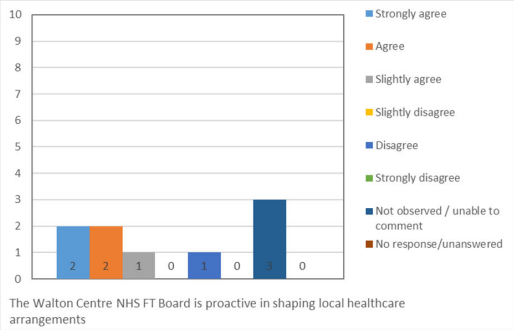
The Walton Centre NHS FT is effective at engaging with external stakeholders



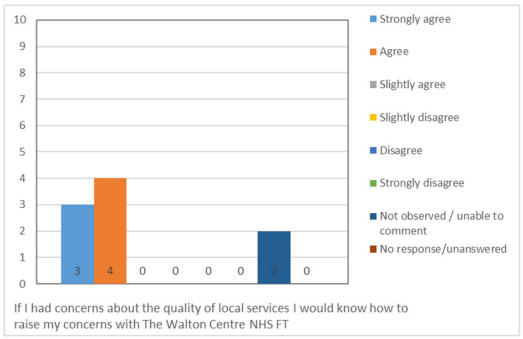
I am satisfied with The Walton Centre NHS FT's arrangements to involve stakeholders in its delivery

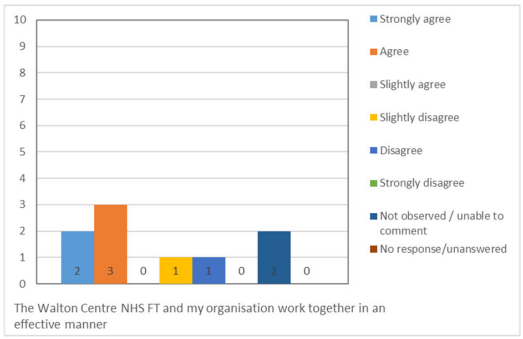


The Walton Centre NHS FT communication is of high quality and consistent



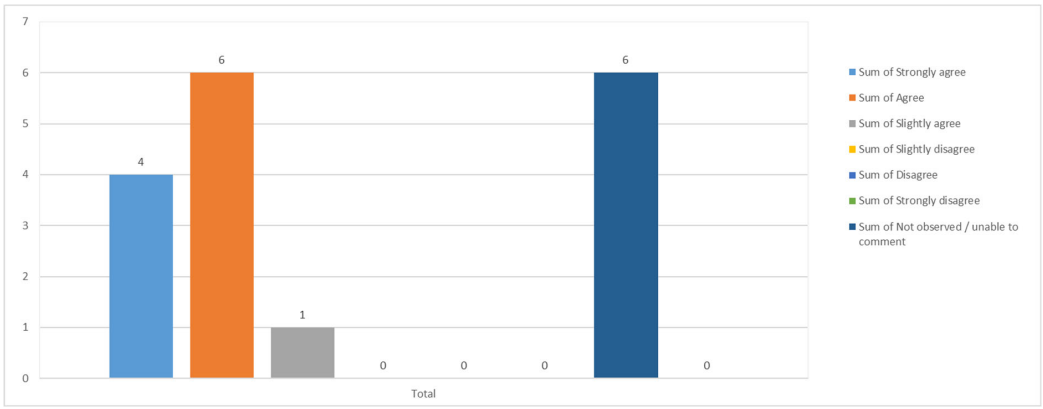
The Walton Centre NHS FT Board is proactive in shaping local healthcare arrangements



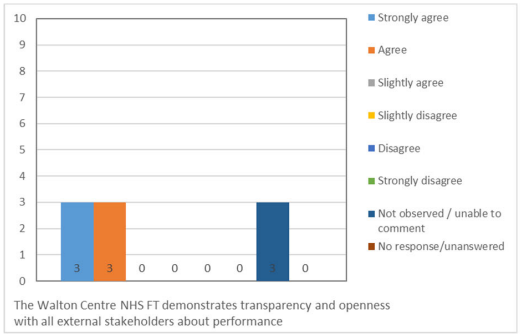


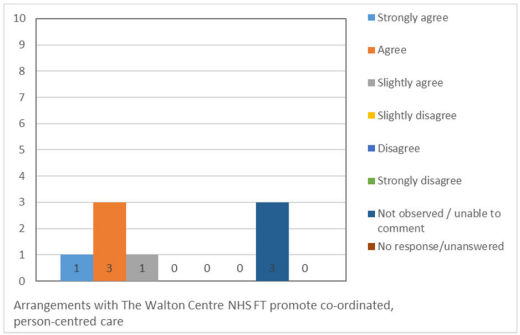
Culture

The below chart shows the total aggregate number of responses across each answer option for all of the Culture domain survey questions for external stakeholders.



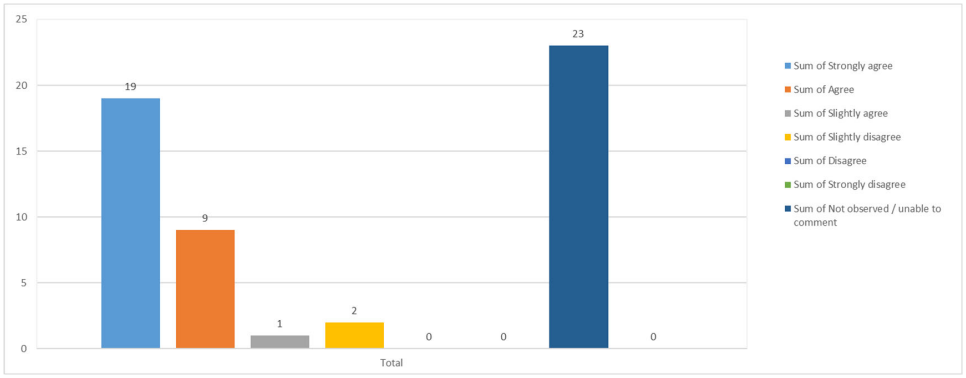
Individual question responses:



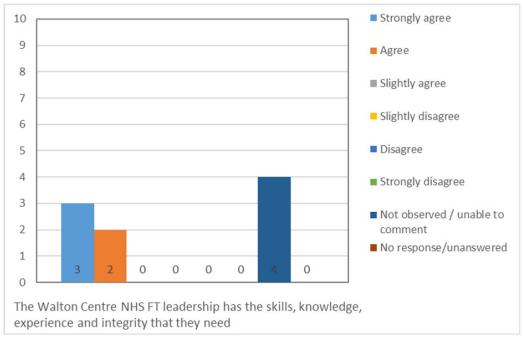


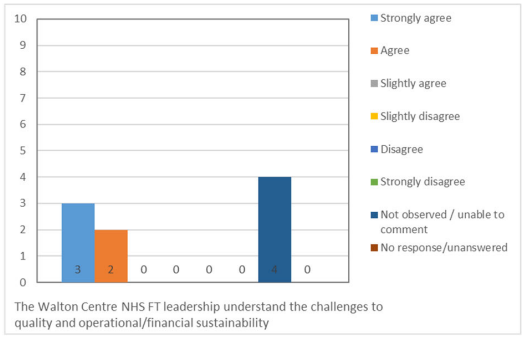
Leadership

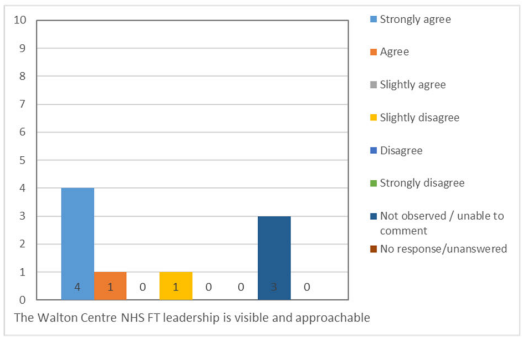
The below chart shows the total aggregate number of responses across each answer option for all of the Leadership domain survey questions for external stakeholders.

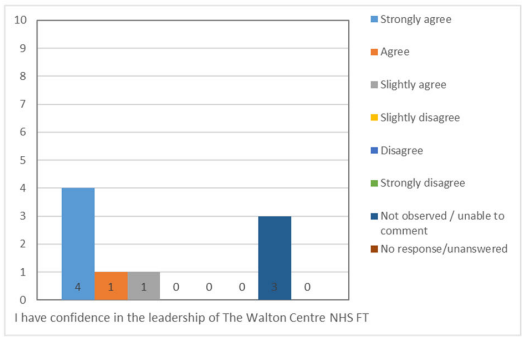


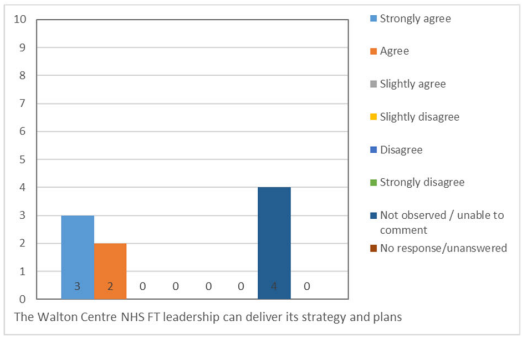
Individual question responses:

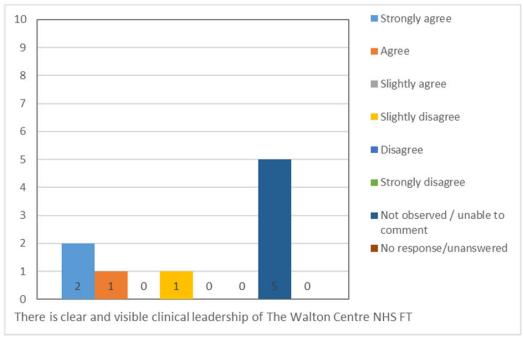






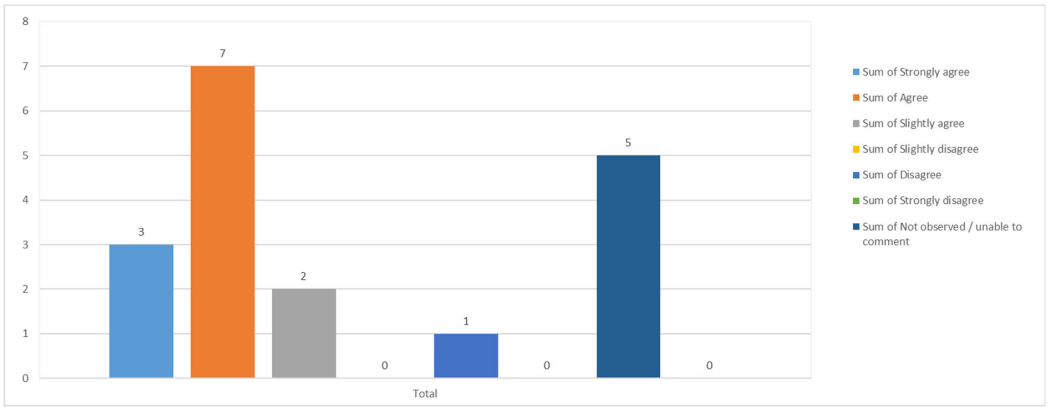




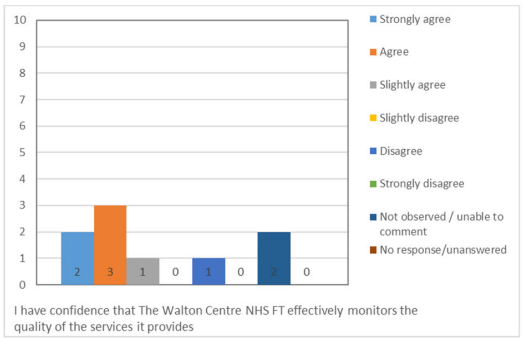


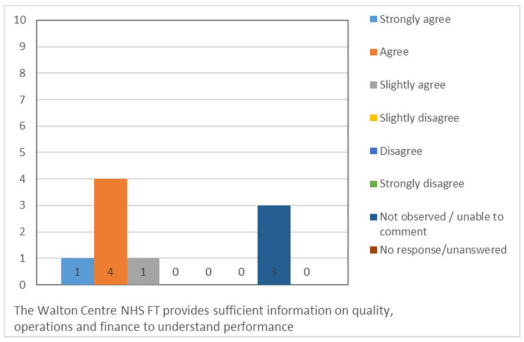
Information

The below chart shows the total aggregate number of responses across each answer option for all of the Information domain survey questions for external stakeholders.



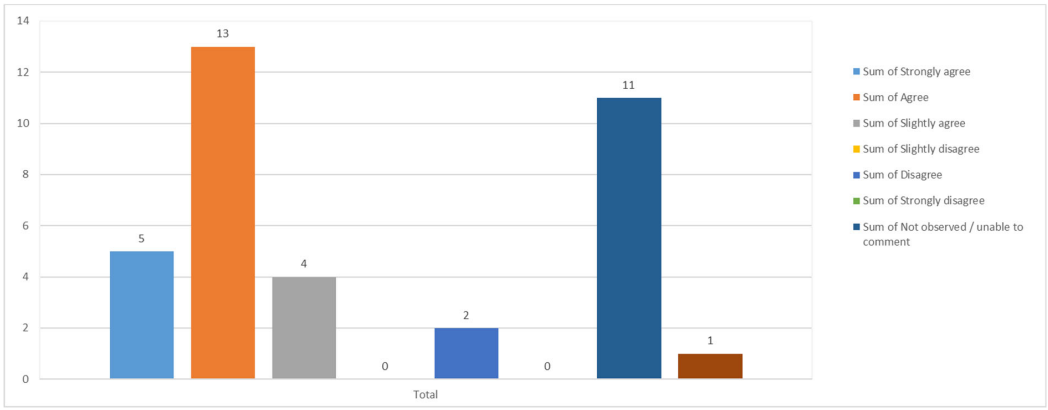
Individual question responses:



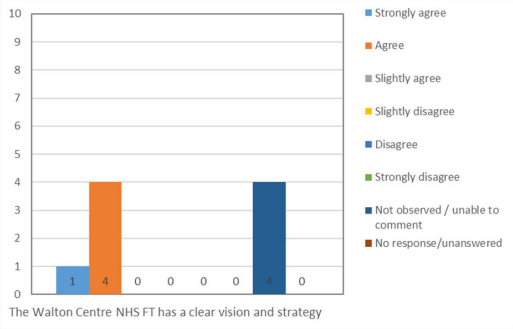


Strategy

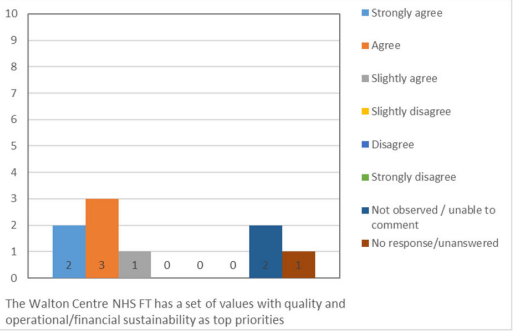
The below chart shows the total aggregate number of responses across each answer option for all of the Strategy domain survey questions for external stakeholders.



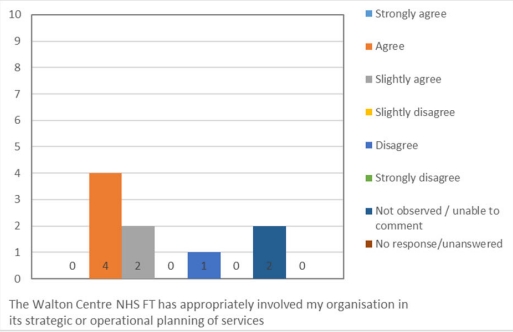
Individual question responses:



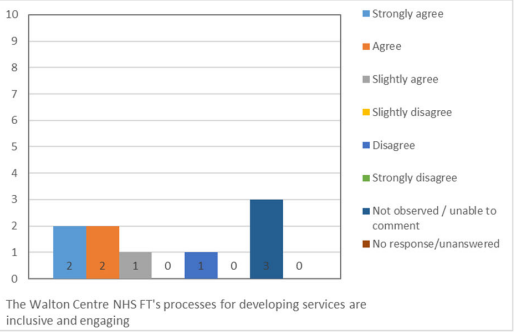
The Walton Centre NHS FT has a clear vision and strategy



The Walton Centre NHS FT has a set of values with quality and operational/financial sustainability as top priorities



The Walton Centre NHS FT has appropriately involved my organisation in its strategic or operational planning of services



The Walton Centre NHS FT's processes for developing services are inclusive and engaging

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26/04/23		**Report of:** Joint Site Committee Meeting		
Date of last meeting: 26/04/23		**Membership Numbers:** Quorate		
1.	**Agenda**	The Committee considered an agenda which included the following: • Draft Terms of Reference (ToR) of the Joint Committee • Development of a Joint Committee Workplan		
2.	**Alert**	• The Committee reviewed and approved the draft Committee ToR and recommended it to be taken to their individual Boards with the caveat that the Integrated Care Board governance arrangements that sit above the Joint Committee are still emerging and therefore there are likely to be further revisions to the ToR as early as the next Board meeting.		
	Assurance	• The development of the draft Joint Site Committee workplan will reflect the recommendations from the Liverpool Clinical Services review (LCSR) and highlight clinical pathways and areas for collaborative working to improve the delivery of care and reduce cost.		
	Advise	• The Committee expressed disappointment that a draft work plan had not yet been developed for the Joint Site Committee. Discussions were ongoing to ensure that a draft work plan is developed at pace.		
2.	**Risks Identified**	N/A		
3.	**Report Compiled by**	Andy Nicolson, Medical Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	The Walton Centre NHS Foundation Trust & Liverpool University Hospitals NHS Foundation Trust Joint Committee Terms of Reference (ToR)
Executive Lead	Andy Nicolson, Deputy Chief Executive and Medical Director
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Terms of Reference (ToR) have been agreed by the Joint Committee for the Aintree Site
- The new Joint Committee will have delegated powers from the Board to make decisions as described in the ToR to support collaborative programmes of work between the two Trusts

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

- Joint Committee to be formally established
- Delegated decision-making authority to be defined by a workplan to be agreed by the Committee and approved by the Board

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

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

002 Collaborative Pathways	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Joint Committee	26 April 2023	K Dowson, Corporate Secretary	Terms of Reference agreed

The Walton Centre NHS Foundation Trust & Liverpool University Hospitals NHS Foundation Trust Joint Committee Terms of Reference (ToR)

Executive Summary

1. In response to the recommendations outlined in the Liverpool Clinical Services Review, a Joint Committee between The Walton Centre & Liverpool Universities Hospital NHS Foundation Trust (LUHFT) has been established with a view to agreeing established programmes of work to implement, in particular, but not limited to, new emergency care pathway elements proposed by the Liverpool Clinical Services Review across the joint Aintree site. This will build on the existing collaborations already in place such as shared Pharmacy Services and car parking services

2. The draft ToR for this Joint Committee is attached at Appendix 1 for approval by the Board.

Joint Committees

3. The Health and Care Bill 2022 brought in new powers for Trusts to establish Joint Committees with the aim of giving organisations more flexibility to work together to improve people's health and wellbeing and reduce health inequalities. The intent of the 2022 Act is to make collaborative working between those involved in planning, purchasing and delivering care easier nationally, at system level and at place level, to accelerate progress in meeting the most critical health and care challenges.

4. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the NHS Act 2006. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act and potentially to establish and maintain a pooled fund.

5. The objectives to be delivered through the establishment of the Joint Committee will be to ensure each hospital site delivers optimal care and efficiency, uninhibited by organisational boundaries – responding to the Liverpool Clinical Services Review. These arrangements will oversee the design, proposition and, when approved, the delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The scope of any such work will be governed by a workplan developed in sight of system partners and approved by Boards (to also reflect any changes to the delegations required to the committee - as and when identified and appropriate).

Development of Terms of Reference

6. The Joint Committee met in shadow form in March 2023, at which time a draft Terms of Reference was presented for review. Feedback from members of the Joint Committee was taken, alongside feedback from members of The Clatterbridge Cancer Centre NHS Foundation Trust & LUHFT Joint Committee, and the Liverpool Heart & Chest NHS Foundation Trust & LUHFT Joint Committee at the respective meetings. Feedback from each meeting was applicable to the initial draft template, and has been noted on the attached Terms of Reference in Appendix 1 in red.

7. In line with recommendations made at the initial meetings, Company Secretaries from each of the four Foundation Trusts met on 21 March 2023, at which time a further review took

place from the lens of those with governance expertise. Proposed amendments are noted on the attached Terms of Reference in Appendix 1 in green for consideration.

8. Two further amends were proposed following a review undertaken by the Liverpool Heart & Chest & LUHFT Joint Committee meeting held in April 2023, to cover aspects of ensuring consultation is facilitated in areas of service change, and the inclusion of the Liverpool ONE Partnership as appropriate. No further changes are proposed by the Joint Committee for the Aintree site.

9. These ToR will be evaluated in six months.

Reporting

10. The reporting arrangements for this Committee will be to each Trust Board with reporting at system level to be further developed at pace.

Recommendation

To approve the Terms of Reference.

Author: Katharine Dowson, Corporate Secretary
Date: 26 April 2023

Appendix 1 – Joint Committee Draft Terms of Reference

Appendix 1

Joint Committee
The Walton Centre Hospital NHS FT and Liverpool University Hospitals NHS FT for the Royal Hospital site
Terms of Reference
DRAFT

1. Purpose

The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts and to optimise acute care clinical pathways in Liverpool and beyond.

~~One of the critical priorities from the review was to improve outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Royal and Royal Liverpool Hospital sites.~~

In endorsing the recommendations of the Liverpool Clinical Services Review, Liverpool's acute and specialist trusts agreed to establish programmes of work to implement new emergency care pathway elements proposed by the review - fast-tracking, passporting and in-reach. [1]. This review was commissioned by the Cheshire & Merseyside Integrated Care Board (ICB), as the convenor of our NHS system and should be progressed in the sight of partners.

~~The recommendations of the review include proposals for a site-based focus, work plan, and collaboration at three city 'hospital' locations and that these should be governed by Joint Committee arrangements between the affected Trusts.~~

~~The objectives to be delivered through the establishment of the joint committee will be to ensure each hospital site delivers optimal care and efficiency, uninhibited by organisational boundaries – responding to the Liverpool Clinical Services Review. These arrangements should oversee the design, proposition and, when approved[2], the delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The scope of any such work will be governed by a workplan developed in sight of system partners and approved by Boards (to also reflect any changes to the delegations required to the committee - as and when identified and appropriate).~~

The Joint Committee is a committee of the two Trust Boards and its members, including those who are not members of the Board, are bound, by agreement, by the Standing Orders and other policies of the Trust with the lesser delegation limits (The Walton Centre Hospital NHS FT Board) through this Joint Committee arrangement. Should there be a change to the delegated levels of either Trust, this requirement will be subject to review by the Joint Committee.

Whilst any delegation will primarily focus on the programmes of work to implement new emergency care pathways on the Royal site, as proposed by the Liverpool Clinical Services Review, these Terms of Reference do not limit the Joint Committee to collaborate only on the recommendations of the review. Existing or further opportunities to explore other aspects of joint working between the trusts should be considered as the Committee finds appropriate . Site based workplans (for the Committee) will be developed and agreed by Boards and shared with the ICB and CMAST[3]. Proposals related to clinical pathways and efficiency at scale will connect with and may be governed by CMAST Programmes where this is appropriate. Accordingly, the Committee will have delegated authority from the Boards of both Trusts to exercise functions and jointly take decisions that have been delegated by their individual organisations, via the agreement of a workplan[3], in line with their schemes of delegation.

[1] Liverpool Clinical Services Review: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-meeting-january-2023/

[2] Efficiency at Scale and Clinical Pathway proposals in C&M are governed by CMAST and as such will have check point discussions on proposals with these programmes to ensure system alignment and full benefits realisation

[3] The agreed workplan will be appended to this ToR at Annex one when developed

~~**2. Legal context and guidance**~~

~~The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the NHS Act 2006. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund.~~

~~The Trusts must have regard to the guidance published by NHS England in September 2022 (and any subsequent/replacement guidance) about the exercise of these powers.~~

~~The guidance explains the purpose and benefits of the new powers, introduced by the Health and Care Act 2022:~~

> ~~*With the NHS focused on integrating delivery of care, the range of legislative changes Parliament has put in place (based on recommendations by NHS England) is designed to support this aim. They give organisations more flexibility to work together to improve people's health and wellbeing and reduce health inequalities. The intent of the 2022 Act – and the sections to which this guidance relates – is to make collaborative working between those involved in planning, purchasing and delivering care easier nationally, at system level and at place level, to accelerate progress in meeting our most critical health and care challenges.*~~

3. Responsibilities / duties

The Committee's duties are as follows:

- To oversee the development of a site-based operating model ensuring optimised site-based working, guided by the principles of efficiency, value and optimal patient outcomes where related to emergency care pathways. Accountability for the delivery and operation of all proposals will be clear.
- To make proposals for consideration by system partners on developing deploying and / or optimising the highest quality clinical pathways. Such activities will also be guided by the principles of clear accountability and realising optimal patient outcomes with recommendations for action referred back to the Joint Committee, for implementation, as necessary.
- Where proposals are seen to have impact on the development of a target financial model or the potential to reset financial flows this will be referred to the ICB for determination and system consideration which may require recommendation back to the Joint Committee, for implementation.
- Where proposals recommend service change, the requirement for consultation/engagement will need to be considered and or undertaken by the ICB in line with national guidance.
- Implement an approach to ensure efficiencies are realised, including through reduced length of stay and reduced interhospital ambulance transfers.
- Be assured of the delivery of all elements of the workplan and identify and address programme risks and issues.
- Seek external clinical and professional advice where specialist or independent review is required.
- Utilise available system clinical and professional advice where a broader ICS, system or regional perspective is needed.
- Report on progress, performance, risks, issues and delivery to the Boards of the The Walton Centre Hospital NHS FT and Liverpool University Hospitals NHS FT, CMAST, One Liverpool Partnership and the ICB regularly.

The following principles will drive the work of the Committee:

i. Ensure that proposals are underpinned by demand and capacity analysis
ii. Ensure that clinicians are at the forefront of the development of the envisaged approach, with appropriate clinical leadership from each organisation, on each site, to oversee the work and facilitate involvement from the clinical community
iii. Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway

iv. Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighboring Places, CMAST, NHS Commissioning: Specialist Services, and the MHLDC Collaborative

v. Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts and ICB to support the joint committee to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations

vi. Ensure that the programme complies with statutory duties and best practice standards in delivering service change

vii. Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the workplan and form part of a planned engagement approach with patients, public and stakeholders

viii. Ensure no detriment to patients within a wider geography to Liverpool

4. Authority

For the avoidance of doubt, in the event of any conflict, the two NHS Boards' Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference. In establishing these terms of reference, the Boards have agreed for the work and recommendations of the Joint Committee to be guided by the Trust named in section one paragraph 5.

5. Membership & Attendance

Membership

The committee should include at least one non-executive director and executive director from each organisation as well as a senior site-based leadership team representative. Membership will be equal for all parties bound through the establishment of the Joint Committee. In accordance with Schedule 7 paragraph 15 of the NHS Act 2006 Foundation Trust Joint Committees, it is anticipated and assumed that representatives of FT Board of Directors should be the only voting members.

The Committee members shall be appointed by the Boards of the The Walton Centre NHS FT and Liverpool University Hospitals NHS FT. The Committee Membership will be composed of:

- A Chair. This will be the Chair of The Walton Centre NHS Foundation Trust as appointed by agreement between Trusts.
- A minimum of one Trust non-executive members from each Trust (the Non-Executive Director member from Liverpool University Hospitals NHS FT to act as Vice Chair)
- A minimum of one Executive Director[4] from each Trust ~~(voting member)~~
- A medical or clinical leader from each Trust who operates from the site[5]
- ~~Programme Director (non voting)~~
- ~~A wider C&M representative (to be identified and proposed by the two affected Trust's CEOs) bringing a wider system perspective (non voting)~~

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite any relevant contributor to the meeting as necessary, in accordance with the business of the Committee.

The Company Secretary or a nominated representative from each Trust will be invited to attend meetings of the Committee in a non-voting capacity.

Substitutes, when pre notified, are permitted and will hold any relevant vote but consistency of participation is strongly encouraged.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Conduct of the meetings will be governed by applicable standards or business conduct and conflict of interest requirements.

[4] Or nominated senior deputy

[5] Wider clinical and medical participation and contribution to the meetings and delivery of the workplan will be critical to the success of delivery and will be detailed in the workplan

6. Meetings

6.1 Leadership

~~Committee members may appoint a Vice Chair from amongst the standing members where this is a NED.~~

In the absence of the Chair, or Vice Chair, where it has been agreed by those absent that business should continue, the remaining members present may elect one of their member to Chair the meeting. However this position will usually only be held by a NED.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

6.2 Quorum

For a meeting or part of a meeting to be quorate a minimum of two members from each participant Trust must be present.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

6.3 Decision-making and voting

The Committee will ordinarily reach conclusions by consensus. When this is not possible the issue will be taken back to the Trust Boards and/or escalated to the Cheshire & Merseyside Integrated Care Board for an alternative non-binding perspective to be offered. ~~Chair may call a vote.~~

~~Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.~~

~~Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.~~

~~If it is impossible for a conclusion to secured or a consensus reach the Chair has the ability to refer to matter for discussion to Trust Boards or to CMAST or the ICB for an alternative non-binding perspective to be offered.~~

6.4 Frequency and meeting arrangements

The Committee will meet in private. The Committee will meet at least bi-monthly. Additional meetings may take place as required.

Committee meetings will be scheduled to take place in-person, however, may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

6.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed having been agreed by the Chair.
- Good quality minutes are taken in accordance with the standing orders and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to Trust Boards.
- The Committee is updated on pertinent issues / areas of interest / policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

The Committee is accountable to the Boards of The Walton Centre NHS FT and Liverpool University Hospitals NHS FT and shall report to the Board on how it discharges its responsibilities. Reports will also regularly be made available by an in scope CMAST Trust CEO to CMAST and the ICB CEO to the ICB.

A summary of key issues discussed and concluded shall be produced and made available to both Boards following each meeting, to be approved by the Chair of the Joint Committee. Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

7. Behaviours and Conduct

The Committee will take proper account of guidance and requirements issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

Members will be expected to conduct business in line with the values of their respective NHS Trusts. Members of, and those attending, the Committee shall behave in accordance with Trust Standing Orders, and Standards of Business Conduct Policy.

Members will act in accordance with the principles for collaboration agreed by All Trusts:

- The best interests of patients and the financial sustainability of the system will lead decision making. Organisational interests are important, but subservient to this principle.
- The brand identity of good organisation must be maintained as this is important to the retention and attraction of high calibre staff and inward investment to the city.
- Decision-making will be evidenced based and collective. An infrastructure will be established to ensure consistency of evidence and data to enable all boards to seek assurance on a case for change, proposals and business cases.
- Joint Committee decisions will be made within a framework that provides each board with assurance of the accountability of such decisions on operational and financial performance within the scope of each board's responsibility.
- Joint Committees must meet the standards of openness and engagement that are expected of NHS bodies delivering care for patients. Decision making will be clinically-led, with patients, public, staff and other stakeholders engaged and involved.
- The six Trusts within the scope of the Liverpool Clinical Services Review are partners within the Liverpool Place and members of the One Liverpool Partnership Board. Implementation of joint proposals will align with and complement the One Liverpool strategy.

All members shall comply with their Trust's Conflicts of Interest Policy and their relevant organisation COI policy at all times. In accordance with best practice on managing conflicts of interest, members should:

- Inform the chair of any interests they hold which relate to the business of the Joint Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, members should:

- Uphold the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary

7.2 Equality diversity and inclusion

In taking any decisions as a committee, due consideration must be given to any equality, diversity and inclusion implications and also to the need to reduce inequalities across C&M between individuals with respect to their ability to access health services and with respect to the outcomes achieved for those individuals by the provision of health services.

8. Review

The Committee will review its effectiveness at least annually. Initially after the first 6 months of its operation (by no later than October 2023).

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be required to be approved by both trust Boards.

The Walton Centre NHS Foundation Trust

Report to Trust Board
04/05/2023

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman - Chief Operating Officer
Author (s)	Rebecca Sillitoe – Senior Information Analyst
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- See summary for performance overview

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

- Ongoing

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

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

001 Quality Patient Care	004 Operational Performance	003 System Finance

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Integrated Performance Report

Executive Summary

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

Operations & Performance Indicators

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

Opportunity for improvement
Activity Restoration

Underperforming

Workforce Indicators

High Performing
Vacancies

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
VTE
CAUTI
Hospital Acquired Pressure Ulcers
Mortality
Friends and Family Test (% Recommended)
Moderate Harm Falls
Surgical Site Infections
Serious Incidents

Opportunity for improvement
14 Day Stranded Patients (Flow)
Hospital Acquired CPE

Underperforming
Hospital Acquired E. Coli
Hospital Acquired MSSA
Hospital Acquired Klebsiella Bacteraemia
Complaints

Finance Indicators

Key Performance Indicators	January	February	March
% variance from plan - Year to date	38.2%	50.3%	59.4%
% variance from plan - Forecast	59.4%	59.4%	59.4%
% variance from efficiency plan - Year to date	1.3%	0.6%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	33.1%	33.8%	1.8%
Capital % variance from plan - Forecast	0.0%	0.0%	1.8%
Capital Service Cover *	3.3	3.5	4.9
Liquidity **	41.7	43.4	37.7
Cash days operating expenditure ***	104.1	106.3	102.6
BPPC - Number	83.5%	83.8%	83.8%
BPPC - Value	82.3%	82.4%	82.8%

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

Conclusion

As listed above many of the indicators are high performing either against a set target, local improvement or external benchmarking, with only a few indicators underperforming. Hospital acquired E. Coli (YTD), MSSA and Klebsiella are all above trajectory and will remain underperforming metric for the remainder of this financial year. There is work on going to improve the training and appraisal compliance.

Recommendation

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

Author: Rebecca Sillitoe – Senior Information Analyst
Date: 13/04/2023

Board Report
May 2023

Data for March 2023 unless indicated

The Walton Centre NHS Foundation Trust

Notes

Explanation of SPC Charts and Assurance Icons

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

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

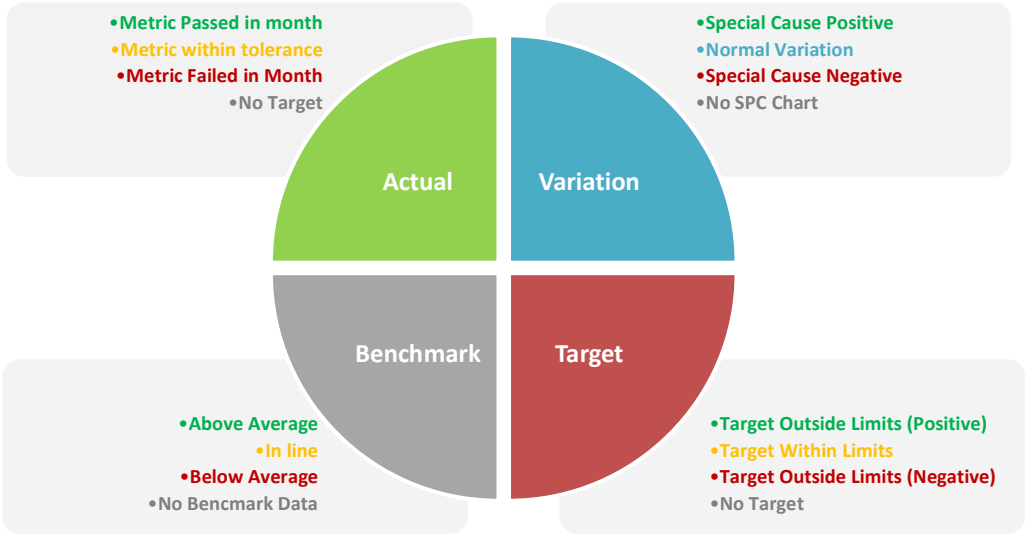
All SPC charts will follow the below key unless indicated

Actual UCL Average LCL National Average Target

= Part of Single Oversight Framework = Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

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

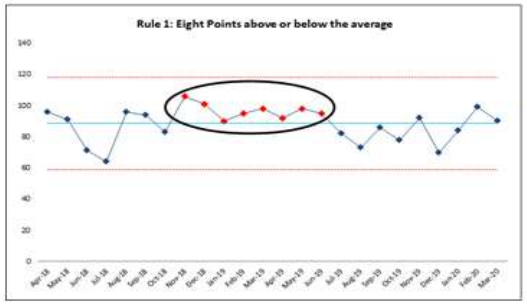


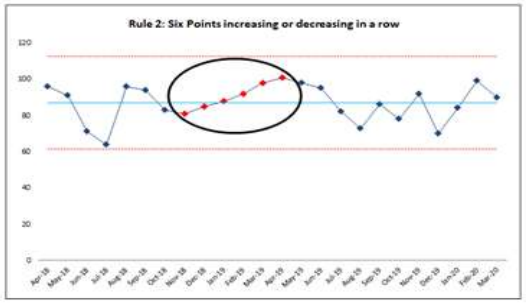
The Walton Centre
NHS Foundation Trust

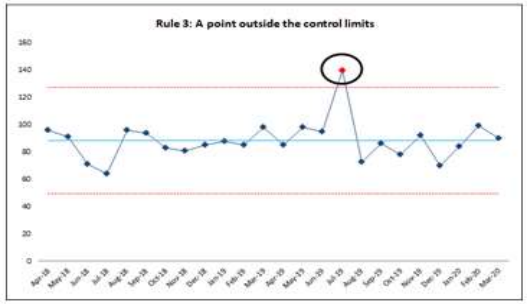
Notes

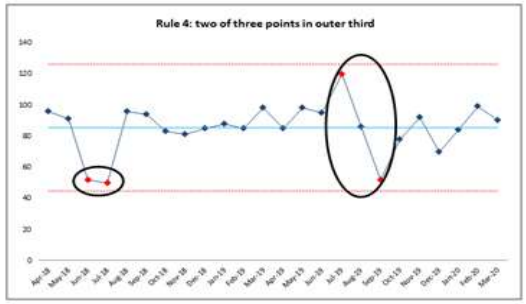
Statistical Process Control Chart Rules

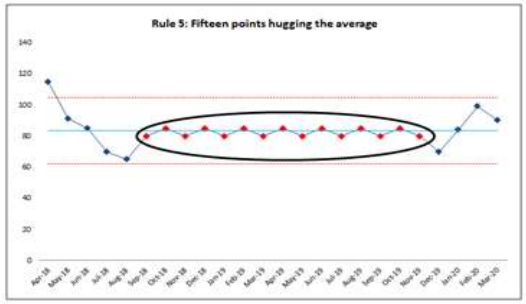
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).











NHS
The Walton Centre
NHS Foundation Trust

Operations & Performance Indicators

The Walton Centre NHS Foundation Trust

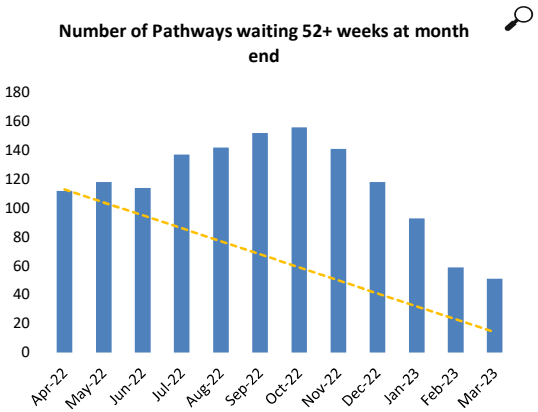
Operational - Responsive

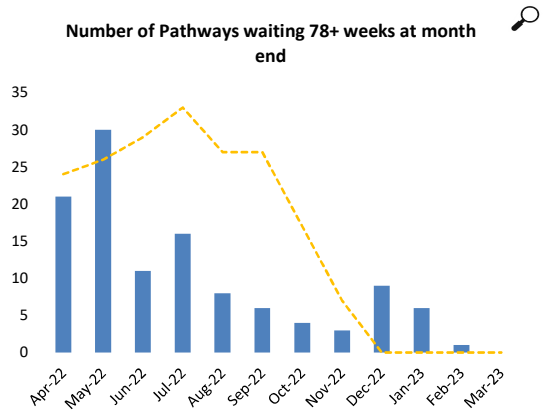
Referral to Treatment

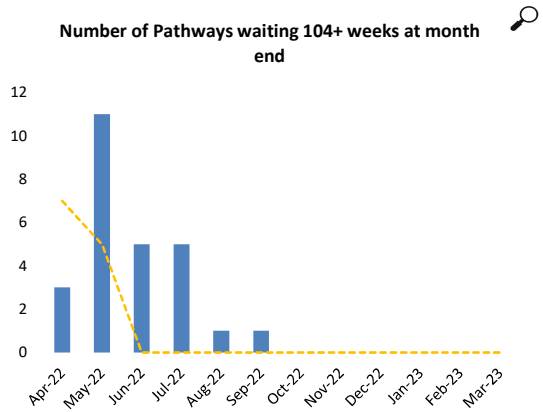
The number of patients waiting more than 52 weeks for treatment has decreased for the fourth consecutive month and, the position at end March is there are no patients waiting more than 78 weeks.

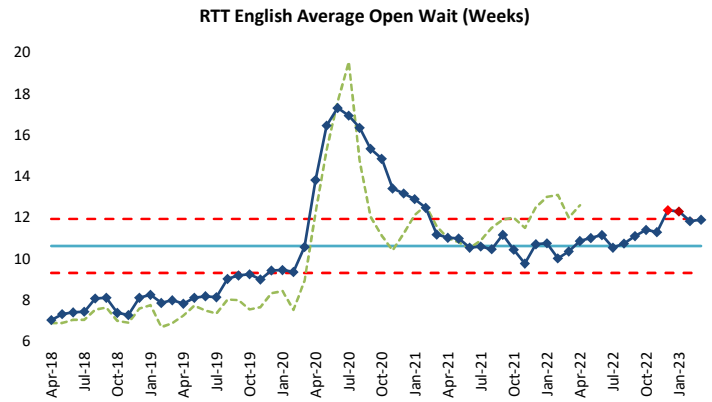
Unfortunately the average waiting times in Wales remains in special cause negative variation with a run of 15 months below mean, the last 9 of which have been below the lower control limit, this will be the focus now the long waiters have reduced.

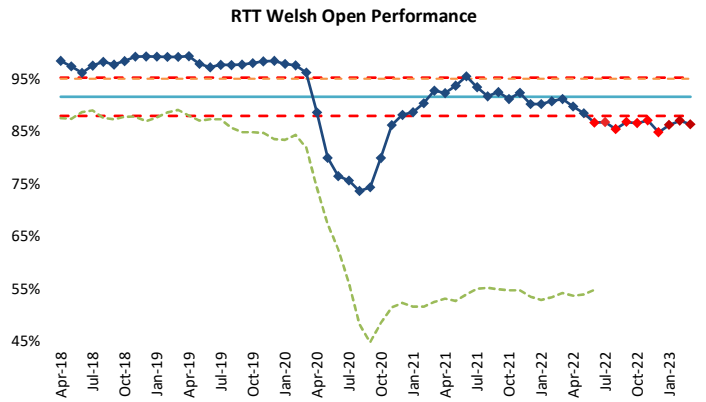
As part of plans to restore services to pre-COVID levels, each Trust was required to submit a trajectory along with timescales for reducing long waits. The Walton Centre have achieved this trajectory but may see fluctuations with mutual aid requests.











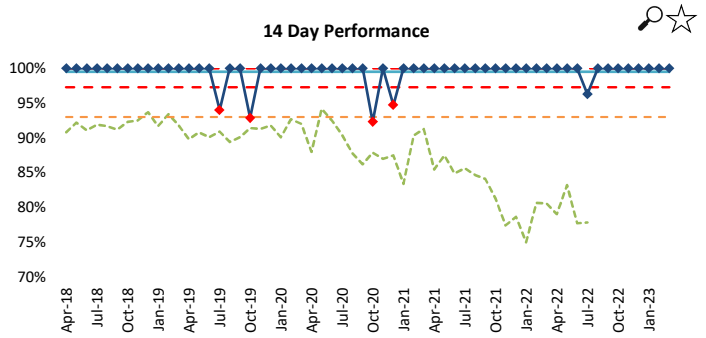
The Walton Centre NHS Foundation Trust

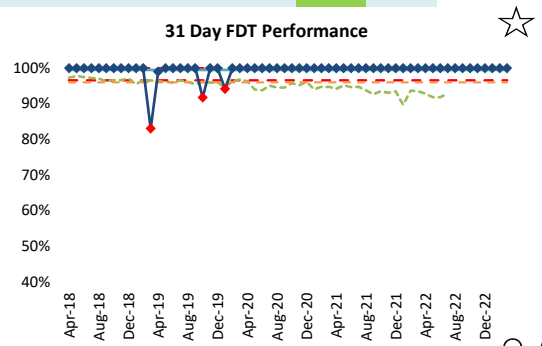
Operational - Responsive

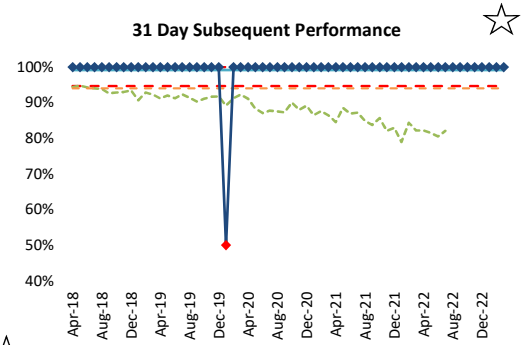
Cancer Standards

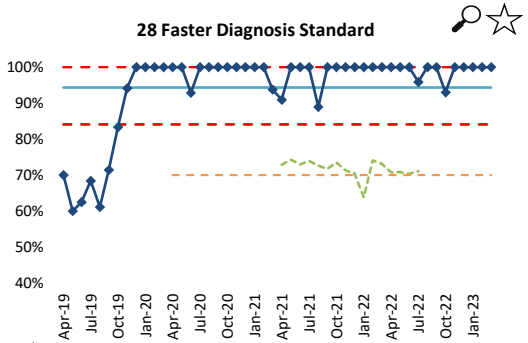
Access Standards	Target	Actual
Cancer TWW	93%	100%
Cancer 31 Day FDT	96%	100%
Cancer 31 Day Sub	94%	100%
Cancer 62 Day Standard	85%	NA
28 Day Faster Diagnosis Standard	70%	100%

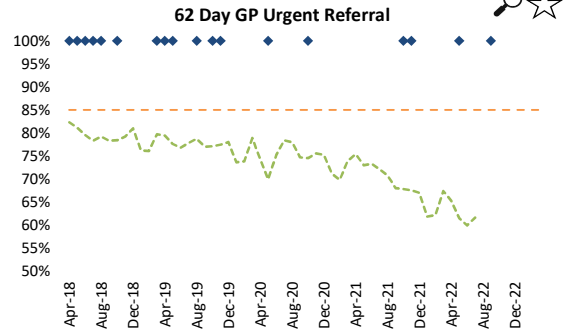
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, this is in line with NHSE requirements.

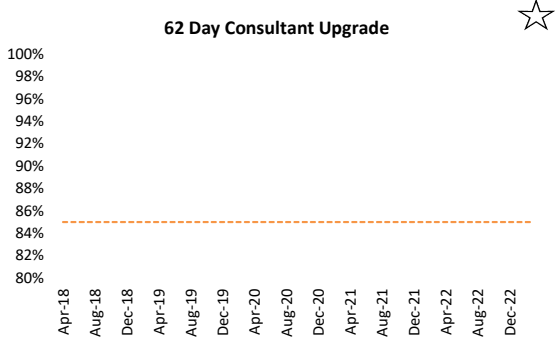












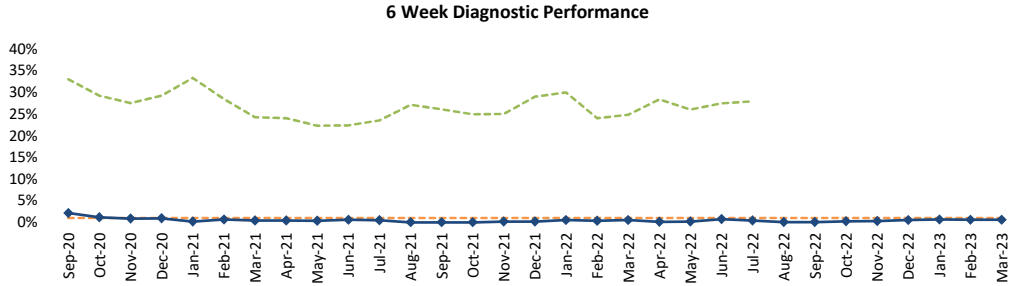
The Walton Centre NHS Foundation Trust

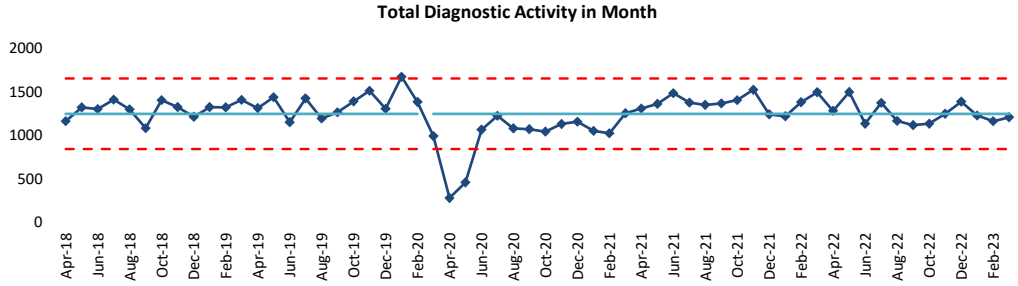
Operational - Responsive

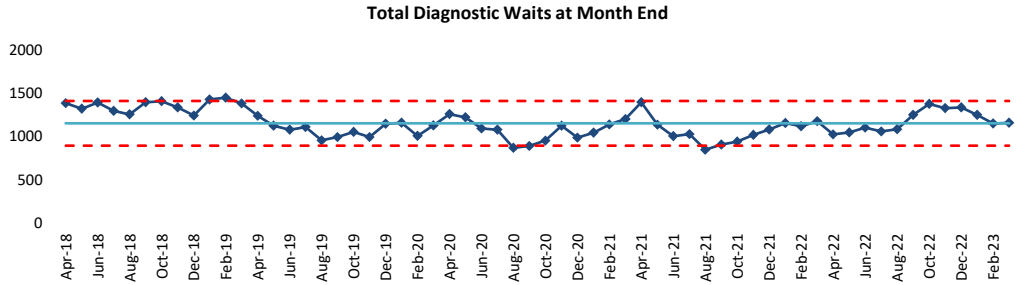
Diagnostics

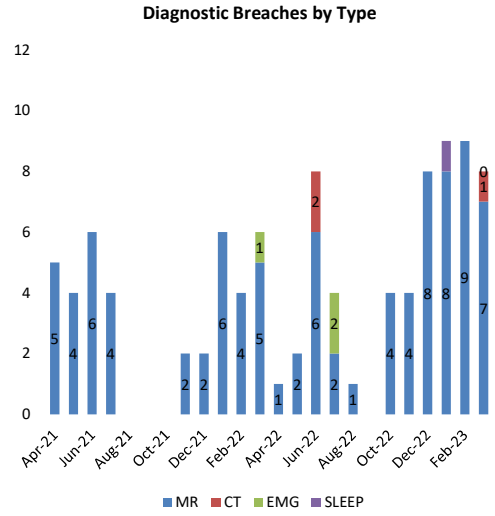
Access Standards	Target	Actual
Diagnostic 6 Week Performance	1%	0.57%

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









The Walton Centre NHS Foundation Trust

Operational - Effective

Theatres

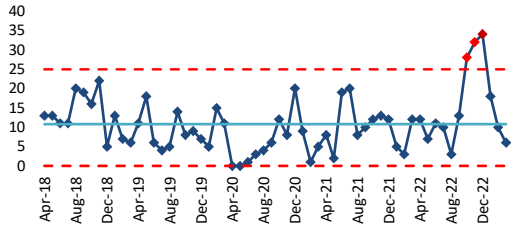
	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	6	
% Cancelled operations non clinical on day	0.80%	0.47%	
28 Day Breaches in month	0	2	

The majority (17 from 22) of unutilised sessions in March were due to the junior doctors industrial action. The trust is working with product partners as part of the theatre utilisation transformation work to ensure theatre capacity is utilised appropriately.

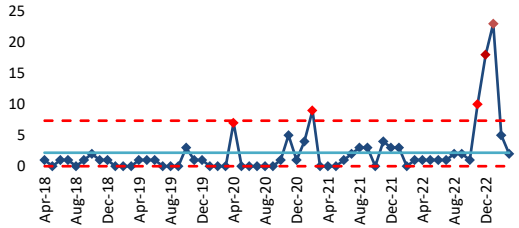
There were six non-clinical cancellations in month of which: 2 related to list overrun; 1 to emergency/trauma; 2 to ITU/HDU beds being unavailable and 1 to unavailability of a ward bed, which is a reduction from last month.

Neither of the 28 day breaches were able to be rescheduled within the 28 limit because of the complexity of the required procedures.

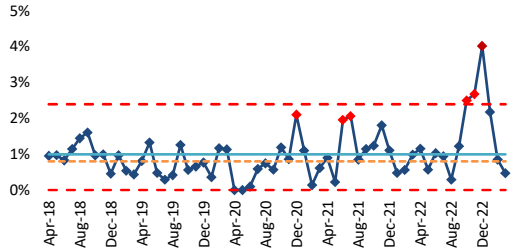
Number of Cancelled operations non clinical (on day)



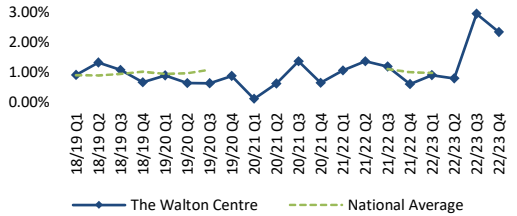
Number of cancelled operations not re-admitted within 28 days



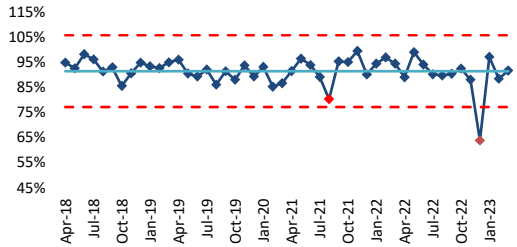
% of Cancelled operations non clinical (on day)



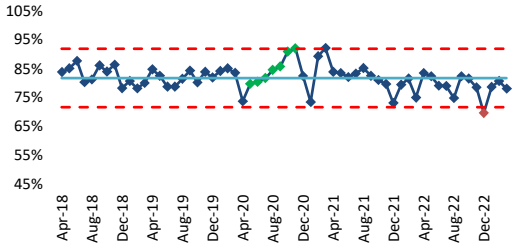
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



The Walton Centre NHS Foundation Trust

Operational - Effective

Elective Recovery Fund

Legend for all charts on page

19/20 Actual — 22/23 Actual

March 2023 Overall Activity Performance % of 19/20

POD	Actual 22/23	Plan 22/23	Actual	Target*	YTD
Daycase	1022	997	112.7%	104%	97.27%
Elective	251	287	90.9%	104%	93.11%
Elective & Daycase Total	**1273**	**1284**	107.6%	**104%**	96.31%
Non Elective	198	-	118.6%	-	96.21%
New Outpatients	4987	4822	107.5%	104%	105.35%
Follow Up Outpatients	7612	8133	93.6%	100%	99.02%
English Admitted Stops	272	294	96.1%	110%	88.72%
English Non Admitted Stops		2012	110.6%	110%	105.49%
Total English Stops		**2306**	**108.7%**	**110%**	**103.44%**

*Target a guide for ERF purposes

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

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

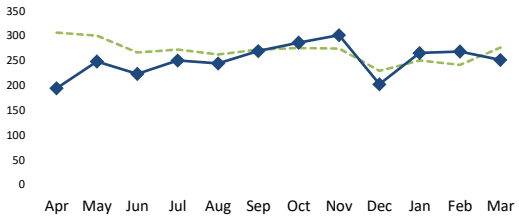
The Trust achieved ERF in month for new outpatients, non-admitted stops and combined elective and daycase activity.

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

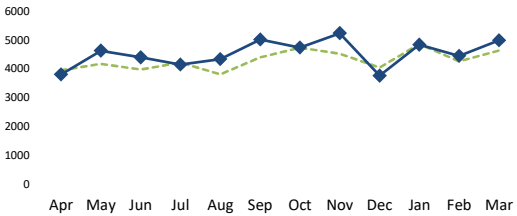
There is no target set against Non Elective activty.

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

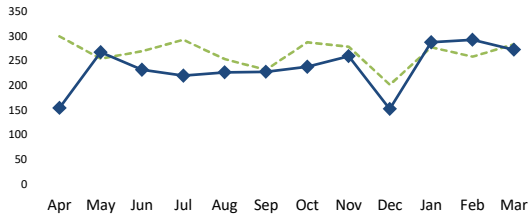
Elective Activity v Plan



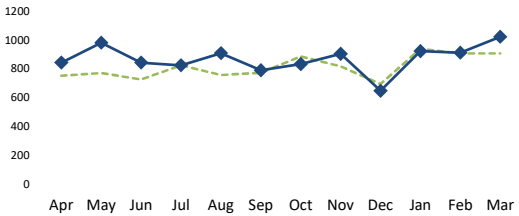
New Outpatients Activity v Plan



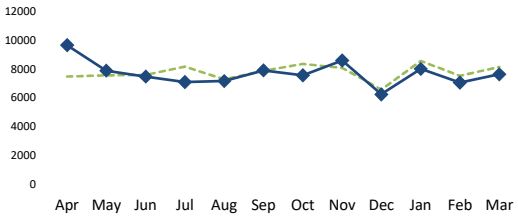
Enlgish Admitted Stops



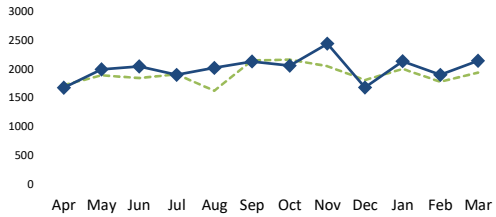
Daycase Activity v Plan



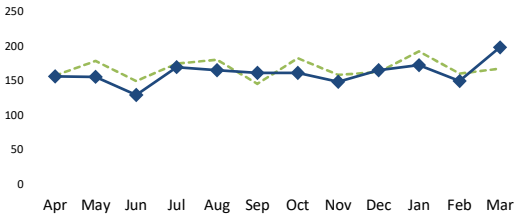
Follow Up Outpatients Activity v Plan



English Non Admitted Stops



Non Elective Activity v Plan



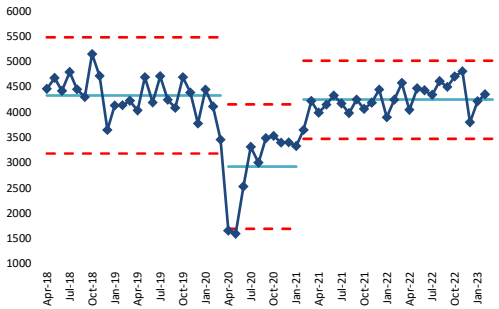
The Walton Centre NHS Foundation Trust

Operational - Effective

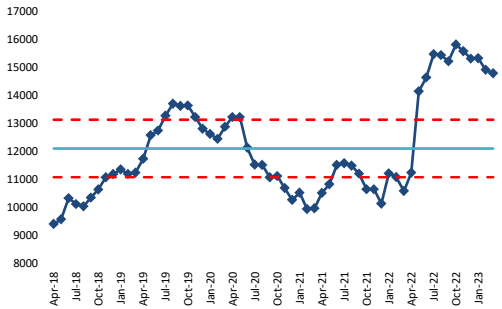
Activity

Most activity metrics remain within normal variation. The obvious exception being New Outpatient Waiting List. It is now eleven months since the significant increase in waiting list last May. The initial jump was due to Spinal patients being brought over from LUHFT in May of 2022 but this has remained high due to staffing pressures in NEU division.

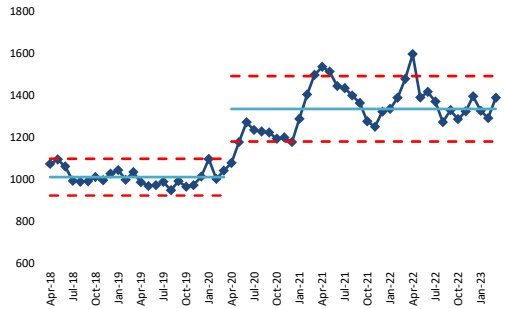
Total New Referrals Received



Trust New Outpatient Waiting List

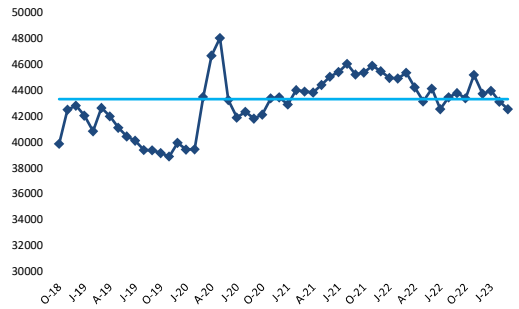


Inpatient Waiting List

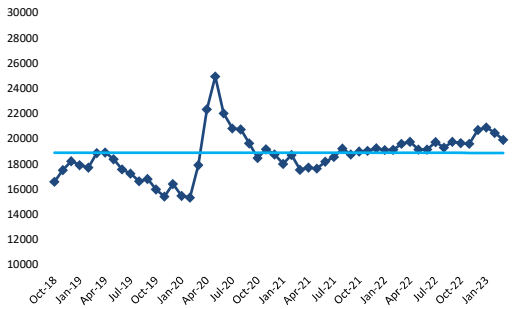


*Spinal transfer patients added to OPWL

Follow Up Outpatient Waiting List



Follow Up Outpatient Waiting List (Overdue)



The Walton Centre NHS Foundation Trust

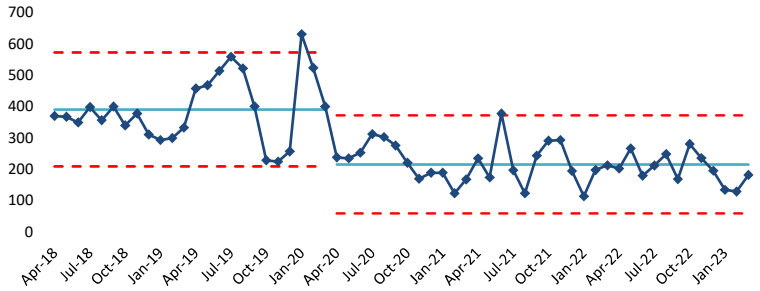
Operational - Effective

Flow

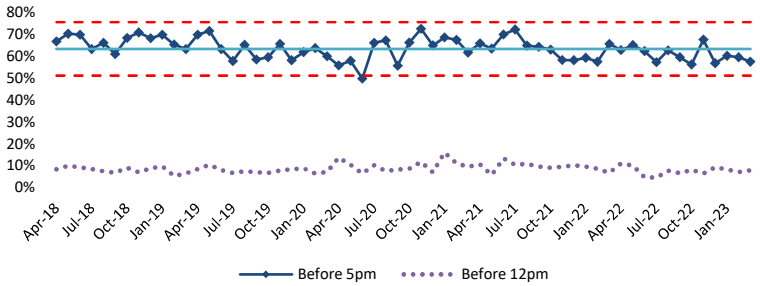
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	**6.42%**	
Total Delayed Discharge Days	-	**183**	
% Discharges by 5pm	-	**57.62%**	
% 14 Day Stranded Patients	-	**29.89%**	

Several flow metrics have increased in month but all remain within normal variation. Further work will be undertaken as part of the patient flow transformation group to ensure we can safely discharge patients before 5pm. No themes have been identified for patients readmitted within 28 days but this will continue to be monitored. The percentage of 14 day stranded patients remains within normal variation but mutual aid has been provided during the junior doctors strikes.

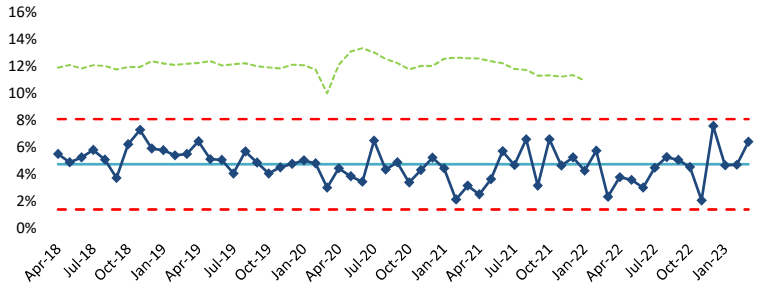
Total Delayed Transfer of Care Days



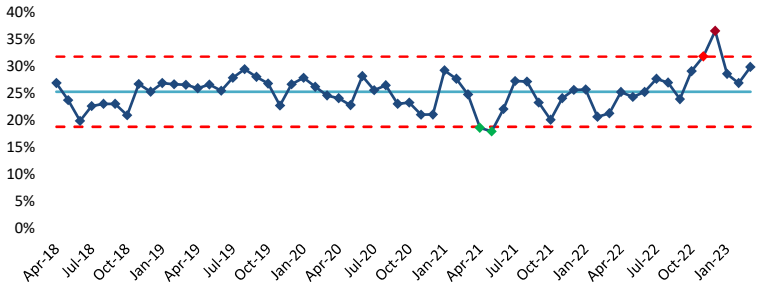
% Discharges to usual residence before 5pm



% 28 Day Emergency Readmissions (Local)



% of Beds Occupied by 14 Day Stranded Patients



The Walton Centre NHS Foundation Trust

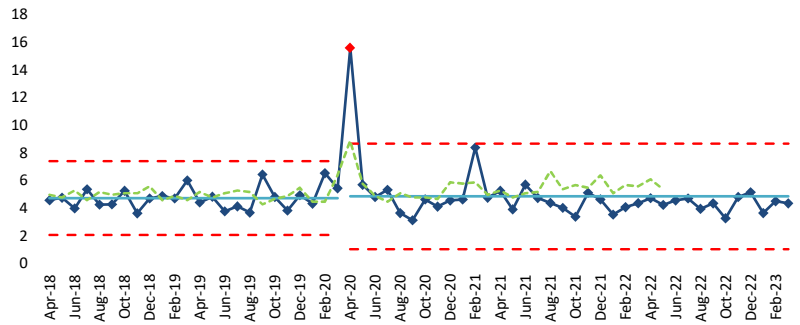
Operational - Effective

Flow (Leading Indicators)

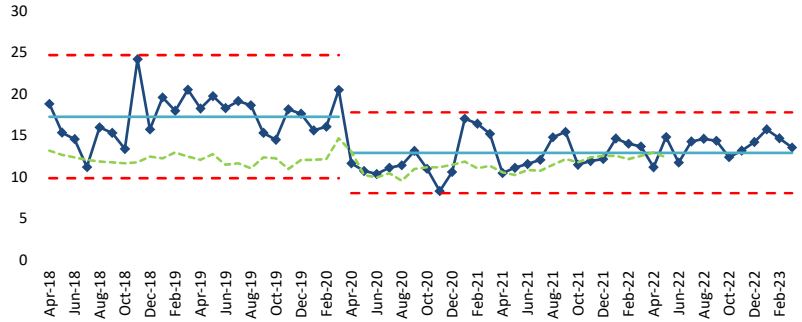
Effective - Flow	Target	Actual	Assurance
Elective LOS	-	4.36	
Non Elective LOS	-	13.61	
Day of Surgery Admission %	-	65.97%	
Daycase Rate	-	80.18%	

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

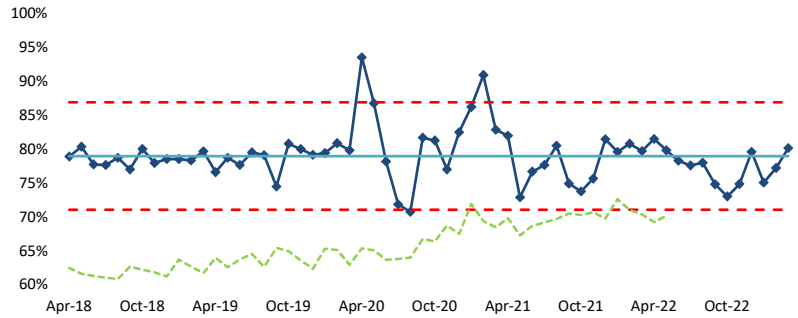
Elective Length of Stay (Days)



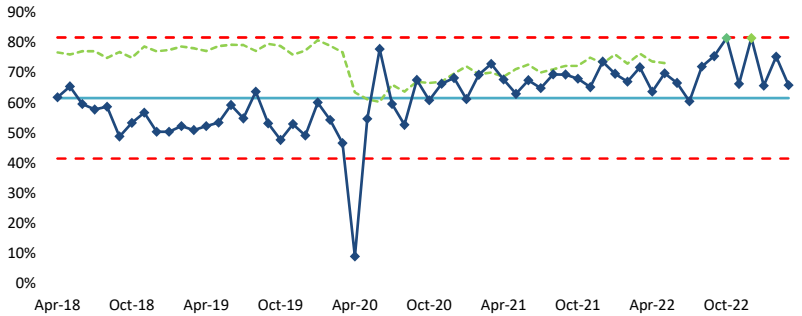
Non Elective Length of Stay (Days)



% of Elective Admissions as Daycases



Day of Surgery Admission %



The Walton Centre NHS Foundation Trust

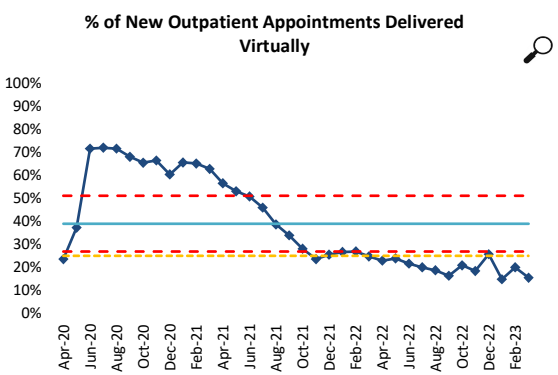
Operational - Effective

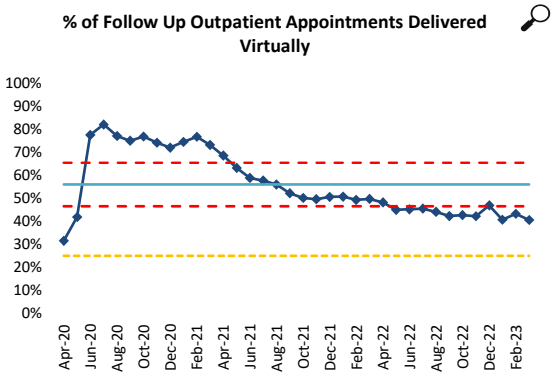
Outpatient Transformation

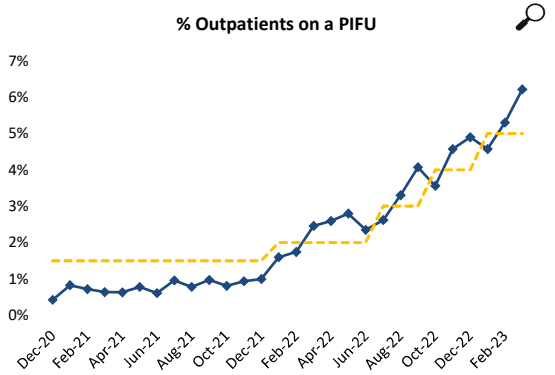
Virtual Appointments
The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. Although new appointments have dipped below this threshold in the last two months the trust as a whole remains above the target at 32%. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

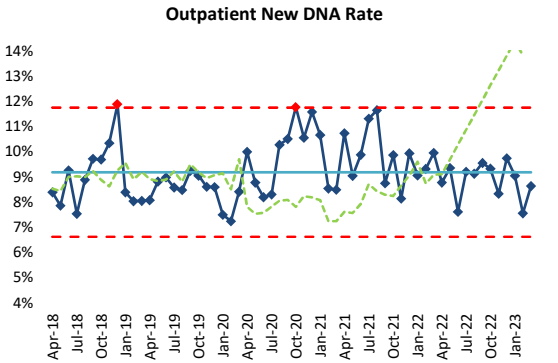
DNA Rate
After noticeable improvements last month the New and Follow Up DNA have increased again this month. This will be a focus of work in outpatient transformation.

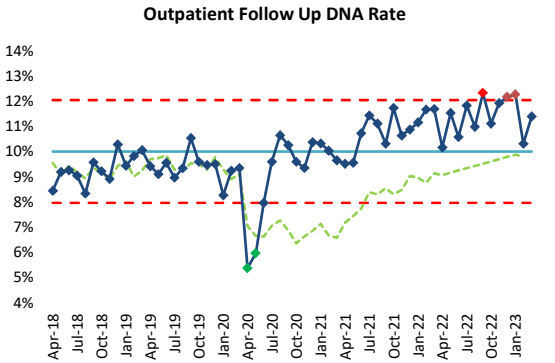
Patient Initiated Follow Up (PIFU)
As part of national Outpatient Transformation schemes the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In March 2023 we achieved 6.21% which is excellent and the Trust is recognised as exemplary within Chershire and Merseyside.

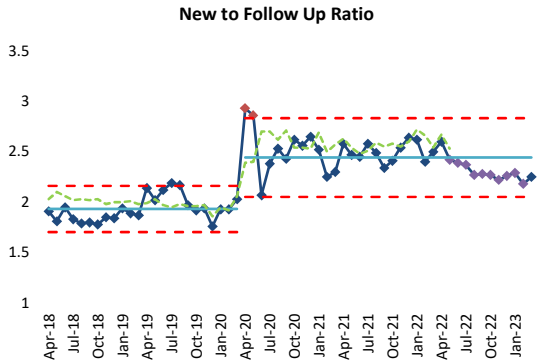












The Walton Centre
NHS Foundation Trust

Workforce Indicators

The Walton Centre NHS Foundation Trust

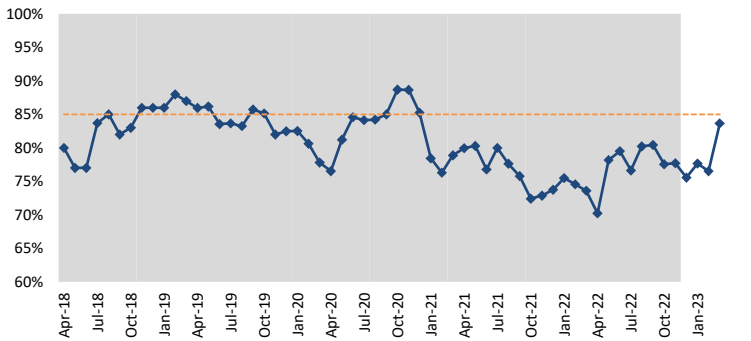
Well Led - Work force

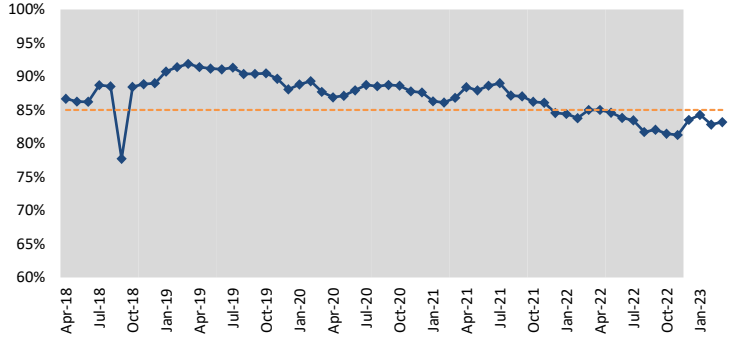
Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	83.69%	
Mandatory Training Compliance	85%	83.19%	

Appraisal compliance has increased noticeably in March. This has been due to the work of Chloe Crozier in chasing up individual managers to ensure compliance especially in recording completed PDRs.

The grey shading represents data inclusive of junior doctors and the white background represents months with junior doctors removed.

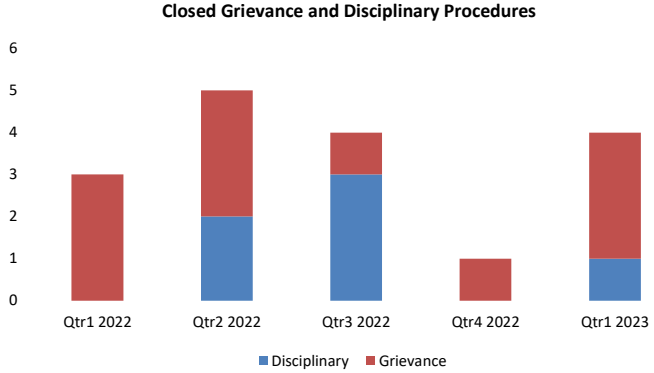




Grievance and Disciplinary Procedures

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

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



Well Led - Work force

Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	6.19%	
Trust Turnover	-	16.39%	
Nursing Turnover	-	11.93%	
Other Staff Turnover	-	17.99%	

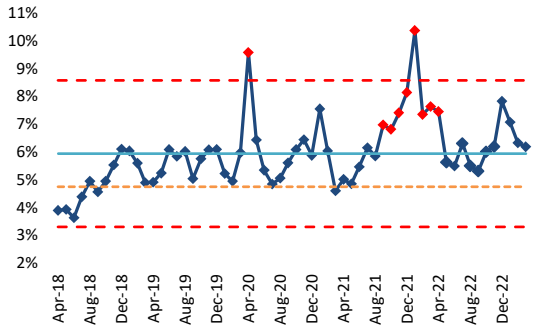
Sickness/Absence

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

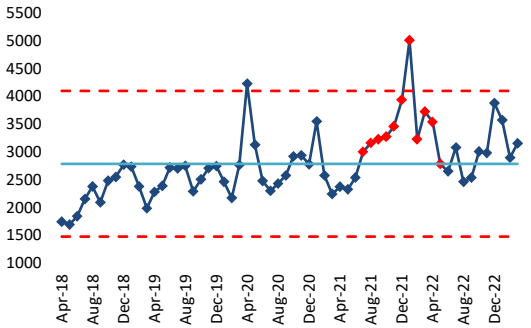
Turnover

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

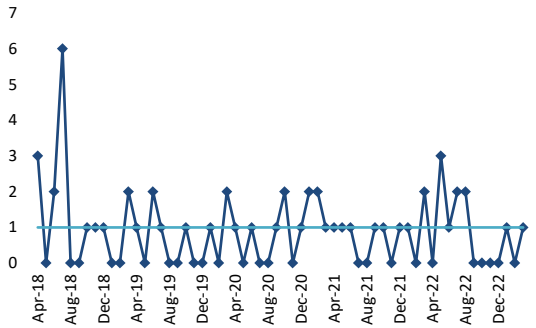
Sickness/Absence (Monthly)



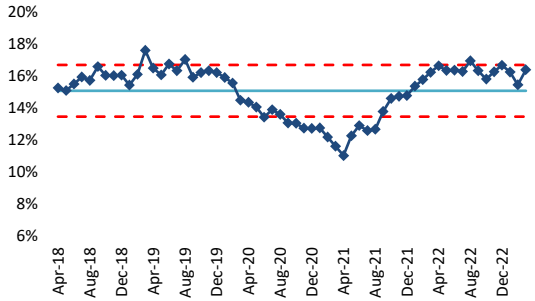
Lost Days due to Sickness/Absence (Monthly)



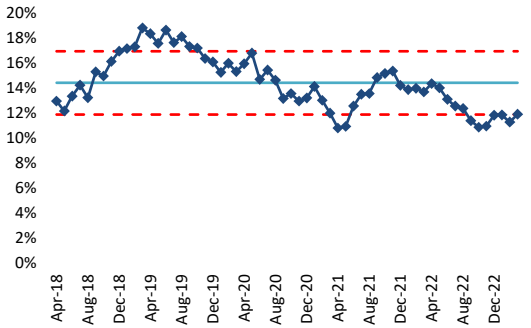
Medical Leavers



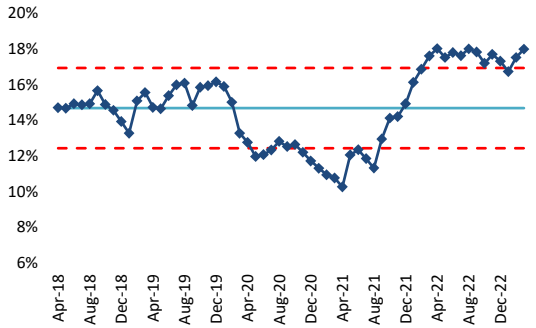
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)

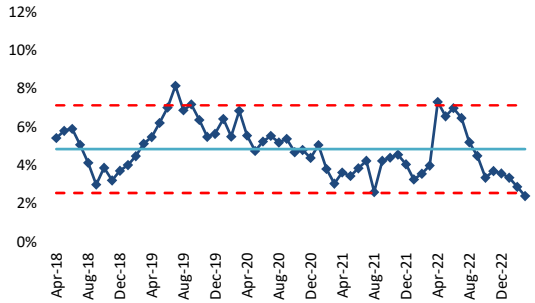


The Walton Centre NHS Foundation Trust

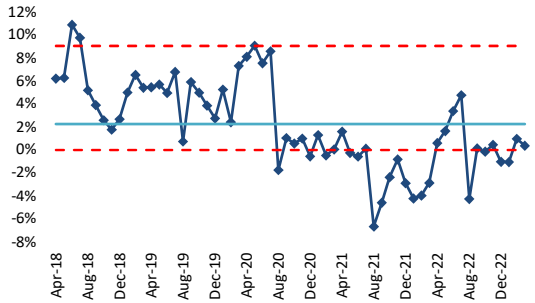
Well Led - Work force

Workforce KPIs

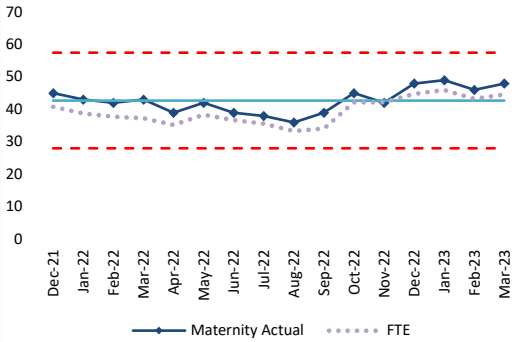
Overall Vacancy Level %



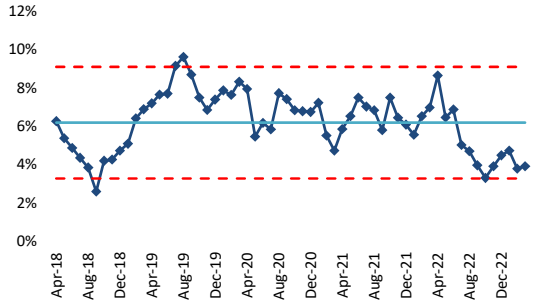
Medical Vacancy Level %



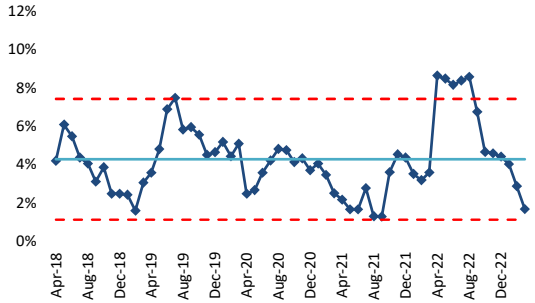
Trust Level Maternity Data



Nursing Vacancy Level %



Other Staff Vacancy Level %



Current month maternity figures

Directorate	Headcount	FTE
Corporate Services Directorate	5	4.23
Neurology & Long Term Care	21	19.77
Surgery & Critical Care	22	20.63
Grand Total	**48**	**44.62**

Vacancy Rates

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

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

Quality Indicators

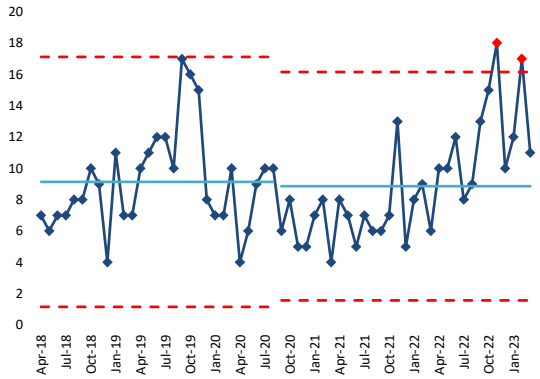
Quality of Care

Complaints

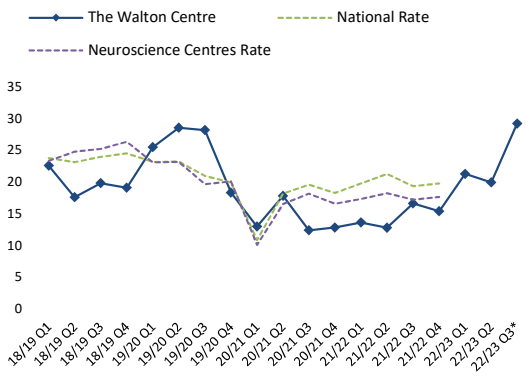
In March 2023 the Trust received 11 new complaints and one has been reopened. Four of these complaints related to Inpatient Concerns, three to diagnosis/treatment, two were corporate and one related to each of communication, waiting times and appointment arrangements.

After a month of unusually high complaints last month 12 complaints (incl. one reopened) this month brings the figure back into normal variation.

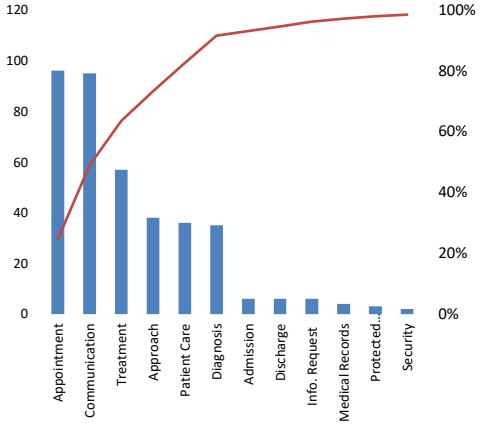
Total New Complaints Received in month



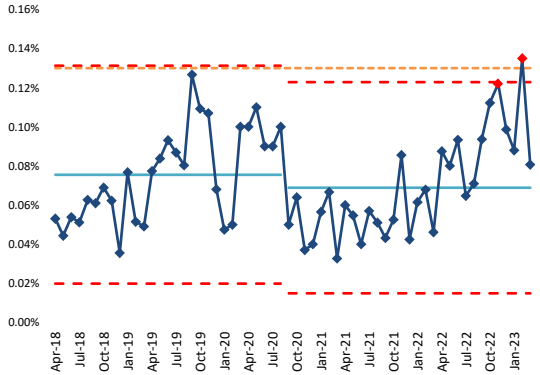
Quarterly Complaints per 1000 WTE



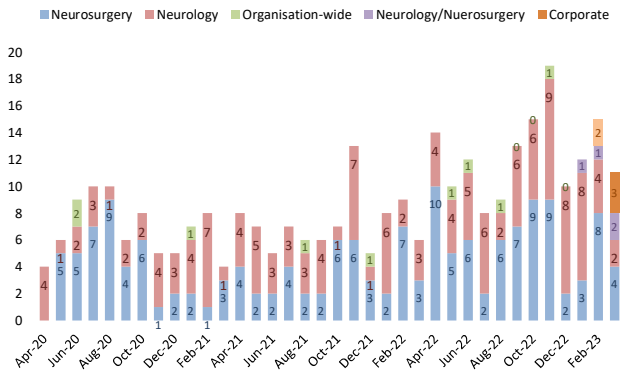
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

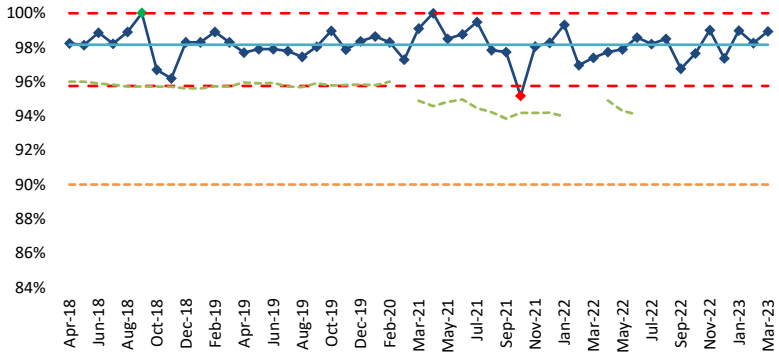
	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	45	19	11
22/23*	51	31	33

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

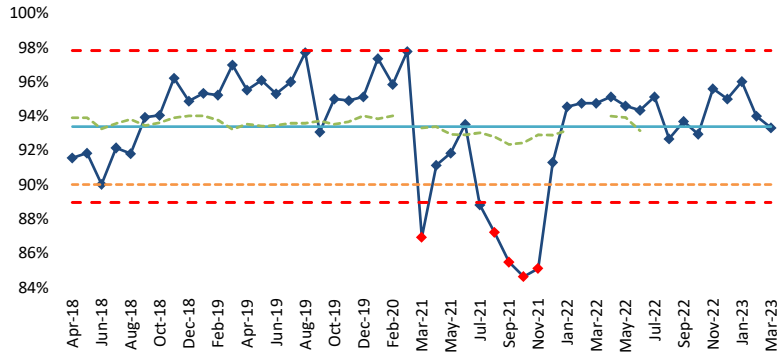
Quality of Care

Family and Friends Test

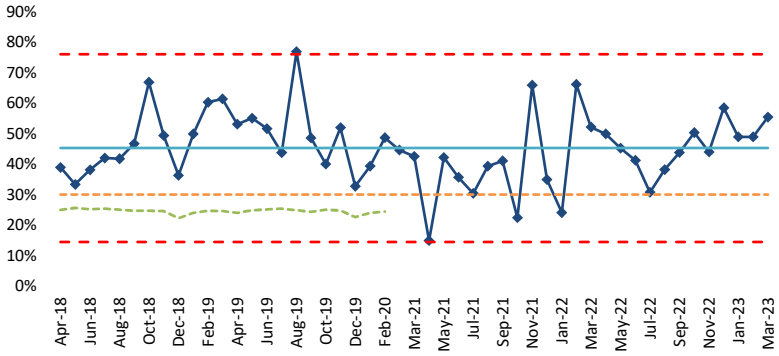
Inpatient FFT % Likely to Recommend



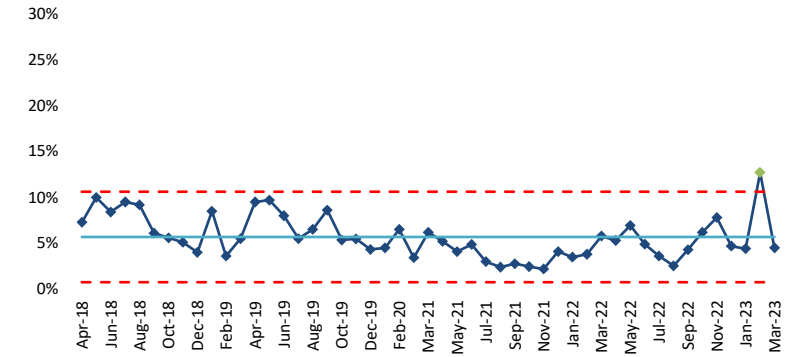
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate

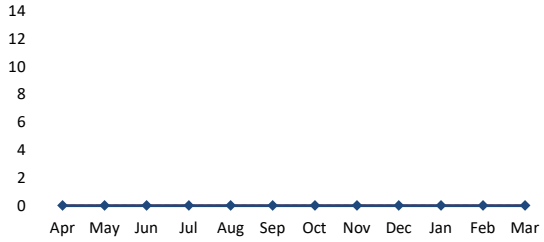


The increase in OP response rate, though genuine, may be slightly inflated by a data collection issue at the end of January which meant that some January responses have been counted in February's data.

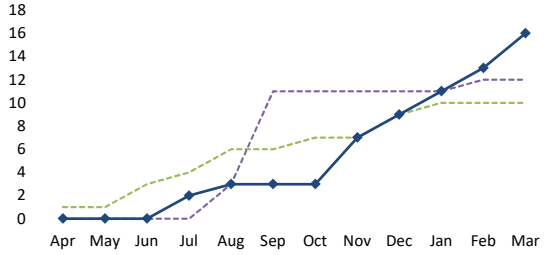
Quality of Care

Infection Control

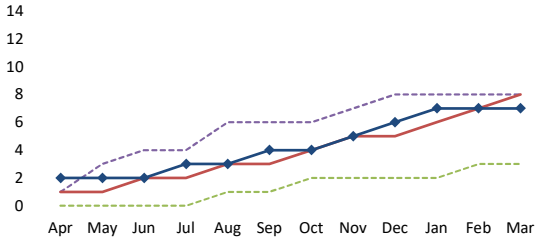
MRSA Bacteraemia



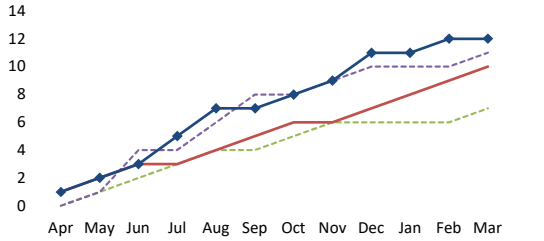
CPE



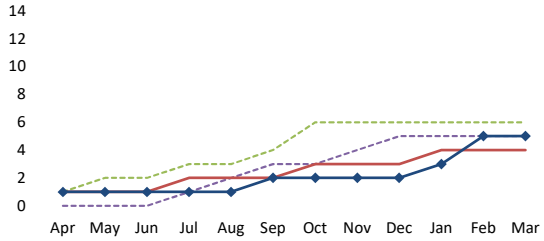
Clostridium difficile



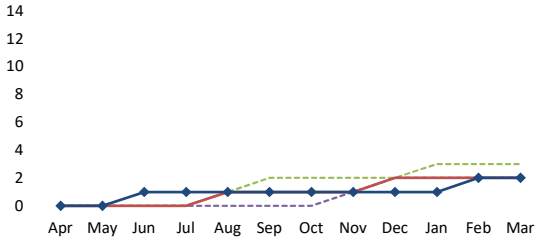
E.Coli



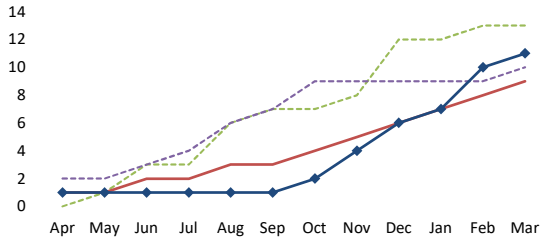
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



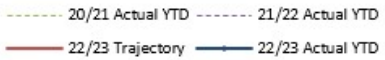
Total Healthcare Acquired Infections 2022/23

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		5		3	2			**10**
Caton		3	2	2		1		**8**
Chavasse		1	1	4				**6**
CRU		2	1	1	1	1	1	**7**
Dott		2		1	1		1	**5**
Horsley		2	2	1	1		9	**15**
Lipton		1	1					**2**
Sherrington								**0**
Total	**0**	**16**	**7**	**12**	**5**	**2**	**11**	**53**

March Breakdown by Ward

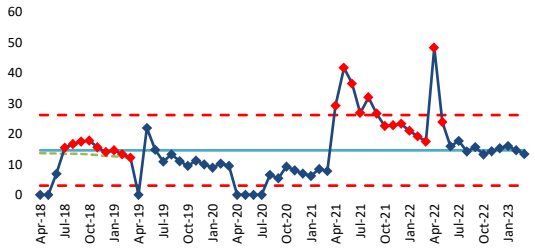
2 x CPE on Cairns
1 x CPE on Dott
1 x MSSA on Horsley

Legend for all charts

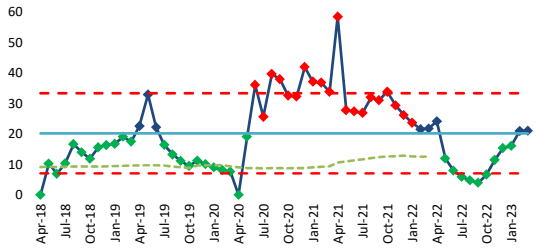


Infection Control

Clostridium difficile Rate per 100,000 Bed Days YTD



MSSA Rate per 100,000 Bed Days YTD

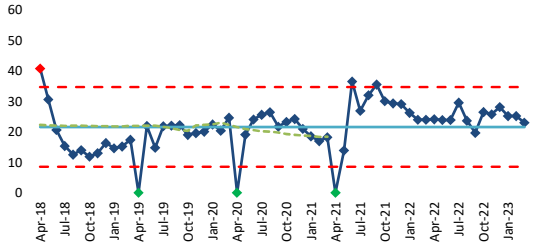


All infection rates are within normal variation this month.

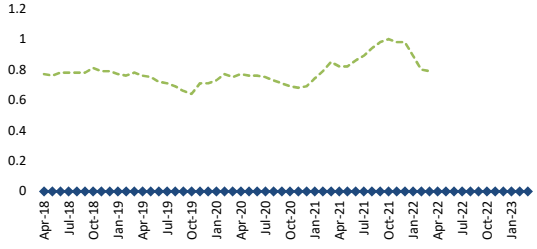
2022/23 to date

Infection	Number	Rate
C. Diff	7	13.43
MSSA	11	21.10
E. Coli	12	23.02
MRSA	0	0.00
Klebsiella Bacteriama	5	9.59
Pseudomonas Baterian	2	3.84
Covid -19	6	(in month)

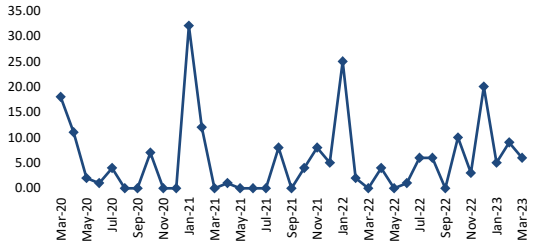
E.Coli Rate per 100,000 Bed Days YTD



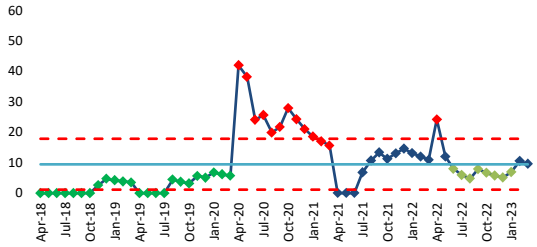
MRSA Rate per 100,000 Bed Days YTD



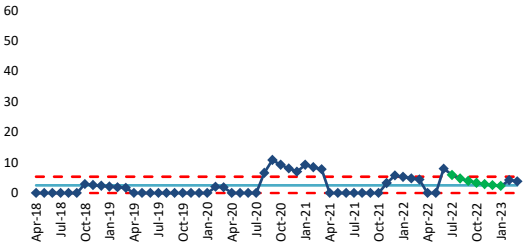
Covid-19 Nosocomial Infections



Klebsiella Rate per 100,000 Bed Days YTD



Pseudomonas Rate per 100,000 Bed Days YTD



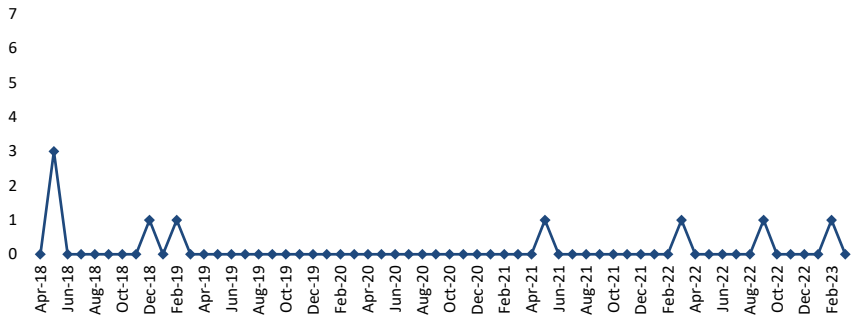
Quality of Care

Harm Free Care

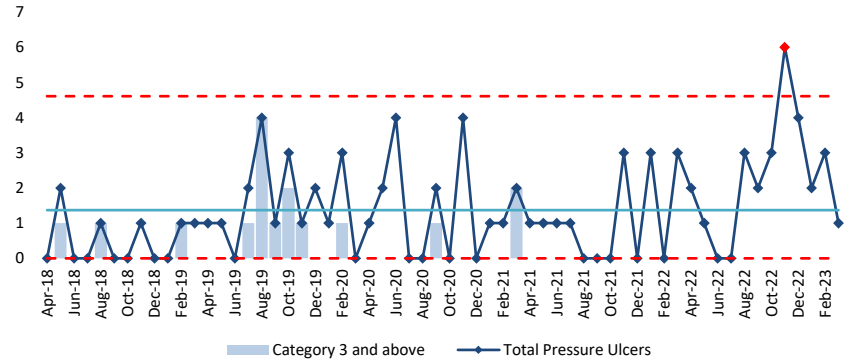
Pressure Ulcers: There was one category 2 pressure ulcer (device related) and one deep tissue injury in March. The TV education programme continues and scheduled dates for 2023/24 have been circulated, with bespoke ward based training currently being offered. A TV resource folder has been devised and will shortly be distributed to all ward areas. TV are currently leading on the evaluation of a new NG fixator, in conjunction with the Cheshire and Merseyside product evaluation group, to support a reduction in

CAUTI: There were no CAUTI incidents this month.
VTE: There were no VTE incident in month.
Falls: There were no moderate and above harm falls in March.
All harm measures are within normal variation this month.

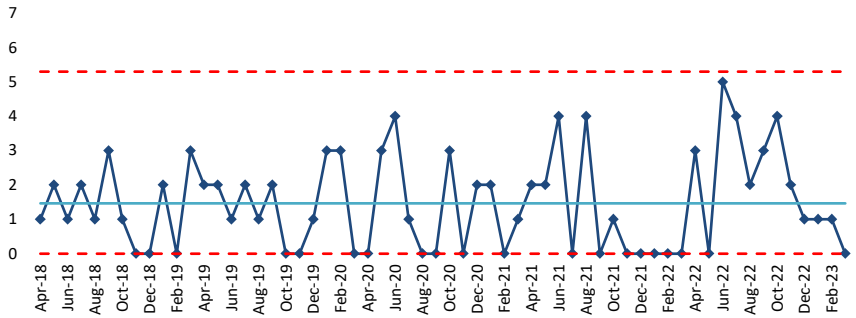
Total Moderate or Above Harm Inpatient Falls



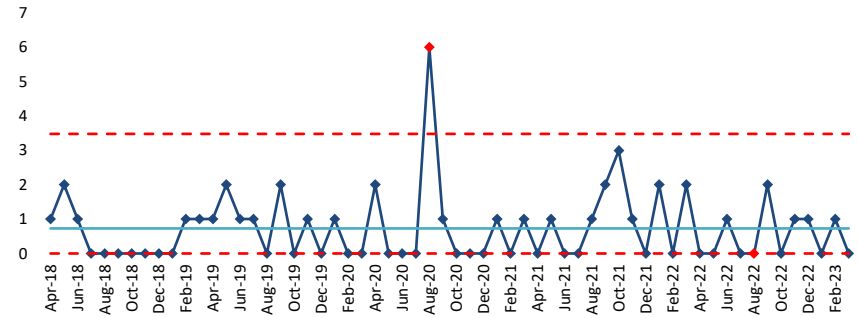
Total Hospital Acquired Pressure Ulcers



CAUTI Incidences



VTE Incidences

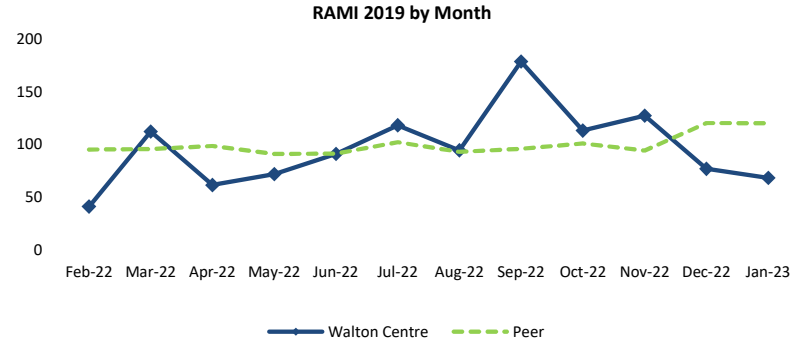


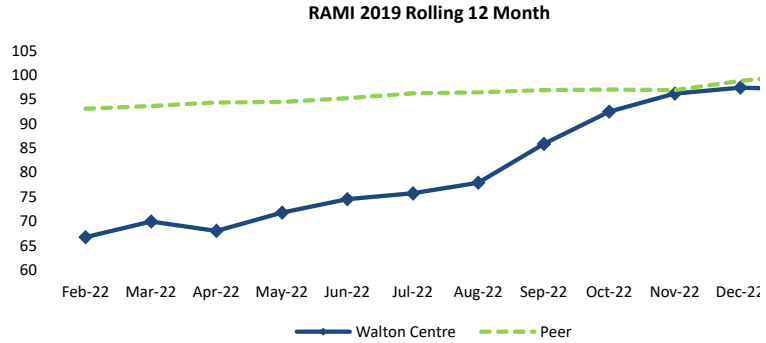
Quality of Care

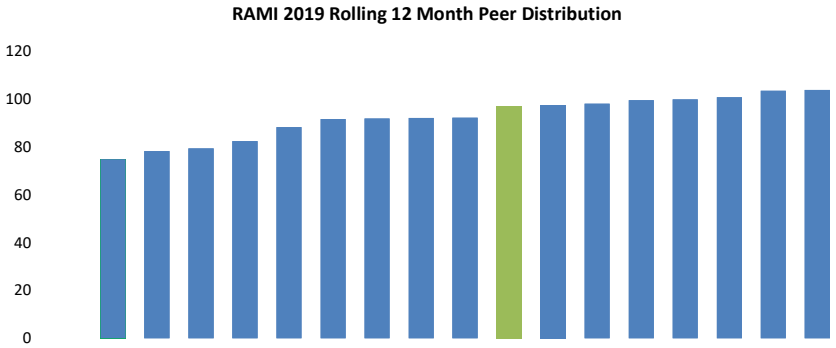
Mortality

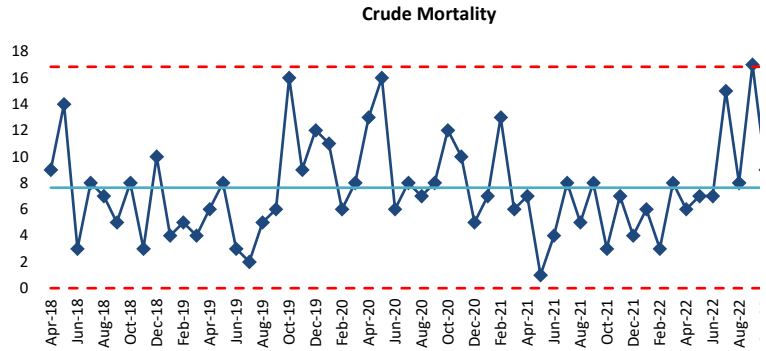
As at Januaryr 2022 the rolling 12 month RAMI19 figure is 97.08. During the period there were a total of 96 observed deaths against 99 expected deaths. When viewed aga peers the Walton Centre has slipped to 10th position. In month RAMI figures for WCFT in January have decreased again compared to December, and remains below peers. increase in rolling twelve month RAMI figures has levelled off this month. When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 9

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





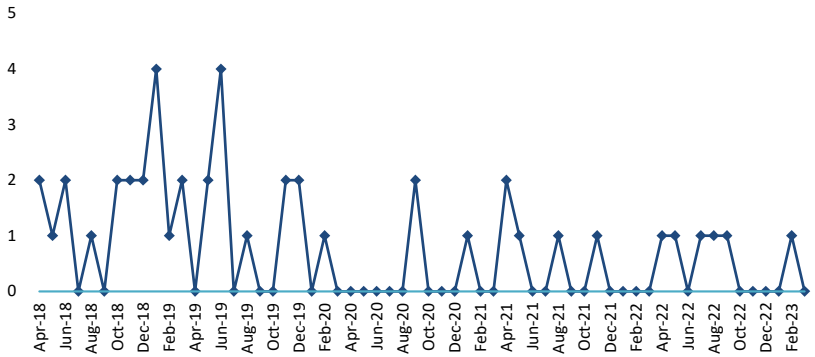




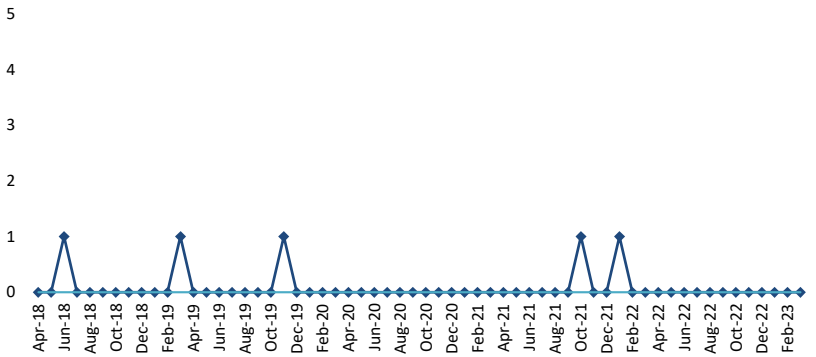
Quality of Care - Safe

Governance

Total Confirmed SIs Reported



Total Confirmed Never Events Reported



Quality of Care

Ward Scorecard

Number of shifts judged in each of the four categories and number flagged overall	Safe Staffing						Harms				Infection Control			
	Green	Grey	Amber	Red	Flagged	Walton Cares	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	8	23	58	4		Gold	0	0	0	0	0	0	0	0
Caton	25	70	1	8		Silver	0	0	0	0	0	0	0	0
Chavasse	0	22	60	11	1	Gold	0	0	0	0	0	0	0	0
CRU	0	36	56	1			0	0	0	0	0	0	0	0
Dott	10	41	40	2	1	Gold	0	0	0	0	0	0	0	0
Horsley ITU	61	24	7	1			0	0	0	0	0	1	0	0
Lipton	48	34	8	3		Silver	0	0	0	0	0	0	0	0

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

Utilisation Key

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

WELL LED

Finance

Key Performance Indicators	January	February	March
% variance from plan - Year to date	38.2%	50.3%	33.4%
% variance from plan - Forecast	59.4%	59.4%	33.4%
% variance from efficiency plan - Year to date	1.3%	0.6%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	33.1%	33.8%	1.8%
Capital % variance from plan - Forecast	0.0%	0.0%	1.8%
Capital Service Cover *	3.3	3.5	4.6
Liquidity **	41.7	43.4	36.0
Cash days operating expenditure ***	104.1	106.3	102.2
BPPC - Number	83.5%	83.8%	83.0%
BPPC - Value	82.3%	82.4%	82.8%

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

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

Trust I&E	In month			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	13,254	21,925	8,671	158,610	173,143	14,533
Other operating income	645	2,455	1,810	7,728	8,341	613
Donated Income	0	78	78	0	78	78
Total Operating Income	**13,899**	**24,458**	**10,559**	**166,338**	**181,562**	**15,224**
Employee expenses	(7,014)	(14,702)	(7,688)	(84,722)	(92,477)	(7,755)
Operating expenses excluding employee expenses	(6,403)	(9,586)	(3,183)	(77,030)	(84,026)	(6,996)
Total Operating Expenditure	**(13,417)**	**(24,288)**	**(10,871)**	**(161,752)**	**(176,503)**	**(14,751)**
EBIT	**482**	**170**	**(312)**	**4,586**	**5,059**	**473**
Finance income	20	144	124	240	857	617
Finance expense	(50)	(48)	2	(583)	(550)	33
PDC dividends payable/refundable	(136)	(190)	(54)	(1,639)	(1,714)	(75)
Other gains/(losses) including disposal of assets	0	0	0	0	(6)	(6)
Financial performance surplus/(deficit)	**316**	**76**	**(240)**	**2,604**	**3,646**	**1,042**
I&E impact capital donations and profit on asset disposals	22	(57)	(79)	264	179	(85)
Adjusted financial performance surplus/(deficit)	**338**	**19**	**(319)**	**2,868**	**3,825**	**957**

Month 12 – in month £319k behind plan and full Year £957k ahead of plan. The final outturn position was £0.7m lower than forecast due to adjustments made to allow for consistency with the prior year. The key drivers for the full Year favourable variance are due to 22/23 final agreed Welsh contract being higher than plan, increased interest receivable (due to interest rate increases) and higher than planned level of vacancies (that have not been backfilled with bank/ agency).

Income – Full Year overperformance of £15,224k, due to:

- Increased NHS England funding relating to the 2022/23 pay award.
- Increased WHSSC funding relating to final agreed contract being above plan.
- Increased reimbursement for High-Cost Drugs and Devices due to higher volumes being used.
- Increased Isle of Man activity (which is paid on PbR basis).
- Increased level of Health Education England funding.
- Offset by risk around thrombectomy, transcranial ultrasound, spinal activity, and Spinal ERF activity.
- Increased income due to additional pay award and additional contribution to pension both offset by pay.

ERF income has been reported to plan and forecast in line with reporting guidance issued by NHS England. ERF Income is reported under patient related income.

Expenditure (inc. Financing Costs) – Final Year over-spend of £14,182k due to:

- Increased pay costs due to 2022/23 pay award being higher than was assumed by NHSE at budget setting.
- Increased spend on High-Cost Drugs and Devices including spend on Botox that is not reimbursed as it is no longer classed as an excluded drug.
- Offset by Non-recurrent vacancy savings and increased interest receivable.
- Increased pay due to additional pay award and additional contribution to pension both offset by income.

It should be noted that the ICS have agreed an additional capital funding allocation of c. £0.5m for 23/24 due to the forecast I & E over performance

STATEMENT OF FINANCIAL POSITION - 2022/23	Plan Mar-23	Actual Mar-23	Variance
	£'000	£'000	£'000
Intangible Assets	567	931	364
Tangible Assets	96,119	103,996	7,877
Right of use assets - leased assets	43	823	780
Receivables	428	324	(104)
TOTAL NON CURRENT ASSETS	**97,157**	**106,074**	**8,917**
Inventories	1,841	1,042	(799)
Receivables	6,315	7,401	1,086
Cash at bank and in hand	34,818	47,718	12,900
TOTAL CURRENT ASSETS	**42,974**	**56,161**	**13,187**
Payables	(24,003)	(36,615)	(12,612)
Borrowings	(1,605)	(1,757)	(152)
Provisions	(55)	(80)	(25)
TOTAL CURRENT LIABILITIES	**(25,663)**	**(38,452)**	**(12,789)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**114,468**	**123,783**	**9,315**
Borrowings	(20,852)	(21,502)	(650)
Provisions	(707)	(527)	180
TOTAL ASSETS EMPLOYED	**92,909**	**101,754**	**8,845**
Public Dividend Capital	37,291	38,028	737
Revaluation Reserve	7,377	14,411	7,034
Income and Expenditure Reserve	48,241	49,315	1,074
TOTAL TAXPAYERS EQUITY AND RESERVES	**92,909**	**101,754**	**8,845**

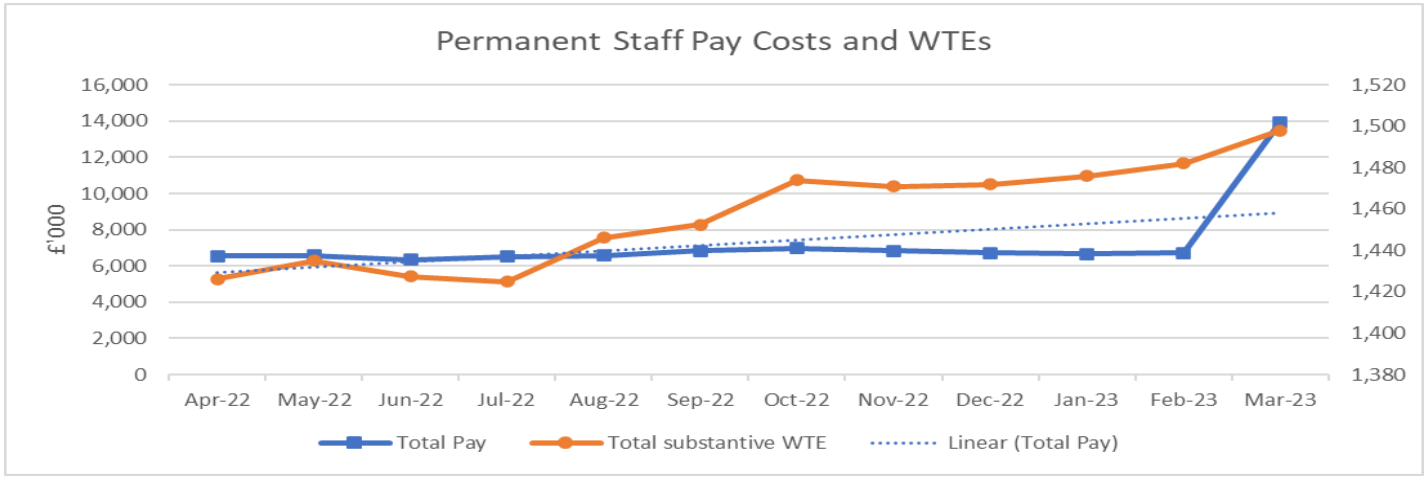
Tangible assets increase is due to full revaluation exercise carried out as part of year end valuation. This is not final and subject to final discussion and agreement with Trust Valuers.

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

STATEMENT OF CASH FLOW - 2022/23	Plan Mar-23	Actual Mar-23	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**4,586**	**5,061**	**475**
Non-cash income and expense:	7,210	7,317	107
Working Capital	(1,381)	6,748	8,129
Net cash generated from/(used in) operations	**10,415**	**19,126**	**8,711**
Cash flows from investing activities	(13,561)	(12,526)	1,035
Cash flows from financing activities	(1,108)	395	1,503
Increase/(decrease) in cash and cash equivalents	**(4,254)**	**6,995**	**11,249**
OPENING CASH	**39,072**	**40,723**	**1,651**
CLOSING CASH	**34,818**	**47,718**	**12,900**

Final Year - £47,718k cash balance compared to £34,818k plan, a Final Year favourable variance of £12,900k:

- Opening cash balance against plan: £1,651k
- Operating surplus above plan: £473k
- Movement in inventories: £577k
- Movement in payables/receivables: £7,079k
- Movement in deferred income: £544k
- Interest Receivable: £617k
- Capital programme: £340k
- Public dividend capital drawdown below plan: £736k
- Other balance sheet movements: £883k
- **Total** **£12,900k**



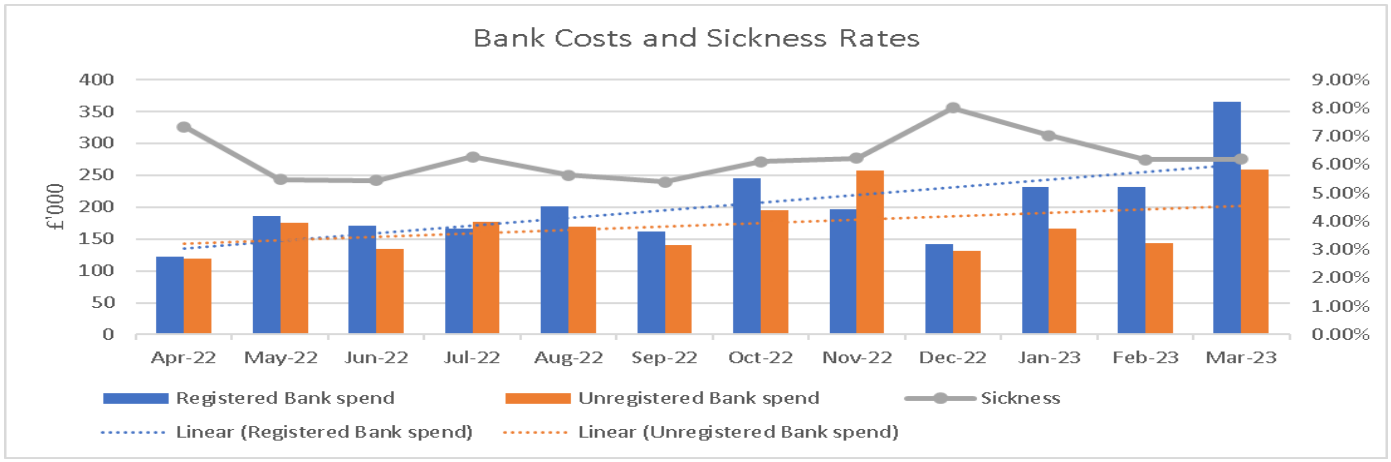
September 2022 increase caused by six months backpay being paid relating to pay award. March 2023 increase is due to additional pay award and additional pension contribution, both offset in income.

Pay costs:

- Jan: £6,653k
- Feb: £6,734k
- Mar: £13,947k

WTE:

- Jan: 1,476 WTE
- Feb: 1,482 WTE
- Mar: 1,498 WTE



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

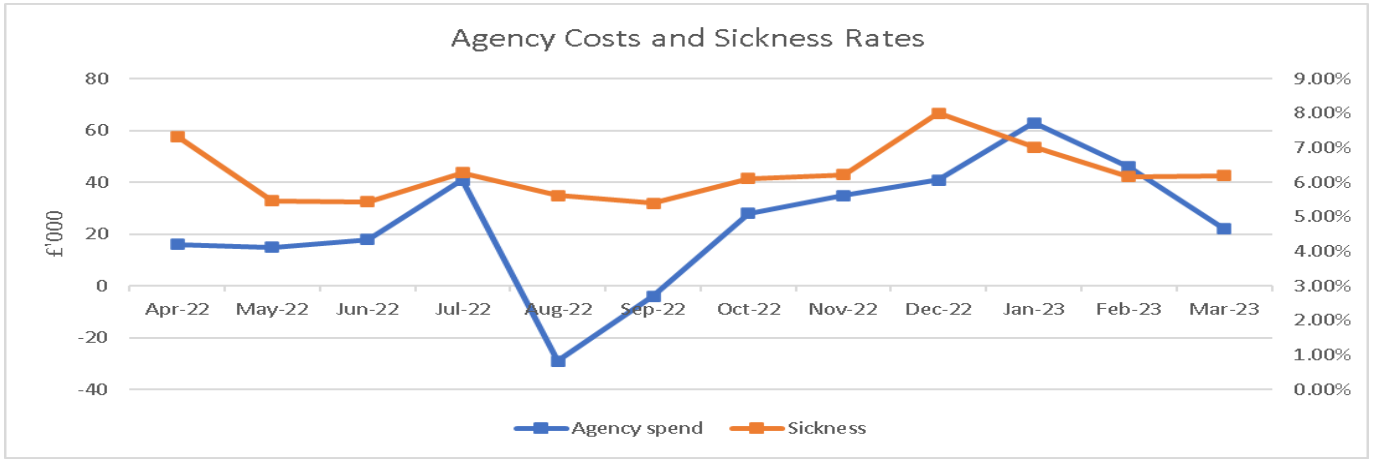
Increase in Registered Bank costs in October 2022, January 2023 and February 2023 across all wards. Increase in November 2022 due to pay award for all bank staff backdated to April 2022. Increase in March 23 is provision for pay award backdating to bank staff.

Nursing Bank costs:

- Jan: £397k
- Feb: £375k
- Mar: £624k

Sickness rate:

- Jan: 7.00%
- Feb: 6.33%
- Mar: 6.19%



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

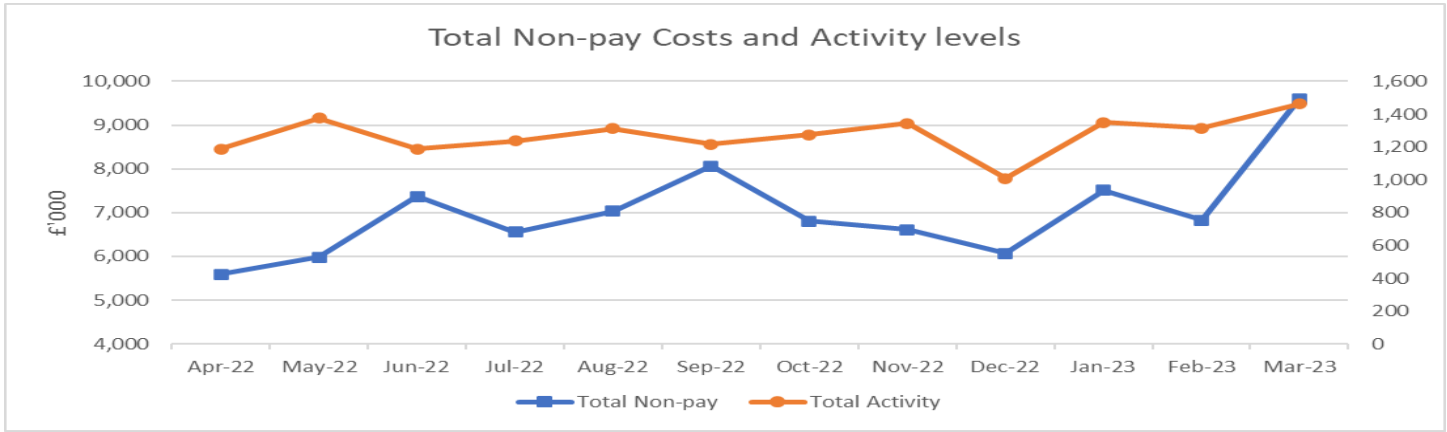
Prior year reversal in August and September, as all invoices have been received, with actual costs being lower than anticipated at the end of the year. Increase in recent months due to increased usage of agency medics.

Agency costs:

- Jan: £63k
- Feb: £46k
- Mar: £22k

Sickness rate:

- Jan: 7.00%
- Feb: 6.33%
- Mar: 6.19%



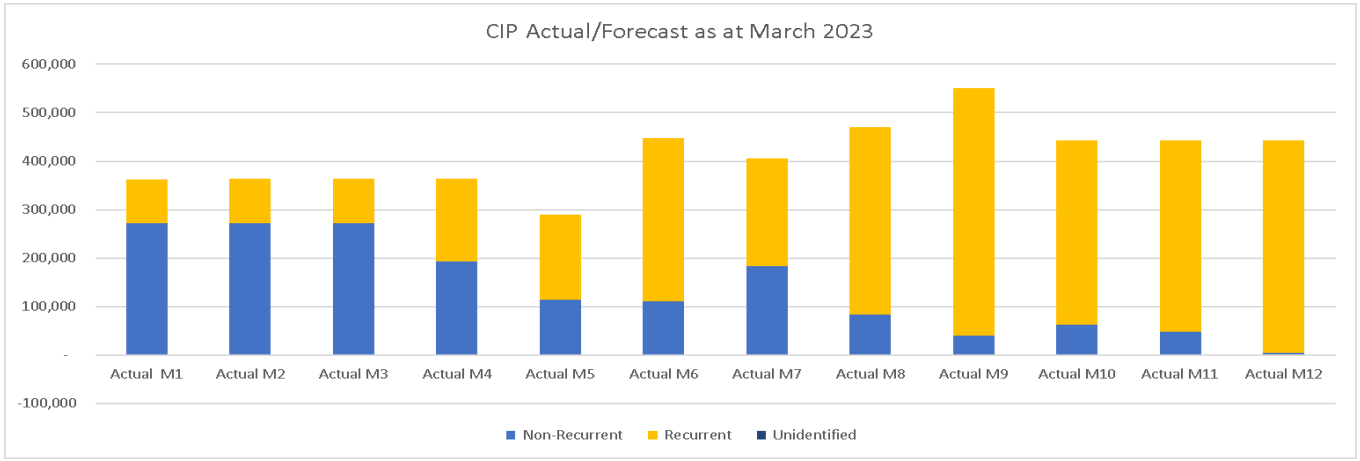
Increased costs in March 2023 are caused by increased consumable spend at the financial year end and works carried out by Estates.

Non-pay costs:

- Jan: £7,507k
- Feb: £6,831k
- Mar: £9,588k

Inpatient activity:

- Jan: 1,351 spells
- Feb: 1,307 spells
- Mar: 1,463 spells



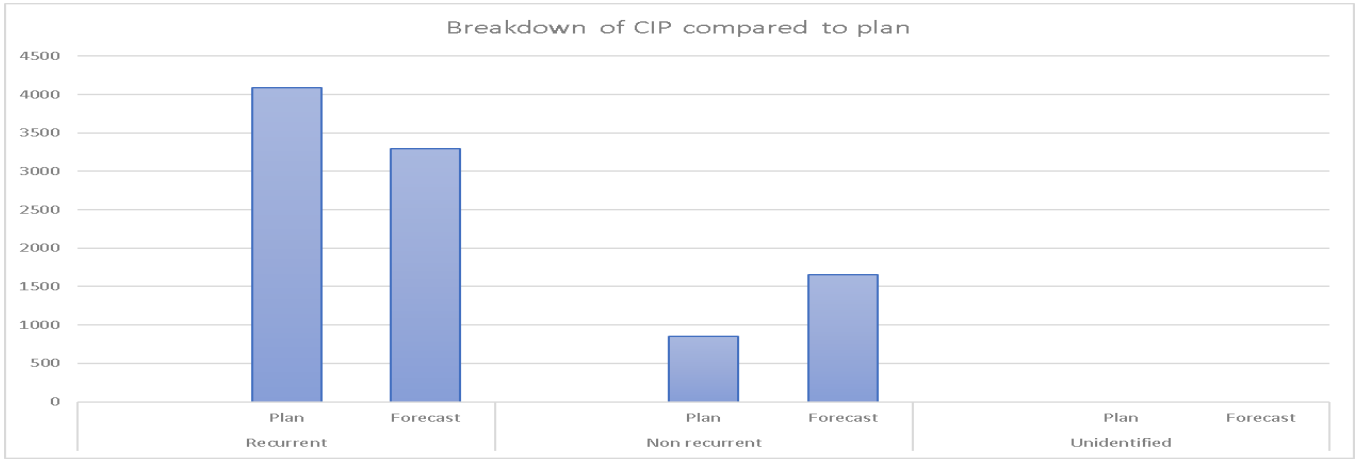
The trust has achieved the full CIP target of £4.9m for the financial year.

Recurrent CIP:

- Jan: £2,459k
- Feb: £2,854k
- Mar: £3,292k

Non-recurrent CIP:

- Jan: £1,602k
- Feb: £1,650k
- Mar: £1,653k



- All CIP has been identified at month 12.
- £4.1m (82.7%) of the CIP plan was required to be delivered recurrently.
- At the end of the year £3.3m (66.5%) was delivered recurrently with the remainder non-recurrent (£1.65m/33.5%).

PATIENT RELATED INCOME

	In month			Final Year		
Patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
NHS England	9,219	14,718	5,499	110,426	119,750	9,324
Clinical Commissioning Groups - ICB	2,131	2,136	5	25,323	25,705	382
Wales	1,705	2,287	582	20,464	21,935	1,471
Isle of Man	140	233	93	1,677	2,406	729
Other Patient Related Income	59	1,547	1,488	720	1,055	335
Total Patient Related Income	**13,254**	**20,921**	**7,667**	**158,610**	**170,851**	**12,241**

To note that patient related income includes ERF income

NON-PATIENT RELATED INCOME

	In month			Final Year		
Non-patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Research & Development Income	65	91	26	783	1,072	289
Education And Training	269	451	182	3,223	3,819	596
Employee Benefits Income	220	281	61	2,635	1,923	(712)
Other Non-patient Related Income	91	2,714	2,623	1,087	3,898	2,811
Total Patient Related Income	**645**	**3,537**	**2,892**	**7,728**	**10,712**	**2,984**

ERF

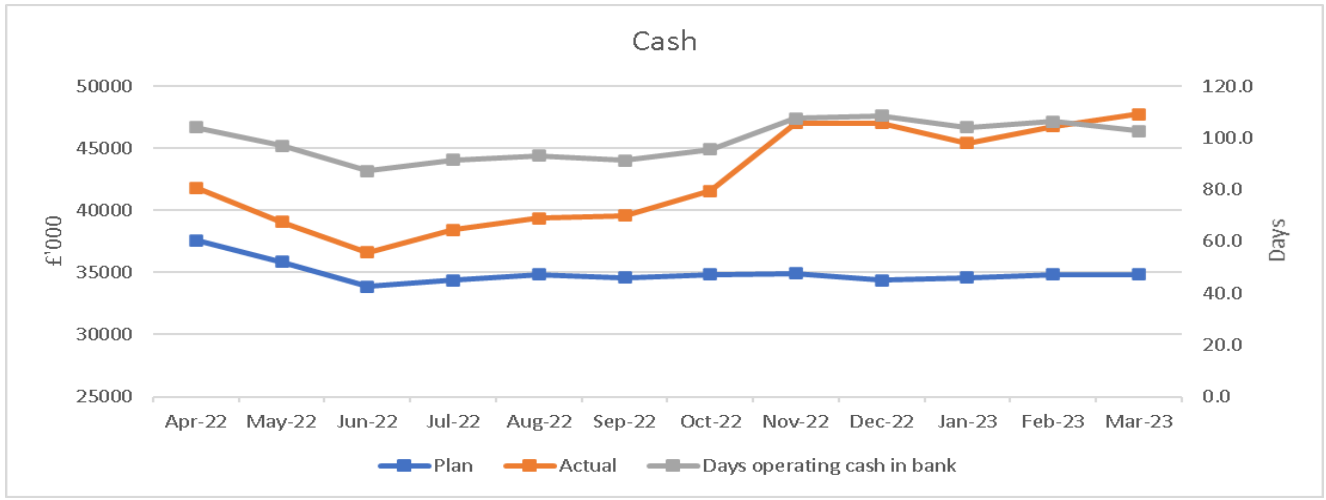
	In month			Final Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Elective Recovery Funding	366	329	(37)	3,947	3,945	(2)

To note: for reporting purposes, Trusts have been asked to include all planned ERF up to month 12. The year-to-date variance is due to the difference in phasing of ERF payments compared to plan.

CAPITAL

	In month			Final Year		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division						
Heating & Pipework	100	1,107	(1,007)	1,200	2,263	(1,063)
Estates	70	583	(513)	836	645	191
IM&T	99	(24)	123	593	339	254
Neurology	0	107	(107)	0	151	(151)
Neurosurgery	1,926	1,584	342	3,109	2,058	1,051
Corporate	0	82	(82)	0	105	(105)
TOTAL (excl. external funding)	**2,195**	**3,439**	**(1,244)**	**5,738**	**5,561**	**177**
Donated Assets	78	78	0	78	78	0
Right of Use Assets - robot (Globus)	907	888	19	907	907	0
Digital Aspirant (PDC)	223	917	(694)	2,675	2,675	0
Diagnostics Digital Capability (PDC)	302	302	0	510	510	0
IM&T - LIMS (PDC)	14	12	2	14	12	2
IM&T - Cyber Security (PDC)	80	77	3	80	77	3
Neurosurgery Cancer Treatment Fund (PDC)	132	132	0	132	132	0
TOTAL (incl. external funding)	**1,736**	**2,406**	**(670)**	**4,396**	**4,391**	**5**
TOTAL	**3,931**	**5,845**	**(1,914)**	**10,134**	**9,952**	**182**

- Capital expenditure in month of £5,845k
- Final Year Capital spend of £9,952k, £2,675k of which is Digital Aspirant.
- Final spend on divisional schemes includes:
  - Heating and pipework replacement
  - Bed repurposing
  - Radiology Syngo equipment
  - Theatres Brain lab, operating table and S7 equipment
  - Walk in freezer and alterations
  - IT Staffing
- Additional Public Dividend Capital (PDC) has been secured in relation to Digital Diagnostic Capability programme (£510k) & IM&T – LIMS and Cyber Security (£94k), which have been incorporated into the capital plan and forecast. Funding has been secured in M12 from the Cancer Treatment fund for the purchase of an ultrasound machine (£132k).

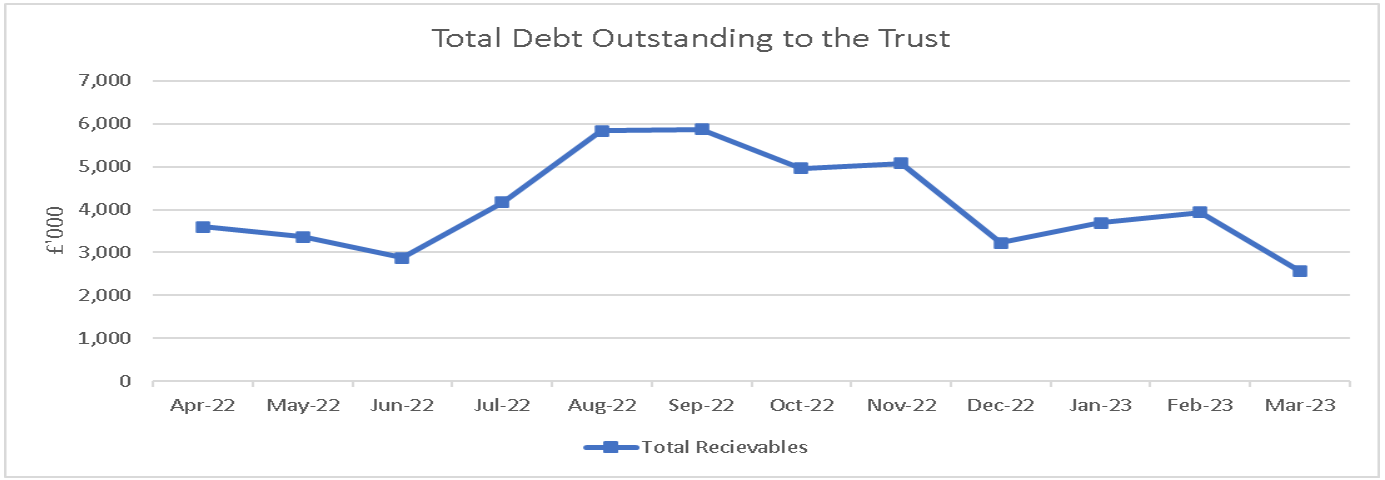


Cash:

- Jan: £45,411k
- Feb: £46,755k
- Mar: £47,718k

Operating expenditure days cover:

- Jan: 104.1 days
- Feb: 106.3 days
- Mar: 102.6 days



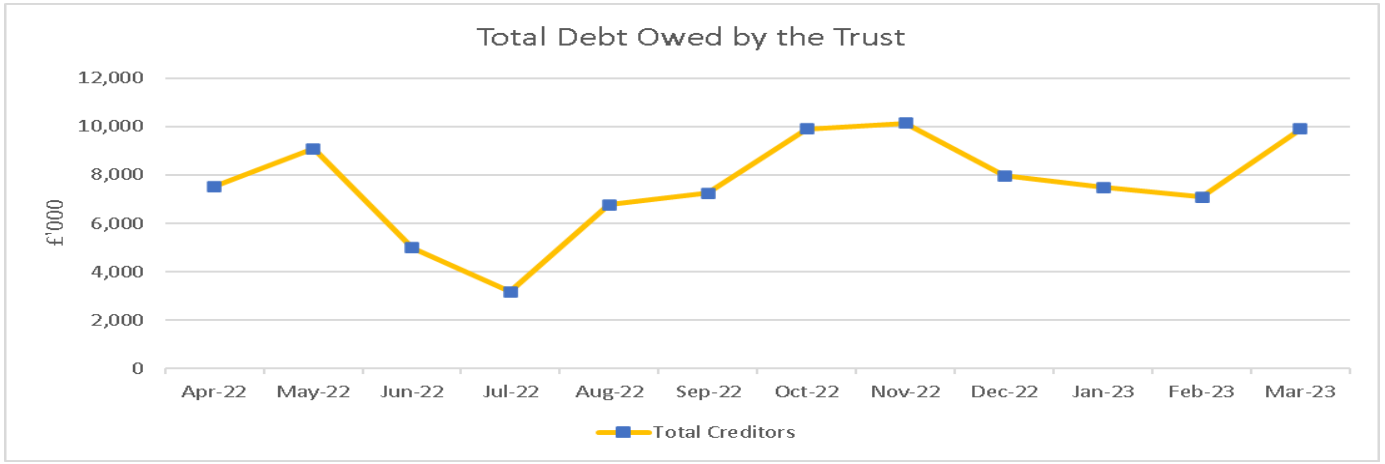
August and September 2022 increase, due to WHSSC year-end settlement invoice, Isle of Man M1-4 invoice, and Health Education England M4-6 invoice.

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

Isle of Man M1-4 invoice settled in January.

Debt outstanding to Trust:

- Jan: £3,689k
- Feb: £3,938k
- Mar: £2,567k

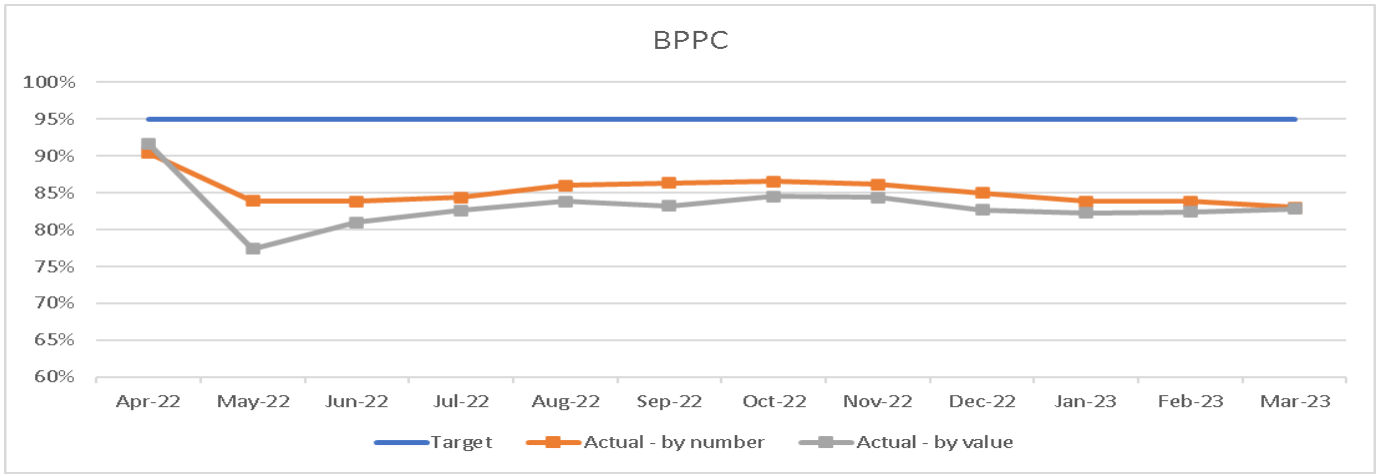


Debt owed by the Trust:

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

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

- Jan: £7,492k
- Feb: £7,088k
- Mar: £9,905k



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

- The Trust BPPC percentage (by number of invoices paid) at the end of March is 83.0%. This has reduced from 83.8% at the end of February.
- The Trust BPPC percentage (by value of invoices paid) at the end of March is 82.8%. This has improved from 82.4% at the end of February
- The Trust has been contacted by NHS England requesting an Action plan to improve BPPC performance. This involves collaborative working across the finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner prior to breaching the 30-day limit.
- BPPC is also being closely monitored by Audit Committee.

EXPENDITURE - NEUROLOGY

	In month			Final Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(481)	(417)	64	(5,634)	(4,995)	639
Allied health professionals	(518)	(485)	33	(6,101)	(5,888)	213
Other scientific, therapeutic and technical staff	(108)	(82)	26	(1,312)	(1,059)	253
Health care scientists	(63)	(68)	(5)	(754)	(761)	(7)
Support to nursing staff	(289)	(263)	26	(3,224)	(2,974)	250
Support to allied health professionals	(81)	(83)	(2)	(936)	(940)	(4)
Support to other clinical staff	(1)	0	1	(15)	(16)	(1)
Medical - Consultants	(1,174)	(1,221)	(47)	(10,278)	(9,881)	397
Medical - Junior	(247)	(278)	(31)	(2,911)	(2,851)	60
NHS infrastructure support	(209)	(199)	10	(2,437)	(2,271)	166
Bank/Agency	(108)	(280)	(172)	(743)	(2,184)	(1,441)
Total Pay Expenditure	**(3,279)**	**(3,376)**	**(97)**	**(34,345)**	**(33,820)**	**525**
Non-executive directors	0	1	1	0	0	0
Supplies and services – clinical (excluding drugs costs)	(677)	(1,060)	(383)	(8,130)	(9,560)	(1,430)
Supplies and services - general	(17)	30	47	(209)	(187)	22
Drugs costs	(1,736)	(3,127)	(1,391)	(20,830)	(27,357)	(6,527)
Establishment	(2)	(7)	(5)	(23)	(34)	(11)
Premises - other	(111)	(252)	(141)	(1,334)	(1,056)	278
Transport	(5)	(5)	0	(63)	(72)	(9)
Education and training - non-staff	(1)	(49)	(48)	(13)	(67)	(54)
Lease expenditure	(5)	(6)	(1)	(64)	(56)	8
Other	(5)	(13)	(8)	(57)	(85)	(28)
Total Non-pay Expenditure	**(2,559)**	**(4,488)**	**(1,929)**	**(30,723)**	**(38,474)**	**(7,751)**
Total Divisional Operating Expenditure	**(5,838)**	**(7,864)**	**(2,026)**	**(65,068)**	**(72,294)**	**(7,226)**

EXPENDITURE - NEUROSURGERY

	In month			Final Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,224)	(1,157)	67	(14,741)	(13,594)	1,147
Allied health professionals	(189)	(209)	(20)	(2,246)	(2,303)	(57)
Other scientific, therapeutic and technical staff	(52)	(47)	5	(629)	(589)	40
Health care scientists	(78)	(74)	4	(938)	(907)	31
Support to nursing staff	(264)	(252)	12	(3,456)	(3,280)	176
Support to allied health professionals	(13)	(15)	(2)	(151)	(154)	(3)
Support to other clinical staff	(2)	(2)	0	(14)	(14)	0
Medical - Consultants	(1,058)	(1,093)	(35)	(9,432)	(9,595)	(163)
Medical - Junior	(377)	(430)	(53)	(4,475)	(4,623)	(148)
NHS infrastructure support	(224)	(215)	9	(2,621)	(2,410)	211
Bank/Agency	(70)	(352)	(282)	(544)	(2,556)	(2,012)
Total Pay Expenditure	**(3,551)**	**(3,846)**	**(295)**	**(39,247)**	**(40,025)**	**(778)**
Supplies and services – clinical (excluding drugs costs)	(1,378)	(1,547)	(169)	(16,536)	(16,570)	(34)
Supplies and services - general	(21)	(40)	(19)	(258)	(323)	(65)
Drugs costs	(71)	(78)	(7)	(858)	(1,051)	(193)
Establishment	(9)	(14)	(5)	(109)	(138)	(29)
Premises - other	(50)	(173)	(123)	(595)	(713)	(118)
Transport	(2)	(4)	(2)	(27)	(68)	(41)
Education and training - non-staff	(5)	(7)	(2)	(54)	(41)	13
Lease expenditure	(6)	(7)	(1)	(69)	(89)	(20)
Other	(21)	(22)	(1)	(249)	(188)	61
Total Non-pay Expenditure	**(1,563)**	**(1,892)**	**(329)**	**(18,755)**	**(19,181)**	**(426)**
Total Divisional Operating Expenditure	**(5,114)**	**(5,738)**	**(624)**	**(58,002)**	**(59,206)**	**(1,204)**

EXPENDITURE - CORPORATE

	In month			Final Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(113)	(199)	(86)	(1,353)	(1,430)	(77)
Support to nursing staff	(1)	0	1	(11)	(9)	2
Medical - Consultants	(6)	(7)	(1)	(77)	(81)	(4)
NHS infrastructure support	(891)	(893)	(2)	(10,798)	(10,185)	613
Apprenticeship Levy	(24)	(25)	(1)	(287)	(307)	(20)
Bank/Agency	(14)	(22)	(8)	(164)	(297)	(133)
Total Pay Expenditure	**(1,049)**	**(1,146)**	**(97)**	**(12,690)**	**(12,309)**	**381**
Non-executive directors	(12)	(11)	1	(150)	(123)	27
Supplies and services – clinical (excluding drugs costs)	(12)	(27)	(15)	(311)	(320)	(9)
Supplies and services - general	(294)	(315)	(21)	(3,523)	(3,446)	77
Consultancy	(6)	(27)	(21)	(68)	(83)	(15)
Establishment	(84)	(135)	(51)	(1,032)	(1,160)	(128)
Premises - business rates payable to local authorities	(65)	(65)	0	(778)	(778)	0
Premises - other	(480)	(1,464)	(984)	(5,762)	(5,797)	(35)
Transport	(6)	(42)	(36)	(68)	(438)	(370)
Audit fees and other auditor remuneration	(12)	(9)	3	(141)	(113)	28
Clinical negligence	(475)	(475)	0	(5,704)	(5,705)	(1)
Education and training - non-staff	(16)	(117)	(101)	(197)	(436)	(239)
Lease expenditure	0	4	4	0	10	10
Other	(97)	(68)	29	(1,169)	(1,498)	(329)
Total Non-pay Expenditure	**(1,559)**	**(2,751)**	**(1,192)**	**(18,903)**	**(19,887)**	**(984)**
Total Divisional Operating Expenditure	**(2,608)**	**(3,897)**	**(1,289)**	**(31,593)**	**(32,196)**	**(603)**

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

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 4/5/2023		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 25/04/23		**Membership Numbers: 6 (Quorate)**
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report • Information Strategy Closure Update • Follow Up Waiting List Update • QIP Annual Programme • Strategic PMO Quarterly Update • NHS Digital Maturity Assessment Update • Digital Transformation Monthly Update • Equality, Diversity and Inclusion Annual Report • Committee Effectiveness and Terms of Reference Review • Digital Strategy Group Terms of Reference • Information and Data Quality Assurance Group Effectiveness Review • Information Governance and Security Forum Effectiveness Review • Heating and Pipework Committee Effectiveness Review • 2023/24 Financial Plan Update
2	**Alert**	• The forthcoming nurses strike will impact operational performance; there is particular concern for the impact on ITU if there are no derogations.
3	**Assurance**	*Integrated Performance Report* • February's activity was strong, especially for elective & day cases and outpatients. • All cancer wait/treatment and diagnostic standards continue to be achieved • The number of long waiters (52+ weeks) continued to reduce (there are none 78+); a bigger focus is now shifting to restore improvement in average waits after Referral to Treatment. • Outpatient waiting lists remain high but are starting to reduce in line with the impact of the comprehensive revalidation project now being implemented; appointments not attended continues as a focused transformation project; the proportion moved to Patient Initiated Follow Up (PIFU) at 6.2% exceeded the end-year target of 5%, an exemplar within the Integrated Care System (ICS) and is expected to continue to increase. • Sickness reduced slightly to 6.2%. Vacancy levels remain very low (~2% overall). Appraisal compliance made a step-change increase to 84% and mandatory training compliance increased slightly; both continue to receive leadership focus and Committee agreed target of September to see both measures at target. • Subject to external audit, the draft end-of-year Income and Expenditure outcome was a £4.6m surplus (£1.7m better than original plan). The Committee requested

		that the draft position was reviewed before being finalised to ensure that all costs are incorporated and there was a consistent approach to prior year. All Cost Improvement Projects (CIP) delivered, albeit the proportion of recurrent at 67% was lower than the 83% planned. • Cash balance at £47.7m exceeded plan and equates to 103 days of operational expenditure. • Full year capital spend at £10m achieved plan after a significant burst of spend in March. • Performance paying creditors on time (Better Payment Practice Code) continues to be well below plan, with continued focus aimed at improvement; a deep dive was made at the recent Audit Committee. *Other matters* • A closure review of the legacy Information Strategy demonstrated almost all objectives were achieved; of particular note is the Data Quality Index (DQMI) which at 99.4% is one of the highest in the NHS, and the accuracy of Clinical Coding which exceeds mandatory and advisory targets by a margin. • The results of the first phase of implementation of the Follow-Up Waiting List (FOWL) clinical review project show 30% reductions to the waiting list, albeit somewhat less than the pilot, and with some wide variation between consultants (partly because of differences in what's appropriate for different long-term conditions). The project will continue through 2023. • The initial 2023/24 CIP/Quality Improvement Plan shows that 25% of the full year target has been identified, with a healthy inventory of further candidate ideas which will now be evaluated. • The ED&I annual report was reviewed. The new Health Inequalities Committee will from now on take stewardship of this. • A digital maturity assessment, which has been peer reviewed with other trusts and by NHSE and McKinsey, was reviewed and passed for Board approval. • A refocused Digital Strategy Group was relaunched to oversee implementation of the Digital Sub-Strategy; the Terms of Reference (ToR) will be updated in line with comments made. • The annual effectiveness review of BPC indicates positive impact and a focus on continual improvement; an updated ToR is presented to Board for approval. • Annual effectiveness reviews of 3 sub-groups were reviewed and updated ToR's were approved. • Key Issues reports from 9 subgroups were received and noted; no alerts presented.		
4.	**Advise**	• The 2023/24 ICS financial plan continues to adapt and develop. The latest update will be presented to closed Board. • The Strategic Project Management Office (SPMO) is now operational, overseeing priorities focused on transformation of elective patient pathways and outpatients, together with monitoring improvement projects arising from all sub-strategies. There are lots of ideas and positive energy evident. • An updated format of report for digital transformation was received.		
5.	**Risks Identified**	It was recommended that Audit Committee review the thresholds of delegated financial authority in line with the proposals tabled at BPC last month aimed at improving the business case process.		
6.	**Report Compiled**	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 4/5/2023		**Report of: Quality Committee**
Date of last meeting: 20/04/23		**Membership Numbers: 8 (Quorate)**
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report and Joint Divisional Report • Quality Substrategy • Clinical Audit Progress Report • PLACE Report • NICE Guidance – Exceptions Update • Quarterly Pharmacy KPI Report • Pathology Quality Assurance Dashboard • Quality Committee Annual Effectiveness and Terms of Reference Review • Neurosurgery Risk, Governance and Quality Group Annual Effectiveness Review • CQUINS 2023/24
2.	**Alert**	**Possible Never Event** – a serious incident has been recorded - discussions pending on whether this would be classified as a Never Event. **Integrated Performance Report and Joint Divisional Report** **Infection Prevention and Control** – there have been a number of healthcare-associated infections recorded and annual targets breached. Comprehensive integrated review taking place within Intensive Therapy Unit (ITU) and infection prevention and control measures form part of this review. Outcomes from this will then be rolled out to the wider ward areas where appropriate. Programme of ward decanting and deep cleans being planned. **Patient Led Assessment of the Care Environment (PLACE) review** – a number of issues identified however a lot of work has already been undertaken around the environment, patient food and cleaning standards since the audit took place in September 2022. The committee acknowledged that this report will be reviewed by BPC however any relevant quality related areas would also need to be reported to this committee. Mini PLACE assessment to be completed and reported to Committee in July 23 to seek assurance that improvements had been made.
	Assurance	**Pathology Quality Assurance Dashboard** – No serious incidents or Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents recorded during the quarter. A third-party Human Tissue Act inspection took place in March 23, positive feedback received with no recommendations issued.

		Clinical Audit Progress Report – Excellent progress continued to be made with only two outstanding projects that had passed the anticipated completion date. Clear rationale in place for these delays. **National Institute for Health and Care Excellence (NICE) Guidance Exceptions Report** – A focussed approach to clear a backlog of outstanding NICE compliance assessments begun in December 2021 and excellent progress continued to be made with only three outstanding assessments remaining (from 60). Agreed to reduce quarterly reporting to bi-annual. **Pharmacy KPI Report** – acceptable assurance against KPIs received **Falls with moderate harm –** two falls with moderate harm recorded since January 2023, root cause analysis reviews to be completed for both.		
	Advise	**Pharmacy KPI Report** – work is underway to understand the governance of pharmacy within the Trust by the new Chief Pharmacist, to include improvements to medicines optimisation and this may lead to a change in reporting going forward. **Quality Substrategy** – some minor amendments were requested and following completion of these the substrategy was endorsed for Board approval. **Annual Effectiveness and Terms of Reference (ToR) Review for Quality Committee -** Terms of reference reviewed and following completion of minor amendments were endorsed for Board approval.		
2.	Risks Identified	No new risks were identified.		
3.	Report Compiled by	Ray Walker – Non-Executive Director	Minutes available from:	Katharine Dowson – Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
4th May 2023

Report Title	Guardian of Safe Working Q3 Report
Executive Lead	Dr Andrew Nicolson, Medical Director
Author (s)	Dr Chrissie Burness, Guardian of Safe Working
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Thrombectomy has impacted Neurology Registrars out of hours working pattern
- During this report period there have been six exception reports from the neurology Registrars.
- Neurology Registrars at times have breached the minimum safety rule for rest during a 24 hour shift.

Next Steps

- Neurology Registrar working hours and rest remain under scrutiny.
- Further alterations to roles and responsibilities out of hours are underway.

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Workforce	Finance	Not Applicable

Strategic Risks

008 Medical Education Strategy	001 Quality Patient Care	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Guardian of Junior Doctor's Safe Working Q3 Report

Executive Summary

1. This report provides the Trust Board with information around contractually defined safe working hours for junior doctors in training November 2022 to end January 2023.
2. There have been six exception reports during this period. All were from Neurology Registrars, five associated with a thrombectomy cases and all six leading to a breach in safe working.
3. Breeches to the minimum rest requirement during a 24 hour shift have lead to six Guardian levied fines during this period.

Background

4. The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February, and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors placed in the Trust on the new 2016 terms and conditions of service.

5. In June 2019, amendments to the 2016 contract were agreed as follows:
   - Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am)
   - Maximum of 72 hours to be worked within any 7 day period.
   - Increased pay for weekend and night shifts (shifts ending between midnight and 4am)
   - £1000 per year extra for LTFT trainees
   - A fifth nodal point on the pay scale when doctors reach ST6
   - Transitional pay protection extended until 2025
   - Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive)
   - Exception reporting for all ARCP/ portfolio requirements
   - Guaranteed annual pay uplift of 2% per year for the next 4 years
   - Fines to be levied by the GoSW for any breach of safe working hours

6. The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue.

7. Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be;
   - Differences in the total hours of work (including opportunities for rest breaks)
   - Differences in the pattern of hours worked
   - Differences in the educational opportunities and support available to the doctor
   - Differences in the support available to the doctor during service commitments

8. We use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner.

9. Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust.

10. Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian.

11. The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum alternating with to the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract.

Analysis

High Level Data (requested by NHS Employers)

Number of doctors in training (total)	52
Number of doctors on 2016 T&C (total)	52
Amount of time in job plan for guardian to fulfil the role	1PA
Admin support provided to the guardian Support provided by Heather Doyle	0
Amount of job-planned time for educational supervisors	0.25 (for education and training)

Expenditure to cover junior doctor rota gaps

	November	December	January 23	**TOTAL**
Neurorehabilitation	£6,862	£9,218	£ 6,654	£22,734
Neurosurgery	£720	£14,684	11,582	£26,986
Total	**£7582**	**£23,902**	**£18,236**	**£49,720**

a) Exception reports

There have been 6 exception reports during this period. All were due to breaches in the minimum rest requirements for doctors working a 24 hour on call shift (the doctor did not achieve 5 hours of continuous rest between 10pm and 7am). In five of the six cases, thrombectomy calls or admissions were a causal factor.

b) Work schedule reviews

We have not had to undertake any work schedule reviews. The neurology registrars working hours were monitored in October 2021 and this exercise was repeated in September to December 2022.

Trainees are aware that they can request a work schedule review or hours monitoring exercise at any time of they have concerned. Potential rota changes to resolve any issues are reviewed in anticipation.

c) Vacancies

The Trust has 52 established training posts, currently none are unfilled.

d) Fines

Payments for a total of 13 hours have been required from the neurology division due to breeches to the regulation regarding minimum rest during an on call shift for neurology registrars.

Qualitative Information

12. Six exception reports have been submitted by a registrar in Neurology and all have been resolved with time of in lieu plus payment when minimum rest requirements have not been met.

13. The hours monitoring exercise is to be repeated annually for the Neurology Specialist Trainees in order to ensure that the rota accurately represents the hours worked. Despite much encouragement, engagement with the exercise was limited. We collected date from 47 days of 109 and so the data is not statistically robust. On 12 occasions, minimum rest requirements were not met resulting in a total of 11.5 hours payment. Seventy five percent of these (9/12) were related to thrombectomy referrals or admissions.

14. Payments for additional hours during this report period have totalled £1964.82 (13 hours).

15. The total payments until this reporting period have totalled £6347.88 (42 hours).

16. The senior neurosurgical registrar rota is also to be monitored if exception reports are received.

Conclusion

17. There have been six exception reports this quarter. All were due to a breech in safe working and minimum rest requirements.

18. A formal hours monitoring exercise was undertaken for the neurology registrars. Compliance with the exercise was poor. There continue to be breeches to the minimum rest requirements for this group of junior doctors the majority of which are related to thrombectomy referrals.

19. The role of the neurology registrars pertaining to thrombectomy is under review as part of the wider review of the Thrombectomy service.

20. No concerns regarding safe working have been raised from any other groups of junior doctors during the report period.

Recommendation

21. The Annual Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

22. The Board is asked to receive, review and comment upon the Guardian's annual report.

Author: Dr Chrissie Burness
Date: 25.04.2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
04/05/2023

Report Title	Freedom to Speak Up Report – Quarter Four 2022/23
Executive Lead	Morag Olsen, Interim Chief Nurse
Author (s)	Julie Kane, Quality Manager & Freedom to Speak Up Guardian
Action Required	To note

Level of Assurance Provided

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

Key Messages

- The purpose of this report is to provide the Board with an overview of the Freedom to Speak Up (FTSU) process and activity during quarter four 2022/23
- The report provides information relating to the requirements of the National Guardians Office (NGO) and the Trust processes
- Further information is provided to triangulate data and intelligence to understand themes

Next Steps

- The NGO Freedom to Speak Up Reflection Tool will be completed in line with national guidance. The tool will help identify strengths/gaps in individuals, the leadership team and the organisation
- Arrange an additional training session for the Speak Up Champions
- Launch the role of the Speak Up Champions in quarter one 2023/24
- Triangulate more data and feedback to understand if there are emerging or ongoing themes across the Trust

Related Trust Strategic Ambitions and Themes	**Impact**		
Leadership	Quality	Equality	Workforce

Strategic Risks		
001 Quality Patient Care	004 Leadership Development	004 Operational Performance

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Freedom to Speak Up Board Report
Quarter Four 2022/23

Executive Summary

1. This report provides data, information and updates on the activities undertaken by the Freedom to Speak Up Guardian (FTSUG) during quarter four 2022/23. It includes data relating to the numbers, types of concerns raised, which division and professional group.

2. The FTSUG plays a vital role in supporting an open and transparent 'speak up' culture of improvement and learning where speaking up and raising concerns are welcomed. A positive speak up culture is essential to ensuring the organisation is well led.

3. The FTSUG operates independently, impartially, and objectively whilst working in partnership with individuals and groups throughout the organisation. The Trust has numerous Speak Up Champions to support speaking up and promote a positive and safe culture.

4. The Guardian and Champions support the organisation to be open, responsive, and compassionate to staff members when they speak up.

5. The Trust recognises how important it is that staff and managers have confidence in the independence, confidentiality and fairness of the Freedom to Speak Up process. We seek regular feedback from staff who have spoken up and from managers involved in addressing concerns and use this feedback to help us to improve the process and experiences of staff and managers in the future.

6. Making it easy for staff to raise concerns is important. There are a range of processes to support staff who wish to raise a concern which include an immediate manager, senior manager within the team/department, and HR processes such as dignity and respect. Trade union representatives are also available to support staff if they wish to raise a concern.

7. Staff should feel empowered, confident and safe to raise concerns and be confident that their concern will be addressed in the most appropriate way.

Background and Analysis

8. Following the Mid-Staffordshire inquiry and the Freedom to Speak Up review, Sir Robert Francis QC stated "Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level must promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination." The full review and executive summary are available on via the following link http://freedomtospeakup.org.uk/the-report

9. Following the publication of the latest version of the national Freedom to Speak Up Policy for the NHS we have revised our policy which has been approved at the Staff Partnership Committee and uploaded onto the Intranet.

10. The NGO have published a FTSU Reflection and Planning Tool which all organisations are required to complete by January 2024. The Executive Lead for Raising Concerns is responsible for completing the tool.

11. The tool is set out in three stages, as per below:
    - Stage 1 Sets out statements for reflection under the eight principles of speaking up
    - Stage 2 Involves summarising high level actions to be taken over the next 6-24 months to develop speak up arrangements. This will help the FTSUG and Executive Lead for Raising Concern carry out more detailed planning
    - Stage 3 Summarises high level actions the Trust need to take to share and promote strengths. This will enable others within the Trust and the wider system to learn

12. An initial meeting with the FTSU Guardian, Executive and Non-Executive Leads for Raising Concerns and the Deputy Chief People Officer took place in September 2022 to review the tool.

13. A further meeting with the Executive Lead for Raising Concerns, Deputy Chief Nurse, Freedom to Speak Up Guardian and the Deputy Chief People Officer has been scheduled for June 2023 to review the tool in greater detail as there is a lot of work to be undertaken during its completion.

14. The NHS Staff Survey results for 2022 have now been published. In response to the results the National Guardian, Dr Jayne Chidgey-Clark, said:

    "It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters."

    "However, fostering a culture where speaking up is supported, and actions taken as a result is the responsibility of each and every one of us. Whether you are a government minister, a regulator, a board member or senior leader; whether you work in a department, in a team, on a ward, or in a GP practice."

    "No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wake up call to leaders at all levels that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services."

15. The FTSUG and Executive Lead for Raising Concerns will review the results of the NHS Staff Survey and provide an update within the annual report.

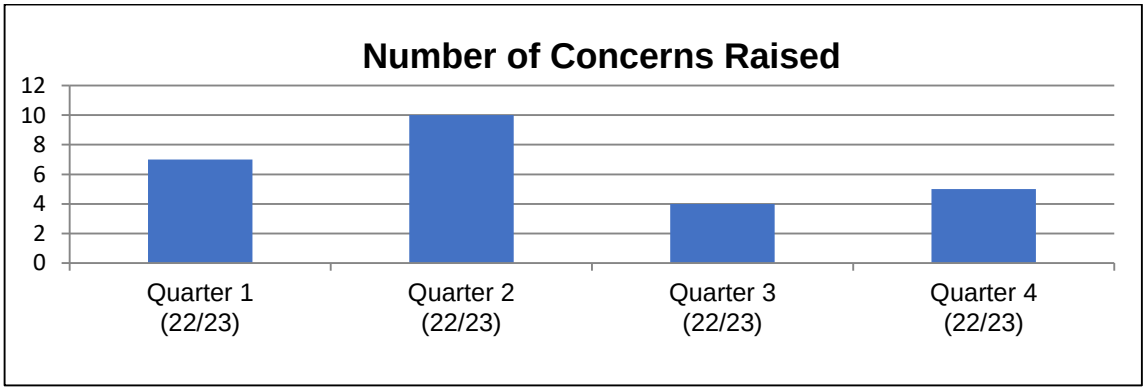
Local Activity – 2022/23

16. The FTSUG has recorded five cases that were raised during this period of reporting (Q4 2022/23). Some cases were resolved quickly and some remain open pending further meetings/investigations. No concerns were raised anonymously with the FTSUG during the quarter.

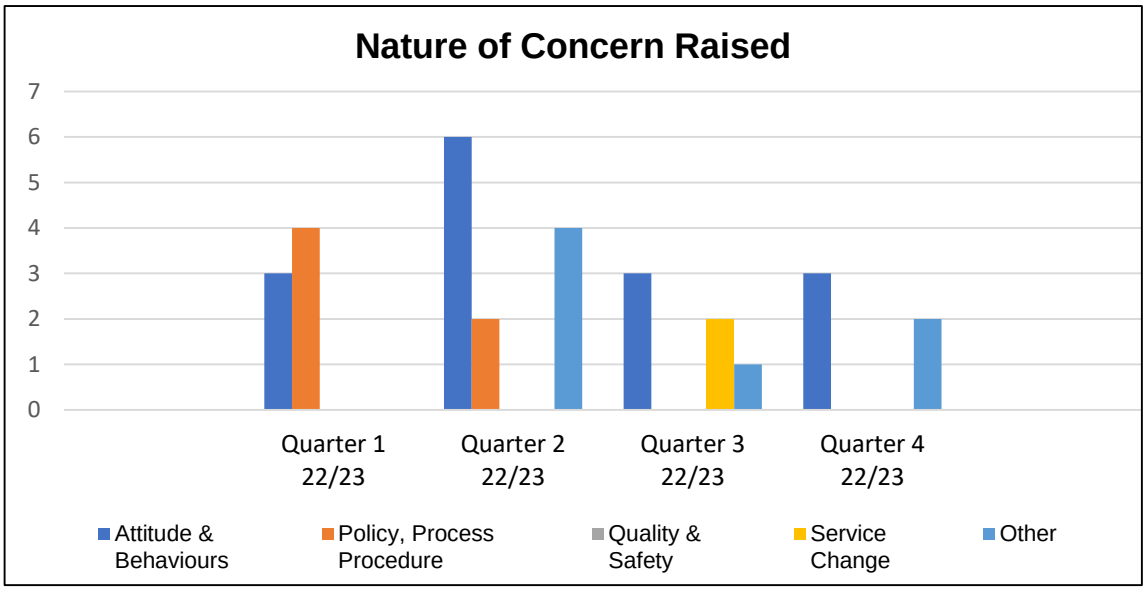
    The concerns raised were from each of the divisions and those raising the concerns included nursing and administrative colleagues.

17. <u>Data for 2022/23</u>

    The graph below indicates how many concerns were raised during each quarter in 2022/23.

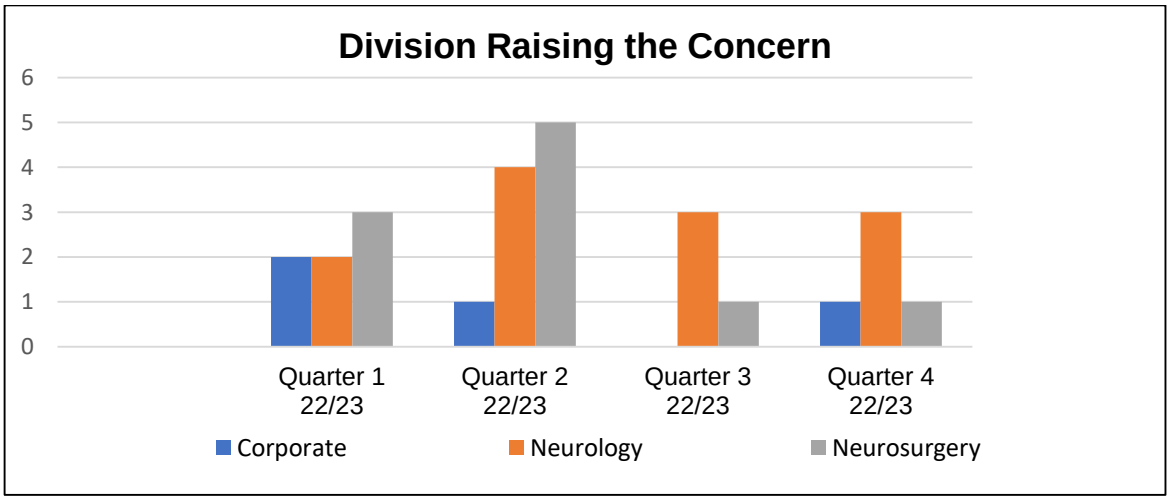


The graph below indicates the nature of the concerns raised during each quarter in 2022/23.



Note: Some concerns raised have more than one element and are displayed across several categories.

The graph below indicates the division raising the concerns during each quarter in 2022/23.



18. Themes which individuals are speaking up about to the FTSUG relate to attitudes and behaviours. Another theme is in relation to service changes or change in practice which has resulted in communication breakdown.

19. <u>What do the numbers mean?</u>

    It is always difficult to interpret whether a high number of concerns is a positive or negative indicator.

    We want staff to feel confident in raising their concerns with their supervisor or line manager as part of business as usual and would hope the small numbers speaking up to the FTSUG is an indicator that concerns are being raised and addressed locally and is therefore a good sign.

    On the other hand if there were larger numbers of concerns raised with the FTSUG this could be seen as positive as staff are aware of the speak up process and have an increased confidence in the importance of the speak up role.

20. Once the NHS staff survey results have been reviewed and benchmarked against other specialist organisations this will give an overall indication on how we are performing in comparison to others.

Submission to the National Guardian Office (NGO)

21. 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 national 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

    The Trust's FTSUG collects information from those who have raised concerns by asking the following questions:
    - Given your experience, would you speak up again
    - Please explain your above response

22. Once a case in closed, with the agreement of the individual raising the concern, they are asked to make contact if they feel they are being treated differently following them raising a concern. Nobody should fear or suffer detriment as a result of speaking up and they are encouraged to speak up if they do.

Triangulating Information/Themes/Data

23. The National Guardians Office have documented the data that could be compared to identify wider issues which include:

    <u>Patient Safety</u>
    - Patient Complaints
    - Patient Claims
    - Serious Incidents
    - Near Misses
    - Never Events

    <u>Employee Experience</u>
    - Grievance Numbers and Themes
    - Employment Tribunal Claims
    - Exit Interview Themes
    - Sickness Rates
    - Retention Figures
    - Staff Survey Results
    - Polls/Pulse Surveys
    - Workforce Race Equality Standard and Workforce Disability Equality Standard Data
    - Levels of Suspension
    - Use of Settlement Agreements

24. The FTSUG will arrange a meeting with the Executive Lead for Raising Concerns and the Chief People Officer to discuss an approach to the above, the gathering of the data/themes and how best to report on the information.

25. **Patient Experience Team**

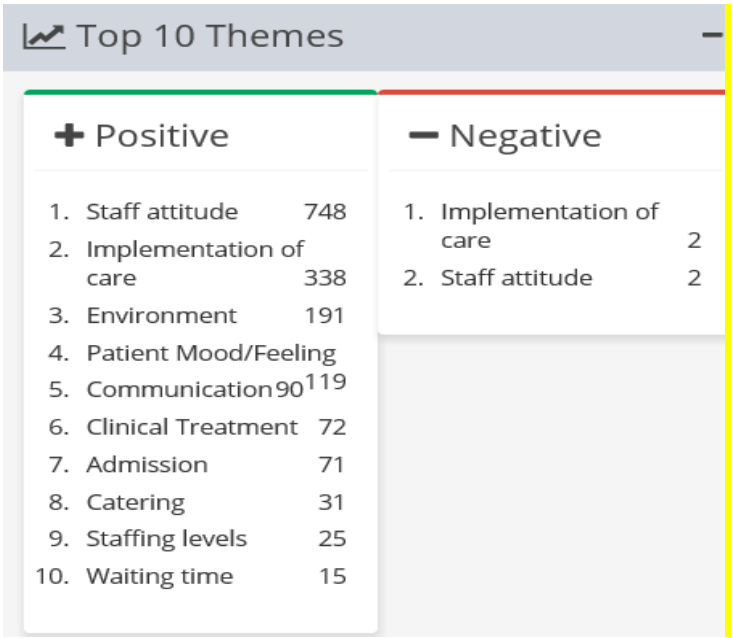
At the close of Q4 2022/23 the Trust received 36 new complaints. Year to date the Trust received 138 complaints compared to 75 received in 2021/22 which confirms the figures are back to pre-covid numbers.

The last Patient Experience Report, to the Executive Team, in February 2023 detailed the numbers of complaints and concerns received which also confirmed the numbers continued to rise in quarter four 2023/23.

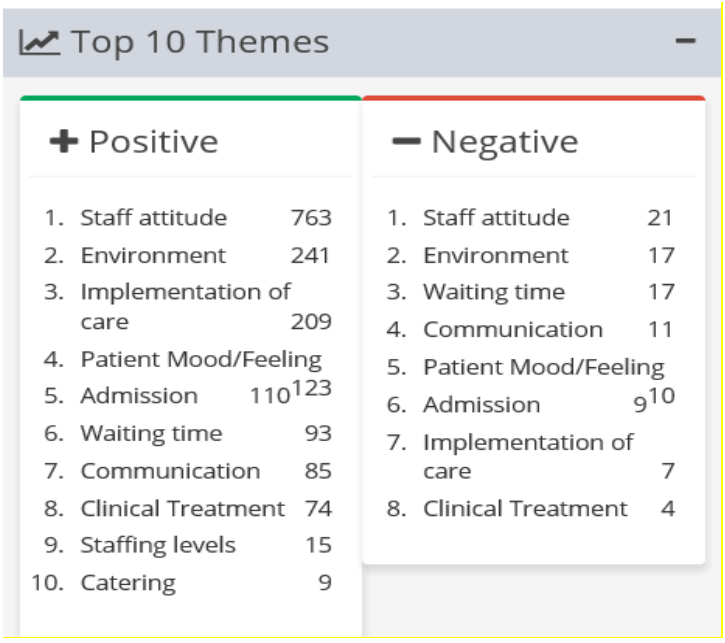
26. Friends and Family Test (FFT) – Quarter 4

All Wards receive a monthly poster from the Patient Experience Team which contains response rates and any positive/negative feedback for actioning. Divisional Nurse Directors undertake a review of any negative comments with teams to consider if there are any current themes or trends and whether these are new or known issues to inform future work plans. This is also discussed at the Ward Managers Risk & Governance Meetings.

FFT - Inpatient Feedback and Top 10 Themes (Positive and Negative):



FFT - Outpatient Feedback and Top 10 Themes (Positive and Negative):



27. Quarter 4 Themes Relating to Concerns and Complaints

The information below shows the figures and categories of where we have received the highest numbers of concerns and complaints:

- 87 Communication
- 86 Diagnosis/Treatment
- 50 Waiting Times
- 39 Inpatient Concerns
- 35 Values and Behaviours

28. **Human Resources Team**

There were no specific themes to note which came via the HR route. In relation to the staff survey there is still an issue of violence against staff from patients.

29. TEA (Talking, Engagement and Actions) Sessions

Virtual and face to face TEA sessions took place in July and August of 2022. These were mostly held virtually with one being face to face with the Chief Executive and Chief People Officer. Moving forwards these will alternate between the two.

The Executive Team met to discuss feedback from these sessions and confirmed the themes echoed those fed back through the national NHS Staff Survey, quarterly People Pulse surveys and were reflected in the work already ongoing across the Trust.

Listed below are key themes from the sessions including actions being taken:

- Technology and Systems
  - ❖ Review of IT structure and processes
  - ❖ 'Bedding in' the Digital Aspirant progress and move into business as usual
  - ❖ Executive oversight

- Reward and recognition
  - ❖ End-to-end review of process of recognising staff achievement
  - ❖ New instant recognition awards
  - ❖ Launch of retirement certificates
  - ❖ Refreshed Employee of the Month and Good Catch in-hospital displays

- How we communicate with each other, and share information and good news
  - ❖ Increasing non-digital channels for staff communication
  - ❖ Refresh of wall space throughout the hospital, with new spaces for sharing good news and patient feedback
  - ❖ TV screens in staff areas for Trust communication
  - ❖ Increased focus on hospital brand and sharing good news externally

- Staff wellbeing – including the rising cost of living
  - ❖ Promotion of Health and Wellbeing plan, including monthly Wellbeing Wednesdays, wellbeing advocates, Mental Health First Aiders, and safety at work
  - ❖ Opening of staff wellbeing hub in the main building later this year
  - ❖ Plans in place for a new staff rest area in the main building following the reconfiguration of other services
  - ❖ Engagement with Joseph Rowntree Foundation to support staff on the cost of living

- Rationale for decision making
  - ❖ Leadership is a key focus for the Trust, and a strategic ambition in the new Trust strategy
  - ❖ Identifying staff for the Building Rapport, and Ward Manager courses and ensuring staff have protected time and support to attend these
  - ❖ Review of policies and processes around recruitment
  - ❖ Better communication of changes in structures and positions

30. Join JAN

The Chief Executive has been running 'Join Jan' sessions which occur bi-monthly and alternate between MS Teams and face to face to ensure all staff have the opportunity to attend. All staff are encouraged to attend these sessions to share good news, raise any concerns and find out what's happening at the Trust.

31. Exit Questionnaires and Interviews

The tables below provide figures and staff groups of those who left the Trust during Quarter 4 2022/23:

Staff Group	Headcount
Add Prof Scientific and Technic	2
Additional Clinical Services	11
Administrative and Clerical	24
Allied Health Professionals	6
Estates and Ancillary	3
Medical and Dental	4
Nursing and Midwifery Registered	13
Grand Total	**63**

Division	Headcount
Corporate Services Directorate	23
Neurology & Long Term Care Directorate	24
Surgery & Critical Care Directorate	16
Grand Total	**63**

Incorporated Division and Staff Group	Headcount
Corporate Services Directorate	23
Administrative and Clerical	19
Nursing and Midwifery Registered	4
Neurology & Long Term Care Directorate	24
Add Prof Scientific and Technic	2
Additional Clinical Services	8
Administrative and Clerical	4
Allied Health Professionals	3
Estates and Ancillary	2
Medical and Dental	2
Nursing and Midwifery Registered	3
Surgery & Critical Care Directorate	16
Additional Clinical Services	3
Administrative and Clerical	1
Allied Health Professionals	3
Estates and Ancillary	1
Medical and Dental	2
Nursing and Midwifery Registered	6
Grand Total	**63**

The tables below provide figures and staff groups of those who returned an exit questionnaire during Quarter 4 2022/23:

Staff Group	Returned Questionnaires
Additional Clinical Services	1
Administrative and Clerical	1
Allied Health Professionals	2
Nursing and Midwifery Registered	1
(blank)	1
Grand Total	**6**

Division	Returned Questionnaires
Corporate	2
Neurology	3
(blank)	1
Grand Total	**6**

32. The return rate of the questionnaires is less than 10% and whilst we cannot make staff complete an exit questionnaire, we could look into the process and encourage staff to complete it. This will enable us to understand why staff are leaving the Trust and whether anything different could have been done to prevent the individual leaving.

33. The main themes across the different routes of speaking up are in relation to communication, values, attitudes and behaviours.

34. There is no central log of exit interviews, therefore, they are not reported on. The employee decides what happens following an exit interview. Sometimes they want HR to take notes and feed back to their department and sometimes they don't want anything to happen so there is no record of the interview. A suggestion would be to look into the process of the exit interviews to determine if anything further needs to be done.

35. Currently an email is sent to the nhs.net work email address asking the staff member, who is leaving, to complete the questionnaire and arrange an exit interview if they wish to do so. It is evident that particular groups of staff do not access work emails regularly such as Health Care Assistants and ISS staff, therefore, this would be seen as a missed opportunity. Previous suggestions when looking into the exit process was for a letter to be sent to their home address but unfortunately the Trust did not have the resource to do this.

36. The FTSUG will arrange a meeting with the Executive Lead for Raising Concerns and the Chief People Office to discuss the above.

37. **Freedom to Speak Up Guardian**

38. The Freedom to Speak Up Guardian actively promotes opportunities for staff to speak up about issues of concern and is available for staff to discuss and raise their concerns. She often helps staff with ways to address their concerns directly with relevant managers or, for whatever reason if this is not possible or the preferred route, the FTSUG will bring the issues to the attention of another individual such as a Team Leader, Divisional Director or Clinical Director. This is only done with the agreement of the person raising the concern.

39. Following the escalation of a concern the FTSUG will maintain in contact with the person raising the concern to ensure that they are appraised on progress and receive feedback on the outcome. The FTSUG will also ask if the person raising the concern is suffering detriment as a result of speaking up which unfortunately is sometimes the reason why staff do not feel able to speak up nationally.

40. The results of the annual NHS Staff Survey have now been published. The next annual report will provide data and benchmarking figures on speak up throughout the NHS.

41. During 'speak up' month in October of last year the FTSUG asked for expressions of interest to become a FTSU Champion. Following this 16 staff will be supporting the Trust in speaking up by championing the role.

42. Six staff undertook the in-house speak up training in February 2023 and the remaining ten Champions will undertake the training during quarter one 2023/24.

43. Drop In sessions have continued throughout the year. The schedule is being updated for 2023/24 which will be made available on the Trust Intranet site.

44. 'Walkabouts' occur throughout the day and evening to ensure those hard to reach groups have the opportunity to speak up, raise any concerns and meet the speak up team.

45. Information relating to speaking up is available on the Intranet which includes how to speak up, who to speak up to, what happens when staff speak up and information on who the FTSU Guardian, Champions, Leads are, their pledges and contact details.

46. The FTSUG meets monthly with the Non-Executive/Executive Leads for Raising Concerns to discuss concerns raised. She also meets with the Head of Business HR and HR Manager for Neurology monthly to discuss concerns, review themes, and provide progress updates as appropriate. Meetings also take place quarterly with the Chair and Chief Executive to keep them appraised of activity. The next meeting is scheduled in April 2023.

47. Going forwards a meeting with the FTSUG, Non-Executive and Executive Leads for Raising Concerns and the Chief People Officer will take place each month to discuss concerns and review progress. The first meeting has been scheduled for May 2023.

48. The Trust has a designated Executive Lead for Raising Concerns who is currently the Interim Chief Nurse, Morag Olsen and a Non-Executive Lead for Raising Concerns, Karen Heslop.

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

50. The first module of the mandatory Speak Up e-learning was launched in July 2022 which all staff are required to complete. A number of issues with the module were identified and have been reported to the National Guardians Office to ascertain if the problem is national and what the resolution could be.

51. The Trust has not launched the other modules until assurance is given that the above issue has been resolved. The second e-learning module is for all line managers and the third is for senior leaders within the organisation, such as the Executive Team.

52. A meeting with the Chief Executive and Chair is scheduled for April 2023 to discuss the issues with the e-learning module and agree next steps.

53. Current compliance for the first module of speak up e-learning stands at 69.97%.

54. The FTSUG presented an Assurance Report to the Audit Committee, in accordance with the NHS Audit Committee Handbook, which is to review the Trusts processes in relation to raising concerns to ensure there is a system of internal control. The FTSUG will present an annual assurance report to the Audit Committee moving forward.

55. The National Guardians Office is launching another FTSUG Refresher Training course. Once this has gone live it is to be completed by November 2023. If this is not completed within the required timeframe the NGO will inform NHSE and the CQC of non-compliance.

56. The FTSUG has completed a Mental Health First Aider Training to support staff further.

Conclusion

57. The Freedom to speak up policy for the NHS has been reviewed, revised and approved. It has been made available on the Trust Intranet Site.

58. There is a problem with module one of the FTSU e-learning which has been raised with the National Guardians Office. Discussions will take place as to the launch of the second and third modules as these have been on hold until the issue with the first module has been rectified.

59. The Board is asked to note that the FTSU Guardian is in place and accessible to staff. She functions independently in line with requirements from the National Guardian's Office. The Guardian continues to promote the role of speaking up mostly through face-to-face engagements with local teams. She encourages Head of Departments to invite her to team meetings to give an overview of the role.

Recommendation

60. To note the content of this report for the purposes of assurance and continue to promote and support the role of speaking up across the Trust.

Author: **Julie Kane**
Date: **20th April 2023**

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 21/04/23		**Report of:** Audit Committee
Date of last meeting: 18/04/23		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Recommendation Report • Internal Audit Charter • Internal Audit Plan 2023/24 • Data Quality Review Report 2022/23 • Sickness Absence Report 2022/23 • Head of Internal Audit Opinion Update • External Audit Plan Year ending 31 March 2023 • Counter Fraud Annual Report 2022/23 • Counter Fraud Annual Plan 2023/24 • Tender Waivers Q4 Report 2022/23 • Finance Compliance Report 2022/23 • Health Procurement Liverpool Progress Update • Annual Governance Statement • Annual Self-Assessment of Committee Effectiveness and Terms of Reference • CQC Assurance Report • External Visits Update Report • Compliance with FT Code of Governance
2.	**Alert**	• The Data Quality Review Report provided moderate assurance with two recommendations. The report noted the Trust had an adequate system of internal control in place, areas for improvement were identified around the recording systems for Pressure Ulcers (PU) and Health Care Acquired Infections (HCAI) and the Standard Operating Procedures (SOPs) for PU and HCAI. Several actions had been implemented in line with the recommendations and there would be follow-up exercises within twelve months to evaluate the progress made. • The Sickness Absence Report provided limited assurance with five recommendations. The report highlighted areas of good practice and areas for improvements and the committee was informed that the HR Team and line managers were working closely to ensure training reports were updated timely and other actions had been put in place to improve compliance. Follow up exercise would be undertaken during the year to demonstrate that actions agreed had been implemented. • The Committee raised concerns about the timeliness of the implementation of some of the internal audit recommendations and the actions agreed to improve the position.

	Assurance	• The Committee considered the Internal Audit Progress Report and noted that the following audits were underway since the meeting on 7 February 2023:
		  o Health Procurement Liverpool (reporting stage)
		  o Accounts Payable and Corporate Credit Card (Fieldwork)
		  o Infection Prevention and Control (Fieldwork)
		• The Internal Audit Progress Report also informed that the following audits had been finalised since the last report:
		  o Data Quality – Pressure Ulcers and Health Care Acquired Infections (Moderate Assurance)
		  o Sickness Absence (Limited Assurance)
		• The Internal Audit Recommendation Report was received by the committee, and it was highlighted that the Trust had closed eight out of the twenty-eight recommendations made and continued to make positive progress against the implementation of the open recommendations.
		• The committee received and approved the 2023/24 Internal Audit Plan.
		• The Internal Audit Charter was received by the committee, and no concerns were raised.
		• The committee received a verbal update on the Head of Internal Audit Opinion 2022/23. The draft report would be submitted to the committee members ahead of the national submission scheduled 27 April.
		• The external auditors presented the External Audit Plan for the year ending 31 March 2023. There were no expected changes to the audit fees and there were no risks identified around the Trust's arrangements to secure value for money. The risks were identified that required special audit considerations.
		• The committee approved the 2022/23 Counter Fraud Annual Report and received the 2023/24 Counter Fraud Annual Plan.
		• The 2022/23 Q4 Tender Waivers Report was received and noted by the committee.
		• The 2022/23 Financial Compliance Report was received by the committee. The recovered aged debts and measures in place to recover aged debts was noted. The Trust's Better Payment Practice Code (BPPC) percentage at the end of March was 83.8% and there was ongoing work by the Finance team to attain the 95% target prescribed by NHSE.
		• Communication had continued and progress had been made to recover the aged debt owed by LUHFT.
		• The committee received the Health Procurement Liverpool Update and noted that an update would also be given at the Business Performance Committee (BPC).
		• The Draft Annual Governance Statement was received by the committee. The final draft will be received at the next meeting for final signoff in June.
		• The Care Quality Commission (CQC) Assurance report was presented to the committee, and it was highlighted that the Trust was compliant with all CQC regulations.
		• The committee received the 2022/23 External Visits Update Report which included any ongoing external visits and inspections since 2021/22 and the proposed changes for the management of external visits and inspections for 2023/24.
		• The 2023 Compliance with FT Code of Governance Report was received by the committee.		

	Advise	• The Committee received the Annual Self-Assessment of Committee Effectiveness and the Committee Terms of Reference (ToR) and recommended the ToR for approval by the Trust Board.		
2.	**Risks Identified**	None		
3.	**Report Compiled by**	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	Audit Committee Review of Terms of Reference
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23.

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Audit Committee	18 April 2023	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Audit Committee Terms of Reference

Executive Summary

1. The purpose of this report is to present the Audit Committee Terms of Reference (ToR) for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - Better balance of financial and non-financial items
   - Expanded cycle of business to include Information Governance, Clinical Audit, Cyber Security and Risk Management as regular items
   - Approved a policy on the supply of non-audit services by external auditors
   - Excellent attendance
   - No items highlighted for action on the Healthcare Financial Management Association (HFMA) Audit Committee Checklist (Appendix 1).

Proposed Changes

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These were reviewed by the Committee and there are no further proposed changes to the membership, purpose or duties following the annual review.

4. The ToR at Appendix 3 are the proposed version for 2023/24. Paragraph 20 has been amended on the advice of the Information Governance Manager in order to reflect updated legislation and the new text proposed is in red.

Conclusion

5. The Board is asked to approve the revised Terms of Reference with minor changes made from the version approved by Board in December 2022.

Recommendation

To approve

Author: Katharine Dowson
Date: 20 April 2023

Appendix 1 – Audit Committee Draft Terms of Reference April 2023

Appendix 1

AUDIT COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Audit Committee (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit Committee.

4. The Audit Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

5. The Committee is authorised to create advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions. The Audit Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.

7. The Audit Committee supports the Board of Directors in its responsibility for ensuring effective financial decision-making and internal control including:
   - management of the Trust's activities in accordance with statute and regulations
   - the establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

Membership

8. The Committee shall be comprised of at least three independent Non-Executive Directors, at least one of whom should have recent and relevant financial experience who should be appointed Chair of the Committee by the Board.

9. The following are required to attend in a non-voting capacity:
   - Chief Finance Officer
   - Chief Nurse
   - Corporate Secretary

- Deputy Chief Finance Officer
- External Audit representative
- Internal Audit representative
- Local Counter Fraud Specialist

10. The Chief Executive will attend as a required. As a minimum this should be when the Committee considers the draft internal audit plan and the Annual Governance Statement and Annual Accounts.

11. Other members of the Executive Team, senior managers and or external advisors leads will be invited to attend by the Chair as appropriate to the Agenda.

12. The Committee will be deemed quorate when two voting members are present.

13. In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting.

14. The Chair shall have a casting vote in the event of a vote.

15. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

16. An open invitation exists for all members of the Board of Directors to attend the Committee. The Chair of the Trust shall not Chair or be a member of the Committee although may be invited to attend meetings of the Audit Committee as required.

Requirements of Membership

17. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

18. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

19. In order to fulfil its role and obtain the necessary assurance, the Committee will review:

Financial Statements and the Annual Report

- Monitor the integrity of the financial statements of the Trust, any other formal announcements relating to the Trust's financial performance, reviewing the significant financial reporting judgements contained in them
- Review the annual statutory accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover, but is not limited to:
  - the meaning and significance of the figures, notes and significant changes

- areas where judgement has been exercised
- adherence to accounting policies and practices
- explanation of estimates or provision having material effect
- the schedule of losses and special payments
- any unadjusted statements
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved

- Review the Annual Report and Annual Governance Statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy
- Review each year the accounting policies of the Trust and make appropriate recommendations to the Board of Directors
- Review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control

Internal Control and Risk Management

- Review the Trust's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance
- Review and maintain an oversight of the Trust's general internal controls and risk management systems
- Review processes to ensure appropriate information flows to the Audit Committee from Executive management and other Board Committees in relation to the Trust's overall internal control and risk management position
- Review the adequacy of the policies and procedures in respect of all counter-fraud work
- Review the adequacy of underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of principal risks
- Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements

Whistleblowing

- Review arrangements that allow staff and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters
- Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

Counter Fraud

- Approve the appointment of the Local Counter Fraud Specialist
- Seek assurance that counter fraud polices are being developed within the Trust, adequate arrangements are in place and review the outcomes of counter fraud work

Corporate Governance

- Monitor corporate governance compliance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interest)

Information Governance

- Review and monitor compliance with information governance standards including the Data Protection and Security Toolkit, statutory data security compliance and secure systems of Cyber Security

Internal Audit

- Monitor and review the effectiveness of the Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements
- Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation
- Oversee on an on-going basis the effective operation of internal audit in respect of:
  - adequate resourcing
  - its co-ordination with external audit
  - meeting relevant internal audit standards
  - providing adequate independent assurances
  - it having appropriate standing within the Trust
- Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations
- Consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff
- Conduct an annual review of the internal audit function

External Audit

- Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
- The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, reappointing and removing external auditors. To support them in this task, the Committee should:
  - provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees
  - make recommendations to the Council of Governors in respect to the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this should be included in the Annual Report, along with the reasons that the recommendation was not adopted
- Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy
- Assess the external auditors work and fees each year and based on this assessment, to make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards
- Oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor
- Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations
- Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

- Review, on behalf of the Board of Directors, the operation of, and proposed changes to, the standing orders, standing financial instructions, the constitution, codes of conduct and standards of business conduct, including maintenance of registers
- Examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension
- Review the scheme of delegation.

Other

- Review performance indicators relevant to the remit of the Audit Committee
- Examine any other matter referred to the Audit Committee by the Board of Directors and initiate investigation as determined by the Audit Committee
- Review the work of all other Board Committees in connection with the Audit Committee's assurance function
- Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions

Data Privacy

20. ~~The Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).~~ The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

21. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

22. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

Administration of Meetings

23. Meetings shall be held as required but not less than five times per year with additional meetings held on an exception basis at the request of the Chair or any two voting members of the Committee.

24. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

25. Agendas and papers will be circulated at least four working days in advance of the meeting.

26. Minutes will be circulated to members for comment as soon as is reasonably practicable.

27. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

28. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

29. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: 4 May 2023
Review Date: May 2024

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 21/04/23		**Report of:** The Walton Centre Charity Committee Meeting
Date of meeting: 21/04/23		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Finance Report as at 31 March 2023 • CCLA and Ruffer Quarterly Investment Reports • Fundraising Activity Report • Charity Risk Register • Cycle of Business 2023-24 • Home from Home Annual Report • Research Innovation and Medical Education Committee Annual Report • Staff Awards • Application - Proposed Project - "Differentiating Multiple Sclerosis and MOG Antibody Disease Using Quantitative MRI Measures" • Committee Effectiveness Review and Terms of Reference • Pipeline of Potential Projects • Fundraising Strategy Bi-annual Update • Draft Grant Making Policy • Reserves Policy • The Walton Centre Charity Committee – Governance Arrangements & Financial Instructions
2	**Alert**	• No issues were identified
3	**Assurance**	• The committee received the quarterly investment reports from CCLA and Ruffer. • The Head of Fundraising presented the Charity Risk Register, no changes to the risk ratings were identified, and no new risks were identified. • The committee received and approved the Draft Grant Making Policy subject to the alterations recommended. • The Walton Centre Charity Governance Arrangements and Financial Instructions were presented but have yet to be approved. These will be approved at the next committee meeting after the changes recommended in the revised Terms of Reference have been incorporated. • The committee received and noted the Cycle of Business for 2023/24. • The pipeline of potential projects was presented to the committee, and it was agreed that the projects will be assessed further for viability and feasibility by the committee. The committee will receive quarterly updates on the pipeline of projects that could be progressed for funding.

		• The committee received the Research Innovation and Medical Education Committee Annual Report, and it was noted that there were no allocations of charitable funds in the 2022/23 financial year due to the success of the Trust's researchers obtaining external funding. • The Fundraising Activity Report was presented, outlining the activities for the next six months. It was highlighted that the proposal for a £28,883 development grant from the NHS Charities Together had been awarded. • The Fundraising Strategy Bi-annual Update was presented, and the committee noted the improvement in digital fundraising awareness since the appointment of the Digital Fundraising Manager. • The committee received the Home from Home Annual report and noted the recommendations outlined to help improve occupancy levels, support patients' families, and mitigate lost occupancy days. It was agreed that the committee would review The Relatives Accommodation Policy at a future committee.		
4	**Advise**	• The committee received the Finance Report, which showed that the fund balances had reduced from £1,438k to £1,373k as at 31 March 2023. • The 2022/23 Walton Centre Charity Committee outturn position was received and showed a reduction of £64k in the fund balance as at 31 March 2023. The budgeted deficit in the plan for 2023/24 was £91K. The 2023/24 Walton Centre Charity Committee Plan was received and recommended to the Board for approval. • Three committee members will be presenting at clinical senate on charitable funds and the importance of utilising these funds. The committee would receive quarterly reports on the plans for the top five funds. • The committee gave formal approval to an application from the NMO Research Fund (£2500) to support a collaborative study on "Differentiating Multiple Sclerosis and MOG Antibody Diseases Using Quantitative MRI Measures" between the Walton Centre and the Liverpool BRAIN Lab agreeing that would lead to the advancement of education and save lives. • The committee approved the application for funds to cover expenditures on the awards for the 2023 Staff Awards on the basis that ticket sales and sponsorships would cover most of the event cost. • The committee received the Committee Annual Effectiveness Review. The Terms of Reference (ToR) were not approved because they needed to reflect the changes proposed at the last committee meeting. The committee agreed it would approve the revised ToR at the next committee meeting, after which it would be recommended to the Board for approval. • The Reserves Policy including monitoring of the reserve levels, was presented to the committee. The committee agreed and approved that the timeline of figures used in calculating the fund reserves amount should be increased from twelve months to two years and the fund reserves be increased from £300k to £500k to cover expenditure for two years. • The committee received the Cash reserves policy outlining the charity cash balance in bank and recommendations for investment options based on available interest rates. The committee recommended for approval to the Board the deposit of the charity cash in the COIF Charities Deposit Fund with CCLA.		
5	Risks Identified	• None		
6	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 4 May 2023		**Report of:** Remuneration Committee (RemCom)		
Date of last meeting: 24 April 2023		**Membership Numbers:** Quorate		
1	**Agenda**	The Committee considered an agenda which included the following: • Report on the Mutually Agreed Resignation Scheme (MARS) • Annual Effectiveness Review of the Committee and Terms of Reference • Report on RemCom for the Annual Report and Accounts		
2	**Alert**	• None		
3	**Assurance**	• The Committee considered the annual review and concluded that the Committee have fulfilled their remit for the year as delegated by the Board and that the Terms of Reference remain appropriate • MARS resulted in a number of job roles being removed from the organisation, full savings will take some time to be realised as in some cases some backfill will be required		
4.	**Advise**	• None		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	Max Steinberg, Chair	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Board of Directors
4 May 2023

Report Title	Remuneration Committee Terms of Reference
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23.

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Remuneration Committee	24 April 2023	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Remuneration Committee (RemCom) Terms of Reference

Executive Summary

1. The purpose of this report is to present the RemCom Terms of Reference (ToR) for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - Approval of Pension Recycling Policy
   - Approval of cost of living increase for Executive Directors
   - Approval of Mutually Agreed Resignation Scheme (MARS)
   - Review of Executive Director Performance
   - Appointment of Chief Operating Officer

Changes to ToR

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These have been reviewed and the proposal is to leave these unchanged apart from paragraph 27 which has been amended on the advice of the Information Governance Manager in order to reflect updated legislation; the new text proposed is in red

Conclusion

4. The Board is asked to approve the revised Terms of Reference.

Recommendation

To approve

Author: Katharine Dowson
Date: 25 April 2023

Appendix 1 – RemCom Draft Terms of Reference April 2023

Appendix 1

REMUNERATION COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Remuneration Committee (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to provide the Board of Directors with assurance that the appointment and remuneration of Executive Directors is conducted in line with statutory and regulatory requirements in order to make the most appropriate appointments to the senior leadership of the Trust. The committee will determine the approach to be taken to appoint Executive Directors and approve any such appointments, taking into account the skills gaps within the Board of Directors. The Committee will also have oversight of any policies or processes that impact on the terms and conditions of remuneration of Very Senior Managers (VSM) who are not subject to agenda for changes terms and conditions.

Membership

7. The Committee shall be comprised of the following voting members:
   - Trust Chair
   - All other Non-Executive Directors

8. The Corporate Secretary is required to attend on a regular basis.

9. The Committee will be deemed quorate when four members are present.

10. In the event that the Chair of the Committee is unable to attend a meeting, the Deputy Chair shall be the Chair for that meeting. In their absence the members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

11. There is no provision for deputies to represent members at meetings of the Committee.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

13. Members should attend at least 75% of all meetings each financial year and should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

14. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

15. Review the leadership needs of the Trust at Executive Director level, to ensure the continued ability of the Trust to operate effectively in the local and regional health economy, taking into consideration the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors. To include using outputs from any Board evaluation process as appropriate and make recommendations to the Board of Directors with regard to any changes.

16. Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

17. Oversee the appointment process for Executive Directors by approving the appointment process, agreeing the job description and skills mix required by the Board of Directors, and agreeing the advertised remuneration package. Making the final approval decision on appointment (excluding Chief Executive).

18. Ensure that proposed candidates are a 'fit and proper person' in accordance with the Trust's Fit and Proper Persons Policy and that any significant commitments are considered before appointment.

19. Establish and keep under review a remuneration policy in respect of VSM.

20. Consult the Chief Executive about proposals relating to the remuneration of VSM.

21. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of VSM including:
    - salary, including any performance-related pay or bonus or earn-back arrangements (none currently in place)
    - provisions for other benefits, including pensions and cars
    - allowances
    - payable expenses
    - compensation payments

22. Establish levels of remuneration which are sufficient to attract, retain and motivate high-quality Executive Directors with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

23. Use national guidance and market benchmarking analysis in the review of Executive Director remuneration (and any senior managers on locally-determined pay), whilst ensuring that increases are not applied where either Trust or individual performance do not justify them, and be sensitive to pay and employment conditions elsewhere in the Trust.

24. Review and assess the output of evaluation of the performance of individual Executive Directors and consider this output when reviewing remuneration levels.

25. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments, to avoid rewarding poor performance.

26. Consider and approve matters regarding extraordinary and additional payments to staff employed by the Trust in relation to Mutually Agreed Resignation Schemes and/or Voluntary/Compulsory Redundancy programmes.

Data Privacy

27. ~~The Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).~~ The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

28. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

29. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

Administration of Meetings

30. Meetings shall be held as required with a minimum of one per year, with additional meetings held as required at the request of the Chair or any three voting members of the Committee.

31. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

32. Agendas and papers will be circulated at least four working days in advance of the meeting.

33. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

34. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

35. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: 4 May 2023
Review Date: April 2024

The Walton Centre NHS Foundation Trust

Report to Board of Directors
4 May 2023

Report Title	Business Performance Committee Terms of Reference
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23.

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
BPC	25 April 2023	Katharine Dowson, Corporate Secretary	Effectiveness review discussed and ToR reviewed. Updates made to subgroups and substrategies/plans list.

Business Performance Committee (BPC) Terms of Reference

Executive Summary

1. The purpose of this report is to present the BPC Terms of Reference (ToR) for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - The quality of reports had improved which allowed for a good level of debate
   - New streamlined membership embedded and changes accepted as permanent
   - Increased focus on compliance with personal development reviews and mandatory training
   - Amendments were made to the Integrated Performance Report (IPR) to provide assurance across different areas.

Changes to ToR

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These have been reviewed and the proposal is to leave these largely unchanged apart from the following:
   - Paragraph 20 has been amended on the advice of the Information Governance Manager in order to reflect updated legislation and the new text proposed is in red
   - Equality, Diversity and inclusion references have been removed as this area of responsibility will move to the Health Inequalities Committee from April
   - Substrategies and strategies list has been updated in paragraph 16
   - Subgroups have been updated in paragraph 23

Conclusion

4. The Board is asked to approve the revised Terms of Reference.

Recommendation

To approve

Author: Katharine Dowson
Date: 20 April 2023

Appendix 1 – BPC Draft Terms of Reference April 2023

Appendix 1

BUSINESS PERFORMANCE COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Business and Performance Committee (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to provide the Board of Directors with assurance that the Trust's operational, financial and workforce activities and plans are viable and that risks have been identified and mitigated. The scope and remit of the Committee encompasses: operational performance, workforce and organisational development, transformation and efficiency improvement, estates & facilities, finance, commercial and business development, investment, procurement and digital.

Membership

7. The Committee shall be comprised of the following voting members:

   - Three Non-Executive Directors, one of whom will be the Committee Chair
   - Chief Finance Officer
   - Chief Operating Officer
   - Chief People Officer

8. The following are required to attend in a non-voting capacity:
   - Chief Digital Information Officer
   - Corporate Secretary

9. The Committee will be deemed quorate when three voting members are present, including at least one Executive and one Non-Executive Director.

10. In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

11. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

13. An open invitation exists for all members of the Board of Directors to attend the Committee.

Requirements of Membership

14. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

15. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

16. In order to fulfil its role and obtain the necessary assurance, the Committee will inform the development and provide assurance against the following areas, strategies, substrategies and associated strategic implementation plans and action plans:
    - Cost/Quality Improvement Plan
    - ~~Communication & Engagement Strategy~~
    - Data Security & Protection Toolkit
    - Digital Substrategy
    - ~~Equality, Diversity and Inclusion Strategy~~
    - Estates, Facilities and Sustainability Substrategy
    - Financial and Commercial Development Substrategy
    - Liverpool Health Partners Procurement Strategy
    - Financial Plan
    - ~~Intelligence Strategy~~
    - Long Term Financial Plan
    - People Substrategy
    - Staff Survey Action Plan
    - ~~Transformation Strategy~~

17. Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas associated with the above strategies and to also include:
    - Capital Expenditure
    - Contract Management

- Data Quality
- Emergency Preparedness
- Health and Wellbeing
- Information Governance, Data Security & Protection
- Learning & Development
- Occupational Health
- Operational Performance
- Organisational Development
- Staff Survey Responses (including Pulse Survey)
- Sustainability
- Workforce Planning

18. The Committee's general duties in the above areas will be to:

- Provide assurance to the Board on compliance with associated legislation, national reporting and regulatory requirements and best practice

- Consider and review relevant metrics, support the development of appropriate performance measures such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks to inform the organisation to support continual improvement

- Oversee the delivery of any corrective action plans in areas where acceptable assurance is not yet in place

- Assess and approve business cases in line with delegated limits for the Committee in the SoRD and SFIs; or review and make appropriate recommendations to the Board of Directors where the approval limit is above the Committee's limits

19. The Committee will also :

- Monitor financial plans, forecasts, mitigation, Cost Improvement Plans and corrective plans including the Capital Expenditure Programmes and seek assurance on the preparation of forward planning for subsequent years

- Consider the financial impact of opportunities to grow new income streams and the market share of existing services.

Data Privacy

~~20. The Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).~~ The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

21. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

22. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

23. Reports including regular assurance reports will be received from the following sub-groups:
    - Capital Management Group
    - Data Quality Group
    - ~~Digital Systems Programme Board~~
    - ~~Equality, Diversity and Inclusion Group~~
    - Heating and Pipework Committee (time limited)
    - Information Governance & Security Forum
    - Information and Data Quality Group
    - Local Negotiating Committee
    - Medical Devices Group
    - Estates & Facilities Group
    - People Group
    - Resilience Planning Group
    - Staff Partnership Committee
    - ~~Transformation Group~~
    - Sustainability Group
    - Strategic Project Management Office

Administration of Meetings

24. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of ten meetings per year.

25. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

26. Agendas and papers will be circulated at least four working days in advance of the meeting.

27. Minutes will be circulated to members for comment as soon as is reasonably practicable.

28. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

29. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

30. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: 4 May 2023
Review Date: April 2024

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	Quality Committee Review of Terms of Reference
Executive Lead	Morag Olsen, Interim Chief Nurse
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Annual review of Committee Effectiveness has been completed including a review of Terms of Reference (ToR)
- Review of Committee Effectiveness had concluded Committee has fulfilled its duties as set out in the Terms of Reference and considered all items on the agreed workplan
- Minor changes proposed

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

- Overarching review of Board Committee effectiveness to be considered by Audit Committee once all Board Committee reviews are complete for 2022/23.

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	20 April 2023	Katharine Dowson, Corporate Secretary	Effectiveness review and ToR agreed.

Quality Committee Terms of Reference

Executive Summary

1. The purpose of this report is to present the Quality Committee terms of reference for approval following the annual effectiveness review.

2. Key Achievements for the Committee this year were:
   - Successful review of the membership and terms of reference culminating in the new meeting format being implemented from January 2023.
   - Improvements in the quality of papers presented
   - Improved and more focused challenge and debate from the membership.

Proposed Changes

3. The ToR (Appendix 1) sets out the responsibilities that the Trust Board have delegated to the Committee. These were reviewed in December and there are no further proposed changes to the membership or duties following the annual review although Chief Operating Officer has now been permanently added to the membership following a trial period. 'Effective' was added to the purpose of the ToR as follows:

   6. *The purpose of the Committee is to provide the Board of Directors with assurance that there is a comprehensive, integrated and effective approach to patient safety and quality throughout the organisation. It ensures that high standards of care are provided by the Trust and in particular, it ensures that adequate governance structures, processes and controls are in place throughout the Trust to:*
      - *Promote safety and excellence in patient care and experience*
      - *Identify, prioritise and manage risk arising from clinical care*
      - *Ensure the effective and efficient use of resources through evidence-based clinical practice*
      - *Ensure compliance with legal, regulatory and other obligations*

   "The smaller attendee list seems to generate a slicker and more focussed meeting"

4. The ToR at Appendix 3 are the proposed version for 2023/24. Paragraph 17 has been amended on the advice of the Information Governance Manager in order to reflect updated legislation and the new text proposed is in red.

Conclusion

5. The Board is asked to approve the revised Terms of Reference with minor changes made from the version approved by Board in December 2022.

Recommendation

To approve

Author: Katharine Dowson
Date: 20 April 2023

Appendix 1 – Quality Committee Draft Terms of Reference April 2023

Appendix 1

QUALITY COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Quality Committee is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Quality Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Quality Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Quality Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Quality Committee is authorised to create operational subgroups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Quality Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to provide the Board of Directors with assurance that there is a comprehensive, integrated and effective approach to patient safety and quality throughout the organisation. It ensures that high standards of care are provided by the Trust and in particular, it ensures that adequate governance structures, processes and controls are in place throughout the Trust to:
   - Promote safety and excellence in patient care and experience
   - Identify, prioritise and manage risk arising from clinical care
   - Ensure the effective and efficient use of resources through evidence-based clinical practice
   - Ensure compliance with legal, regulatory and other obligations

Membership

7. The Committee shall be comprised of the following voting members:

   - Three Non-Executive Directors, one of whom will be the Committee Chair
   - Chief Nurse
   - Medical Director
   - Chief Operating Officer

8. The Corporate Secretary shall also attend as a non-voting member of the Committee.

9. The Quality Committee will be deemed quorate when three voting members are present, including at least one Executive and at least one Non-Executive Director.

10. In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

11. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

13. An open invitation exists for all members of the Board of Directors to attend the Committee.

Requirements of Membership

14. Members should attend at least 75% of all meetings each financial year and aim to attend all scheduled meetings. Attendance will be recorded and monitored.

15. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

16. In order to fulfil its role and obtain the necessary assurance, the Quality Committee will:

- Inform the development and provide assurance against the following strategies, associated policies, sub-strategies, action plans and annual reports:
    - Quality Substrategy
    - Quality Account

- Ensure that governance and assurance systems operate effectively and underpin programme delivery to include:
    - Clinical Audit
    - Clinical Care
    - Complaints, Compliments and Concerns
    - Health and Safety
    - Incident Reporting and Management
    - Infection Prevention and Control
    - Mortality and Morbidity
    - Organ Donation
    - Patient Experience
    - Safeguarding

- Oversee the Trust's arrangements for maintaining licences such as the Care Quality Commission, Human Tissue Authority, Radiation Use and Protection Regulation (IR (ME)

R, ensuring compliance with standards, reviewing recommendations and monitoring of any associated action plans

- Monitor the Trust's arrangements for ensuring that care, treatment and support is delivered in line with legislation, standards and evidence based guidance, including NICE, GIRFT, radiation use and protection regulations (IR(ME)R) and other expert professional bodies, to achieve effective outcomes
- Ensure the Trust acts on learning from internal or external reports including serious incidents, other incidents, inquiries, investigations and Coroner's reports
- Monitor the principal risks assigned annually by the Board by ensuring that relevant assurances are sought with respect to the effectiveness of existing risk controls and that future actions are focused on managing risks to an acceptable level
- Monitor the management of key operational risks relevant to its remit and consider their impact on the strategic risks
- To consider and approve relevant policies, procedures and guidelines in relation to Patient Safety, Patient Experience and Clinical Effectiveness and to escalate to the Board of Directors, with an appropriate recommendation, any that may require approval at that level in line with the Scheme of Reservation and Delegation.

Data Privacy

17. ~~The Quality Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).~~ The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

18. In conducting its business, the Quality Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

19. The Quality Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

20. Reports including regular assurance reports/meeting minutes may be received from the following subgroups:

    - Clinical Effectiveness Group
    - Corporate Risk and Governance Group
    - Health, Safety & Security Group
    - Human Tissue Act Group
    - Infection Prevention and Control Group
    - Neurosurgery Divisional Risk and Governance Group
    - Neurology Divisional Risk and Governance Group

- Organ Donation Committee
- Patient Experience Group
- Quality & Patient Safety Group
- Safeguarding Group
- Serious Incident Review Group
- Sharing and Learning Forum

Administration of Meetings

21. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Quality Committee. There shall be at least nine meetings per year.

22. The Corporate Secretary will make arrangements to ensure that the Quality Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

23. Agendas and papers will be circulated at least four working days in advance of the meeting.

24. Minutes will be circulated to members for comment as soon as is reasonably practicable.

25. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

26. The Terms of Reference shall be reviewed annually (next review date: April 2024) and approved by the Board of Directors.

27. The Quality Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

The Walton Centre NHS Foundation Trust

Report to Trust Board
04/05/2023

Report Title	Nurse Revalidation Annual Report – 2022/23
Executive Lead	Morag Olsen-Interim Chief Nurse
Author (s)	Julie McEnerney – Practice Educator Joseph Towell – Revalidation and Nursing Administrator
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- All staff in 2022 - 23 period successfully revalidated
- All staff in 2023 – 24 on target for successful revalidation

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

- Continue to support the revalidation of nurses this year

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

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

001 Quality Patient Care	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Nurse Revalidation Update Report – 2022/23

Executive Summary

1. All registered nurses/midwives/nursing associates in the UK are required to maintain their registration with the Nursing & Midwifery Council (NMC) and must fulfil a range of requirements to show they are continuing to be able to practice safely and effectively by way of revalidation every three years.

2. The Trust is compliant with all requirements and on target to meet all future requirements

Analysis

3. During 2022/23 a total of 138 staff were required to revalidate. Of these, 138 staff successfully revalidated in accordance with the NMC Guidelines and therefore a 100% success rate *(See Appendix 1 – Table 1 for details)*

4. No issues with the completion process were identified during 2022/23 and the Revalidation and Nursing Administrator either completed the NMC submission with the nurse or obtained confirmation that the process had been undertaken.

5. A proportion of nurses required support with their revalidation submission during 2022/23. The main reasons for the additional support were due to lack of computer skills, confidence, or lack of Continuing Professional Development (CPD) hours.

Conclusion

6. Revalidation process is working successfully in the Trust and the level of support is appropriate. All revalidators for 2023 – 2024 are on track and adequately supported *(See Appendix 1 – Table 2 for details)*

Recommendation *(always required)*

To note

Author: Julie Mcenerney
Date: April 23

Appendix 1

Table 1 – Apr 2022 to Mar 2023

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Submitted	39	9	4	4	7	52	4	3	2	5	4	6
To Submit	0	0	0	0	0	0	0	0	0	0	0	0
Exemption	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of staff members revalidated during 2022/23 – 138												

Table 2 – Apr 2023 – Mar 2024

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Submitted	22	0	0	0	0	0	0	0	0	0	0	0
To Submit	0	3	5	2	6	44	6	5	4	10	1	6
Exemption	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of staff members revalidating during 2023/24 – 114												

The Walton Centre NHS Foundation Trust

Report to Trust Board
4 May 2023

Report Title	Equality, Diversity and Inclusion Annual Report 2023
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Samantha Linaker, Interim ED&I Lead
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- The annual Equality, Diversity and Inclusion Report has set out how the Walton Centre has been demonstrating 'due regard' to our Public Sector Equality Duty' under the Equality Act 2010.
- It also meets the Trust's Specific Duties to publish equality information and set equality objectives.
- The document also describes the headline activity undertaken at the trust in 2022-23 and the work and approaches that need to be undertaken to advance Equality of opportunity.

Next Steps

- Provisional grading completed by trusts Interim ED&I Lead.
- Following review/assurance at Business Performance Committee the report should be approved at Trust Board.
- Final report uploaded onto NHSE website and published on the trust's website.

Related Trust Strategic Ambitions and Themes	**Impact**		
Health Inequalities	Equality	Workforce	Not Applicable

Strategic Risks

006 Prevention & Inequalities	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
BPC	25 April 2023	Mike Gibney	Recommended to Board for Approval

Equality, Diversity and Inclusion Annual Report 2023

Executive Summary

1. The Public Sector Equality Duty requires public bodies to publish information that show they comply with the Equality Duty on an annual basis as a minimum standard. The Equality, Diversity & Inclusion Annual Report 2022 sets out how the trust has been demonstrating 'due regard' to our public sector equality duty under the Equality Act 2010. In addition, it meets the specific duty to publish equality information and sets equality objectives.

2. There is also a requirement to publish the annual report on the Trust's website.

3. This report publishes information about the Trusts equality related activities and equality profile in line with the Specific Equality Duty under the Equality Act 2010, as such its positive effect on equality is self-evident.

Background

4. The Equality Act, introduced in October 2010, replaced previous anti-discrimination laws with a single Act. Bringing together 9 pieces of primary legislation and over 100 pieces of secondary legislation the Act aimed to reduce bureaucracy, simplify the legislation and ultimately ensure that people are treated fairly when using services or whilst at work.

5. The General Duty, as set out in the Equality Act 2010, was introduced in April 2011, and it is the General Duty which guides the everyday work undertaken within the Trust.

6. The Specific Duties under the Public Sector Equality Duty require public bodies to:
   - Publish information to show their compliance with the Equality Duty, **at least annually**; and
   - Set and publish equality objectives, at least every four years.

7. The Equality Delivery System (EDS) for the NHS was made available to the NHS in June 2011. It was formally launched on 11 November 2011. Following an evaluation of the implementation of the EDS in 2012, and subsequent consultation with a spread of NHS organisations, a refreshed EDS is now available. It is known as EDS2.

8. The challenge with EDS2 is the process of grading. The self-assessment parameters are broad and potentially, too broad. The evidence requirements are not explicit enough therefore self-assessment can be subjective and open to personal interpretation. The initial self-assessment/judgement is typically made by the trusts ED&I Lead and then goes on to further discussion. Initially, Healthwatch were involved in a wider assessment process but this ceased some years ago when EDS3 was proposed. This proposed new version of the EDS has been in the pipeline for over 4 years and is still unavailable. It is important to note that the format of the WRES and WDES was shaped in response to the challenges of EDS2.

9. At the core of EDS2 are 18 outcomes against which NHS organisations assess and grade themselves. They are presented in four groups as follows:
   - Better health outcomes
   - Improved patient access and experience
   - A representative and supportive workforce
   - Inclusive leadership

10. The self-assessment/rating must be across all protected characteristics and therefore exceptional progress in one group does not translate into a higher grading on its own. The four areas for grading are **undeveloped, developing, achieving and excelling**. EDS2

should be applied to people whose characteristics are protected by the Equality Act 2010. The nine characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnic origin
- Religion or belief
- Sex
- Sexual orientation

11. The self-assessment attached has the trust principally developing across the two goals and achieving in the two other goals. There are no undeveloped or excelling criteria in the self-assessment. This is a realistic and honest view that is not untypical of trusts as moving forward on most of the characteristics is challenging. There are several reasons behind this, not least that trusts typically don't have a large ED&I resource and/or the agenda of the day results in a specific focus on an individual protected criteria. For example, the twin drivers of COVID and the Black Lives Matters movement has seen a much stronger focus on Black Asian and Minority Ethnic staff and improved outcomes.

12. It is important for Board to note that the way of thinking about Equality, Diversity & Inclusion is continuously evolving. The report format can feel old fashioned in comparison to the more holistic approach of focussing upon indices of deprivation. However, this is the format currently prescribed.

Conclusion

13. The annual Equality, Diversity and Inclusion Report has set out how the Walton Centre has been demonstrating 'due regard' to our Public Sector Equality Duty' under the Equality Act 2010 and the Specific Duties to publish equality information and set equality objectives.

Recommendation

To Approve

Author: Sam Linaker, Interim ED&I Lead
Date: 18 April 2023

1. Appendix 1 ED&I Annual Report 2023
2. Appendix 2 EDS2 2023

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Public Sector Equality Duty

Equality, Diversity and Inclusion Annual Report 2023

Contents

Introduction

The Walton Centre NHS Foundation Trust Annual Equality Diversity and Inclusion (ED&I) Report 2022 sets out the Trust's approach to ED&I and how the Trust meets the Public Sector Equality Duty (PSED).

The Walton Centre is a leader in the treatment and care of neurology and neurosurgery, placing the patient and their family at the heart of everything we do. As the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services we are proud to be rated as an 'Outstanding' Trust by the Care Quality Commission (CQC), and champion change throughout the field of neuroscience. Originally formed in 1992, the Trust received Foundation Trust status in 2009.

We have leading specialists and incredibly dedicated staff delivering excellent clinical outcomes for brain, spinal and neurological care both national and internationally. Teams across our site in Fazakerley, Liverpool, offer a world-class service in diagnosing and treating injuries and illnesses affecting the brain, spine and peripheral nerves and muscles, and in supporting people suffering from a wide range of long-term neurological conditions.

We serve a catchment area of 3.5 million people across Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man, north Wales and beyond with service partnerships with 18 NHS hospitals. Our 'Walton Clinics' model on 44 sites providing care for neurology means that many people are able to access outpatient consultations and many tests closer to home, and takes specialist services as close to service users as possible.

1.1 Our Vision

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

1.2 Our Purpose

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

1.3 Our Ambitions

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

1.4 Our Equality Diversity and Inclusion Vision

The Walton Centre's commitments to equality, diversity, and inclusion can be encompassed in the following statements:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity.
- We are committed to ensuring that staff and patients have good experiences at the Trust and feel comfortable "bringing their whole self" to The Walton Centre.
  We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

Walton Way:

Caring - caring enough to put the needs of others first
Dignity – passionate about delivering dignity for all
Openness – open and honest in all we do
Pride – proud to be part of one big team
Respect – courtesy and professionalism – it's all about respect

The Walton Centre is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place in 2022/23 and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity. We will continue to monitor our equality diversity and inclusion progress against our action plans and report annually and openly.

Equality Act 2010

The Equality Act, introduced in October 2010, replaced previous anti-discrimination laws with a single Act. Bringing together 9 pieces of primary legislation and over 100 pieces of secondary legislation the Act aimed to reduce bureaucracy, simplify the legislation and ultimately ensure that people are treated fairly when using services or whilst at work.

The Act protects people from discrimination based on 'protected characteristics'.

The nine protected characteristics are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership
- Race (ethnicity)
- Religion or belief
- Sex (gender)
- Sexual orientation

2.1 The General Duty

The General Duty, as set out in the Equality Act 2010, was introduced in April 2011, and it is the General Duty which guides the everyday work undertaken within the Trust. This includes having due regard to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between those who share and do not share a protected characteristic.

2.2 The Specific Duty

The Specific Duties under the Public Sector Equality Duty require public bodies to:

- Publish information to show their compliance with the Equality Duty, at least annually; and
- Set and publish equality objectives, at least every four years.

How the Walton Centre Pays due Regard to the General Equality Duty

3.1
The Trust demonstrates its overall values and commitment in regard to Equality Diversity and Inclusion (EDI) via its continued commitment to delivering its Equality, Diversity and Inclusion (ED&I) 5 Year Vision which is currently being redeveloped this year and we are in the process of developing a new vision. The Trust has an ED&I governance structure and includes the ED&I lead, SBAC along with staff network groups for race, disability and LGBTQ

3.2
The Trust continues to demonstrate its compliance with its Public Sector Equality Duty (PSED) under the Equality Act 2010 by producing and publishing an annual EDI report. The annual EDI report shows how the Trust is preforming against EDS2 metrics, which are designed to ensure PSED compliance. The annual EDI report also provides as summary of much of the activity that the Trust conducts to drive improvements in regards to EDI. The EDI Annual Report 2022 can be viewed using the following link:

https://www.thewaltoncentre.nhs.uk/AdminV9/Tracker/ClickTracker.aspx?type=search&id=1323940|0|-1|2143831|37035339&indexid=423&terms=edi%20annual%20report&x=/Downloads/Equality-Diversity-Inclusion/EDI%2520Annual%2520Report%25202022.pdf

3.3
The Trust demonstrates its continuing commitment to race equality via its compliance with the NHS, Workforce Race Equality Standards (WRES). These standards provide a number of indicators and corresponding action to drive improvements. The WRES findings for 2022 can be viewed using the following link:

https://www.thewaltoncentre.nhs.uk/Downloads/Reports-and-Publications/Equality-Diversity-and-Inclusion/WDES%20Report%202022.pdf

3.4
The Trust demonstrates its continuing commitment to disability equality via its compliance with the NHS, Workforce Disability Equality Standards (WDES). These standards provide a number of Metrics and corresponding action to drive improvements. The WDES findings for 2022 can be viewed using the following link:

https://www.thewaltoncentre.nhs.uk/Downloads/Reports-and-Publications/Equality-Diversity-and-Inclusion/WRES%20Report%202022.pdf

In addition to the WDES, the Trust also takes action to ensure that we are giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities. The Trust operates guaranteed interviews for all Disabled job applicants who meet the specified criteria for the job and the Trust also provides Reasonable Adjustments for Disabled applicants at interview. For staff who notify the Trust of their disability during their employment at the Trust, we provide Reasonable Adjustments if required to continue their employment and the Trust make available appropriate training, technology and adjusted work arrangements for those employees where appropriate. Information on reasonable adjustments is made available to all employees via the staff intranet pages.

3.5
The Trust demonstrates its continuing commitment to gender equality via its compliance with the Government Gender Pay Gap reporting requirements. The Trust reports and publishes its gender pay gap on an annual basis. This reporting allows the Trust to understand the average difference in pay between male and female staff. It also allows the Trust to take actions to close the gender pay gap. The Trust's Gender Pay Gap report 2022 can be viewed using the following link:

https://www.thewaltoncentre.nhs.uk/reports-and-publications/gender-pay-gap-report-2022/626914

3.6
The Trust demonstrates its continuing commitment to equality for LGBT+ patients and staff by its participation in the Navajo Charter Mark Scheme. In 2021 the Trust successfully completed reaccreditation and gained the privilege of holding the Navajo Charter Mark for a further two years, which is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA+ people in Merseyside.

3.7
The Trust has continued two innovative areas of EDI work in 2022/23. The Strategic B.A.M.E Advisory Committee (SBAC) has analysed patients by ethnicity to see where there may be inequalities in care and this work is now being expanded to examine health inequalities in terms of both race and the indices of social deprivations, to give the Trust sufficient insight into health inequalities relating to both patients and staff. The second innovative line of EDI work is aimed at ensuring that the Trust can provide equitable services and employment opportunities to armed services personnel, their families and veterans. In 2021/22 the Trust has been networking with other Trust's across the Northwest of England to ensure progress in respect of equality for veterans.

EDI governance and oversight is provided is provided via the Trust's EDI Steering Group and The Strategic B.A.M.E Advisory Committee, further monitoring and oversight is provided by the Trust's Business Planning Committee and the Trust Board.

The Trust's EDI performance if facilitated by a number of policies and guidance documents which include the following:

- Equality, Diversity and Inclusion (ED&I) 5 Year Vision
- Equality Diversity & Human Rights Policy
- Transgender Policy
- Tailored Reasonable Adjustment Template
- Equality Impact Assessment (EIA) Form

4 The Specific Equality Duty and the Walton Centre

The Trust meets its Specific Duties under the Equality Act 2010 via the publication of this Equality, Diversity and Inclusion Annual Report and the equality objectives stated within it. A further level of PSED assurance is provided by the Trust's participation in Equality Delivery System 2 (EDS 2).

EDS 2

EDS2 has four key goals (with 18 specific outcomes) which are achieving better outcomes, improving patient access and experience, developing a representative and supported workforce and finally, demonstration of inclusive leadership. Each of these goals are assessed and a grading applied to illustrate progress. Involvement of the communities and organisations who represent the views of people with protected characteristics is important. The grading's applied are as follows:

Undeveloped	If there is no evidence one way or another for any protected group of how people fare or Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well
Developing	If evidence shows that the majority of people in three to five protected groups fare well
Achieving	If evidence shows that the majority of people in six to eight protected groups fare well
Excelling	If evidence shows that the majority of people in all nine protected groups fare well

4.2 The current equality objectives are:

- Objective 1 Extend patient profiling (equality monitoring) data collection to all protected characteristics
- Objective 2 Improve support for, and reporting of, disability within the workforce
- Objective 3 Ensure ongoing involvement and engagement of protected groups including patients, carers, staff, Healthwatch and other interested parties
- Objective 4 Ensure all staff members are paid equally for equal work done
- Objective 5 Increase the number of BME staff within management positions.

Although the EDS 2 gradings for the vast majority of patient and public related services (Goals 1, 2 & 4) for The Walton Centre have been assessed as ***developing,*** these figures have improved from 2022 report with three more areas upgrated to ***achieving***. The currently proposed 2023 EDS2 grades for The Walton Centre can be viewed in the table immediately below and in the Appendix.

Current 2022/23 The Walton Centre EDS2: The Goals and Outcomes

4.3 Current 2022/23 The Walton Centre EDS2: The Goals and Outcomes			Grade Status
Goal	**Sub**	**Description of outcome**	
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing
	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
	2.3	People report positive experiences of the NHS	Achieving
	2.4	People's complaints about services are handled respectfully and efficiently	Achieving
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

5 Workforce ED&I Profile

Workforce ED&I Profile 31st March 2023.

5.1 Workforce by Age

Age Range	No. of Staff
<20 Years	8
21-25	64
26-30	195
31-35	243
36-40	223
41-45	165
46-50	190
51-55	183
56-60	160
61-65	113
66-70	13
> 71 Years	4
Total	1562

Staff Group by Age

Age Range	Scientific and Technical	Additional Clinical Services	Admin and clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Total
<20 Years	0	2	6	0	0	0	0	0	8
21-25	1	15	23	4	0	1	0	20	64
26-30	1	26	46	27	1	6	6	82	195
31-35	8	32	62	35	2	8	16	80	243
36-40	6	38	43	44	1	6	26	59	223
41-45	12	16	44	24	1	6	21	41	165
46-50	3	39	59	17	1	2	26	43	190
51-55	3	34	51	19	2	2	31	41	183
56-60	4	38	49	11	3	0	16	39	160
61-65	1	38	40	4	3	1	5	21	113
66-70	0	1	3	0	3	0	2	4	13
> 71 Years	0	1	2	0	1	0	0	0	4
Total	39	280	428	185	18	32	149	430	1561

5.2 Workforce by Gender

Gender	No. of Staff
Female	1201
Male	360
Grand Total	1561

Staff Group by Gender

Staff Group	Female	Male	Grand Total
Add Prof Scientific and Technic	31	8	39
Additional Clinical Services	237	43	280
Administrative and Clerical	302	126	428
Allied Health Professionals	150	35	185
Estates and Ancillary	10	8	18
Healthcare Scientists	20	12	32
Medical and Dental	50	99	149
Nursing and Midwifery Registered	401	29	430
Grand Total	**1201**	**360**	**1561**

5.3 Workforce by Ethnic Origin

Ethnic Origin	No. Of Staff
A White - British	1260
B White - Irish	32
C White - Any other White background	41
CP White Polish	1
D Mixed - White & Black Caribbean	3
E Mixed - White & Black African	3
F Mixed - White & Asian	2
G Mixed - Any other mixed background	5
H Asian or Asian British - Indian	120
J Asian or Asian British - Pakistani	9
K Asian or Asian British - Bangladeshi	4
L Asian or Asian British - Any other Asian background	11
LH Asian British	1
LK Asian Unspecified	1
M Black or Black British - Caribbean	3
N Black or Black British - African	23
P Black or Black British - Any other Black background	1
R Chinese	1
S Any Other Ethnic Group	3
SC Filipino	23
Unspecified	1
Z Not Stated	13
Grand Total	**1561**

Staff Group by Ethnic Origin

Ethnic Origin	Scientific and Technical	Additional Clinical Services	Administrative and Clerical	Allied Health Professional	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Total
A White - British	34	252	406	169	17	29	48	305	1260
B White - Irish	1	1	4	8	0	0	3	15	32
C White - Any other White background	1	7	2	2	0	1	20	8	41
CP White Polish	0	0	0	0	0	0	0	1	1
D Mixed - White & Black Caribbean	0	0	3	0	0	0	0	0	3
E Mixed - White & Black African	0	0	0	0	0	0	2	1	3
F Mixed - White & Asian	0	1	1	0	0	0	0	0	2
G Mixed - Any other mixed background	0	2	0	0	1	0	1	1	5
H Asian or Asian British - Indian	0	5	3	1	0	2	41	68	120
J Asian or Asian British - Pakistani	0	0	2	0	0	0	6	1	9
K Asian or Asian British - Bangladeshi	0	0	1	0	0	0	3	0	4
L Asian or Asian British - Any other Asian background	0	1	0	0	0	0	1	9	11
LH Asian British	0	0	0	0	0	0	1	0	1
LK Asian Unspecified	0	0	0	0	0	0	0	1	1
M Black or Black British - Caribbean	1	0	0	0	0	0	1	1	3
N Black or Black British - African	0	3	2	3	0	0	7	8	23
P Black or Black British - Any other Black background	0	0	0	0	0	0	0	1	1
PC Black	0	0	1	0	0	0	0	0	1
R Chinese	0	1	0	0	0	0	1	1	3
S Any Other	2	4	1	2	0	0	6	8	23
SE Other	0	1	0	0	0	0	0	0	1
Z Not Stated	0	2	2	0	0	0	8	1	13
Grand Total	**39**	**280**	**428**	**185**	**18**	**32**	**149**	**430**	**1561**

5.4 Workforce by Disability

Disability	No. Of Staff
No	1300
Not Declared	36
Prefer not to answer	3
Unspecified	166
Yes	56
Grand Total	**1561**

5.5 Staff Group by Disability

Staff Group	No	Not Declared	Prefer not to answer	Unspecified	Yes	Grand Total
Add Prof Scientific and Technic	37	0	0	2	0	39
Additional Clinical Services	240	8	0	26	6	280
Administrative and Clerical	353	9	2	39	25	428
Allied Health Professionals	152	2	1	18	12	185
Estates and Ancillary	17	0	0	0	1	18
Healthcare Scientists	25	0	0	7	0	32
Medical and Dental	123	11	0	13	2	149
Nursing and Midwifery Registered	353	6	0	61	10	430
Grand Total	**1300**	**36**	**3**	**166**	**56**	**1561**

5.6 Workforce by Religion or Belief

Row Labels	No. Of Staff
Atheism	195
Buddhism	9
Christianity	976
Hinduism	43
I do not wish to disclose my religion/belief	129
Islam	31
Judaism	2
Other	113
Unspecified	63
Grand Total	**1561**

5.7 Staff Group by Religion or Belief

	Atheism	Bhuddism	Christianity	Hinduism	Does not wish to declare	Islam	Judaism	Other	Unspecified	Total
Add Prof Scientific and	9	0	20	0	3	1	0	5	1	39
Additional clinical services	20	2	182	1	25	2	0	34	14	280
Administrative and clerical	65	0	279	1	27	2	1	38	15	428
Allied Health Professionals	33	1	129	0	12	0	0	3	7	185
Estates and Ancillary	3	0	12	0	1	0	0	2	0	18
Healthcare Scientists	8	0	16	0	3	1	0	3	1	32
Medical and Dental	20	1	37	28	25	20	1	7	10	149
Nursing and Midwifery	37	5	301	13	33	5	0	21	15	430
Grand Total	**195**	**9**	**976**	**43**	**129**	**31**	**2**	**113**	**63**	**1561**

5.7 Staff Group by Sexual Orientation

Sexual Orientation	No. Of Staff
Bisexual	13
Gay or Lesbian	29
Heterosexual or Straight	1356
Not stated (person asked but declined to provide a response)	84
Other sexual orientation not listed	1
Undecided	2
Unspecified	76
Grand Total	**1561**

5.9 Staff Group by Sexual Orientation

Staff Group	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated	Unlisted sexual orientation	Undecided	Unspecified	Grand Total
Add Prof Scientific and Technical	1	04	36	0	0	1	1	39
Additional clinical services	1	10	231	22	0	0	16	280
Administrative and clerical	4	8	381	20	0	0	15	428
Allied Health Professionals	1	5	164	6	0	0	9	185
Estates and Ancillary	0	0	17	1	0	0	0	18
Healthcare Scientists	1	0	28	1	0	0	2	32
Medical and Dental	0	2	116	20	0	1	10	149
Nursing and Midwifery Registered	5	4	383	14	1	0	23	430
Grand Total	**13**	**29**	**1356**	**84**	**1**	**2**	**76**	**1561**

5.10 Workforce by Marital Status

Status	No. Of Staff
Civil Partnership	27
Divorced	74
Legally Separated	8
Married	724
Single	673
Unknown	47
Widowed	8
Grand Total	**1561**

Staff Group by Marital Status

Staff Group	Civil Partnership	Divorced	Legally Separated	Married	Single	Not Known	Widowed	Total
Add Prof Scientific and Technical	3	1	0	20	14	1	0	39
Additional clinical services	6	17	1	104	140	11	1	280
Administrative and clerical	7	28	4	175	200	11	3	428
Allied Health Professionals	3	3	0	99	78	1	1	185
Estates and Ancillary	1	1	0	8	6	2	0	18
Healthcare Scientists	0	1	0	14	17	0	0	32
Medical and Dental	2	7	2	103	25	10	0	149
Nursing and Midwifery Registered	5	16	1	201	193	11	3	430
Grand Total	**27**	**74**	**8**	**724**	**673**	**47**	**8**	**1561**

6 New Starters 1st April 2022 to 31st March 2023.

Disability	No. of Staff
No	289
Not Declared	3
Prefer not to answer	1
Yes	14
Grand Total	**307**

6.1

Gender	No. of Staff
Female	216
Male	91
Grand Total	**307**

6.2

Marital Status	No. of Staff
Civil Partnership	9
Divorced	13
Legally separated	3
Married	135
Single	145
Unknown	11
Widowed	
Grand Total	**307**

6.3

Age Band	No. of Staff
<=20 Years	5
21-25	39
26-30	60
31-35	46
36-40	41
41-45	19
46-50	28
51-55	23
56-60	24
61-65	19
66-70	2
>=71 Years	1
Grand Total	**307**

6.4

228Ethnic Origin	No. of Staff
A White - British	228
B White - Irish	9
C White - Any other White background	8
FMixed - White & Asian	2
H Asian or Asian British - Indian	39
J Asian or Asian British - Pakistani	5
K Asian or Asian British - Bangladeshi	1
M Black or Black British - Caribbean	1
N Black or Black British - African	3
PC Black Nigerian	1
R Chinese	1
S Any Other Ethnic Group	6
SE Other Specified	1
Z Not Stated	2
Grand Total	307

6.5

Nationality	No. of Staff
Australian	1
Bangladeshi	1
British	244
Central African	2
Egyptian	1
Filipino	2
Greek	1
Guinean	1
Indian	32
Irish	8
Italian	1
Maltese	2
Nigerian	1
Northern Irish	1
Pakistani	2
Polish	4
Portuguese	1
Sri Lankan	1
Swedish	1
Grand Total	**307**

6.6

Sexual Orientation	No. of Staff
Bisexual	5
Gay or Lesbian	7
Heterosexual or Straight	286
Not stated (person asked but declined to provide a response)	9
Grand Total	**307**

6.7

Religious Belief	No. of Staff
Atheism	43
Buddhism	2
Christianity	205
Hinduism	11
I do not wish to disclose my religion/belief	17
Islam	7
Judaism	1
Other	21
Grand Total	**307**

7 Recruitment Data 1st April 2021 to 31 March

Category	Description	Number of applications	Constituting the following % of applications	Number of applications shortlisted	Constituting the following % of those shortlisted	% of applications shortlisted under each Description
Gender	Male	1344	39.29%	319	25.40%	23.74%
	Female	2061	60.25%	931	74.12%	45.17%
	Undisclosed	16	0.47%	6	0.48%	37.50%
Disability	Yes	194	5.67%	98	7.81%	50.52%
	No	3170	92.66%	1137	90.60%	35.87%
	Undisclosed	57	1.67%	20	1.59%	35.09%
Criminal Conviction	Yes	7	0.20%	0	0.0%	0.0%
	No	1554	45.43%	638	50.84%	41.06%
	Undisclosed	1835	53.64%	617	49.16%	33.62%
Ethnicity	WHITE - British	1631	47.68%	950	75.64%	58.25%
	WHITE - Irish	34	0.99%	22	1.75%	64.71%
	WHITE - Any other white background	160	4.68%	39	3.11%	24.38%
	ASIAN or ASIAN BRITISH - Indian	420	12.28%	58	4.62%	13.81%
	ASIAN or ASIAN BRITISH - Pakistani	304	8.89%	24	1.91%	7.89%
	ASIAN or ASIAN BRITISH - Bang-ladeshi	57	1.67%	10	0.8%	17.54%
	ASIAN or ASIAN BRITISH— Chinese	24	0.70%	9	0.72%	37.50%
	ASIAN or ASIAN BRITISH - Any other Asian background	93	2.72%	13	1.04%	13.98%
	MIXED - White & Black Caribbe-an	10	0.29%	2	0.16%	20.00%
	MIXED - White & Black African	44	1.29%	7	0.56%	15.91%
	MIXED - White & Asian	16	0.47%	7	0.56%	43.75%
	MIXED - any other mixed background	41	1.20%	15	1.19%	36.59%
	BLACK or BLACK BRITISH - Carib-bean	8	0.23%	2	0.16%	25.00%

Category	Description	Number of applications	Constituting the following % of applications	Number of applications shortlisted	Constituting the following % of those shortlisted	% of applications shortlisted under each Description
	BLACK or BLACK BRITISH - African	387	11.31%	63	5.02%	16.28%
	BLACK or BLACK BRITISH - Any other black back-ground	12	0.35%	3	0.24%	25.00%
	OTHER ETHNIC GROUP - Any other ethnic group	129	3.77%	19	1.51%	14.73%
	Undisclosed	51	1.49%	13	1.04%	25.49%
Age Band	Under 24	390	11.40%	140	11.15%	35.90%
	24-44	2414	70.56%	790	62.90%	32.73%
	45-59	558	16.31%	294	23.41%	52.69%
	60-74	52	1.52%	26	2.07%	50.00
	75+	0	0.00%	0	0.00%	0.00%
	Prefer not to say	7	0.20%	6	0.48%	85.71%
Religion	Atheism	498	14.56%	276	21.97%	55.42%
	Buddhism	39	1.14%	10	0.80%	25.64%
	Christianity	1653	48.32%	732	58.28%	44.28%
	Hinduism	235	6.87%	33	2.63%	14.04%
	Islam	396	11.5%	46	3.66%	11.62%
	Jainism	229	6.69%	17	1.35%	7.42%
	Judaism	5	0.15%	2	0.16%	40.00%
	Sikhism	5	0.15%	0	0.0%	0.0%
	Other	152	4.44%	67	5.33%	44.08%
	Undisclosed	209	6.11%	73	5.81%	34.93%

Category	Description	Number of applications	Constituting the following % of applications	Number of applications shortlisted	Constituting the following % of those shortlisted	% of applications shortlisted under each Description
Sexual Orientation	Heterosexual	3129	91.46%	1142	90.92%	36.50%
	Gay/Lesbian	89	2.60%	40	3.18%	44.94%
	Bisexual	76	2.22%	29	2.31%	38.16%
	Other	15	0.44%	3	0.24%	20.00%
	Undecided	14	0.41%	5	0.40%	35.71%
	Undisclosed	98	2.86%	37	2.95%	37.76%
Marital Status	Married	1185	34.64%	398	31.69%	33.59%
	Single	1984	57.99%	728	57.96%	36.69%
	Civil partnership	65	1.90%	42	3.34%	64.62%
	Legally separated	10	0.29%	8	0.64%	80.00%
	Divorced	70	2.05%	37	2.95%	52.86%
	Widowed	18	0.53%	7	0.56%	38.89%
	Undisclosed	89	2.60%	36	2.87%	40.45%
Disability	Physical Impairment	22	10.09%	8	7.08%	36.36%
	Sensory Impairment	12	5.50%	9	7.96%	75.00%
	Mental Health Condition	32	14.68%	18	15.93%	56.25%
	Learning Disability/Difficulty	42	19.27%	28	24.78%	66.67%
	Long-Standing Illness	64	29.36%	30	26.55%	46.88%
	Other	46	21.10%	20	17.70%	43.48%
Total		**3421**	**100.00%**	**1256**	**100.00%**	**36.71%**

8 Patient ED&I Profile

WCFT Patient Diversity Breakdown: 1st Apil 2022 to 31st March 2023

8.1 Gender

Sex	Description	Inpatient	Outpatient	Grand Total	% of Total
F	Female	9483	81057	90540	58.52%
I	Indeterminate/Other	2	21	23	0.014%
M	Male	5922	58193	64115	41.44%
U	Unknown/Not Stated	6	30	36	0.023%
Grand Total		15413	139301	154714	100%

8.2 Age Band

Age Band	Inpatient	Outpatient	Grand Total	% of Total
Under 18	65	1012	1077	0.70%
18-24	577	7371	7948	5.14%
25-34	131	15802	17533	11.33%
35-44	2304	19773	22077	14.27%
45-54	3512	25225	28737	18.57%
55-64	3507	29689	33196	21.46%
65-74	2381	23855	26236	16.95%
75+	1336	16574	17910	11.58%
Grand Total	15413	139301	154714	100%

8. 3 Religion

Religion	Religion Description	Inpatient	Outpatient	Grand Total	% of Total
NK	NOT KNOWN	2589	54060	56649	36.62%
AGN	AGNOSTIC	14	85	99	0.06%
ANG	ANGLICAN	12	102	114	0.07%
ATH	ATHEIST	63	511	574	0.37%
BAP	BAPTIST	5	195	200	0.13%
BUD	BUDDHIST	15	146	161	0.10%
CHR	CHRISTIAN	804	3963	4767	3.08%
COE	CHURCH OF ENGLAND	3441	26493	29934	19.35%
CON	CONGREGATIONAL	0	15	15	0.01%
COS	CHURCH OF SCOT-LAND	24	76	100	0.06%
COW	CHURCH OF WALES	45	299	344	0.22%
GO	GREEK ORTHODOX	6	39	45	0.03%
HIN	HINDU	18	178	196	0.13%
JEW	JEWISH	13	143	156	0.10%
JW	JEHOVAH'S WITNESS	16	286	302	0.19%
MET	METHODIST	102	868	970	0.63%
MOR	MORMON	2	28	30	0.02%
MUS	MUSLIM	68	592	660	0.43%
NRP	NO RELIGIOUS PREFER-ENCE	4318	25680	29998	19.39%
OC	OTHER CHRISTIAN	142	1150	1292	0.83%
ONC	OTHER NON CHRIS-TIAN	19	93	112	0.07%
PRE	PRESBYTERIAN	24	58	82	0.05%
QUA	QUAKER	0	10	10	0.01%

8 Patient ED&I Profile

RC	ROMAN CATHOLIC	2723	18379	21102	13.64%
REF	PATIENT REFUSED TO GIVE INFO	1	19	20	0.013%
RO	RUSSIAN ORTHODOX	9	3	12	0.01%
SAL	SALVATION ARMY	1	18	19	0.012%
SEI	SEIKH	20	46	66	0.43%
SPR	SPIRITUALIST	4	57	61	0.39%
UNK	UNKNOWN	914	5705	6619	4.28%
WES	WESLEYAN	0	2	2	0.001%
WW	WHITE WITCHCRAFT	1	2	3	0.002%
Grand Total		15413	139301	154714	

8.4 Ethnicity

Ethnic Group	Ethnic Group Desc	Inpatient	Outpatient	Grand Total	% of Total
NK	NOT KNOWN	340	14352	14692	9.49%
A	WHITE - BRITISH	13384	102925	116309	75.18%
B	WHITE - IRISH	51	323	374	0.24%
C	WHITE - ANY OTHER BACKGROUND	162	1331	1493	0.96%
D	MIXED - WHITE/BLACK CARIBBEAN	24	129	153	0.10%
E	MIXED - WHITE/BLACK AFRICAN	5	140	145	0.09%
F	MIXED - WHITE AND ASIAN	16	165	181	0.12%
G	MIXED - ANY OTHER	58	261	319	0.21%
H	ASIAN - INDIAN	38	338	376	0.24%
J	ASIAN - PAKISTANI	14	149	163	0.11%
K	ASIAN - BANGLADESHI	11	67	78	0.50%
L	ASIAN - ANY OTHER BACKGROUND	30	283	313	0.20%
M	BLACK - CARIBBEAN	0	96	96	0.06%
N	BLACK - AFRICAN	14	182	196	0.13%
P	BLACK - ANY OTHER BACKGROUND	22	243	265	0.17%
R	OTHER - CHINESE	12	210	222	0.14%
S	OTHER - ANY OTHER	61	706	767	0.49%
Z	NOT STATED	1171	17401	18572	12.00%
Grand Total		15413	139301	154714	100%

8.5 Disability

Disability Risk Flag Y/N	Total	% of Total
No	149028	96.32%
Yes	5686	3.68%
Grand Total		

Please note that patient disability the figures are compiled from aggregating known medical conditions that are considered to be disabilities, as patient data is not collected specifically under the general category of disability.

9 The use of interpretations services

9.1

Number of interpreter appointments conducted per language spoken 1st April 2022 to 31st March 2023					
Polish	Arabic	Cantonese	Farsi	Romanian	Kurdish
221	184	58	87	61	68
Portuguese	Turkish	Russian	Mandarin	Tamil	Urdu
39	52	30	23	30	22
Hungarian	Lithuanian	Spanish	Bulgarian	Slovak	Bengali
24	21	22	17	18	13
Czech	Somali	Amharic	Latvian	French	Italian
23	12	1	3	8	12
Albanian	Pashtu	German	Dari	Punjabi	Thai
2	6	0	0	13	5
Sinhalese	Chinese	Macedonian	Hindi	Sorani	Tigrinya
3	0	4	1	0	10
Vietnamese	5				
Total appointments made: 1098					

9.2

Number of sign language interpreter appointments made 1st April 2022 to 31st March 2023.			
Total number of appointments	110	Number of cancellations by the provider	

10 Conclusion

This annual Equality, Diversity and Inclusion Report has set out how the Walton Centre has been demonstrating 'due regard' to our Public Sector Equality Duty' under the Equality Act 2010 and the Specific Duties to publish equality information and set equality objectives.

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END OF REPORT

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Equality Delivery System – *EDS2* Summary Report 2023

The Equality Delivery System – EDS2 was made mandatory in the NHS standard contract from April 2015. NHS organisations are strongly encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at:
http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. Once completed, this Summary Report should be published on the organisation's website.

NHS organisation name:

The Walton Centre NHS Foundation Trust

Organisation's Board lead for EDS2	Organisation's EDS2 lead
Mike Gibney (Chief People Officer)	Jane Mullin (Deputy Chief people Officer)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Staff Partnership Committee
Patient Experience Group
Business Performance Committee

Organisation's Equality Objectives (including duration period):

2017-2022 – currently undergoing review for 2023-2028

Objective 1 - Extend patient profiling (equality monitoring) data collection to all protected characteristics
Objective 2 - Improve support for, and reporting of, disability within the workforce
Objective 3 - Ensure ongoing involvement and engagement of protected groups including patients, carers, staff, Healthwatch and other interested parties

EDS2 Grades (Date: 31/03/2023)		
Goal	**Outcome**	**Grade and reasons for rating**
Better health outcomes	**1.1**	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** **Grade: Developing** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust has now adopted a new standard operating procedure and policy to ensure that reasonable adjustments and made to make our service accessible to patients with disabilities.** **The Trust has analysed patient equality data and has identified lower numbers of Black Asian and minority ethnic staff using our services than we would expect given the local demographics in terms of racial diversity.** **In order to tackle health inequalities, the Trust will analyse its patient data against indices of social deprivation and broken down by ethnicity.** **The Trust believes that the highest quality services should be provided to all patients, which is reflected in the Trust's corporate objectives and mission statement. This belief is the key driver in the design and procurement of all its services. The Trust works in partnership with commissioners to shape their contract thus ensuring that services are commissioned to meet the needs of the local population and to reduce health inequalities. The Trust has completed in a joint retendering process with local Trusts and CCGs to ensure that interpretation and translations services of the highest quality. Equality performance is routinely monitored in the quality contract with the Trust's commissioners.** **Any new services or existing services undergoing change are assessed for possible equality impact on patients, visitors and staff. In addition, services are designed to be compliant with the Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) standards and guidelines, and are fully accredited by awarding bodies.** **The Trust believes that the services offered by the Trust are available to all irrespective of their protected characteristics, and data from the patient data report, complaints monitoring, patient surveys and engagement supports this belief. Patients, carers, Foundation Trust members and other stakeholders and local organisations and community groups are consulted with and involved in the design and delivery of services, thus ensuring that the health needs of the local communities are considered. All tenders assess equality and diversity, with responses considered as part of the tender process. All contracts include equality clauses.** **For this outcome, the Trust has good evidence and data to demonstrate that services are equality impact assessed. The Trust can also demonstrate that the health and well-being of its staff and patients is taken seriously through strategic planning processes and policy making. Patients from all protected characteristics are engaged with in the above processes, but the Trust currently does not capture all characteristics and therefore is unable to demonstrate a higher number of protected characteristics that fare well. Continuing actions will be implemented to address these issues in the next 12 months.**
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** **Grade: Developing** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **Risk assessments are undertaken on all patients and therefore from all protected characteristics in relation to falls, pressure ulcers, venous thromboembolism (VTE) and nutrition, in line with Commissioning and quality targets. The assessment includes review of patient's religious and cultural requirements, communication and care requirements, family support and carer needs. Individual care plans are developed for each patient and reviewed throughout their period of care. These plans are contributed to by all members of the Trust multidisciplinary team as and referrals made to subsequent services such as smoking cessation, dieticians, support groups or district nursing and rehabilitation services as appropriate.** **The Trust remains in a similar position for sub goal 1.2. Due to the limited data captured the Trust is unable to evidence further progression to show all protected characteristics fair well. However, processes are in place to ensure that all patients' health needs are assessed and met regardless of protected characteristics. The Trust is committed to provide individualised patient care and, where required, for all patient during the health needs assessment and through the patient journey. For example, the Trust ensures that reasonable adjustments are made for disabled patients, patients with learning disabilities, and patients with dementia. In addition, the Trust has access to 24-hour interpretation services that cover the languages or dialects that are spoken within the organisations catchment area. Signalise provide 24 hour 7 days a week service for deaf patients and can provide face to face or video interpretation** **Following an individual health needs assessment, either in an outpatient, inpatient or in a community setting, all patients are provided access to the services they require in an appropriate and effective manner. The Trust ensures effective assessments are undertaken and case note and nursing quality audits support this process.** **For this outcome, the Trust is satisfied that the processes in place across the organisation allow for all the patients who are referred to services or self-refer, where appropriate, are provided with individualised health needs assessments. Any concerns and complaints are investigated and reported. Action and learning from complaints is summarised in the complaint responses and actions are closely monitored by the Patient**

1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** **Grade: Developing** **Number of protected characteristics that fare well: 8** **Evidence drawn upon for rating:** **The Trust has numerous examples to demonstrate effective and appropriate transitions from services to support individual needs. This happens during transfer of patients into the Trust from the Trauma Network, from District General Hospitals, from other specialist Trust, for example Alder Hey, and GP referrals. We also transfer patients onto various points of care, including services within the Rehab Network, repatriating hospitals and social care or specialist services. This includes patients from Warrington, Cheshire, Merseyside, Wales and the Isle of Man. The Trust is currently gathering data looking into patient transitioning from children to adult service in order to look at a Pathway for transitioning.** **Individual care plans are developed for each patient and reviewed throughout their period of care. The patient's assessment includes a review of their religious and cultural requirements, communication and care requirements, family support and carer needs. These plans are contributed to by all members of the Trust's multidisciplinary teams with input from the patient and carers, alongside health and social care professionals. Any change in services provided is planned and communicated with all concerned and any referrals are made to subsequent services with full handover of information.** **The Trust has good links with local communities and social services across its footprint. Holding multi-disciplinary meetings with internal and external stakeholders, as well as family members, to ensure arrangements are agreed and planned in the best interests of individual patients.** **The Trust actively signposts carers to appropriate support, includes them as partners in care and has implemented the 'Carers Passport' along with 11 other trust across Merseyside and Cheshire to highlight and acknowledge the importance of involving families as partners in care. The Trust is currently allocating space for a carers resource where it will provide information and a quiet space for carers to access. This resource will be supported by the Brain Charity in partnership with the Trust.** **For this outcome, despite good examples, the Trust cannot provide data to demonstrate that people from all protected groups are supported and have smooth transitions between services. However, complaints received by the organisation do not support this**
1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade: Developing** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust believes that patient safety and quality must be at the heart of everything it does. The Quality Accounts Annual Report provides the backdrop to demonstrate the organisations commitment to improving the quality of services and safety of care. The Trust must ensure that it listens to and acts on feedback received.** **The Trust takes patient safety very seriously and has reported on several current work streams within the Quality Accounts report, including medication errors, cancelled operations and healthcare acquired infections. Data is available for 4 protected characteristics at the present time however, as previously stated, work is being undertaken to extend the data collection systems to improve data capture.** **Patient Led Assessment of Cleanliness and Environment (PLACE) inspections are carried out annually. Teams are made up of patient representatives and members of staff, volunteers and patients with long term conditions and disabilities. The visits are planned but unannounced the areas and intended to review the hospital for standards in cleanliness, hand hygiene, quality of accommodation and food and food service.** **The organisation has a system in place whereby incidents of abuse must be reported by staff whether the abuse is directed at staff by patients, patient to patient or patient to staff, patient to patient and staff to patient. All incidents are reported via Datix, our incident reporting system to the Safeguarding Team. Abuse includes behaviours such as violence, verbal abuse, gestures, sexual or racial abuse. Reporting is web based, and all incidents are investigated thoroughly, and actions undertaken to address the behaviours. All incidents are reported through the appropriate governance committee structures. Some incidents, such as neglect, abuse of vulnerable adults or children, are reported directly to the Strategic Executive Information System (STEIS) as per NHS standard procedures for external reporting. The Trust also has an appointed Freedom to Speak Up Guardian to ensure that staff are encouraged and supported to report any mistakes, mistreatment and abuse.** **Reporting incidents by protected characteristic is difficult at the present time. Work is being undertaken to tie in together the three data systems required: the patient administration system, the electronic staffing record and the incident reporting system in order that data can be gathered for protected characteristics. The Trust seeks causes through incident reporting and whistle-blowing systems and Freedom To Speak Up Guardians, which informs actions to be undertaken. Therefore, having a robust and safe complaints and whistle-blowing process is vital. Policies are in place to protect people making complaints and follow strict guidelines. Staff and patients are able to make complaints without fear of victimisation.** **Along with the safeguarding annual report, the Trust has a Safeguarding Adults and Children team to ensure the Trust operates within national statutory and non-statutory guidance for on safeguarding vulnerable people. Policies have been introduced to provide guidance to staff on the management of allegations of abuse and deprivation of liberty safeguards. In addition, staffs have access to taught sessions and e-learning training packages on safeguarding issues.** **For this outcome, the Trust firmly believes that all people from all protected characteristics are given the same protection in accordance with its mission statement to provide the very best care for each patient on every occasion, which is at the core of everything it does. However, grading has been identified as developing. This is due to the good data and evidence to demonstrate patient safety across the protected characteristics available in comparison to the less adequate data available for incident reporting of bullying or harassing behaviours. Patients from all protected characteristics are engaged with in the above processes.**

1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade: Developing** **Number of protected characteristics that fare well: 4** **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has an extensive range of health programmes and initiatives in place to support staff and patients alike in accessing public health, vaccination and screening programmes. The Trust is able to provide evidence to demonstrate that people are accessing services; Previously, due to the data collection system we were only able to collect information on 4 of the protected characteristics but this has now risen to 8. Work is underway to enhance the current data collection systems to cover all protected characteristics.** **Throughout the hospital's wards, outpatients and public areas there is an extensive range of public health information for staff and patients to access, examples being for infection control and smoking cessation. Audits are undertaken to ensure sufficient coverage and appropriate placement of information is provided. All patient information is available on request in alternative formats. Interpreters are utilised to ensure communication is most effective.** **The Trust carried out an extensive COVID-19 vaccination programme on 2020 and took particular steps to ensure a high vaccination rate amongst Black, Asian and minority ethnic staff in response to national reports of their being a disproportionate impact of COVID-19 on these groups. This vaccination programme continues alongside our flu campaign which runs each year.** **Health, vaccination and screening programmes include: pre-natal advice for epilepsy patients, flu vaccination programmes and smoking and alcohol intake screenings. After a positive trial for epilepsy patients a number of Nurse advice lines have also been rolled out to enable patients to get disease specific advice and support between appointments.** **The Trust believes that a healthy workforce leads to safer and better patient care and is committed to improving the health and wellbeing of all staff. The Trust has also been re-accredited with the Workplace Wellbeing charter and continues to run regular schemes and initiatives including health checks, fitness classes, various mental well-being initiatives, and discounted weight loss programmes.** **For this outcome, the Trust is again able to present data for 4 of the protected characteristics for patients, and all but 1 protected characteristic for staff (although not all staff services are monitored for equality purposes).**
Improved patient access and experience 2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade: Developing** **Number of protected characteristics that fare well: 7** **Evidence drawn upon for rating:** **The Trust has undertaken an analysis of accessibility to our service regarding race and ethnicity via the Trust's Strategic BAME Advisory Committee, which indicated that fewer patients from Black, Asian and Minority Ethnic backgrounds are currently accessing our service when compared with their proportionate demographic percentage of the population we serve. The Trust has taken steps to ascertain the reasons for this disparity with relatively fewer numbers of Black, Asian and minority ethnic patients accessing the service.** **The following barriers have been identified by the Trust through networking with voluntary sector organisations such as the Neurological Alliance:** **A lack of knowledge in some newer communities as to how the health system works and how to access health services e.g. refugees and asylums seekers.** **Language can be a barrier for people who have English as a second language. Basic information as to how to navigate the health system can be more difficult to access, resulting in patients not being referred on from primary care in the numbers we might expect.** **Different ways of understanding illness and describing symptoms in some communities leading to greater difficulties in diagnosis of some conditions e.g. in some languages there is no separate word for a neurological condition and a mental health condition.** **Stigma and a reluctance to come forward for diagnosis because of fear of being stigmatised in some communities.** **A greater emphasis in some communities on families taking care of their own family members rather than relying on health care services, leading to later presentation at health services and later diagnosis.** **The Trust is continuing to network with the Neurological Alliance and other organisations to find ways to address these barriers and have patient representation in the meetings.** **Due to the limitations of the current patient administration system (PAS), the Trust is only able to provide quantitative data for 4 of the protected characteristics: namely, age, ethnicity, religion and belief and sex. Plans are already in place to update PAS to collect additional information regarding disability, sexual orientation and carer status.** **The Trust recognises that accessing services can be more difficult for some people – such as people with a disability, people with learning difficulties or people whose first language is not English. The Trust is committed to ensuring that reasonable adjustments are made for disabled patients and patients with learning difficulties where required. For example, where a patient is distressed by waiting rooms and bright lighting, staff arrange for the patients appointment to be first on the list and the patient seated in a quiet area to wait for their appointment, thus reducing anxiety for the patient and carer or relatives. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities.**

2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade: Developing** **Number of protected characteristics that fare well: 7** **Evidence drawn upon for rating:** **The Trust has undertaken an analysis of accessibility to our service regarding race and ethnicity via the Trust's Strategic BAME Advisory Committee, which indicated that fewer patients from Black, Asian and Minority Ethnic backgrounds are currently accessing our service when compared with their proportionate demographic percentage of the population we serve. The Trust has taken steps to ascertain the reasons for this disparity with relatively fewer numbers of Black, Asian and minority ethnic patients accessing the service.** **The following barriers have been identified by the Trust through networking with voluntary sector organisations such as the Neurological Alliance:** • **A lack of knowledge in some newer communities as to how the health system works and how to access health services e.g. refugees and asylums seekers.** • **Language can be a barrier for people who have English as a second language. Basic information as to how to navigate the health system can be more difficult to access, resulting in patients not being referred on from primary care in the numbers we might expect.** • **Different ways of understanding illness and describing symptoms in some communities leading to greater difficulties in diagnosis of some conditions e.g. in some languages there is no separate word for a neurological condition and a mental health condition.** **The Trust recognises than accessing services can be more difficult for some people – such as people with a disability, people with learning difficulties or people whose first language is not English. The Trust is committed to ensuring that reasonable adjustments are made for disabled patients and patients with learning difficulties where required. For example, where a patient is distressed by waiting rooms and bright lighting, staff arrange for the patients appointment to be first on the list and the patient seated in a quiet area to wait for their appointment, thus reducing anxiety for the patient and carer or relatives. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities.** **Pictorial menus have also been developed to support patients to choose their meals and interpreters are in place to support patients who are unable to read or comprehend English. The Trust has implemented the Accessible Information Standard and is working on ensuring this remains fully implemented. Since its implementation we have received requests from a number of patients to meet their needs and have been able to accommodate all of these. When patients telephone to make appointments, the access, booking and choice receptionists ask patients whether they have caring responsibilities or any disability in order to ensure that the best appointment possible is provided to suit their needs. Patients are also able to make appointments via email if preferred. Text messages are also sent to patients to remind them of their appointment, and the Trust has a self-check in kiosk, which has been reviewed regarding its accessibility.** **The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings** **The Trust has an interpreting service that is readily available and covers languages and dialects required, there also a provision for British sign language. Language interpretation is available face to face and by telephone. The Trust has an interpreting policy to ensure that staff understand how to access the interpreting services.** **'Meet and Greet' volunteers have been recruited to support patients to navigate around the hospital and the Trust is working with local communities and charities to ensure training is appropriate regarding peoples cultural and disability requirements, i.e. patients with vision impairment being guided appropriately.** **For this outcome, the Trust is able to demonstrate that patients, carers and communities from 4 of the protected characteristics readily access services and there are no obvious concerns as demonstrated in the patient data report.**
2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade: Achieving** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust is committed to ensure that all patients, irrespective of protected characteristics, are informed, supported and involved in their diagnosis and decisions about their care where appropriate.** **The CQC National Inpatient Survey is the main source of reporting the perceptions of patients across the NHS and is used in comparative performance tables and quality indicators. Action plans have been developed and targeted work undertaken where patient perception has been less than anticipated. Improvements were made over the last few years, with the result that when asked, the majority of patients felt they had been involved in decisions about their care, had been kept informed about medication side effects and were provided with information in a way that was easy to understand. Local real-time surveys are undertaken in departments and the regular patient listening events undertaken across the Trust support the findings of the national survey.** **All patients give consent to treatment in line with Trust and national consent policies. The Trust policy has recently been reviewed and reflects discussions with local communities.** **The Trust has an active Patient Experience Group which meet quarterly, and the membership includes Healthwatch representatives and governor, the group receives a report bi-annually on the progress of patient information developed across the Trust. Standard, easy read and talking leaflets are being developed continually. The Trust strives to meet the communication needs of all patients and menus can be read to support patients to make choices.**

	Staff are able to access the interpreting services to ensure that patients whose first language is not English, or those patients who use British Sign Language, are fully able to understand their diagnoses and treatment and this should always be used during the consent process Indeed, where patients are to be given 'bad news' interpreting provision takes place face to face and not by telephone. **For this outcome, the Trust is again able to demonstrate that patients from 4 of the protected characteristics are informed and supported to be as involved as they wish to be in decisions about their care. However, changes are underway to improve the data monitoring information collected at a local level. The national inpatient survey is limited to 6 protected characteristics at the present time.**
2.3	**People report positive experiences of the NHS** **Grade: Achieving** **Number of protected characteristics that fare well: 6** **Evidence drawn upon for rating:** **The Trust has been assessed as Outstanding by the CQC. As part of this assessment NHS England reviewed and assessed the delivery of care to patients and their experiences when accessing services. They also undertook a review of equality and diversity provision and compliance within the Trust and found the outcome to be good.** **Feedback through surveys and social media indicate a very good patient experience of services at the Walton Centre. In CQC National Surveys results do not indicate any discrimination due to a particular characteristic. Scheduled quarterly reports on all patient experience and dignity and respect activities are presented to the Trust Board and to the specialist CCG commissioners. The patient experience team meet with divisions on a weekly basis to discuss experiences of patients and discuss any open concerns or complaints. This is then reported via a report monthly to Divisional Governance meeting and the bi-monthly Executive meeting and the Quarterly Quality Committee of the Board. This information also goes to Patient Experience Group which has representatives from Healthwatch, Trust Governors and local charitable organisations.** **All patients are asked to complete a Friends and Family Test during their admission and upon discharge. The results of these surveys are reported though the Integrated Performance Report and the quarterly Patient Experience Group. All wards received feedback on a monthly basis to share the positive comments and put actions in place for any negative comments or themes.** **The Trust has Dignity Champions across the organisation with each ward having at least one Dignity Champion. The Champions act as role models, identifying breaches of dignity in care, addressing and challenging issues as they arise and promoting dignity in care for every patient.** **The Trust has already identified gaps in engagement with some seldom heard groups, such as gypsy, traveller and Roma communities and homeless people communities. Work will continue to forge better relationships with all community groups to ensure that their voices are heard through partnership working with local communities and interest groups, CCGs and Local Authorities and the Health watch.** **For this outcome, the Trust is firmly committed to listening to the views of patients, carers and other local interest groups and communities and ensuring positive patient experience. Evidence from all of the above leads us to suggest that we are Achieving with regards to this sub-goal.**
2.4	**People's complaints about services are handled respectfully and efficiently** **Grade: Achieving** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **Complaints about care and our services are taken very seriously and all concerns and complaints are managed by Patient Experience Team and investigated by the appropriate division to provide a response. Statistical information and lessons learnt are reported to the Patient Experience Group and the Quality Committee and Trust Board on a quarterly basis. This report also highlights actions taken as a result of complaints, together with any trends and themes. Responses are provided in line with the complainant's preference, for example written responses from the Chief Executive are provided for formal complaints but some patients/family members prefer a verbal explanation following raising a concerns.** **Local resolution meetings following complaints are also advocated especially following a death or sensitive complaint to provide complainants with the opportunity to discuss their concerns face to face with senior staff/clinicians. All patients/families are supported by the Patient Experience Team both prior to and during the meeting. All meetings are followed by a written response.** **Providing Patient & Family Centred Care is a high priority, and the key stages of the patient & family journey is outlined as 6 steps. This strategy was recently re-designed and relaunched in February 2023. A workplan and working groups underpins the progress and on-going work.** **The Trust Board receive a monthly Patient & Family Story at the beginning of each board meeting. This can be in person or via MS teams where both positive and negative experiences are shared from all service lines and following any new innovations.** **In 2021/22 the Trust were awarded High Assurance for complaints management** **The Patient Experience Team capture all concerns/enquiries and complaints in line with the 9 protected characteristics. The details of which along with any action or learning is included within the quarterly reports, reported to Quality Committee. For example, following a complaint from a transgender patient in 2022, a patient story was shared and Trust wide trans awareness sessions have been provided for all staff. This has been received well and the sessions will continue into 2023/24. A policy for transgender, non-binary patients has been developed in partnership with a transgender person and is now in place.** **In line with Trust Policy, complaints are responded to within a specific timeframe which is negotiated with the complainant. All complaints are responded to within either Level 1 (25 working days), Level 2 (45 working days) and Level 3 (60 working days). These KPIs are closely monitored and reported bi-monthly to the Exec Team, Quarterly to Quality Committee.** **For this outcome, whilst the Trust feels it has strong processes in place to respond to all complaints.**

3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade: Achieving** **Number of protected characteristics that fare well: 6** **Evidence drawn upon for rating:** **The Trust uses NHS Jobs which collects data on 7 of the 9 protected characteristics (gender reassignment and pregnancy/maternity are currently not recorded). Recruiting managers are unable to see any of the monitoring information at any point and are also unable to see the applicants name or right to work status until after the shortlisting process has been completed either. All figures and demographics can be found in the E&D Workforce Annual Report as at 31st March 2023 however the following outlines a brief overview and some additional actions taken to support a fairer recruitment process.**
3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade: Achieving** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Gender Pay Gap** **The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and will be making use of the data to inform action planning for the coming year.**
3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade: Achieving** **Number of protected characteristics that fare well: 7** **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust provides mandatory equality, diversity & human rights training on a 3 yearly basis, as opposed to a one off session. Furthermore, the Trust's e-Learning allows employees to complete parts of their mandatory training at a time and place convenient to them. Adjustments have been accounted for to support individuals as needed including 1:1 support sessions.** **All training opportunities are well publicised, through weekly communications and the monthly team brief. Data is collected on 7 of the protected characteristics (gender reassignment and pregnancy/maternity are not captured, although questions are asked around pregnancy where appropriate to ensure training can be adjusted where necessary). There is still an under-representation of BME staff, compared to the overall workforce demographics accessing training. The percentages of applications by age group, sexual orientation and religion or belief are all comparable with the workforce demographics with the percentage by disability also being broadly in line.**
3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade: Developing** **Number of protected characteristics that fare well: 6** **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Data in respect of all employee relation cases (grievances, disciplinaries, and dignity at work) is monitored against the 7 protected characteristics currently recorded in ESR. The E&D Annual Report includes analysis of this.** **In relation to race, monitoring is also conducted via the Workforce Race Equality Standard (WRES).** **In relation to Disability, monitoring is also conducted via the Workforce Disability Equality Standard (WDES).** **The trust has developed a Trans-awareness policy for staff as well as one for patients.** **The Trust are currently running Trans-awareness sessions and four more sessions are planned throughout the year.** **Due to the nature of the patients treated by the Walton Centre aggression is quite common and is often a symptom of their illness. Whilst any patient behaving inappropriately will be spoken to it is often the case that they are either unable to help their actions or they forget the warning given, this makes it very difficult to eradicate this behaviour completely, however, the Trust does try to offer staff additional support in these case.** **Initiatives undertaken to try and ensure staff feel able to raise any concerns and to enable the Trust to address these issues include:** **Staff listening weeks** **CQC internal visits** **Friends and family tests** **Dignity at Work Policy** **Raising Concerns Policy** **Violence and Aggression Training** **A number of trained mediators who can support in resolving conflict without escalation where necessary** **The use of exit questionnaires and interviews** **The promotion of access to the Freedom to Speak Up Guardian**

A representative and supported workforce

3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade: Developing** **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust's Flexible Working Policy enables all employees from the point at which they join the Trust to request a flexible working arrangement. In addition to part-time working, flexible working options also include compressed or adjusted hours, job-sharing, flexi-time, term-time working, home working (where possible) and career breaks.** **The Trust also offers flexible retirement options, as detailed in the Trust's Flexible Retirement policy. This aims to support older employees in their retirement plans and therefore demonstrates our commitment, and appreciation of, a diversity workforce. Take up of flexible retirement has been at an all-time high over the last 12 months, more than doubling the previous year.**
3.6	**Staff report positive experiences of their membership of the workforce** **Grade: Developing** **Number of protected characteristics that fare well: 5** **Evidence drawn upon for rating:** **Evidence can be taken from the National Staff Survey which reports against 4 of the protected characteristics, this can also be collaborated by local data collected from the Trust Friends and Family Tests and Staff Listening weeks although these do not currently capture any protected characteristics.** **In 2021 there was only a marginal difference between the average and the best performing trusts, with The Walton Centre indicated at slightly above average. The trajectory across the five years measured is relatively flat for The Walton Centre, as is also indicated for all but the worst performing trust, which is on a downward trajectory.** **The Trust also monitors staff experience via Workplace Race Equality Standards (WRES) reporting and Workplace Disability Equality Standards (WDES) reporting and has corresponding action plans to improve staff experience. The Trust also has an extensive suite of wellbeing activities that a promoted to staff.**
Inclusive leadership 4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade: Developing** **Number of protected characteristics that fare well: 5** **Evidence drawn upon for rating:** **The Trust board review and approve the Equality and Diversity Annual Report, which covers all the protected characteristics. All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed.** **The Director of Nursing and Governance is the Executive Lead for Equality within the Trust. Examples of when Board members and senior leaders have demonstrated their commitment to equality include clear statements of the Trusts commitment to ED&I by the Chief Executive both in policy documents and in personal statements and online blogs, the creation of a designated Executive Lead for ED&I on the Board. and the Trust. The Trust has also set up a Strategic BAME Advisory Group Chaired by the Chief Executive and reporting directly to the Board to advance race equality objectives.**
4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade: Developing** **Number of protected characteristics that fare well: 9 (however not always completed, see below)** **Evidence drawn upon for rating:** **All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed. To support this, the EIA screening tool has been added to the policy template.**
4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade: Developing** **Number of protected characteristics that fare well: 6** **Evidence drawn upon for rating:** **In 2019/2020 the Trust introduced its Building Rapport training programme for managers, which has an equality section aimed at Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. This programme was halted during the COVID-19 pandemic, but has now resumed.**

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Equality Delivery System – *EDS2* Summary Report 2023

The Equality Delivery System – EDS2 was made mandatory in the NHS standard contract from April 2015. NHS organisations are strongly encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at:
http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. Once completed, this Summary Report should be published on the organisation's website.

NHS organisation name:

The Walton Centre NHS Foundation Trust

Organisation's Board lead for EDS2	Organisation's EDS2 lead
Mike Gibney (Chief People Officer)	Jane Mullin (Deputy Chief people Officer)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

- Staff Partnership Committee
- Patient Experience Group
- Business Performance Committee

Organisation's Equality Objectives (including duration period):

2017-2022 – currently undergoing review for 2023-2028

- *Objective 1* – Extend patient profiling (equality monitoring) data collection to all protected characteristics
- *Objective 2* – Improve support for, and reporting of, disability within the workforce
- *Objective 3* – Ensure ongoing involvement and engagement of protected groups including patients, carers, staff, Healthwatch and other interested parties
- *Objective 4* – Ensure all staff members are paid equally for equal work done
- *Objective 5* – Increase the number of BME staff within management positions

EDS2 Grades (Date: 31/03/2023)

Goal	Outcome	Grade and reasons for rating
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 9** • **Evidence drawn upon for rating:** **The Trust has now adopted a new standard operating procedure and policy to ensure that reasonable adjustments and made to make our service accessible to patients with disabilities.** **The Trust has analysed patient equality data and has identified lower numbers of Black Asian and minority ethnic staff using our services than we would expect given the local demographics in terms of racial diversity.** **In order to tackle health inequalities, the Trust will analyse its patient data against indices of social deprivation and broken down by ethnicity.** **The Trust believes that the highest quality services should be provided to all patients, which is reflected in the Trust's corporate objectives and mission statement. This belief is the key driver in the design and procurement of all its services. The Trust works in partnership with commissioners to shape their contract thus ensuring that services are commissioned to meet the needs of the local population and to reduce health inequalities. The Trust has completed in a joint retendering process with local Trusts and CCGs to ensure that interpretation and translations services of the highest quality. Equality performance is routinely monitored in the quality contract with the Trust's commissioners.** **Any new services or existing services undergoing change are assessed for possible equality impact on patients, visitors and staff. In addition, services are designed to be compliant with the Royal College of Nursing and National Institute for Health and Clinical Excellence (NICE) standards and guidelines, and are fully accredited by awarding bodies.** **The Trust believes that the services offered by the Trust are available to all irrespective of their protected characteristics, and data from the patient data report, complaints monitoring, patient surveys and engagement supports this belief. Patients, carers, Foundation Trust members and other stakeholders and local organisations and community groups are consulted with and involved in the design and delivery of services, thus ensuring that the health needs of the local communities are considered. All tenders assess equality and diversity, with responses considered as part of the tender process. All contracts include equality clauses.** **For this outcome, the Trust has good evidence and data to demonstrate that services are equality impact assessed. The Trust can also demonstrate that the health and well-being of its staff and patients is taken seriously through strategic planning processes and policy making. Patients from all protected characteristics are engaged with in the above processes, but the Trust currently does not capture all characteristics and therefore is unable to demonstrate a higher number of protected characteristics that fare well. Continuing actions will be implemented to address these issues in the next 12 months.**
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** • **Grade: Developing** • **Number of protected characteristics that fare well: 9** • **Evidence drawn upon for rating:** **Risk assessments are undertaken on all patients and therefore from all protected characteristics in relation to falls, pressure ulcers, venous thromboembolism (VTE) and nutrition, in line with Commissioning and quality targets. The assessment includes review of patient's religious and cultural requirements, communication and care requirements, family support and carer needs. Individual care plans are developed for each patient and reviewed throughout their period of care. These plans are contributed to by all members of the Trust multidisciplinary team as and referrals made to subsequent services such as smoking cessation, dieticians, support groups or district nursing and rehabilitation services as appropriate.** **The Trust remains in a similar position for sub goal 1.2. Due to the limited data captured the Trust is unable to evidence further progression to show all protected characteristics fair well. However, processes are in place to ensure that all patients' health needs are assessed and met regardless of protected characteristics. The Trust is committed to provide individualised patient care and, where required, for all patient during the health needs assessment and through the patient journey. For example, the Trust ensures that reasonable adjustments are made for disabled patients, patients with learning disabilities, and patients with dementia. In addition, the Trust has access to 24-hour interpretation services that cover the languages or dialects that are spoken within the organisations catchment area. Signalise provide 24 hour 7 days a week service for deaf patients and can provide face to face or video interpretation** **Following an individual health needs assessment, either in an outpatient, inpatient or in a community setting, all patients are provided access to the services they require in an appropriate and effective manner. The Trust ensures effective assessments are undertaken and case note and nursing quality audits support this process.** **For this outcome, the Trust is satisfied that the processes in place across the organisation allow for all the patients who are referred to services or self-refer, where appropriate, are provided with individualised health needs assessments. Any concerns and complaints are investigated and**

		reported. Action and learning from complaints is summarised in the complaint responses and actions are closely monitored by the Patient Experience/Divisional Management Teams.
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed • Grade: Developing • Number of protected characteristics that fare well: 8 • Evidence drawn upon for rating: The Trust has numerous examples to demonstrate effective and appropriate transitions from services to support individual needs. This happens during transfer of patients into the Trust from the Trauma Network, from District General Hospitals, from other specialist Trust, for example Alder Hey, and GP referrals. We also transfer patients onto various points of care, including services within the Rehab Network, repatriating hospitals and social care or specialist services. This includes patients from Warrington, Cheshire, Merseyside, Wales and the Isle of Man. The Trust is currently gathering data looking into patient transitioning from children to adult service in order to look at a Pathway for transitioning. Individual care plans are developed for each patient and reviewed throughout their period of care. The patient's assessment includes a review of their religious and cultural requirements, communication and care requirements, family support and carer needs. These plans are contributed to by all members of the Trust's multidisciplinary teams with input from the patient and carers, alongside health and social care professionals. Any change in services provided is planned and communicated with all concerned and any referrals are made to subsequent services with full handover of information. The Trust has good links with local communities and social services across its footprint. Holding multi-disciplinary meetings with internal and external stakeholders, as well as family members, to ensure arrangements are agreed and planned in the best interests of individual patients. The Trust actively signposts carers to appropriate support, includes them as partners in care and has implemented the 'Carers Passport' along with 11 other trust across Merseyside and Cheshire to highlight and acknowledge the importance of involving families as partners in care. The Trust is currently allocating space for a carers resource where it will provide information and a quiet space for carers to access. This resource will be supported by the Brain Charity in partnership with the Trust. For this outcome, despite good examples, the Trust cannot provide data to demonstrate that people from all protected groups are supported and have smooth transitions between services. However, complaints received by the organisation do not support this
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse • Grade: Developing • Number of protected characteristics that fare well: 9 • Evidence drawn upon for rating: The Trust believes that patient safety and quality must be at the heart of everything it does. The Quality Accounts Annual Report provides the backdrop to demonstrate the organisations commitment to improving the quality of services and safety of care. The Trust must ensure that it listens to and acts on feedback received. The Trust takes patient safety very seriously and has reported on several current work streams within the Quality Accounts report, including medication errors, cancelled operations and healthcare acquired infections. Data is available for 4 protected characteristics at the present time however, as previously stated, work is being undertaken to extend the data collection systems to improve data capture. Patient Led Assessment of Cleanliness and Environment (PLACE) inspections are carried out annually. Teams are made up of patient representatives and members of staff, volunteers and patients with long term conditions and disabilities. The visits are planned but unannounced the areas and intended to review the hospital for standards in cleanliness, hand hygiene, quality of accommodation and food and food service. The organisation has a system in place whereby incidents of abuse must be reported by staff whether the abuse is directed at staff by patients, patient to patient or patient to staff, patient to patient and staff to patient. All incidents are reported via Datix, our incident reporting system to the Safeguarding Team. Abuse includes behaviours such as violence, verbal abuse, gestures, sexual or racial abuse. Reporting is web based, and all incidents are investigated thoroughly, and actions undertaken to address the behaviours. All incidents are reported through the appropriate governance committee structures. Some incidents, such as neglect, abuse of vulnerable adults or children, are reported directly to the Strategic Executive Information System (STEIS) as per NHS standard procedures for external reporting. The Trust also has an appointed Freedom to Speak Up Guardian to ensure that staff are encouraged and supported to report any mistakes, mistreatment and abuse. Reporting incidents by protected characteristic is difficult at the present time. Work is being undertaken to tie in together the three data systems required: the patient administration system, the electronic staffing record and the incident reporting system in order that data can be gathered for protected characteristics. The Trust seeks causes through incident reporting and whistle-blowing systems and Freedom To Speak Up Guardians, which informs actions to be undertaken. Therefore, having a robust and safe complaints and whistle-blowing process is vital. Policies are in place to protect people making complaints and follow strict guidelines. Staff and patients are able to make complaints without fear of victimisation.

		Along with the safeguarding annual report, the Trust has a Safeguarding Adults and Children team to ensure the Trust operates within national statutory and non-statutory guidance for on safeguarding vulnerable people. Policies have been introduced to provide guidance to staff on the management of allegations of abuse and deprivation of liberty safeguards. In addition, staffs have access to taught sessions and e-learning training packages on safeguarding issues. **For this outcome, the Trust firmly believes that all people from all protected characteristics are given the same protection in accordance with its mission statement to provide the very best care for each patient on every occasion, which is at the core of everything it does. However, grading has been identified as developing. This is due to the good data and evidence to demonstrate patient safety across the protected characteristics available in comparison to the less adequate data available for incident reporting of bullying or harassing behaviours. Patients from all protected characteristics are engaged with in the above processes.**
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** • **Grade: Developing** • **Number of protected characteristics that fare well: 4** • **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust has an extensive range of health programmes and initiatives in place to support staff and patients alike in accessing public health, vaccination and screening programmes. The Trust is able to provide evidence to demonstrate that people are accessing services; Previously, due to the data collection system we were only able to collect information on 4 of the protected characteristics but this has now risen to 8. Work is underway to enhance the current data collection systems to cover all protected characteristics.** **Throughout the hospital's wards, outpatients and public areas there is an extensive range of public health information for staff and patients to access, examples being for infection control and smoking cessation. Audits are undertaken to ensure sufficient coverage and appropriate placement of information is provided. All patient information is available on request in alternative formats. Interpreters are utilised to ensure communication is most effective.** **The Trust carried out an extensive COVID-19 vaccination programme on 2020 and took particular steps to ensure a high vaccination rate amongst Black, Asian and minority ethnic staff in response to national reports of their being a disproportionate impact of COVID-19 on these groups. This vaccination programme continues alongside our flu campaign which runs each year.** **Health, vaccination and screening programmes include: pre-natal advice for epilepsy patients, flu vaccination programmes and smoking and alcohol intake screenings. After a positive trial for epilepsy patients a number of Nurse advice lines have also been rolled out to enable patients to get disease specific advice and support between appointments.** **The Trust believes that a healthy workforce leads to safer and better patient care and is committed to improving the health and wellbeing of all staff. The Trust has also been re-accredited with the Workplace Wellbeing charter and continues to run regular schemes and initiatives including health checks, fitness classes, various mental well-being initiatives, and discounted weight loss programmes.** **For this outcome, the Trust is again able to present data for 4 of the protected characteristics for patients, and all but 1 protected characteristic for staff (although not all staff services are monitored for equality purposes).**
Improved patient access and experience	**2.1**	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** • **Grade: Developing** • **Number of protected characteristics that fare well: 7** • **Evidence drawn upon for rating:** **The Trust has undertaken an analysis of accessibility to our service regarding race and ethnicity via the Trust's Strategic BAME Advisory Committee, which indicated that fewer patients from Black, Asian and Minority Ethnic backgrounds are currently accessing our service when compared with their proportionate demographic percentage of the population we serve. The Trust has taken steps to ascertain the reasons for this disparity with relatively fewer numbers of Black, Asian and minority ethnic patients accessing the service.** **The following barriers have been identified by the Trust through networking with voluntary sector organisations such as the Neurological Alliance:** • **A lack of knowledge in some newer communities as to how the health system works and how to access health services e.g. refugees and asylums seekers.** • **Language can be a barrier for people who have English as a second language. Basic information as to how to navigate the health system can be more difficult to access, resulting in patients not being referred on from primary care in the numbers we might expect.** • **Different ways of understanding illness and describing symptoms in some communities leading to greater difficulties in diagnosis of some conditions e.g. in some languages there is no separate word for a neurological condition and a mental health condition.**

		• Stigma and a reluctance to come forward for diagnosis because of fear of being stigmatised in some communities. • A greater emphasis in some communities on families taking care of their own family members rather than relying on health care services, leading to later presentation at health services and later diagnosis. The Trust is continuing to network with the Neurological Alliance and other organisations to find ways to address these barriers and have patient representation in the meetings. Due to the limitations of the current patient administration system (PAS), the Trust is only able to provide quantitative data for 4 of the protected characteristics: namely, age, ethnicity, religion and belief and sex. Plans are already in place to update PAS to collect additional information regarding disability, sexual orientation and carer status. The Trust recognises that accessing services can be more difficult for some people – such as people with a disability, people with learning difficulties or people whose first language is not English, including those who are Deaf. The Trust is committed to ensuring that reasonable adjustments are made for disabled patients and patients with learning difficulties where required. For example, where a patient is distressed by waiting rooms and bright lighting, staff arrange for the patient's appointment to be first on the list and the patient seated in a quiet area to wait for their appointment, thus reducing anxiety for the patient and carer or relatives. Reasonable adjustments are made on a regular ad hoc basis, although the Trust does not record this officially for all disabilities. When patients telephone to make appointments, the access, booking and choice receptionists ask patients whether they have caring responsibilities or any disability in order to ensure that the best appointment possible is provided to suit their needs. Patients are also able to make appointments via email if preferred. Text messages are also sent to patients to remind them of their appointment, and the Trust has a self-check in kiosk, which has been reviewed regarding its accessibility. The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings The Trust has an interpreting service that is readily available and covers languages and dialects required, there also a provision for British sign language. Language interpretation is available face to face and by telephone. The Trust has an interpreting and translation policy to ensure that staff understand how to access the interpreting services. Written translation is available upon request. 'Meet and Greet' volunteers have been recruited to support patients to navigate around the hospital and the Trust is working with local communities and charities to ensure training is appropriate regarding peoples cultural and disability requirements, i.e. patients with vision impairment being guided appropriately. The Trust has recently provided Visually Impaired or Blind/Deaf training for staff and continues to provide Visually Impaired Training for all staff and volunteers. For this outcome, the Trust is able to demonstrate that patients, carers and communities from 4 of the protected characteristics readily access services and there are no obvious concerns as demonstrated in the patient data report.
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care • Grade: Achieving • Number of protected characteristics that fare well: 9 • Evidence drawn upon for rating: The Trust is committed to ensure that all patients, irrespective of protected characteristics, are informed, supported and involved in their diagnosis and decisions about their care where appropriate. The CQC National Inpatient Survey is the main source of reporting the perceptions of patients across the NHS and is used in comparative performance tables and quality indicators. Action plans have been developed and targeted work undertaken where patient perception has been less than anticipated. Improvements were made over the last few years, with the result that when asked, the majority of patients felt they had been involved in decisions about their care, had been kept informed about medication side effects and were provided with information in a way that was easy to understand. Local real-time surveys are undertaken in departments and the regular patient listening events undertaken across the Trust support the findings of the national survey. All patients give consent to treatment in line with Trust and national consent policies. The Trust policy has recently been reviewed and reflects discussions with local communities. The Trust has an active Patient Experience Group which meet quarterly, and the membership includes Healthwatch representatives and governor, the group receives a report bi-annually on the progress of patient information developed across the Trust. Standard, easy read and talking leaflets are being developed continually. The Trust strives to meet the communication needs of all patients and menus can be read to support patients to make choices. Staff are able to access the interpreting services to ensure that patients whose first language is not English, or those patients who use British Sign

		Language, are fully able to understand their diagnoses and treatment and this should always be used during the consent process Indeed, where patients are to be given 'bad news' interpreting provision takes place face to face and not by telephone. **For this outcome, the Trust is again able to demonstrate that patients from 4 of the protected characteristics are informed and supported to be as involved as they wish to be in decisions about their care. However, changes are underway to improve the data monitoring information collected at a local level. The national inpatient survey is limited to 6 protected characteristics at the present time.**
	2.3	**People report positive experiences of the NHS** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust has been assessed as Outstanding by the CQC. As part of this assessment NHS England reviewed and assessed the delivery of care to patients and their experiences when accessing services. They also undertook a review of equality and diversity provision and compliance within the Trust and found the outcome to be good.** **Feedback through surveys and social media indicate a very good patient experience of services at the Walton Centre. In CQC National Surveys results do not indicate any discrimination due to a particular characteristic. Scheduled quarterly reports on all patient experience and dignity and respect activities are presented to the Trust Board and to the specialist CCG commissioners. The patient experience team meet with divisions on a weekly basis to discuss experiences of patients and discuss any open concerns or complaints. This is then reported via a report monthly to Divisional Governance meeting and the bi-monthly Executive meeting and the Quarterly Quality Committee of the Board. This information also goes to Patient Experience Group which has representatives from Healthwatch, Trust Governors and local charitable organisations.** **All patients are asked to complete a Friends and Family Test during their admission and upon discharge. The results of these surveys are reported though the Integrated Performance Report and the quarterly Patient Experience Group. All wards received feedback on a monthly basis to share the positive comments and put actions in place for any negative comments or themes.** **The Trust has Dignity Champions across the organisation with each ward having at least one Dignity Champion. The Champions act as role models, identifying breaches of dignity in care, addressing and challenging issues as they arise and promoting dignity in care for every patient.** **The Trust has already identified gaps in engagement with some seldom heard groups, such as gypsy, traveller and Roma communities and homeless people communities. Work will continue to forge better relationships with all community groups to ensure that their voices are heard through partnership working with local communities and interest groups, CCGs and Local Authorities and the Health watch.** **For this outcome, the Trust is firmly committed to listening to the views of patients, carers and other local interest groups and communities and ensuring positive patient experience. Evidence from all of the above leads us to suggest that we are Achieving with regards to this sub-goal.**
	2.4	**People's complaints about services are handled respectfully and efficiently** • **Grade: Achieving** • **Number of protected characteristics that fare well: 9** • **Evidence drawn upon for rating:** **Complaints about care and our services are taken very seriously and all concerns and complaints are managed by Patient Experience Team and investigated by the appropriate division to provide a response. Statistical information and lessons learnt are reported to the Patient Experience Group and the Quality Committee and Trust Board on a quarterly basis. This report also highlights actions taken as a result of complaints, together with any trends and themes. Responses are provided in line with the complainant's preference, for example written responses from the Chief Executive are provided for formal complaints but some patients/family members prefer a verbal explanation following raising a concerns.** **Local resolution meetings following complaints are also advocated especially following a death or sensitive complaint to provide complainants with the opportunity to discuss their concerns face to face with senior staff/clinicians. All patients/families are supported by the Patient Experience Team both prior to and during the meeting. All meetings are followed by a written response.** **Providing Patient & Family Centred Care is a high priority, and the key stages of the patient & family journey is outlined as 6 steps. This strategy was recently re-designed and relaunched in February 2023. A workplan and working groups underpins the progress and on-going work.** **The Trust Board receive a monthly Patient & Family Story at the beginning of each board meeting. This can be in person or via MS teams where both positive and negative experiences are shared from all service lines and following any new innovations.** **In 2021/22 the Trust were awarded High Assurance for complaints management.** **.** **The Patient Experience Team capture all concerns/enquiries and complaints in line with the 9 protected characteristics. The details of which along**

		with any action or learning is included within the quarterly reports, reported to Quality Committee. For example, following a complaint from a transgender patient in 2022, a patient story was shared and Trust wide trans awareness sessions have been provided for all staff. This has been received well and the sessions will continue into 2023/24. A policy for transgender, non-binary patients has been developed in partnership with a transgender person and is now in place. **In line with Trust Policy, complaints are responded to within a specific timeframe which is negotiated with the complainant. All complaints are responded to within either Level 1 (25 working days), Level 2 (45 working days) and Level 3 (60 working days). These KPIs are closely monitored and reported bi-monthly to the Exec Team, Quarterly to Quality Committee.** **For this outcome, whilst the Trust feels it has strong processes in place to respond to all complaints.**
A representative and supported workforce	**3.1**	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** • **Grade: Achieving** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust uses NHS Jobs which collects data on 7 of the 9 protected characteristics (gender reassignment and pregnancy/maternity are currently not recorded). Recruiting managers are unable to see any of the monitoring information at any point and are also unable to see the applicants name or right to work status until after the shortlisting process has been completed either. All figures and demographics can be found in the E&D Workforce Annual Report as at 31st March 2023 however the following outlines a brief overview and some additional actions taken to support a fairer recruitment process.**
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** • **Grade: Achieving** • **Number of protected characteristics that fare well: 9** **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Gender Pay Gap** **The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and will be making use of the data to inform action planning for the coming year.**
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** • **Grade: Achieving** • **Number of protected characteristics that fare well: 7** • **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **The Trust provides mandatory equality, diversity & human rights training on a 3 yearly basis, as opposed to a one off session. Furthermore, the Trust's e-Learning allows employees to complete parts of their mandatory training at a time and place convenient to them. Adjustments have been accounted for to support individuals as needed including 1:1 support sessions.** **All training opportunities are well publicised, through weekly communications and the monthly team brief. Data is collected on 7 of the protected characteristics (gender reassignment and pregnancy/maternity are not captured, although questions are asked around pregnancy where appropriate to ensure training can be adjusted where necessary). There is still an under-representation of BME staff, compared to the overall workforce demographics accessing training. The percentages of applications by age group, sexual orientation and religion or belief are all comparable with the workforce demographics with the percentage by disability also being broadly in line.**
	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** • **Grade: Developing** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **The Trust is currently working with local CCGs and other local hospital trusts on Merseyside to engage collectively across multiple protected characteristics and will form a new high level and diverse EDS 2 grading panel to assure future grading and ensure PSED compliance.** **Data in respect of all employee relation cases (grievances, disciplinaries, and dignity at work) is monitored against the 7 protected characteristics currently recorded in ESR. The E&D Annual Report includes analysis of this.** **In relation to race, monitoring is also conducted via the Workforce Race Equality Standard (WRES).** **In relation to Disability, monitoring is also conducted via the Workforce Disability Equality Standard (WDES).**

		The trust has developed a Trans-awareness policy for staff as well as one for patients. **The Trust are currently running Trans-awareness sessions and four more sessions are planned throughout the year.** **Due to the nature of the patients treated by the Walton Centre aggression is quite common and is often a symptom of their illness. Whilst any patient behaving inappropriately will be spoken to it is often the case that they are either unable to help their actions or they forget the warning given, this makes it very difficult to eradicate this behaviour completely, however, the Trust does try to offer staff additional support in these case.** **Initiatives undertaken to try and ensure staff feel able to raise any concerns and to enable the Trust to address these issues include:** ○ **Staff listening weeks** ○ **CQC internal visits and engagement meetings** ○ **Dignity at Work Policy** ○ **Raising Concerns Policy** ○ **Violence and Aggression Training** ○ **A number of trained mediators who can support in resolving conflict without escalation where necessary** ○ **The use of exit questionnaires and interviews** ○ **The promotion of access to the Freedom to Speak Up Guardian**
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** • **Grade: Developing** • **Number of protected characteristics that fare well: 9** • **Evidence drawn upon for rating:** **The Trust's Flexible Working Policy enables all employees from the point at which they join the Trust to request a flexible working arrangement. In addition to part-time working, flexible working options also include compressed or adjusted hours, job-sharing, flexi-time, term-time working, home working (where possible) and career breaks.** **The Trust also offers flexible retirement options, as detailed in the Trust's Flexible Retirement policy. This aims to support older employees in their retirement plans and therefore demonstrates our commitment, and appreciation of, a diversity workforce. Take up of flexible retirement has been at an all-time high over the last 12 months, more than doubling the previous year.**
	3.6	**Staff report positive experiences of their membership of the workforce** • **Grade: Developing** • **Number of protected characteristics that fare well: 5** • **Evidence drawn upon for rating:** **Evidence can be taken from the National Staff Survey which reports against 4 of the protected characteristics, this can also be collaborated by local data collected from the Trust Friends and Family Tests and Staff Listening weeks although these do not currently capture any protected characteristics.** **In 2021 there was only a marginal difference between the average and the best performing trusts, with The Walton Centre indicated at slightly above average. The trajectory across the five years measured is relatively flat for The Walton Centre, as is also indicated for all but the worst performing trust, which is on a downward trajectory.** **The Trust also monitors staff experience via Workplace Race Equality Standards (WRES) reporting and Workplace Disability Equality Standards (WDES) reporting and has corresponding action plans to improve staff experience. The Trust also has an extensive suite of wellbeing activities that a promoted to staff.**
Inclusive leadership	**4.1**	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** • **Grade: Developing** • **Number of protected characteristics that fare well: 5** • **Evidence drawn upon for rating:** **The Trust board review and approve the Equality and Diversity Annual Report, which covers all the protected characteristics. All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed.** **The Director of Nursing and Governance is the Executive Lead for Equality within the Trust. Examples of when Board members and senior leaders have demonstrated their commitment to equality include clear statements of the Trusts commitment to ED&I by the Chief Executive both in policy documents and in personal statements and online blogs, the creation of a designated Executive Lead for ED&I on the Board. and the Trust. The Trust has also set up a Strategic BAME Advisory Group Chaired by the Chief Executive and reporting directly to the Board to advance race equality objectives.**

	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** • **Grade: Developing** • **Number of protected characteristics that fare well: 9 (however not always completed, see below)** • **Evidence drawn upon for rating:** **All papers presented to the Trust Board and to other senior committees ask the author to confirm whether an Equality Impact Assessment (EIA) has been completed. To support this, the EIA screening tool has been added to the policy template.**
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** • **Grade: Developing** • **Number of protected characteristics that fare well: 6** • **Evidence drawn upon for rating:** **In 2019/2020 the Trust introduced its Building Rapport training programme for managers, which has an equality section aimed at Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. This programme was halted during the COVID-19 pandemic, but has now resumed.**