NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 4th November 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
Thursday, 4 November 2021
The Walton Centre Board Room
09:30am – 12:00pm

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	S Crofts	N/A
2	09.30	Declaration of Interests	S Crofts	N/A
3	09.35	Minutes and actions of meeting held on 7 October 2021	S Crofts	Decision (d)
4	09.40	Patient Story	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update	S Crofts / J Ross	Information (v)
PERFORMANCE & GOVERNANCE				
6	10.10	Recovery & Restoration Update	M Woods	Information (v)
7	10.20	Integrated Performance Report	CEO/Execs	Assurance (d)
8	10.40	Nurse Staffing – Bi-Annual Acuity Review	L Salter	Assurance (d)
9	10.50	Quarterly Governance Report	L Salter	Assurance (d)
10	11.00	Freedom to Speak Up Guardian Report	L Salter	Assurance (d)
11	11.10	IPC Board Assurance Framework	L Salter	Assurance (d)
12	11.25	Walton Centre Charity Accounts and Annual Report	M Burns	Assurance (d)
13	11.30	Audit Committee Key Issues Report	S Rai	Assurance (d) **TO FOLLOW**
14	11.35	Charity Committee Key Issues Report	S Rai	Assurance (d) **TO FOLLOW**
15	11.40	Quality Committee Key Issues Report	S Crofts	Assurance (d)
16	11.45	RIME Committee Key Issues Report	S Crofts	Assurance (v)
17	11.50	Business Performance Committee Key Issues Report	D Topliffe	Assurance (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Review of Scheme of Reservation & Delegation – **TO FOLLOW** • Review of Standing Financial Instructions – **TO FOLLOW** • EPRR Core Standards Self-Assessment • Modern Slavery Act Statement				
CONCLUDING BUSINESS				
18	11.55	Any Other Business	S Crofts	Information

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

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting held at Aintree Racecourse

7th October 2021

Present:

Mr S Crofts	Non-Executive Director – Deputy Chair
Ms K Bentley	Non-Executive Director
Ms S Rai	Non-Executive Director
Prof N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Ms J Ross	Chief Executive
Dr A Nicolson	Medical Director
Mr M Burns	Chief Financial Officer
Ms L Salter	Chief Nurse
Mr M Gibney	Chief People Officer
Mr M Woods	Interim Chief Operating Officer

In attendance:

Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary
Dr C Burness	Consultant Neurologist (item TB91-21/22 only)
Ms D Lee	Therapy Services Manager (item TB86-21/22 only)
Ms S Hanton	Principal Clinical Scientist, Laboratories (item TB86-21/22 only)
Dr K Mathews	Consultant Clinical Psychologist, Pain Management (item TB86-21/22 only)
Ms Y Shanks	Radiology Directorate Manager / AHP Lead (item TB86-21/22 only)
Mr O Tierney	Clinical Lead For Education & Development, Theatres (item TB86-21/22 only)

Observing:

Ms N Mellor	Partnership Governor – The Brain Charity
Ms B Strong	Public Governor – Merseyside

Trust Board Attendance 2021-22

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

TB83-21/22 Welcome and apologies

Apologies were noted from Ms Rosser. Mr Crofts welcomed those present to the meeting

and noted that Ms N Mellor was observing in her capacity as Partnership Governor for The Brain Charity and Ms B Strong was observing in her capacity as Public Governor for Merseyside.

TB84-21/22 Declarations of interest

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

TB85-21/22 Minutes of the meeting held on 2nd September 2021

The minutes of the meeting held on 2nd September 2021 were agreed as a true and accurate record.

TB86-21/22 Staff Story – Allied Health Professionals (AHP) Showcase Session

Ms Lee, Ms Hanton, Dr Mathews, Ms Shanks and Mr Tierney joined the meeting.

It was noted that National AHP Day was taking place on 14th October and members of the Board would be shadowing members of the AHP team on this date to gain a greater understanding of the various roles within the team. Ms Shanks provided a presentation detailing an overview of the Allied Health Professional (AHP) and Health Care Scientists (HCS) team, noting that there were 14 different AHP roles working across a range of different sectors and also over 60 different HCS roles with the main three HCS groups in the Trust being Physiological Sciences, Life Sciences and Psychology. An overview of achievements implemented by Ms Shanks in her role as Lead AHP since May 21 was also provided.

Ms Shanks also provided an overview of the Radiographer's team noting some of the key achievements and highlighting that the 24/7 Thrombectomy service would be launching on 11th October and there was an intensive in-house training programme for Radiographers. It was also noted that the department provided an award winning Claustrophobia Clinic that was well renowned across the country.

Mr Tierney presented a brief history of the Operating Department Practitioner (ODP) role noting that the role had undergone many changes and would be moving to a degree standard role over the next 2 to 3 years. It was highlighted that the ODP specialised in all areas of the operating theatre and the role was also seen in a variety of other settings including ITU, accident and emergency departments and resuscitation and transfer teams.

Ms Shanks noted a number of highlights within the Neurophysiology department and recognised that the mobile telemetry system had been received very positively from the patient point of view.

Ms Lee noted that there were 5 AHP disciplines within the therapies team and an overview of the pathways to recovery that the AHP team were part of was provided. It was recognised that the therapies team was a diverse service and a number of innovations within the therapies team were highlighted.

Dr Mathews provided a brief overview of therapies within the Pain Management Department and highlighted the roles of Occupational Therapists within the pain management programme noting that they enabled patients with chronic pain to engage or re-engage in meaningful occupation. Psychologists were also involved in the pain management programme and it was noted that chronic pain significantly impacted on an individual's life including their mental health, self-esteem and all aspects of their lives, the

Psychology Department worked alongside physical teams to provide therapy. It was noted that physiotherapy helped people with long term pain manage their condition, increase their activity and manage the physical impact on their lives.

Ms Hanton presented an overview of the Neuroscience Laboratories and noted that this was a specialised laboratory to support the Trust providing specialist analysis of blood and cerebral spinal fluids along with the provision of analytical services across the UK. There were three Clinical Scientists and 11 Biomedical Scientists in the team that also included Consultant Neuropathologists, a Biobank Manager, Associate Practitioners and Laboratory Assistants. Highlights of the work undertaken by the team were provided and it was noted that the laboratory held UKAS accreditation to ISO 15189 with annual re-accreditation inspections undertaken.

The Chair recognised the huge contribution the team provided to how the Trust runs and the Board wished to thank all involved. Dr Nicolson noted that the focus and innovation of the team was specifically for the patients of the Trust.

Professor Thakkar queried if the national shortage on Clinical Scientists had affected the team and Dr Mathews clarified that the Trust was fully staffed in this area.

Ms Rai queried what the impact of Covid had been on the teams and their work. Ms Shanks noted that the Radiology Department had continued to function throughout the pandemic and were the first point of contact for many patients. The department had been heavily involved in the Stroke Unit that was introduced to provide mutual aid and a second on call service had been implemented. Robust recovery plans were in place which had enabled the department to fully recover activity by June 2020. It was recognised that the impact on staff had been hard however the department had been well supported throughout this time. Dr Mathews noted that the Pain Management Programme had been implemented online and this had been heavily reliant on the IT and Information Governance teams who had been extremely helpful in getting the service up and running in a short space of time. The team were now offering the most intensive online treatments in the UK. A hybrid model had now been implemented with online clinics utilised where appropriate and it was noted that patients could be triaged appropriately. Mr Tierney highlighted that ODPs had been redeployed to ITU and had adapted to the new roles very quickly. The team had also been involved in Covid transfer teams while ensuring that oncology and trauma theatres continued to run efficiently.

Ms Lee, Ms Hanton, Dr Mathews, Ms Shanks and Mr Tierney left the meeting.

TB87-21/22 Chair & Chief Executive's Report

Ms Ross noted that there had been a Care Quality Commission (CQC) inspection within the Radiology department and this had been focussed on the Ionising Radiation (Medical Exposure) Regulations (IRMER) standards. Initial feedback had been generally positive and it had been noted that the Trust went over and above what was in the policies and protocols so these would need to be updated to reflect the processes followed.

Ms Ross presented an update regarding the ongoing North Mersey Hyper Acute Stroke Services review and provided an overview of the current situation. The Trust was actively involved in the service review attending both the North Mersey Stroke Board and operational meetings along with providing the regional Thrombectomy service.

System meetings regarding the future direction of travel for system working were ongoing and the Cheshire and Mersey Health and Care Partnership (HCP) had appointed a Managing Director; collaborative working opportunities continued to be reviewed.

Ms Ross noted that the Trust had been shortlisted for the Investors in People Health and Wellbeing Award 2021 and also in the Engage Awards for best employee support in a crisis.

Ms Ross informed that Trust wide communications regarding Black History Month had been issued to all staff.

Financial guidelines for H2 (October 2021 to March 2022) had been published and the finance team were working through a number of scenarios.

Mr Crofts advised that he had attended a number of meetings including the Integrated Care System (ICS) Partnership Board and North West Providers Chair's meeting and highlighted that discussions around staff wellbeing, increasing activity and ensuring financial stability had been held. It was also noted that work to transition to the ICS model would progress in the coming weeks.

Mr Crofts also wished to record thanks on behalf of the Board to all who had taken part in the virtual London marathon who had raised over £10k for the Trusts Home From Home charity.

The Board noted the report.

TB88-21/22 Recovery and Restoration Update

Mr Woods provided an update on the Trust's recovery and restoration programme noting that the Trust had received notification in July that the criteria for Elective Recovery Fund (ERF) had been raised from 85% of 2019/20 activity levels to 95%. Day case activity was achieved however performance had dropped in September and it was recognised that elective performance had remained challenging. It was noted that ERF performance was value based and not just based on activity levels and although ERF targets had been met during the first half of H1 (April – June 2021) they had not been met during the second half of H1 (July – September 2021).

Mr Woods highlighted that there were currently 101 patients waiting over 52 weeks against a trajectory of 196 and the Trust was forecasting no 104 week waiters. Additional gateway criteria for ERF had been published and an overview of this was provided. It was recognised that the planned transfer of spinal services was likely to increase the number of 52 week waiters.

Ms Bentley queried what the impact of the transfer of spinal services would be on activity recovery and meeting ERF criteria. Mr Woods noted that two Spinal Consultants from Warrington had been transferred to the Trust which would assist with recovery however the impact on the waiting lists was not yet known. Discussions had been held with Specialist Commissioners around the expected impact.

Professor Thakkar queried the opportunities to transform the service and how the Trust would focus on staff wellbeing. Mr Woods noted that a review was underway to understand the details of what staff required and recognised that the changes in the

service had caused a lot of stress and anxiety. A number of staff who had been on long term sickness absence were now returning to work which was reducing staffing pressures. Infection Prevention and Control (IPC) pathways through theatres were also under review and it was noted that the implementation of the E-roster system would equalise the fairness of on calls across the service. It was highlighted that a lot had been learned from outpatient activity and it was recognised that the Attend Anywhere platform did not work for all specialities, however the Trust was maximising usage in the appropriate areas. The implementation of Patient Initiated Follow Up (PIFU) had given control back to the patient and resulted in a lower number of DNAs.

Ms Rai noted that the Trust needed to be mindful of the impact of flu and winter pressures on recovery performance and it was noted that robust flu and Covid booster vaccine plans were in place and invites had been sent out to staff via email.

The Board noted the progress made against the Trust's recovery and restoration programme.

TB89-21/22 Integrated Performance Report

Ms Ross provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Committee meetings as noted in the relevant key issues reports. It was highlighted that cancer and diagnostic targets continued to be met however Referral to Treatment (RTT) targets continued to be a challenge.

Quality

Ms Salter highlighted that there were currently 35 wte Nurse vacancies however it was noted that 35 Nurses had been recruited via the international recruitment programme and 12 Nurses recruited via other channels. It was noted that Divisional Nurses were discussing plans to manage vacancies within their teams. The first 11 Nurses recruited under the international recruitment programme had undertaken their OSCE examinations and the results were being awaited.

There had been an outbreak of CPE within the Trust and an action plan was now in place which had been presented to the Executive Team. Human factors had been identified and lessons learned had been rolled out across all areas. It was also noted that improvement plans were also in place around MSSA infections.

Workforce

Mr Gibney advised that appraisals continued to be a challenge and work was underway to target areas for improvement and also review reporting mechanisms. Sickness rates were noted to be improving and it was highlighted that short term sickness remained low and was mostly long term sickness. Deep dives into sickness absence were being undertaken and would be monitored at Business and Performance Committee (BPC).

Finance

Mr Burns noted that finance performance was slightly behind forecast in month however was ahead of forecast for the year to date and on track to achieve forecast at the end of H1. Work was ongoing to bring plans forward on the Capital programme and it was noted that there was a focus on better payment processes to improve the payment times to non-NHS providers.

Ms Bentley queried if pastoral support was in place for the international Nurse cohort and Ms Salter confirmed that there was a pastoral support role in place and a group of staff were also working with the group to help them settle in.

Mr Topliffe queried the scoring process on the ward scorecard and Ms Salter noted that there were national red flags around staffing ratios and breaks and this was reviewed on a shift by shift basis. It was recognised that the document did not clearly explain what staffing levels were and work was underway on improving the ward scorecard and to break the information down to ward level.

The Board noted the Integrated Performance Report.

TB90-21/22 Gender Pay Gap Annual Report

Mr Gibney presented the annual gender pay gap report and noted that the average hourly rate pay gap was approximately 30% and this was in line with other Trusts and across the wider public sector. There was a predominantly female workforce within the Trust and it was noted that gender was not a block to progression and promotion within the Trust. An overview of support available to staff was provided and it was noted that the Trust was one of the first in the country to introduce a menopause policy.

It was recognised that Neurology and Neurosurgery were traditionally male orientated however there was now an approximate 50/50 split in Consultant Neurologists. Neurosurgery continued to be male dominated and it was recognised that this had a major impact on this report. Challenges reported included work life balance and how the Consultant role could be accommodated within this, The Trust had a good track record for flexible working patterns and the biggest challenge was extending this to Consultant level.

The Board noted the gender pay gap annual report.

TB91-21/22 Guardian of Safe Working Report

Dr Burness joined the meeting.

Dr Burness presented the Guardian of Safe Working Hours annual report and noted that there had been 31 exception reports during the period from August 2020 to July 2021. The majority of these exception reports related to the changes in the Thrombectomy service and this would be monitored as the service moved to a 24/7 service from 11th October. All exception reports had been resolved utilising time off in lieu and no fines had been issued.

There was some furniture still to be installed in the Doctor's mess and it was noted that room would be required for Neurology Registrars.

Ms Bentley queried what work was being undertaken to avoid Thrombectomy issues and Dr Burness noted that a Neurology Registrar would be required to be on site and the options available for this were currently under review. There were some anxieties being reported from the Neurology Registrar team however it was noted that there may not need to be any changes to their working patterns. Dr Nicolson highlighted that it was standard practice to monitor working hours when there was a change in service and there had been a lot of discussion regarding Registrars catching up on training in relation to out of hours working and all alternative options were being explored.

Dr Burness left the meeting.

The Board noted the Guardian of Safe Working Report.

TB92-21/22 Senior Information Responsible Officer (SIRO) Annual Report

Mr Burns presented the SIRO annual report for 2020/21 and noted that the service from the Information Governance team had not dropped during the pandemic and the team had worked collaboratively with the IT team to implement agile working across the organisation.

It was noted that the internal audit of the Data Security and Protection Toolkit had provided substantial assurance for the 11th consecutive year and the Trust had successfully obtained full ISO27001:20013 accreditation with no major or minor observations recorded.

The number of freedom of information (FOI) requests received had dropped during the pandemic and the time spent responding to FOI requests was now recorded as requests were taking much longer to respond to, however it was noted that the Trust had never had an FOI breach.

There had been 121 incidents reported during 2020/21 and it was noted that this had reduced from 213 during 2019/20. There were also 3 externally reportable incidents which was a reduction from 12 the previous year and it was confirmed that these had all been closed down. It was highlighted that 2 of the 3 externally reported incidents were due to human error and related to patients receiving the incorrect patient letter. This function had since been outsourced and moved to an automated service.

It was noted that the Trust had completed a number of cyber security exercises, the Trust had also commissioned an external HiMSS audit which had been scored at level 5 and it was highlighted that the Trust was working to achieve level 6 or above via the digital aspirant programme.

Professor Thakkar queried if digital incidents such as incorrect email addresses were recorded and it was confirmed that they were recorded via Datix and treated as an Information Governance incident. It was also noted that there were 'safe haven' organisations such as other NHS organisations who would be asked to delete an email if it was sent there in error, these incidents would be recorded internally however would not be externally reportable.

The Board noted the Senior Information Responsible Officer (SIRO) report .

TB93-21/22 Update from the Wellbeing Guardian

Ms Bentley provided a verbal update in her role as Wellbeing Guardian, she highlighted that the Trust had been accredited with the Investors in People gold standard and also the Investors in People Wellbeing gold standard.

Staff sickness was reported to be on the rise for a number of years however fatigue and burnout were now an increasing factor with 30% of staff reported to be having trouble sleeping, 30% reporting financial concerns and 87% reporting musculoskeletal problems. There had been a shift in focus from the 5% staff off sick to the wellbeing of the 95% of staff in work and a preventative approach and consideration was required to understand if

staff had time to access the offers available. There were a number of initiatives available and a cultural change towards a person-centred structure; work was ongoing to equip leaders with improved skills to understand the needs of the workforce.

Ms Salter added that under the Improving Working Lives initiative a number of staff with carers responsibilities had agreed personal contracts which would require regular review.

Ms Bentley requested that the Trust sign a pledge to agree to wellbeing themes and a timetable for implementation. This timetable would be forwarded to Ms Ross and Mr Crofts for discussion.

The Board noted the update from the Trust Wellbeing Guardian.

TB94-21/22 Board Assurance Framework

Mr Buckingham presented the Board Assurance Framework for Q2 and noted that proposed amendments had been highlighted in blue or strikethrough. It was highlighted that Risk ID001 and Risk ID002 had both reduced in scoring. The risk score for Risk ID002 had been scrutinised at BPC which had resulted in a recommendation to reduce the score.

It was noted that Risk ID013 was currently scored at 12 and this was accurate at Q2 however it was highlighted that H2 planning guidance had not been published at the time of review and this could affect the risk with potential for the risk score to increase in Q3 and this would be reviewed at BPC.

It was recognised that all risks were based on the Trust strategic objectives and may change as the Trust strategy was updated so there may be a requirement to change the BAF risks when the updated Trust strategy was launched.

Mr Crofts queried if IPC challenges were reflected enough in the BAF. Ms Salter noted that specific concerns had previously been included however these had been removed and a discussion was required around the potential requirement for a separate risk to be recorded on the BAF. Mr Buckingham confirmed that it was correct to consider this approach in principle and noted that consideration should be given to the impact on the strategic objectives of the Trust.

The Board approved the updated Board Assurance Framework content for 2021/22.

TB95-21/22 Quality Committee Key Issues Report

Mr Crofts provided an update from the meeting of the Quality Committee held on 23rd September 2021 and highlighted that there had been an incident of whistleblowing to the CQC on one of the wards and detailed engagement had been undertaken with ward staff to understand and review the concerns with action plans in place.

Ms Rai queried if the whistleblowing report had been a new incident and Ms Salter confirmed that this incident had been escalated in September and dealt with internally on the day however it had also been reported to the CQC as staff had not been aware of the internal escalation processes.

A review of the pharmacy service to HITU (Horsley Intensive Therapy Unit) had been undertaken and this had concluded that a 24/7 pharmacy service was not required,

however pharmacy cover would increase.

The Board noted the Quality Committee Key Issues Report.

TB96-21/22 Business Performance Committee Key Issues Report

Mr Topliffe provided an update from the meeting of BPC held on 28th September 2021 and noted that a service improvement update had been presented which provided assurance that the Trust was on track to deliver short term Quality Improvement Project (QIP) improvements. Some aspects of the digital aspirant capital spend had been delayed due to the global shortage of semiconductors and this was noted to be a risk to delivery of the capital programme.

A number of departmental strategies were due to be reviewed and these reviews would be undertaken in parallel with the review of the main Trust strategy.

It was noted that the terms of reference for the People Group and the Transformation Programme Board had been reviewed and approved.

The Board noted the Business Performance Committee Key Issues Report.

TB82-21/22 Any Other Business

There was no other business to be discussed.

There being no further business the meeting closed at 12.15pm

Date and time of next meeting
Thursday 4th November 2021 at 09:30am, Board Room.

TRUST BOARD
Matters arising Action Log
September 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
01/07/21	TB53-21/22	**Trust Strategy 2018-2023** Executive Team to review and identify three Commitments for each Ambition in 2021/22. Outcomes to be presented to the Board of Directors on 2 September 2021.	Ms Ross	**02/09/21** The Trust Strategy was discussed at the recent Executive Away Day and a session to review the strategy would be held at the Board Development session scheduled to be held on 16th September. A meeting had been arranged with Deloittes to plan the Board Development session and the three priorities for each ambition would be shared following this session. **07/10/21** The updated priorities for each ambition on the current Trust strategy had been circulated to all. Remove from tracker.	~~02/09/21~~ 07/10/21	
01/07/21	TB54-21/22	**Board Assurance Framework** Ms Salter to circulate the report completed following an audit of the LASTLAP initiative recorded under Risk ID003 to the Board.	Ms Salter	**02/09/21** Ms Salter updated that an audit would be held in early October and the outcome report would be shared following completion. **07/10/21** Ms Salter noted that an update would be available at the next meeting	~~02/09/21~~ ~~07/10/21~~ 04/11/21	

Actions not yet due

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

REPORT TO THE TRUST BOARD

Date 4th November 2021

Title	Integrated Performance Report – Business & Performance
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations and Strategy
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Access & Performance Director
Previously considered by:	• Not applicable

Executive Summary

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

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

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Board KPI Report
October 2021

Data for August 2021 unless indicated

Explanation of SPC Charts and Assurance Icons

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

All SPC charts will follow the below Key unless indicated

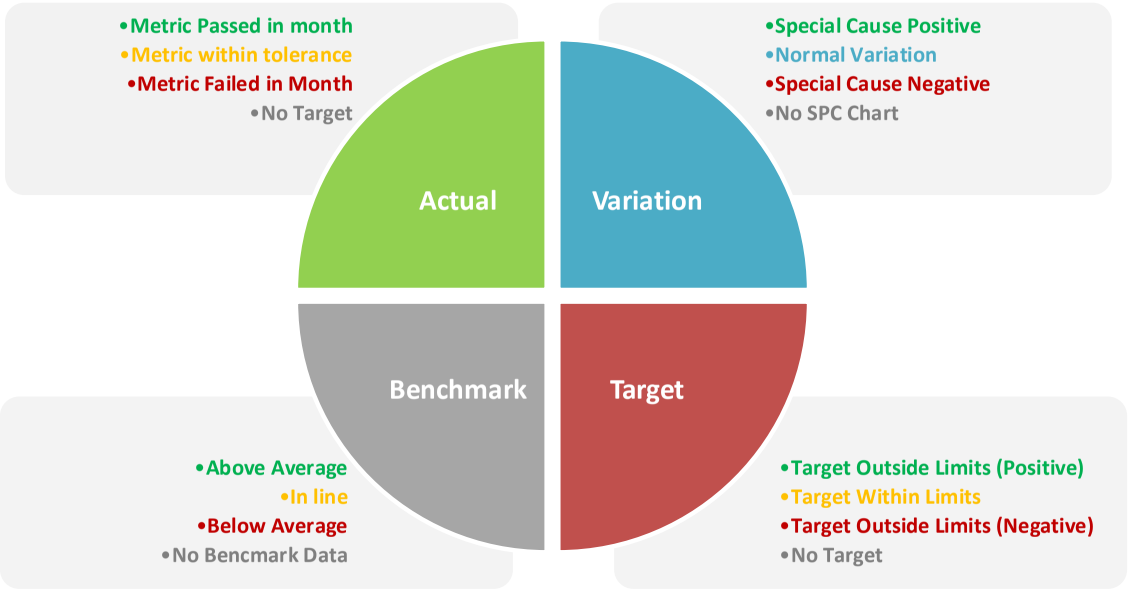
Actual | UCL | Average | LCL | National Average | Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

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



SPC Chart Rules

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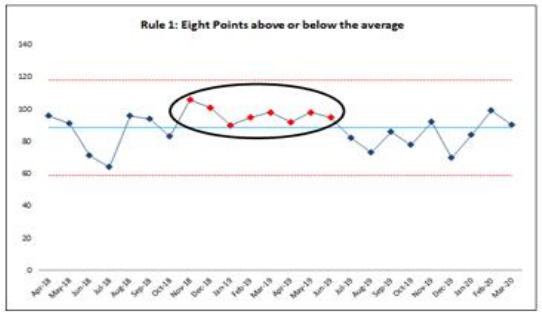
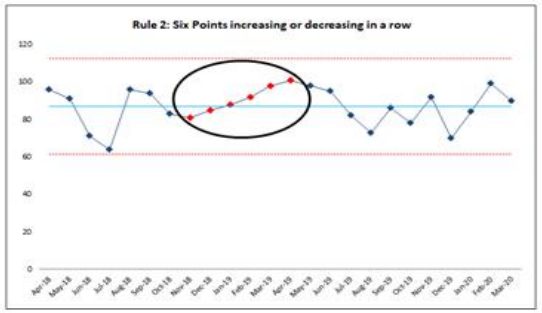
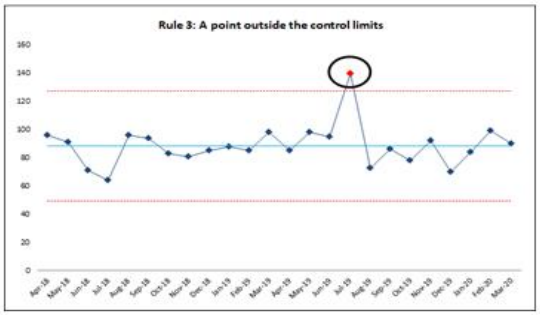
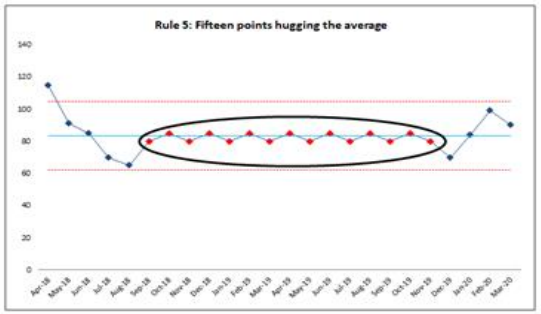
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in seperating normal variation (exepcted performance) from special cause variation (unexpected performance).









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Operations & Performance Indicators

Operational

Responsive - Cancer Standards

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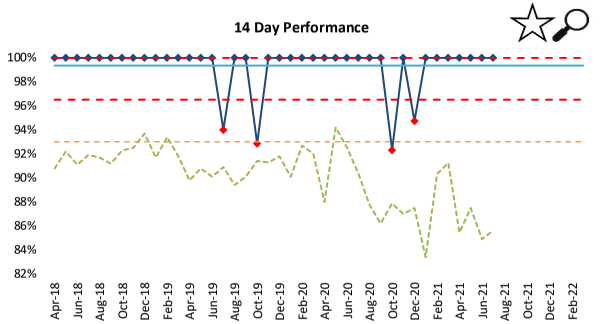
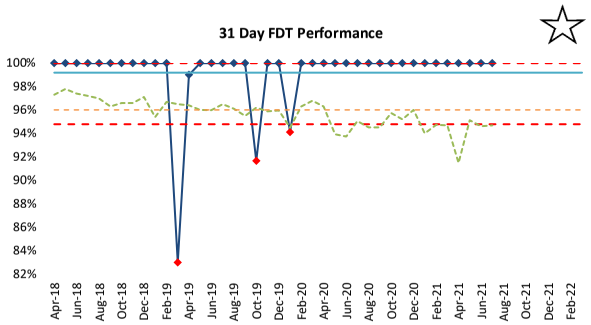
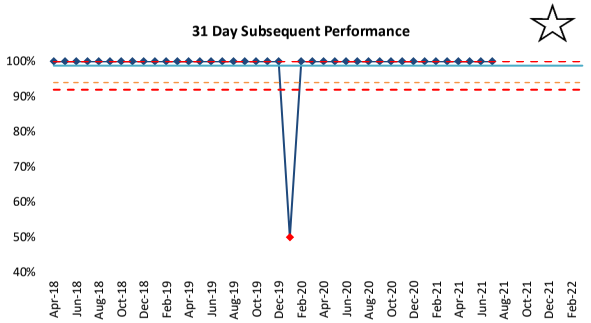
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	-	
28 Day Faster Diagnosis Standard	70%	100%	

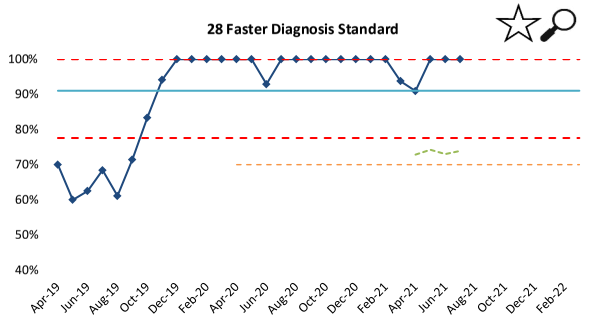
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

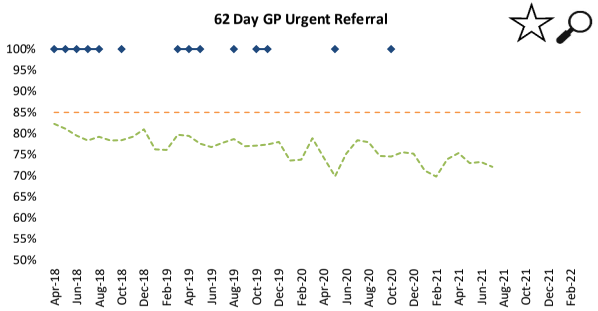
Associated Risks
001 - Covid-19
003 - Performance Standards

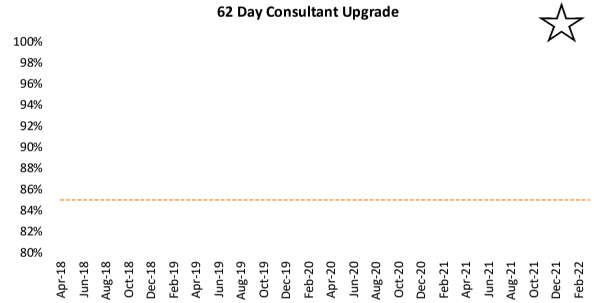












Operational

Responsive - Diagnostics

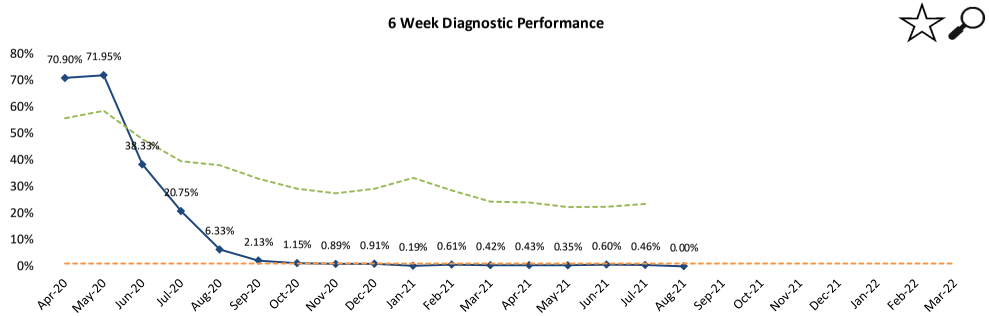
The Walton Centre NHS Foundation Trust

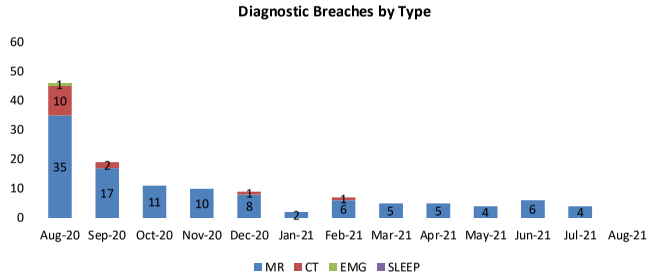
Excellence in Neuroscience

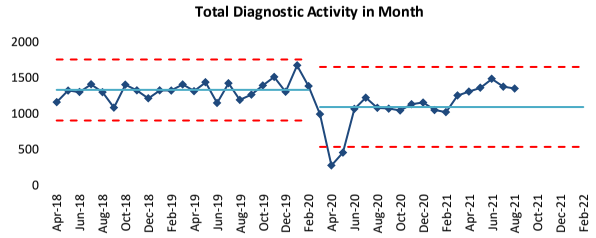
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.00%	

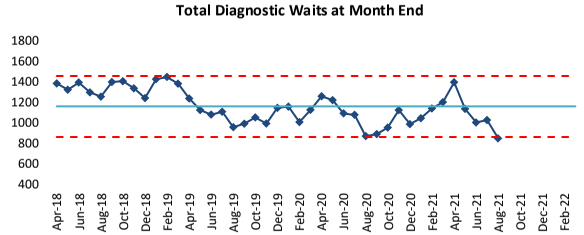
Associated Risks
001 - Covid-19
003 - Performance Standards

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









Operational

Effective - Theatres

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	8	
% Cancelled operations non clinical on day	0.80%	0.85%	
28 Day Breaches in month	0	3	
Theatre utilisation of Elective Sessions	90%	80.30%	
Theatre utilisation of in Session Time	90%	85.17%	

Non Clinical Cancellations

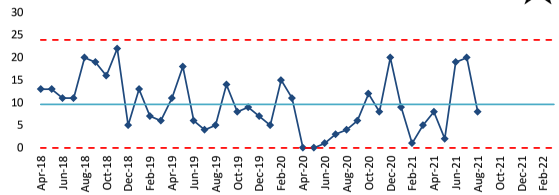
There were 8 patients cancelled at last minute for non-clinical reasons in August 2021, the reasons for the cancellations were bed unavailable (7) and equipment failure (1). Three patients were not rebooked within the 28 day target in month.

Theatres – Theatre Utilisation

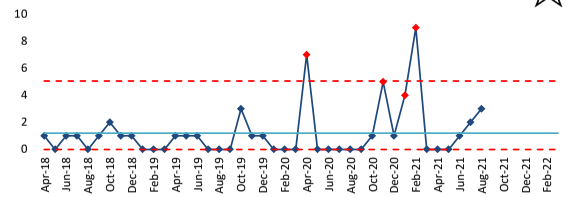
Elective in-session utilisation was 80.30% during August 2021. The Trust is continuing to focus on urgent cases in addition to reducing the number of 52 week waiters, t herefore it is more difficult than normal to effectively utilise in session theatre time. 25 of the 40 sessions lost in August were due to staff unavailability.

A briefing paper was presented to the Executive Team in September which described the challenges and plans to mitigate against these.

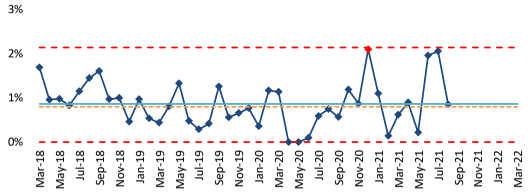
Number of Cancelled operations non clinical (on day)



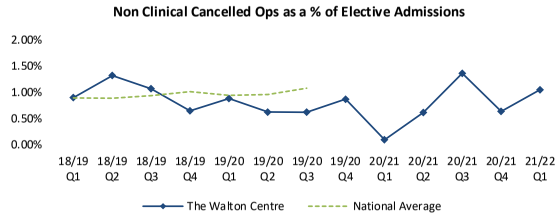
Number of cancelled operations not re-admitted within 28 days



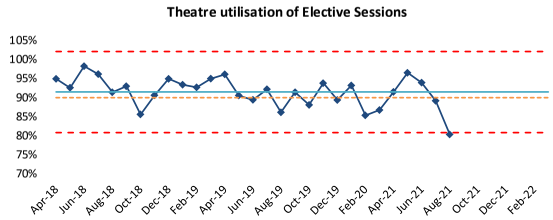
% of Cancelled operations non clinical (on day)



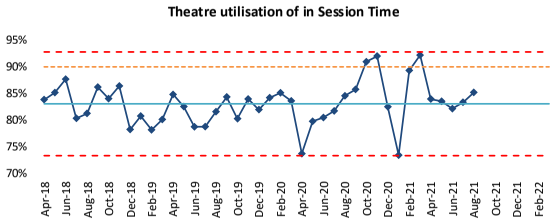
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

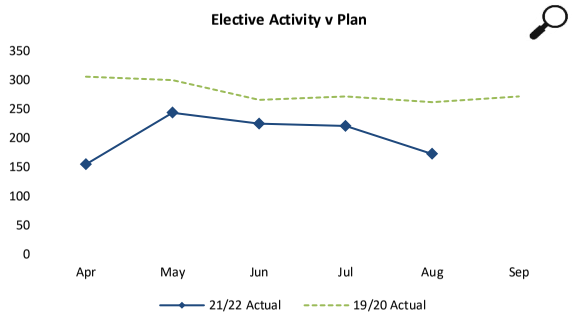
August 21 Activity Performance

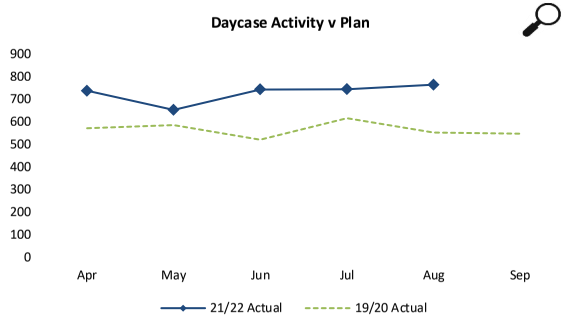
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	138.16%	95%
Elective	66.03%	95%
Elective & Daycase Total	**94.55%**	**95%**
Non Elective	83.33%	-
New Outpatients	89.94%	95%
Follow Up Outpatients	101.26%	95%
Outpatient Total	**97.38%**	**95%**

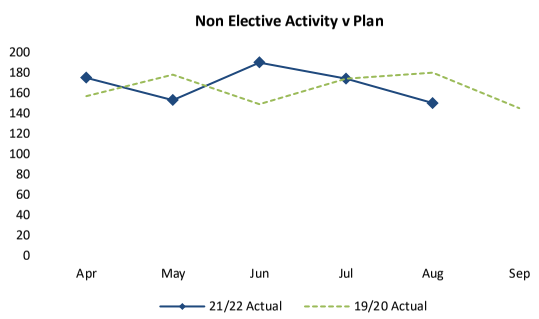
As part of plans to restore services to pre-COVID levels, each Trust was required to include trajectories and timescales for delivery of 100% of the pre-COVID activity levels (comparing with the baseline of actual 19/20 SUS activity levels). The Trust is forecasting delivery of 100% of all elective activity by March 2022, although noting that initial plans submitted are for H1 only (April 2021 – September 2021).

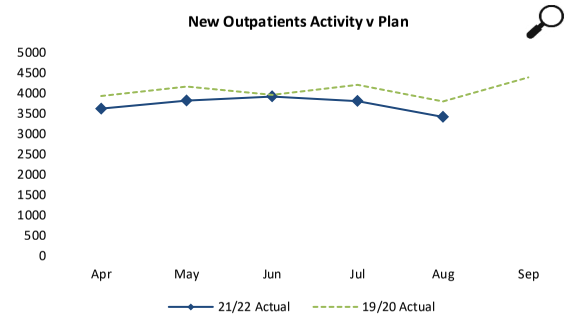
On 9th July the Trust received updated guidance stating that Elective Recovery Fund thresholds have been reviewed and have be en adjusted to 95% of 2019/20 activity levels from 1 July 2021. Daily operational huddles continue to review the activity performance against the revised thresholds set for the remainder of H1. Noting that the plan vs actual for 2019/20 will differ slightly due to working days calculation adjustment.

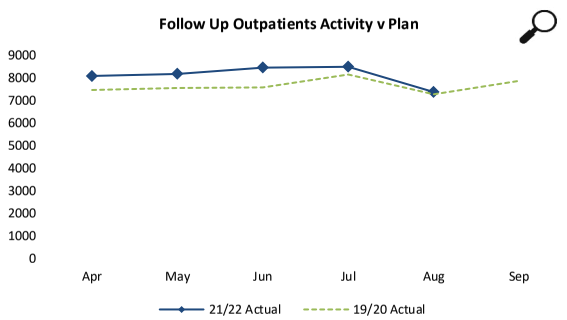
During August 2021 the Trust exceeded the national threshold of 95% for daycase activity and overall outpatient activity combined, however elective activity was below at 66.03%. Under-performance in month for elective activity is in the main due staff availability.











Workforce Indicators

Workforce

Well Led - Workforce KPIs

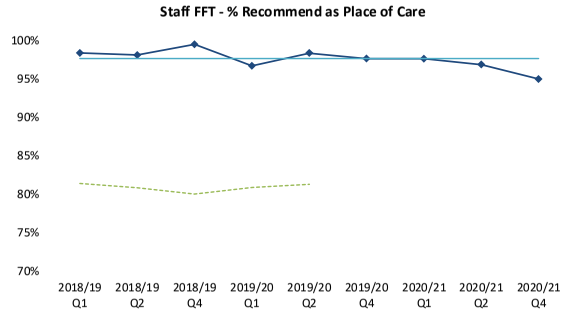
Well Led - Workforce	Target	Actual	Assurance
Staff FFT - Recommend Care (Q4 20/21)	-	95.00%	
Staff FFT - Recommend Work (Q4 20/21)	-	79.44%	
Appraisal Compliance	85%	77.64%	
Mandatory Training Compliance	85%	87.15%	

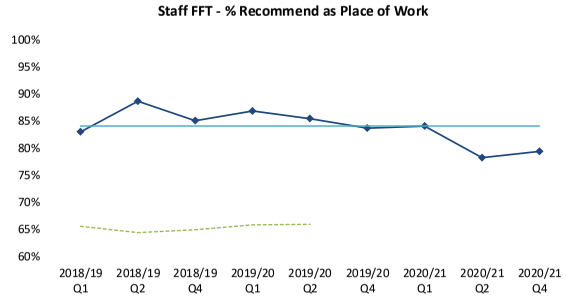
Mandatory Training Compliance

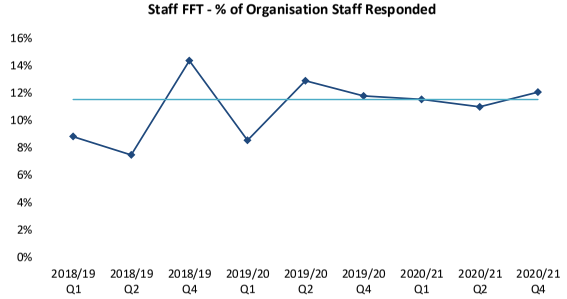
Overall mandatory training compliance in August 2021 was still above the target of 85% with some individual topics dropping below target. Compliance remains high for E-Learning topics and hopefully now training has restarted we will see an increase in topics included on study days.

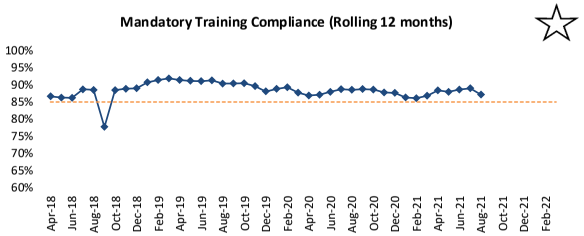
Appraisal Compliance

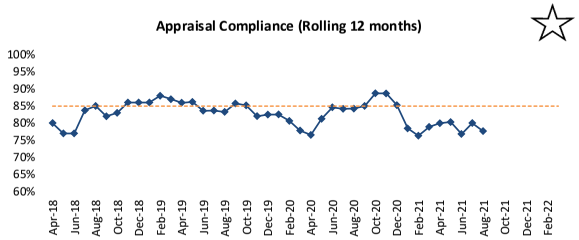
Appraisal compliance in August 2021 is 77.64% compared with 80.00% in July 2021. The training team are continuing to work with individual departments to improve compliance.











Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

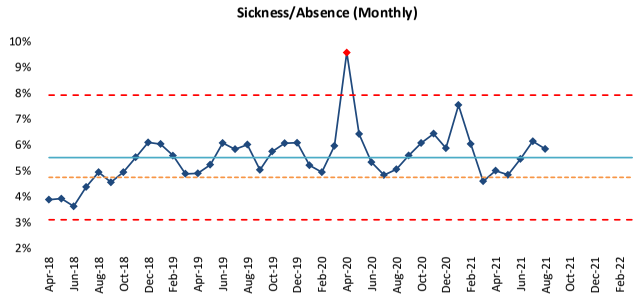
Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	5.85%	
Vacancy Levels	-	4.23%	
Nursing Turnover	10%	13.58%	
Other Staff Turnover	-	11.33%	

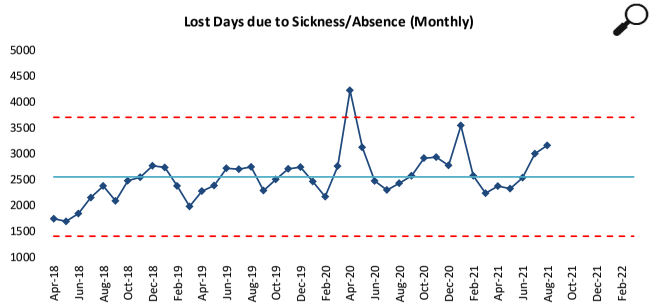
Sickness/Absence

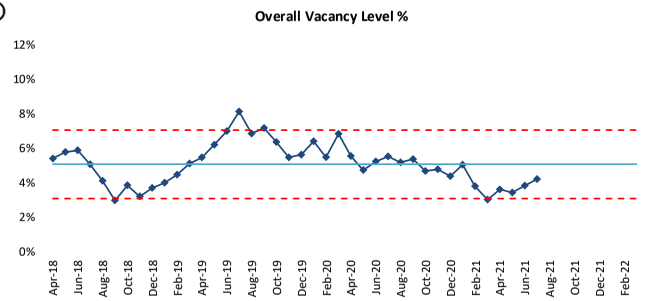
Sickness/Absence levels in August 2021 were above the target of 4.75% at 5.85%.

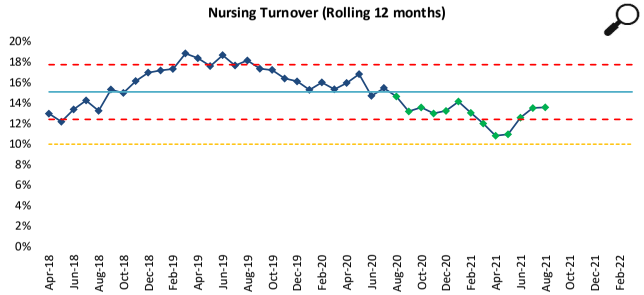
Nursing Turnover

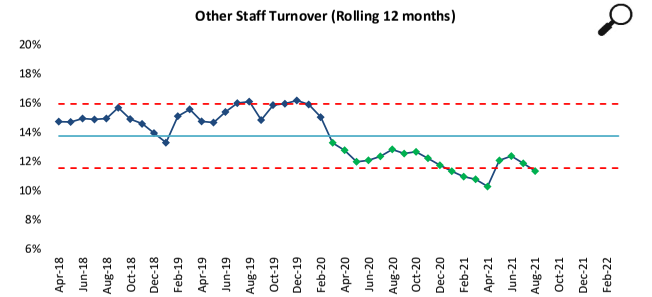
Nursing turnover has worsened when compared with last month following a period of consistent improvement and now stands at 13.58% for August 2021.

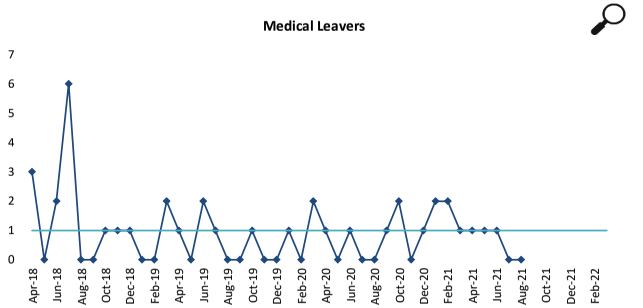












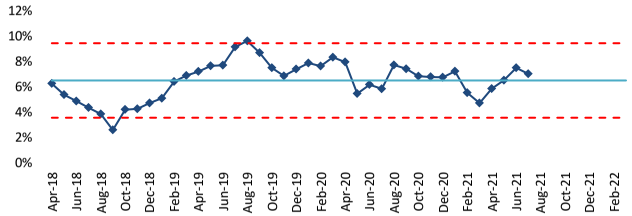
Quality of Care

Well Led - Workforce KPIs

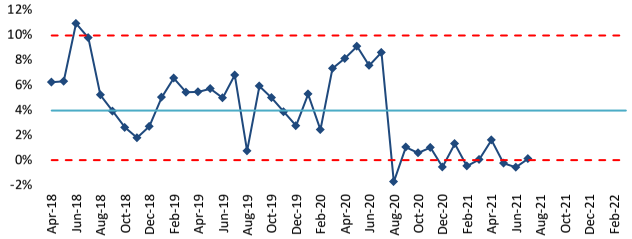
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

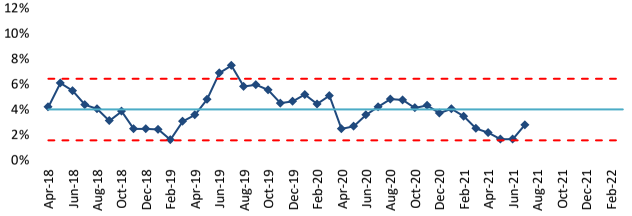
Nursing Vacancy Level %



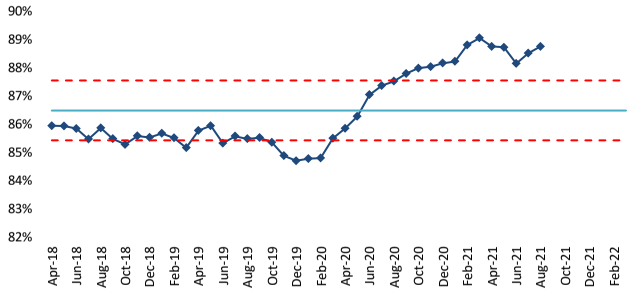
Medical Vacancy Level %



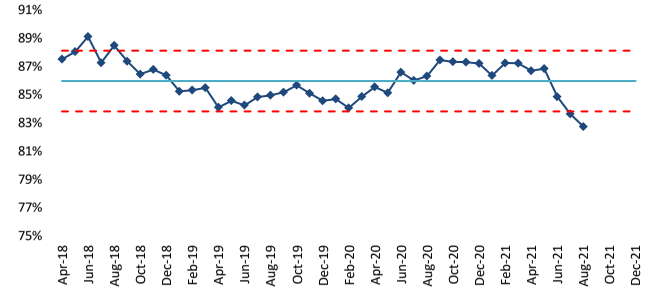
Other Staff Vacancy Level %



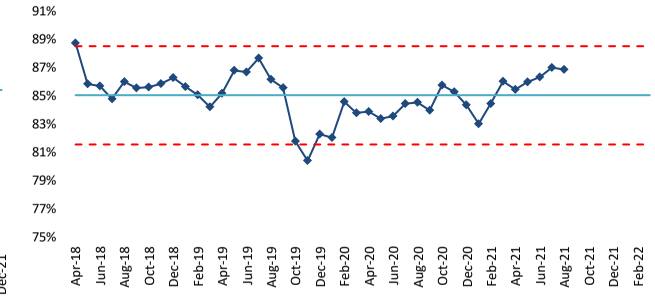
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



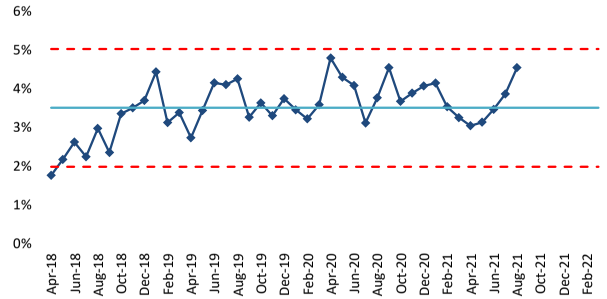
Quality of Care

Well Led - Workforce KPIs

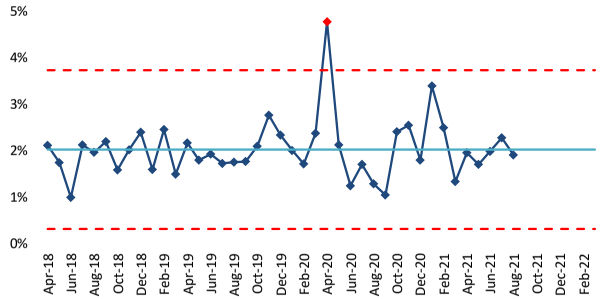
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

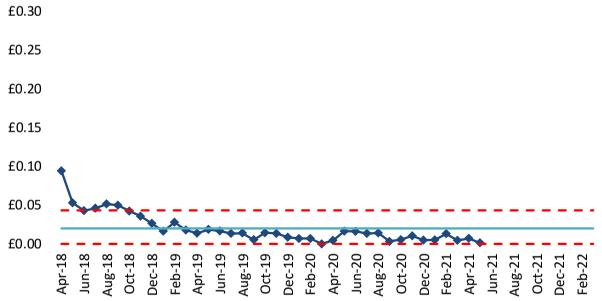
Long Term Sickness/Absence (Monthly)



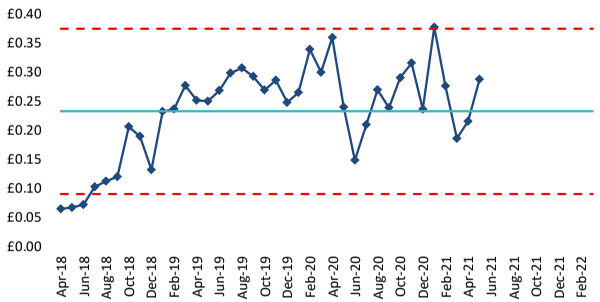
Short Term Sickness/Absence (Monthly)



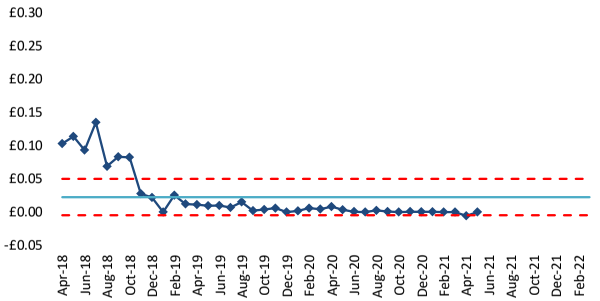
Nursing & HCA Overtime Spend (£m)



Nursing & HCA Bank Spend (£m)



Nursing & HCA Agency Spend (£m)



The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Indicators

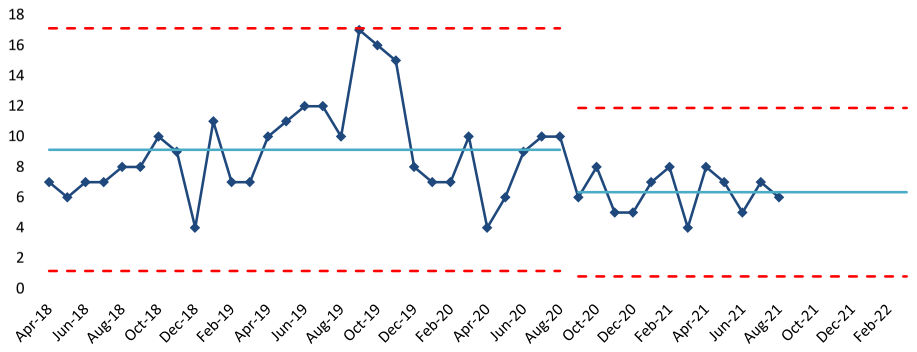
Quality of Care

Caring - Complaints

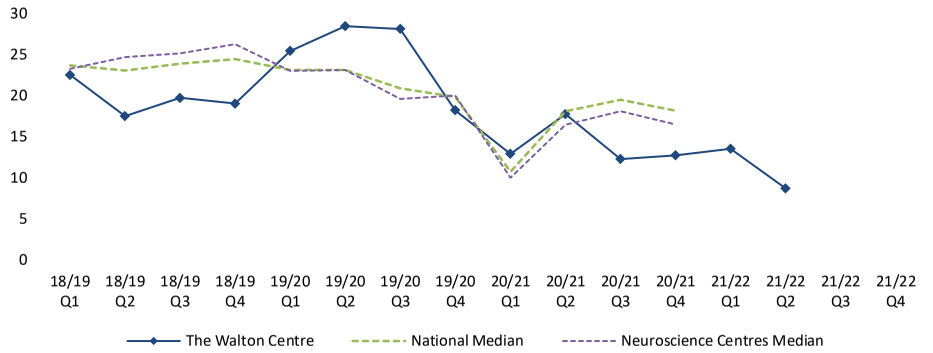
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

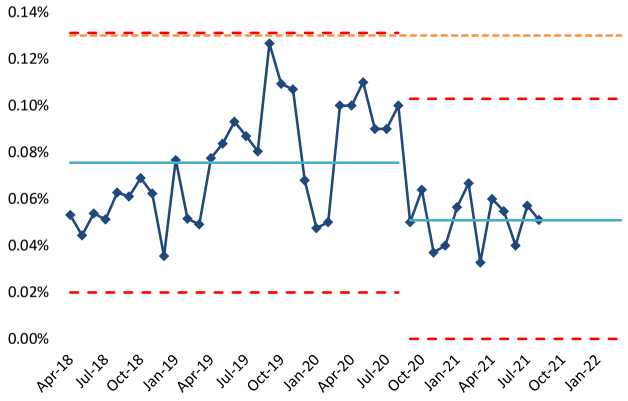
Total Complaints Received in month



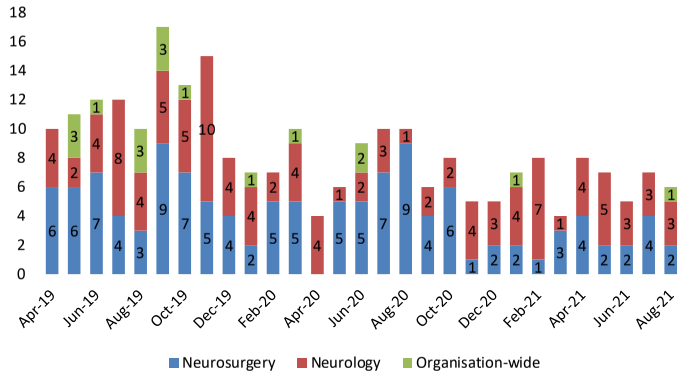
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In August 2021 the Trust received 6 complaints. 3 Neurology (1 reopened), 2 Surgery and 1 cross divisional.

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

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

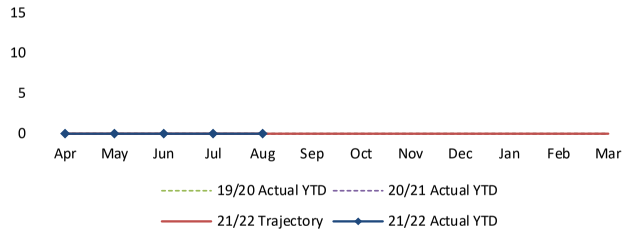
Quality of Care

Safe - Infection Control

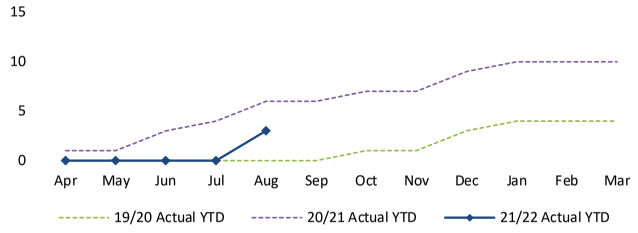
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

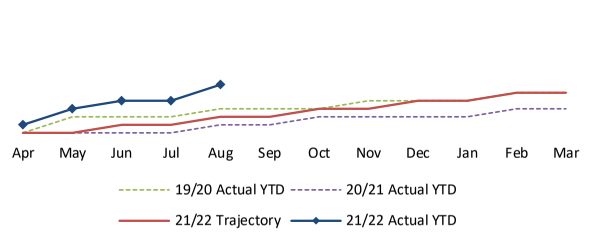
MRSA Bacteraemia



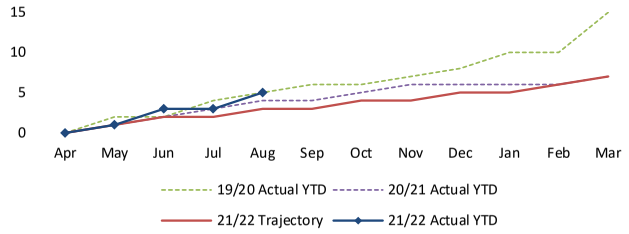
CPE



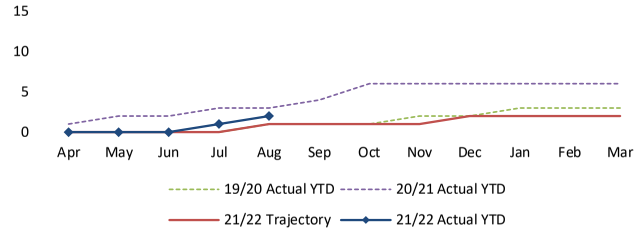
C.Diff



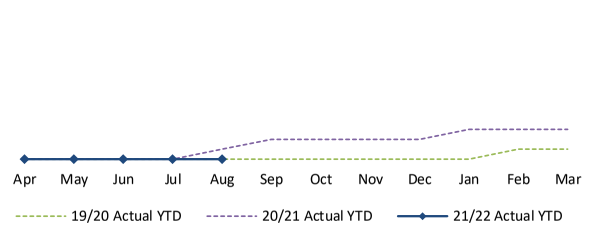
E.Coli



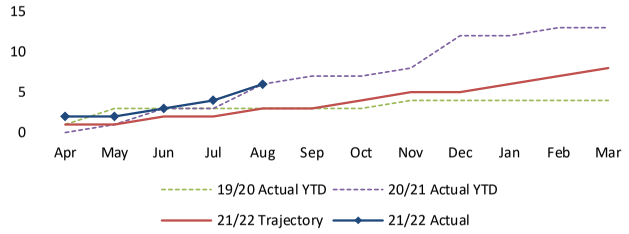
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2021/22

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		1						**1**
Caton								**0**
Chavasse				1			1	**2**
CRU								**0**
Dott				1			1	**2**
Horsley			5	3	2		4	**14**
Lipton								**0**
Sherrington		2	1					**3**
Total	**0**	**3**	**6**	**5**	**2**	**0**	**6**	**22**

August Breakdown by Ward

2x MSSA - Horsley, Chavasse
1x KB - Horsley
2x E.Coli - Horsey, Dott
1x Klebsiella - Horsley
3x CPE - Sherrington, Cairns x2

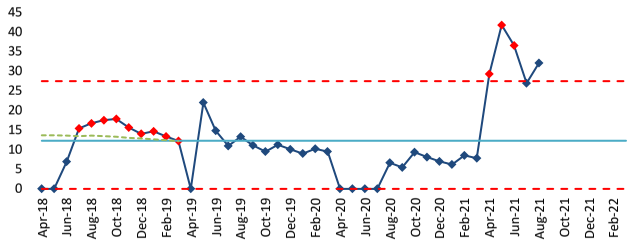
Quality of Care

Safe - Infection Control

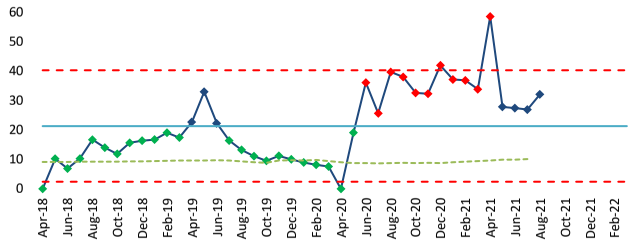
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

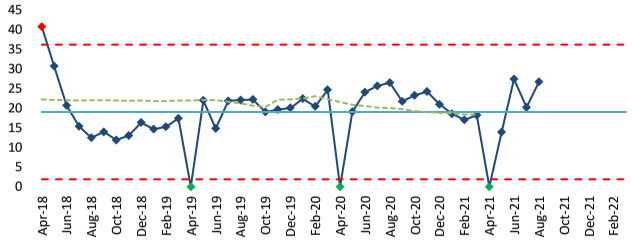
C.Diff Rate per 100,000 Bed Days YTD



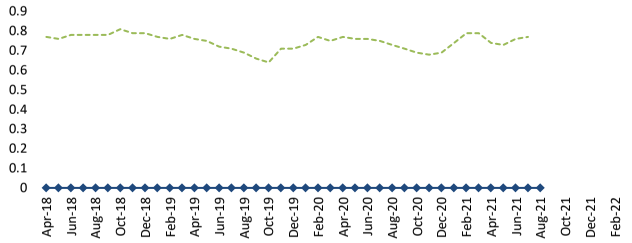
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

There are currently six MSSA instances reported year to date against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 32.06 which is significantly above the latest national average (10.15).

There have been six C.Diff instances year to date against a year end trajectory of five. The rate per 100,000 bed days is currently at 32.06

Year to date there have been five instances of E.Coli against a year end trajectory of seven. The current rate per 100,000 bed days is 26.72. Due to a counting and coding change nationally there is a delay in publishing the national E.Coli rate.

The following improvement actions have been set;

- Task and finish group has met and action plan underway
- Plan for a single digital VIP chart across the Trust to standardise practice
- Line education and training discussed with SMART
- Working with medical education to deliver ANTT training
- Blood culture policy reviewed to include HITU competency, and plan rollout across ward areas (HITU in process of delivering this)
- A C Diff action plan is in place led by Matron and lead nurse for Infection prevention and control, this will be monitored via the Trust Infection Prevention and Control Committee
- ITU Has received enhanced cleans by ISS team and nursing staff
- Infection control awareness session with all senior nursing team to take place 16/9/21

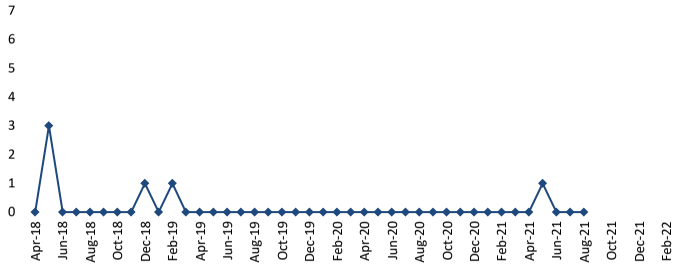
Quality of Care

Safe - Harm Free Care

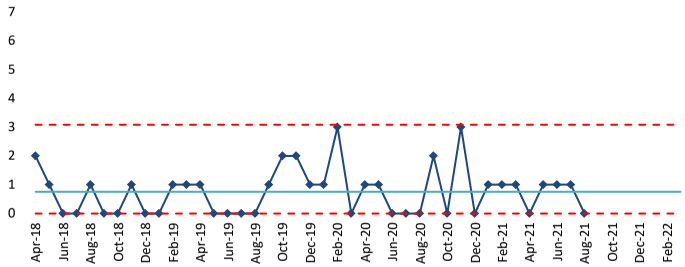
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

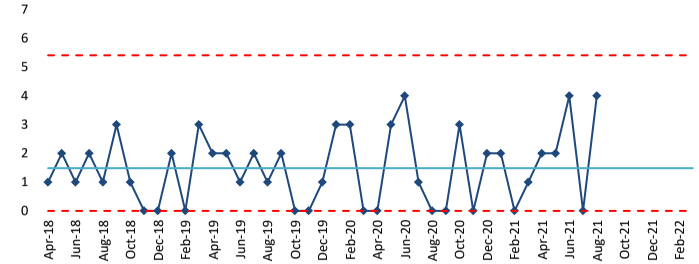
Total Moderate or Above Harm Inpatient Falls



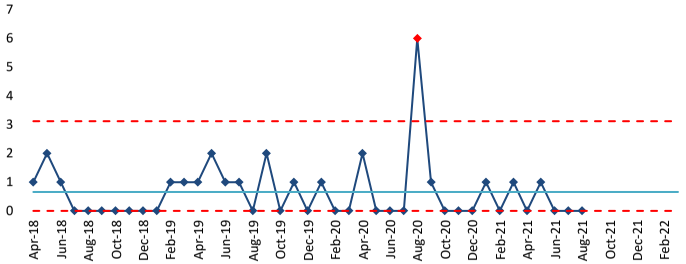
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

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

There was zero Hospital Acquired Pressure Ulcers in month

There were four CAUTI incidence in month

There were no VTE incidences in month

All harm measures are within normal variation.

Ward Scorecard

August 2021

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

	Safe Staffing						Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Day Reg Nurse Associates	Day Non Reg Nurse Associates	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	44.4%	116.7%	66.7%	133.3%	100.0%	-	0	0	0	0	0	0	0	0
Caton	87.8%	176.1%	95.6%	182.2%	100.0%	-	0	0	0	0	0	0	0	0
Chavasse	87.7%	136.0%	87.1%	169.4%	100.0%	100.0%	0	0	0	0	0	1	0	0
Dott	71.9%	67.2%	79.6%	64.5%	100.0%	-	0	0	2	0	0	0	1	0
Lipton	96.2%	121.0%	100.0%	130.1%	-	100.0%	0	0	0	0	0	0	0	0
Sherrington	82.8%	149.1%	95.7%	143.0%	109.0%	-	0	0	1	0	0	0	0	1
CRU	79.6%	141.4%	82.3%	216.1%	100.0%	113.0%	0	0	1	0	0	0	0	0
Horsley ITU	87.7%	94.2%	89.7%	88.0%	-	-	0	0	0	0	0	1	1	1

Safe Staffing Narrative

During the month, in addition to RNAs and TNAs, the Ward Managers were also on occasion in the numbers. Staffing levels are discussed at numerous points throughout the day including within the trust safety huddle and bed meetings, there is also a robust escalation process both in and out of hours to ensure safe staffing levels. During the month there were no red flags or datix incidents in relation to staffing levels.

Work is ongoing to improve the data collection process for this metric to ensure it is as accurate as possible.

WELL LED

Finance

Trust I&E	In month			Year to date			H1 plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Patient Care Income	9,368	10,761	1,393	56,209	57,963	1,754	56,209	57,963	1,754
Exclusions	2,063	1,864	(199)	12,379	12,682	303	12,379	12,682	303
Private Patients	9	3	(6)	52	12	(40)	52	12	(40)
Other Operating Income	458	366	(92)	2,748	3,051	303	2,748	3,051	303
Total Operating Income	**11,898**	**12,994**	**1,096**	**71,388**	**73,708**	**2,320**	**71,388**	**73,708**	**2,320**
Pay	(6,384)	(7,399)	(1,015)	(37,470)	(38,999)	(1,529)	(37,470)	(38,999)	(1,529)
Non-Pay	(2,898)	(2,967)	(69)	(16,691)	(17,095)	(404)	(16,691)	(17,095)	(404)
Exclusions	(2,063)	(2,140)	(77)	(12,379)	(13,194)	(815)	(12,379)	(13,194)	(815)
COVID	(161)	(77)	84	(966)	(530)	436	(966)	(530)	436
Total Operating Expenditure	**(11,506)**	**(12,583)**	**(1,077)**	**(67,506)**	**(69,818)**	**(2,312)**	**(67,506)**	**(69,818)**	**(2,312)**
EBITDA	**392**	**411**	**19**	**3,882**	**3,890**	**8**	**3,882**	**3,890**	**8**
Depreciation	(487)	(494)	(7)	(2,922)	(2,929)	(7)	(2,922)	(2,929)	(7)
Profit / Loss On Disp Of Asset	0	1	1	0	69	69	0	69	69
Interest Receivable	0	0	0	0	0	0	0	0	0
Financing Costs	(53)	(48)	5	(318)	(294)	24	(318)	(294)	24
Dividends on PDC	(127)	(127)	0	(762)	(762)	0	(762)	(762)	0
I & E Surplus / (Deficit)	**(275)**	**(257)**	**18**	**(120)**	**(26)**	**94**	**(120)**	**(26)**	**94**
I&E impact capital donations and profit/(loss) on asset disposals	**20**	**21**	**1**	**120**	**26**	**(94)**	**120**	**26**	**(94)**
I & E Surplus / (Deficit)	**(255)**	**(236)**	**19**	**0**	**0**	**0**	**0**	**0**	**0**

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

The current H1 plan includes:

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

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

In month 6, the Trust reported a £236k deficit position. This is a £19k improvement on the planned in month position of £255k deficit. This improvement in month is due to an over-performance in NHS England funding, Isle of Man activity, Health Education England funding, as well as lower spend than planned on clinical supplies to deliver increased ERF activity offset by an under-performance in ERF income.

The position includes £1,061k pay award funding for H1 which is equally offset in expenditure as payroll processed the pay award (3%) for M1-6 in month.

The position includes £2,089k elective recovery fund against a planned position of £2,526k, £437k below plan (relating to over performance national trajectories in M1-3). In M4, 5 and 6 the Trust delivered below the 95% (activity by value 2019/20) trajectory (estimated 94.0% M4 and 85.0% M5) and as such no ERF income has been assumed. Please note NHSE/I have yet to confirm ERF income values for M4-6 to the Trust therefore this may be subject to change.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	September-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	800	(69)
Tangible Assets	86,164	84,251	(1,913)
TOTAL NON CURRENT ASSETS	**87,033**	**85,051**	**(1,982)**
Inventories	1,157	1,969	812
Receivables	7,523	6,290	(1,233)
Cash at bank and in hand	35,689	36,488	799
TOTAL CURRENT ASSETS	**44,369**	**44,747**	**378**
Payables	(25,914)	(25,066)	848
Provisions	(245)	(245)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,569)	0
TOTAL CURRENT LIABILITIES	**(27,780)**	**(26,932)**	**848**
NET CURRENT ASSETS/(LIABILITIES)	**16,589**	**17,815**	**1,226**
Provisions	(701)	(686)	15
Finance Lease	(63)	(45)	18
Loans	(23,635)	(22,938)	697
TOTAL ASSETS EMPLOYED	**79,223**	**79,197**	**(26)**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,737	(26)
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,197**	**(26)**

STATEMENT OF CASH FLOW - 2021/22	September-21 plan	September-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(120)**	**(26)**	**94**
Non-Cash Flows In Operating Surplus/(Deficit)	3,865	4,004	139
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**3,745**	**3,978**	**233**
Increase/(Decrease) In Working Capital	(328)	1,452	1,781
Increase/(Decrease) In Non-Current Provisions	(14)	(14)	(0)
Net Cash Inflow/(Outflow) From Investing Activities	(4,550)	(2,809)	1,741
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(1,147)**	**2,607**	**3,754**
Net Cash Inflow/(Outflow) From Financing Activities	(27)	(1,808)	(1,781)
NET INCREASE/(DECREASE) IN CASH	**(1,174)**	**799**	**1,973**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**34,515**	**36,488**	**1,973**

COVID-19 expenditure:

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

In month Actual: £87k.

Year to date Actual: £539k.

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

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Jun-21 Actual £'000	Jul-21 Actual £'000	Aug-21 Actual £'000	Sep-21 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	54	47	350
Decontamination	0	7	3	0	0	0	10
Agile working	0	12	1	0	0	0	13
Infection Control	0	0	0	0	22	4	26
Other	20	1	43	19	21	36	140
TOTAL	**113**	**70**	**104**	**68**	**97**	**87**	**539**

Other spend includes providing free car parking for staff, heavy duty mobile Sani-station units to be used across the trust and quarantine costs for overseas nurse recruitment.

Capital

In month variance - £266k below plan.

Year to date variance - £1,668k below plan.

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

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

The Trust has received an allocation of external funding in relation to Digital Aspirant for IM&T innovation of £3.6m (which needs to be spent in year) to be received in year.

CAPITAL

	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	92	80	12	550	413	137	1,100	920	180
Estates	0	(4)	4	0	(4)	4	850	738	112
IM&T	81	50	31	485	224	261	969	1,052	(83)
Neurology	0	0	0	0	9	(9)	2,349	1,703	646
Neurosurgery	0	(12)	12	0	24	(24)	2,594	2,390	204
Corporate	0	0	0	0	0	0	491	150	341
Capital Slippage	(40)	0	(40)	(245)	0	(245)	(2,150)	(750)	(1,400)
TOTAL (excl. external funding)	**133**	**114**	**19**	**790**	**666**	**124**	**6,203**	**6,203**	**0**
Donated Assets	0	0	0	32	32	0	32	32	0
Digital Aspirant	302	55	247	1,812	268	1,544	3,746	3,746	0
TOTAL (incl. external funding)	**302**	**55**	**247**	**1,844**	**300**	**1,544**	**3,778**	**3,778**	**0**
TOTAL	**435**	**169**	**266**	**2,634**	**966**	**1,668**	**9,981**	**9,981**	**0**

Capital spend in month is £169k.

- **Heating & Pipework**: £80k – Phase 4 works;
- **IM&T:** £50k - Staffing in relation to specific projects;
- **Digital Aspirant (PDC funded):** £55k – Whiteboard development and interoperability.

The year-end capital forecast is £10.0m (including external funding) which is in-line with the agreed funding allocations. This assumes that a further £0.8m slippage is managed to bring anticipated spend back in line with the annual capital allocation.

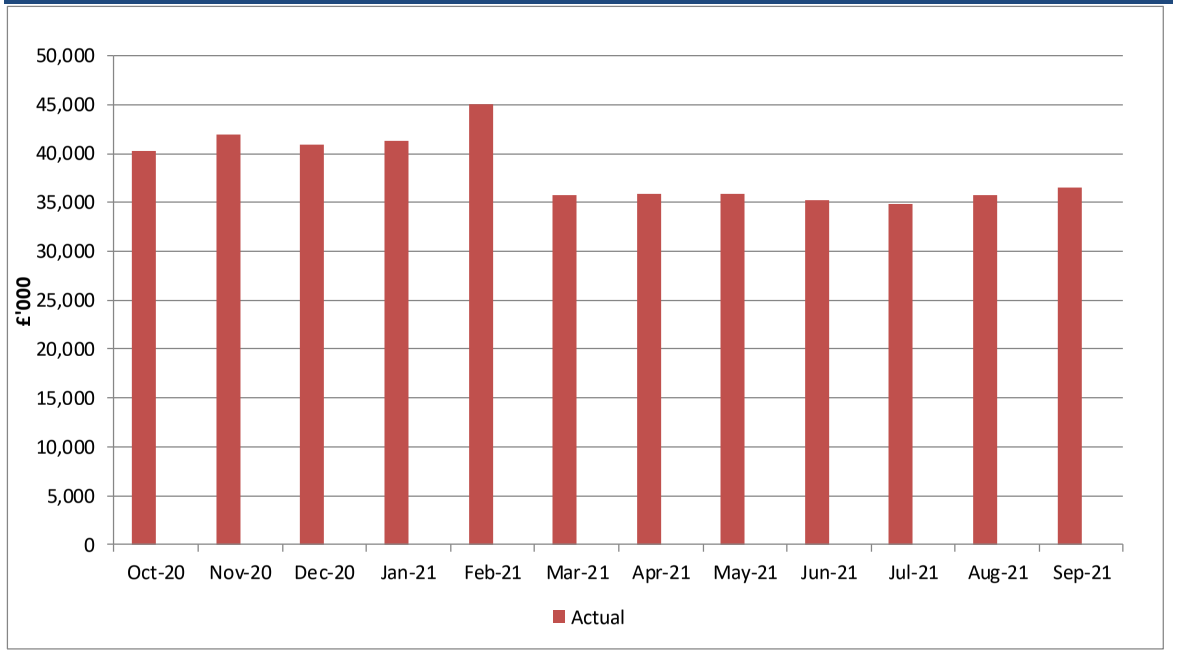
Work is ongoing with clinical and operational leads to prioritise capital spend for 21/22 to ensure that it is delivered in line with agreed funding levels. If capital is not spent in line with plan it could result in HCP allocations being reduced next year.

As of the end of September:

Actual Cash Balance: £36.5m.

Number of days operating expenses = 94 days.

Cashflow against plan (Rolling 12 months)



The Trust cash balance at the end of September was £36.5m. This is an increase of £0.8m compared with the end of August due to

- An increase in non-cash flows within the operating position;
- A decrease in receivables and accrued income;
- Off-set by a payment in PDC dividends.

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

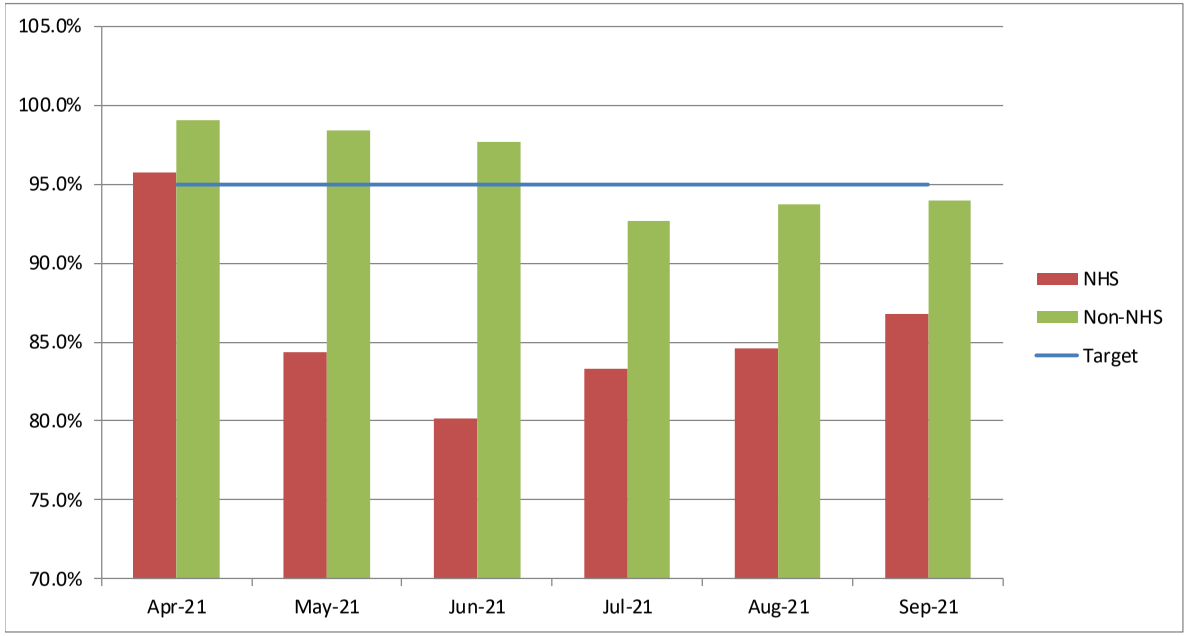
Block payments will be made in month and not in advance throughout 2021/22.

Better Payments Practice Code (BPPC):

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

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

Cumulative PSPP by value of invoices



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

- Non NHS 94.0%;
- NHS 86.8%;
- Total 91.3%.

This has seen an improvement in non-NHS payments of 0.3% and an improvement in NHS payments of 2.2% since the end of August.

The Trust BPPC percentage (by number of invoices paid) at the end of September is 91.9%.

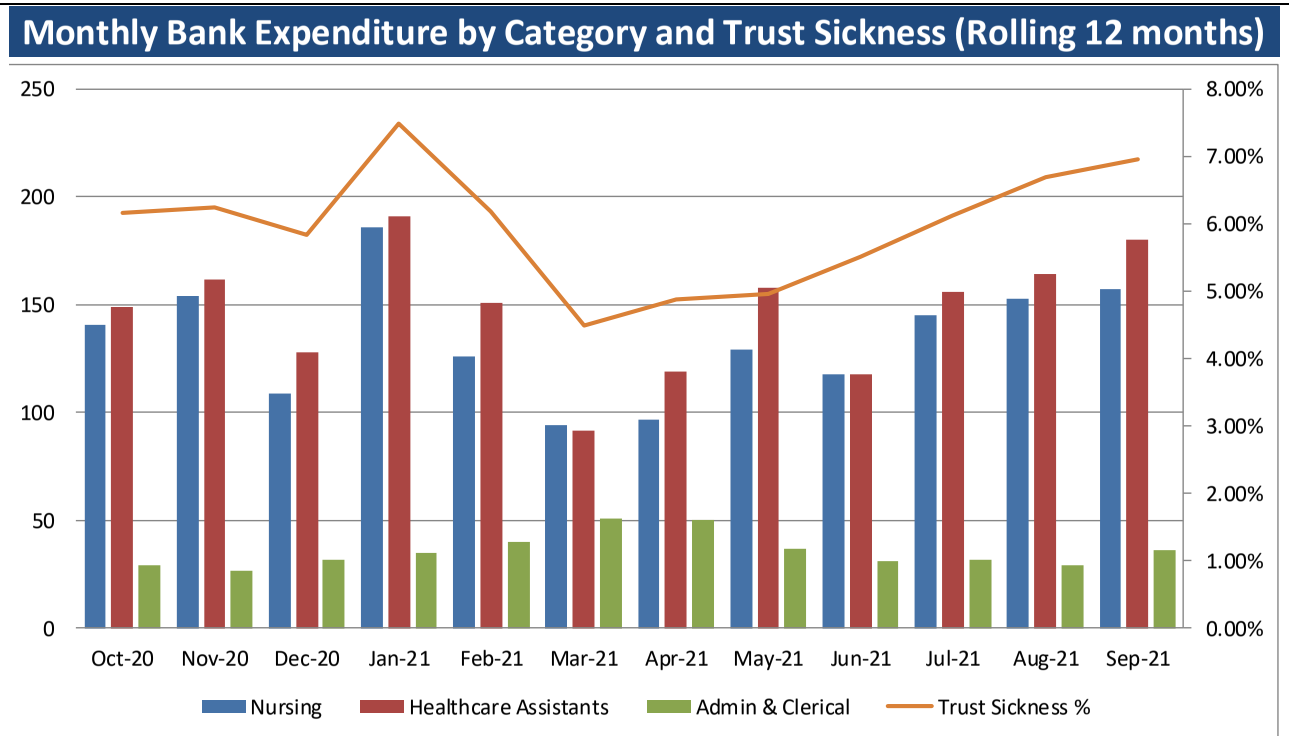
The finance team have put in place a weekly meeting to review and implement payment processes to bring payment to within 30 days.

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

Bank Expenditure:

In month Actual: £381k.

Year to date Actual: £1,953k.



Bank expenditure incurred in September was £381k, an increase of £28k when compared to August.

At the end of September, £268k bank expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

The trusts overall sickness rate increased from 6.69% to 6.97% in September.

Key Risks and Actions in 2021/22

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

- Delay of 2021/22 business planning until 2nd half of 21/22, with finance regime of 2020/21 to continue for at least 6 months of 2021/22 (H1);
- Payment by Results (PbR) continued suspension for the first 6 months of the year and income being based on block values determined nationally (based on 2020/21 Q3 levels plus 0.5% inflation, incorporating a 0.28% efficiency requirement) and adjusted for the impact of CNST increases;
- System funding has been allocated to C&M HCP for M1-6 which has been distributed to all organisations and included within organisational H1 plans to cover costs in relation to Top-up, COVID-19 (in relation to reasonable COVID-19 expenditure), growth and CNST;
- The trust is currently being monitored against plans for April to September forecast to break-even submitted to NHSE/I and C&M HCP on 26nd May;
- System level financial targets have also been submitted with a forecast for the system to breakeven at the end of H1;
- An Elective Recovery Fund (ERF) came into effect in April 21 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M1-M6). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then may receive a retrospective financial penalty. The elective recovery scheme will be monitored at C&M HCP system level. The H1 plan incorporates forecast income and expenditure to deliver the trusts activity plan for H1 based on national trajectory requirements (operational and clinical teams will work to deliver these planned activity levels), further guidance has now been issued by NHSE/I increasing the trajectory threshold from 85% to 95% for M4-M6 which has now put the elective recovery fund income in the plan for that period at risk as the Trust would need to considerably over-perform the 95% threshold to recover the same levels of planned income;
- 2021/22 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this includes an allocation of additional PDC (Digital Aspirant Funding) allocated for IM&T innovation;
- H2 and multiple year settlements have been set out by the government and planning for H2 is underway with guidance being issued early October and 2022/23 by the end of the financial year;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

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

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

RISK	COMMENT/ ACTIONS
Access to Elective Recovery Fund	As noted above the H1 plan incorporated forecast income and expenditure to deliver the trusts activity plan for H1 plan based on the original national trajectory requirements. The updated trajectory

	threshold of 95% required from M4-M6 meant the Trust was unable to deliver any further ERF in this period (the system also did not deliver the new trajectory). The forecast currently does not take account of the reduced income assumed within the H1 plan as a result of the increased national activity trajectories. The new ERF requirements of delivering 89% of admitted and non-admitted clock stops is still being assessed by the Trust but there is a risk that if the Trust is able to achieve this, whilst the wider C&M system fails to deliver, then there will be an increased cost of delivery without a corresponding increase in income. Whilst it is recognised that the achievement of these targets is imperative to reducing waiting lists and ensuring patients are treated, it must be recognised that delivery at organisational level could result in increased costs to the organisation.
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification was received that 2021/22 financial planning has been deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for all of 2021/22. Current national guidance states that H1 funding will be based on Q3 20/21 spend extrapolated for 6 months with system allocations for providers to achieve a breakeven position. The financial framework has recently been published for H2 and the trust is working up plans to be submitted in late November, however it is currently anticipated this will be similar to H1 (albeit an increased efficiency requirement) for H2.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be in H2 of this financial year and as such planning to deliver recurrent savings is difficult. Clearly the delay in 2021/22 business planning may impact on national and local system efficiency requirements and it is currently not clear what internal efficiencies may need to be delivered to meet overall system financial plans. However recurrent efficiencies will be required to be

	delivered in 2021/22 and work is being undertaken to identify these. Meanwhile the Trust is anticipating it will deliver CIP non-recurrently in H1.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account the changes to IPC guidance. The Trust will be carrying out risk assessments to determine the risk of reducing IPC requirements as it continues to review processes for the delivery of safe services. There is also a risk to delivery of activity as a result of staff sickness / burnout due to and following the COVID-19 pandemic and also the potential impact on services if the Trust is required to support other Trusts in the region during the anticipated winter pressures that the NHS will face in H2 e.g. critical care surge capacity.

REPORT TO THE TRUST BOARD
Date October 2021

Title	**Staffing Paper – 6 monthly report**
Sponsoring Director	Name: Lisa Salter Title: Chief Nurse
Author (s)	Name: Nicola Martin Title: Deputy Chief Nurse
Previously considered by:	Senior nursing team
Executive Summary The purpose of this paper is to provide assurance regarding nurse staffing and other clinical staffing at The Walton Centre. This is the first full review that has been undertaken since covid, it is undertaken 6-monthly as per NICE guidance, with the last papers being presented in a different format due to COVID 19. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand the risks and assurances associated with current staffing levels and the actions required ensuring quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and Quality Committee and Trust Board are requested to receive a further report in 6 months, or sooner should staffing alter.	
Related Trust Strategic Objectives	Deliver best practice care Invest, be financially strong Lead research, education and innovation Recognised as excellent in all we do
Risks associated with this paper	As contained within the paper
Related Assurance Framework entries	Related to BAF risk on national nurse shortages and ability to maintain safe staffing levels. Risk Number 0035 COVID 19 Risk Number 0001
Equality Impact Assessment completed	N/A
Are there any associated legal implications / regulatory requirements?	• Yes – NHSE / NHSI and CQC requirements and regulations
Action required by the Board	• To acknowledge the report • Receive a further report in 6 months

1. Executive Summary

The purpose of this paper is to provide assurance regarding nurse staffing and other clinical staff groups at The Walton Centre. All NHS providers are required to undertake a minimum annual review of nursing staffing levels (NQB, National Quality Board *Safe, sustainable and productive staffing* an improvement resource for adult inpatient wards in acute hospitals) (Quote NQB doc). This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in May 2021. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand the risks and assurances associated with current nurse staffing levels and the actions required to ensure quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and Quality Committee and Trust Board are requested to receive a further report in 6 months.

2. Introduction and Background

In January 2018, the National Quality Board (NQB)[1] released updated guidance in respect of adult in-patient areas, defined as wards that provide overnight care for adult patients in acute hospitals. For the purpose of this review, it includes the following areas;

Wards: Cairns, Dott, Sherrington, Chavasse, CRU, Lipton, ITU, Theatres and OPD

(NB Note that Caton Ward is currently closed due to heating work)

The functionality of each ward here at The Walton Centre can be found in appendix one.

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1; NQB's expectations for safe, sustainable and productive staffing

Expectation 1 - Right staff

[1] National Quality Board *Safe, sustainable and productive staffing* An improvement resource for adult inpatient wards in acute hospitals

The NQB recommends that there is an annual strategic staffing review, with evidence that is developed using a triangulated approach (accredited tools, professional judgement and a comparison with peers). This should be followed with a comprehensive staffing report to the Board after 6 months.

Here at The Walton Centre the Safer Nursing Care Tool used is the Shelford model. This was developed to help NHS hospital staff measure patient acuity to inform evidence based decision making on staffing and workforce. This acuity review is undertaken twice a year in line with NQB recommendations.

Table 2 shows the outcomes of the acuity review taken over a 21 day period for the month of October 2021. It is important to note that wards are currently not functioning at their speciality level and colour coded pathways remain in place to support the safe management and risks of covid. Occupancy is also low therefore the acuity review demonstrates that all areas are currently safely staffed but a further review in 6 month's time is required when hopefully wards will be back to their specific speciality. The tool is clear that changes should not be made as a consequence of only one or two sets of data as occupancy and acuity can have seasonal differences.

Ward	**Funded establishment (wte)**	**Acuity tool outcome (wte)**	**Professional judgement tool**	**Additional information**
CRU	56.21	49.36	58.7	4 empty beds
Lipton	29.37	30.3	29.6	1empty bed
Cairns	40.57	28.13	37.7	3-12 empty beds and day case patients
Caton	Closed at time of review	Closed at time of review	Closed at time of review	Closed at time of review
Sherrington	40.57	31.50	37.7	Empty beds range from 4-7
Chavasse	56.95	31.13	59.8	Empty beds range from 4-10
Dott	39.99	22.7	37.7	Empty beds and day case patients

Table 2: Outcome of acuity review October 2021

Process for determining staffing levels

a) Professional judgement

The judgement of senior experienced nurses should also be a critical factor in determining staffing levels. Judgement takes into consideration;

- Cohort nursing requirement

- Ward leadership
- Ward layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

Each division is working to ensure safe staffing for every area on a shift by shift basis. The Matrons and Ward Managers work closely to ensure effective and efficient strategic monitoring and management of staffing with the principle aim to promote patient safety and optimise patient and staff experience.

A ward still remains closed in the Trust due to pipework and staff from this area have been redeployed to other wards to support safe staffing, increase in sickness levels and to reduce shift requests to NHSP where and when possible.

b) Registered Nurse to Patient ratio

The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for patients during a shift. NICE and RCN guidelines recommend no more than 8 patients per RN on a day shift (early or late). This is based on NICE evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward manager should have supervisory capacity. All ward managers at The Walton Centre are supernumerary but do cover sickness and staffing gaps as and when required. There is no specific guidance regarding night duty, albeit the RCN guidance on safe nurse staffing levels in the UK 2021 states no more than 10 patients to 1 RN.

Staffing data, Care Hours per Patient Day (CHPPD) and actual and planned staffing is analysed monthly. This information is uploaded onto the national database (Unify), to the WCFT website for public access and reported to Trust Board; this reporting has continued throughout the COVID 19 pandemic.

The Trust continues to have a daily safety huddle chaired by the Chief Nurse and staffing is discussed for the organisation at this meeting. Following this a bed meeting is held every day at 10 am chaired by a Divisional Nurse Director, whereby nurse staffing levels are discussed and dynamic risk assessments completed, staff are moved, where required, to support patient and staff safety.

Staffing situation since the presentation of the May 2021 nurse staffing review

- New Deputy Chief Nurse is now in post
- New Tissue viability nurse for the trust has been appointed to and commences post in November 2021.
- The Infection Prevention and Control team is now fully recruited to.
- The original Trust (PEF) continues to act up into an 8A role to oversee International Recruitment, nursing education and competencies.
- Neurology Matron has moved into the service improvement team and a new Matron is due to start early November
- Divisional Nurse Director for Neurosurgery is currently off and so the Matron for neurosurgery is currently acting into the role and a specialist nurse acting into the Matron role.

Table 3; Compliance against key recommendations

Recommendation	Assessment	Compliant	Variation
RN to Patient ratios not exceeding 1:8 day shifts	All adult in-patient areas achieve a maximum ratio of 1 RN to 8 patients on day shifts	√	Some areas have benefitted from higher RN to patient ratios due to ward closure and reduction in bed occupancy (please see occupancy levels below)
Evidenced based Tool	The Organisation has Safer Nursing Care Tool which analyses acuity and dependency and review was undertaken for 21 days from 1st October	√	Whilst this has been undertaken, it is noted that there is a lack of validity and reliability due to the current ward case-mix changes during covid-19 pandemic
Headroom/uplift	Headroom/uplift is calculated at 21% - compliant	√	In line with guidance
Skill Mix	All areas re-reviewed in 2021	√	A ward closed due to pipework resulting in redeployment of staff to various wards
Professional judgement	All areas have been reviewed in 2021 and are also reviewed monthly by the Divisional Nurse Directors and the Informatics team	√	All areas current staffing levels deemed safe

c) Headroom / Uplift

Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered and patient care delivery is safe.

The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave

and ‘other’. The uplift of establishments at The Walton Centre is set at 21% RN and 19% HCA to ensure that staffing is appropriate and financially viable. The uplift whilst lower than the national average, accounts for the higher dependency of newly qualified staff who do not have the additional leave (week) that staff who have worked for the NHS longer are entitled to, training requirements of each staff groups, as well as other leave arrangements.

Actions have been taken to improve fill rate of shifts with NHSP and the nurse bank has successfully been implemented across the Trust. This has been very positive and from September 2018 when work was commenced, we have continually seen a reduction in agency and an increase in bank which was the pattern we required and anticipated. The Trust is also in the process of implementing Health Roster; this is an electronic system which gives clear transparency of shifts covered and shifts out to NHSP. This calculates staff hours also ensuring staff don’t accumulate hours owed to them or to the Trust. These rosters will be built 6 weeks in advance with a sign off process in place and shifts going out in advance to NHSP which in turn will improve the fill rate.

d) Skill Mix

This is the ratio of RNs to unregistered staff, such as healthcare assistants (HCA). Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%/35% split. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can actually still be appropriate and compliant.

The current RN/HCA skill mix at The Walton Centre is:

Wards	Number of beds	Establishment Early	Late	Night
Cairns	26	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Caton	25	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Dott	27	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Sherrington	25	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Chavasse	29	Ward manager supernumerary 6 RNs 6 HCAs	5 RNs 6 HCAs	4 RNs and 5 HCAs
CRU	30	Ward manager supernumerary 5 RNs 6 HCAs	4 RNs 6 HCAs	4 RNs 6 HCAs
Lipton	10	Ward manager supernumerary	3RNs 3HCAs	2RNs 2HCAs

Table 4: Current skill mix establishment

At The Walton Centre there are more HCAs on duty than RNs due to the nature of the patient’s conditions. HCAs will support the enhanced needs of the patient particularly when they require one to one support or require rehabilitation.

e) Safety outcome indicators

NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were noted to be specifically affected by the presence (and hence absence) of registered nursing staff. These indicators include;

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

Walton Accreditation Tool

The Walton CARES (Communicate, Assess, Respect, Experience and Safety) Review assesses performance based on the Trust core standards. The framework is designed around 15 standards with each one subdivided into four categories including, patient experience, and observations, documentation and staff experience. Compliance against these standards is measured in various ways to gather a full picture of the ward and care delivered.

During COVID the CARES reviews were paused but have since restarted. It was agreed a condensed version of the review would be undertaken to ensure face to face contact with patients and staff for periods of time were kept to a minimum due to the current climate.

The following areas have had the shortened version of the CARES Review undertaken and results are pending:

- Theatre Department
- Caton Ward
- Chavasse Ward
- Radiology

Following a review, the manager of the above area will meet with a review panel who consider the findings and the additional portfolio of information they provide and inform the manager of the overall rating which is Bronze, Silver, Gold or Platinum.

The above areas have not awarded as yet until presentations at Panel is completed.

The overall outcome of the review will determine the frequency of forthcoming reviews as per below:

Bronze	Review again in 3 months
Silver	Review again in 9 months
Gold	Review again in 12 months
Platinum (achieved Gold rating for 3 consecutive reviews)	Review again in 12 months

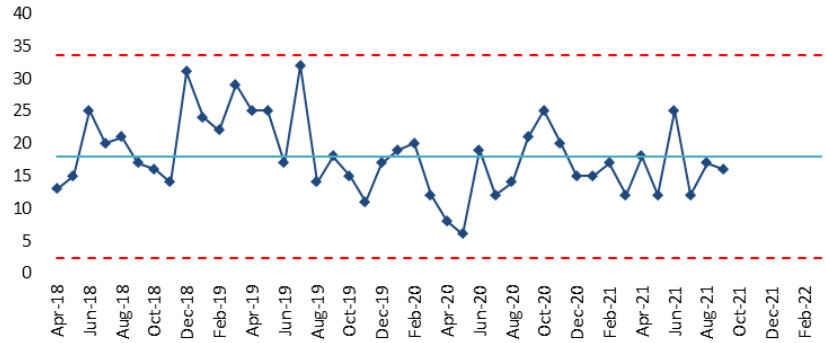
The plan is to ensure all clinical areas across the Trust have a CARES review undertaken by year end.

Harm data per 1000 bed days

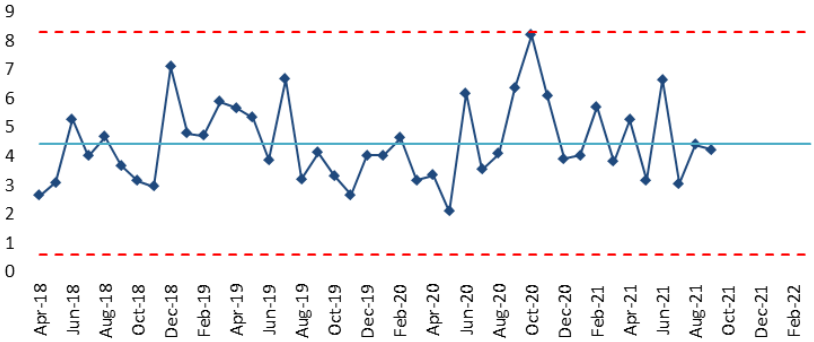
The overall falls and pressure ulcers remain within normal variation and outcomes per 1000 beds days were favourable compared to national data at last reporting pre covid-19.

For individual ward data please see appendix Two

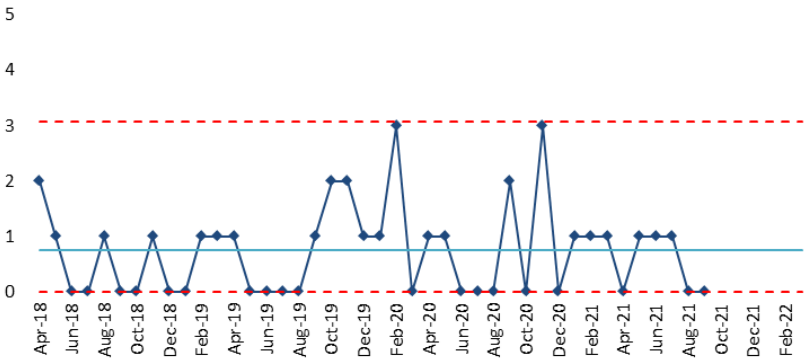
Total Inpatient Falls

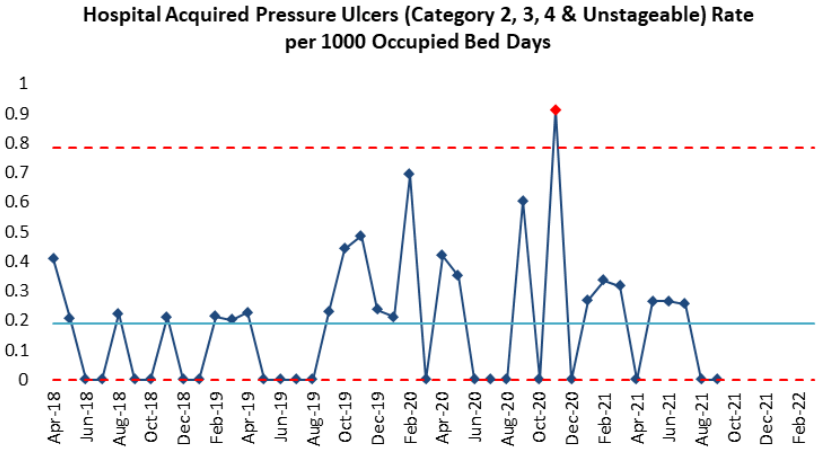


Inpatient Falls Rate per 1000 Occupied Bed Days



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




Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable) Rate per 1000 Occupied Bed Days
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Apr-18
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
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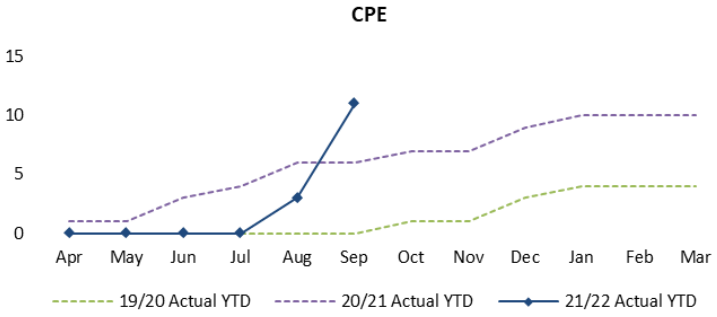
Feb-22


CPE
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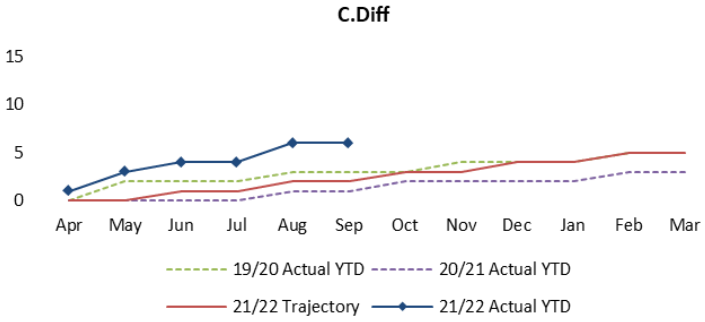
19/20 Actual YTD
20/21 Actual YTD
21/22 Actual YTD


C.Diff
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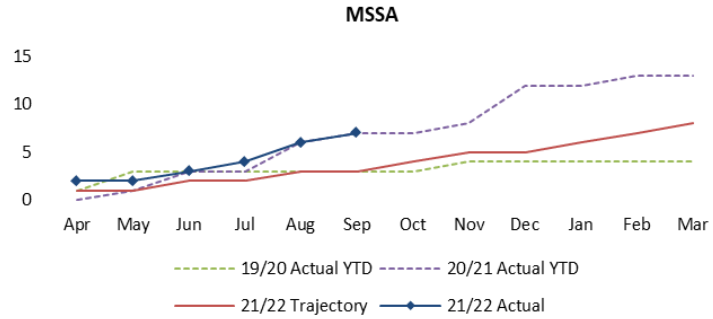
19/20 Actual YTD
20/21 Actual YTD
21/22 Trajectory
21/22 Actual YTD



The senior nursing team are in the process of trialling perfect ward; this is an electronic solution to nursing audits in order to undertake additional quality audits/reviews of activities and environments at a local level. This local drive to incrementally improve care will support significant changes in patient quality outcomes and experience.

Red Flags

In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

- An unplanned omission in providing medications
- A delay in providing pain relief
- An incidence where vital signs have not been assessed or recorded
- Missed intentional (3Cs)
- A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
- Less than two Registered Nurses or Midwives available on a shift.

Red flags for inpatient services are reported by clinical staff via the datix system.

Red Flags April 2021-October 2021Red Flags	**Totals**
	TWC
An unplanned omission in providing medications	0
A delay in providing pain relief	1 in sept Dott ward
An incidence where vital signs have not been assessed or recorded	0
Missed 3Cs	1 in sept cairns ward
A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift	0
Less than two Registered Nurses or Midwives available on a shift.	0

Both red flags were investigated by the Divisional Nurse Director with an outcome of no harm to the patients.

f) Staffing data & Training and Education

- Appraisal, retention, vacancy, sickness, maternity leave
- Mandatory training, clinical training

The Trust currently has 26 RNs and 2 healthcare assistants on maternity leave. In order to mitigate this, the Trust recruits 1wte for every 2 nurses who are on maternity leave. In addition, bank staff are sought if there are insufficient nurses recruited / acuity is high.

	Statutory training			Mandatory training			PDR		
	July 21	Aug 21	Sept 21	July 21	Aug 21	Sept 21	July 21	Aug 21	Sept 21
Corporate	94%	92%	94%	90%	88%	90%	83%	81%	79%
Neurology	94%	94%	94%	93%	93%	91%	83%	83%	80%
Surgery	91%	90%	91%	87%	87%	86%	76%	71%	70%

Table 6: Percentage of staff completed training and PDR

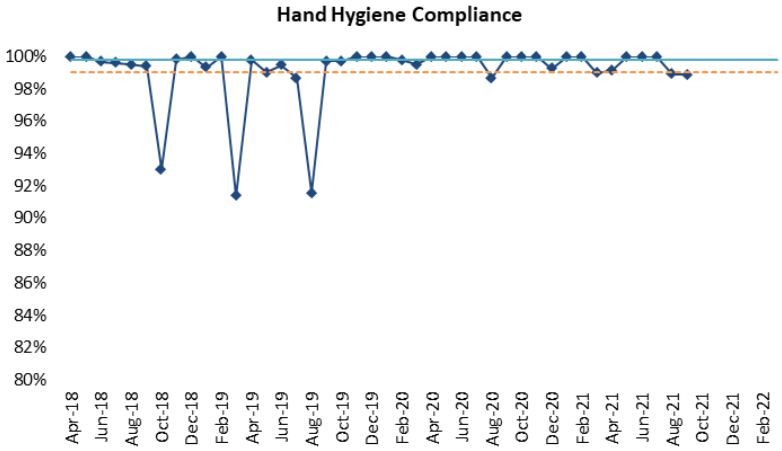
- **Triangulation of Quality metrics and staff and patient reported outcomes**

  Evidence contained demonstrates that there has been an overall deterioration across infection prevention and control. Clearly it is a challenge to isolate this to a specific cause and the covid-19 pandemic obviously remains an over-riding factor. The Nursing leadership team has held IPC awareness sessions in September 2021 to share lessons learnt and a detailed action place is in place for CPE, C diff and MSSA. All HCAI infections are in the process of review also and lessons learnt will be shared.

g) Process measures

- Hand hygiene, documentation standards

A process is now in place to monitor hand hygiene submissions on a weekly basis. The IPC team provide the Deputy Chief Nurse and Divisional Nurse Directors with areas submission data, any shortfalls are escalated and assurance provided this is completed.



h) Comparison with peers

Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

Usually the report would cover benchmark with other trusts to provide assurance however no benchmarking exercise has been undertaken since COVID 19 and due to the redesigned ward pathways during the pandemic the numbers would not reflect the current ratios and the way we are working to ensure patients are allocated safely. The next paper provided to the board will include a benchmark with peers.

Expectation 2 – Right Skills

The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended;

- Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may take into account presence of additional roles
- Training – all members of the clinical team must be appropriately trained to be effective in their role
- Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows;

  "Ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."

  As noted earlier in the report, all ward managers at The Walton Centre are supernumerary but at times do work clinically when the ward is at reduced establishments.

  Recruitment and retention – strategies should be in place

International Nurse Recruitment

With the national challenges in nurse staffing, the Trust have joined the Cheshire and Merseyside collaborative to participate in International Recruitment. A business case was developed and approved by the executive team for 40 international nurses and a fixed term post for a band 6 pastoral care nurse to support the international nurses.

The Walton Centre has recruited 39 / 40 nurses with final interview date 26/10/21 for last candidate. 12 of the nurses have commenced in the Trust across wards, ITU and Jefferson day ward. 9 of these nurses are awaiting their pin number from the Nursing & Midwifery Council (NMC) which may take up to 10 weeks to arrive. The other 3 nurses are taking resit exams on 28th October.

All other nurses are due to arrive in the trust from November through to February and should be fully trained and practicing on their areas no later than February 2022.

Age Profile of staff

Age Band	Headcount	WTE
21-25	25	25.00
26-30	68	65.73
31-35	65	60.48
36-40	43	40.01
41-45	51	48.94
46-50	41	38.30
51-55	43	39.85
56-60	44	33.33
61-65	16	11.05
66-70	3	1.88
Grand Total	**399**	**364.58**

Table 5: current age profile of nursing staff

It is clear from the data above that work needs to continue to support recruitment and retention at The Walton Centre, as the Trust has 106 nurses above the age of 50. The Walton Centre should continue to engage with the international recruitment process as funding allows and continue with the work to recruit nurse's externally ensuring engagement continues with student nurses also to support recruitment.

Expectation 3 – Right place, right time

The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise.

Recommendations to support this include;

- Productive working (LEAN, Productive ward)
- E-rostering

- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

During the ongoing clinical challenges and changes in direct response to the covid-19 pandemic, the current bed base pathways at The Walton Centre has developed inconsistencies in nurse staffing levels and also has been subject to various alterations in specialty location as a response to covid requirements.

Right place, right time

The Walton Centre is in the process of launching a SMART E-Rostering system to support the inpatient nursing workforce. E-Rostering enables organisations to provide further assurance on their effective use of resources by targeting key performance indicators (KPIs) for roster publications, annual leave, sickness levels, study requests, changes to rosters after sign off and if rosters are signed off on time. E-Rostering KPI reports have been compiled and cascaded across the areas that are currently utilising e roster.

Safe care is in the implementation phase, this will provide daily data regarding acuity and dependency on each area to support decision making when risk assessing to move nurses from other areas to support safe staffing.

Temporary staffing

Overall bank spend has not significantly increased due to Covid-19 during this current time period, however, assurance around booking and deployment has been detected as lacking reliability and additional measures need to be considered. Historically ITU and Theatres have not utilised NHSP, this culture has now progressed and both areas are engaged with the use of NHSP staff. All outstanding shifts for ITU are requested until january 2022 in order to try and pro actively increase the fill rate for this area. Other organisations are reviewing their NHSP rates and introducing incentives which is making it difficult to improve fill rates therfore the divisions have requested block bookings from agencies to support shortfall until the vacancy gaps of these areas improve.

Graphs can be found in Appendix Three for our RN and HCA hours required for September 2021.

Enhanced care rates (Specialling)

Inpatients that require enhanced care through direct 1:1, bay tagging or cohorting are managed at ward level and any additional staff required to support is requested via NHSP.

This is requested as a HCA on NHSP therefore data isn't currently available to provide detail regarding the number of 1:1 shifts requested via NHSP. The Deputy Chief Nurse is currently working with NHSP to separate this from establishment requests in order to see the level of 1:1 shifts requested.

CRU does have cameras that support the management of patient safety and reduces the numbers of 1:1s required across the unit; however staff have also been identified to monitor the screens and coordinate where care is required.

Vacancies

The table below displays the current Registered Nurse vacancies

Row Labels	Budgeted WTE	M6 Actual WTE	Vacancies/Over Establishment
Cairns Ward	21.94	17.59	4.35
Caton Ward	21.44	15.71	5.73
Chavasse Ward	26.66	20.24	6.42
Complex Rehab Unit	24.53	19.15	5.38
Dott Ward	20.53	15.79	4.74
Horsley Ward	106.08	96.38	9.7
Lipton Ward	15.83	16.88	+1.05
Outpatients Department	4.48	4	0.48
Sherrington Ward	21.24	21.24	0
Theatres	67.55	65.16	2.39
Grand Total	**330.28**	**270.9**	**59.38**

Table 6:Current RN vacancies not including staff in pipeline

Row Labels	Sum of Budget WTE	Sum of Actual WTE	Vacancies/Over Establishment
Cairns Ward	18.75	24.59	-5.84
Caton Ward	17.75	26.24	-8.49
Chavasse Ward	31.29	35.62	-4.33
Complex Rehab Unit	32.68	36.79	-4.11
Dott Ward	18.05	25.77	-7.72
Horsley Ward	16.44	17.41	-0.97
Lipton Ward	15.41	15.66	-0.25
Nursing Pool	8.51	2.56	5.95
Outpatients Department	16.67	16.42	0.25
Sherrington Ward	19.66		19.66
Theatres	21.03	19.69	1.34
Grand Total	**216.24**	**220.75**	**-4.51**

Table 7: Current HCA establishment, the Trust is currently over recruited for HCAs

There are also currently 8.76 nurse associates in RN Budget and 2 trainee nurse associates in place.

Sickness

Staff sickness plays a huge role in shortfalls on the majority of wards and results in temporary shifts being requested or staff redeployment occurring to maintain safety. This has a cumulative effect on the redeploying ward as pressures to maintain patient safety is increased. Sickness is managed by the Ward Manager, with Divisional Nurse Director support, Human Resources monitoring and when required, input from Occupational Health. Sickness is managed actively, fairly and consistently balancing the needs of staff with the efficient running of a safe, clean and personal service. The trust does have a ward closed for pipework which is supporting safe staffing of other areas following temporary staff redeployment. The target for sickness is 5%.

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Absence FTE %	11.30%	8.87%	6.25%	8.04%	8.13%	8.15%	9.96%	10.15%	9.50%

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
160 Cairns Ward (1602100)	7.46%	5.75%	7.68%	7.18%	6.97%	11.94%	14.15%
160 Caton Ward (1602130)	13.80%	4.20%	1.88%	3.67%	5.35%	9.02%	9.79%
160 Dott Ward (1602110)	6.74%	7.20%	10.57%	9.09%	4.25%	4.72%	9.59%
160 Horsley Ward (1602000)	7.11%	5.92%	8.28%	9.06%	9.63%	12.01%	8.58%
160 Jefferson Ward (1602090)	15.27%	8.52%	7.58%	3.98%	6.80%	1.32%	0.00%
160 Sherrington Ward (1602120)	12.08%	9.56%	26.15%	24.33%	29.03%	19.67%	0.00%

Retention

NHS Improvement (2019) advises the retention of staff is a key issue for the NHS and it is critical that organisations focus on securing skilled and sustainable workforce for the future. In addressing the challenges of workforce supply, organisations must focus not only on recruitment but also should ensure new and existing staff are supported and encouraged to remain in the NHS. All staff is encouraged to undertake exit interviews to aid managers in identifying themes and learning related to why staff are leaving. Current themes from exit interviews are staff are leaving for promotion, the trust has lost a number of nurses to the community setting also. People group meetings are now set up and this is one aspect of work the group will be focusing on.

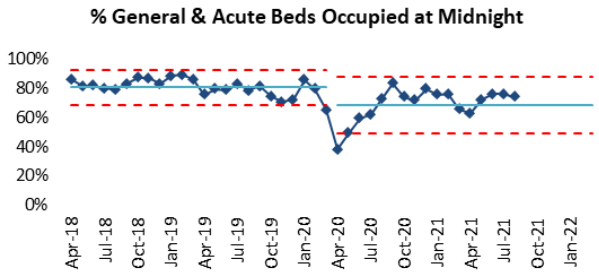
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Turnover Rate (FTE)	1.00%	0.60%	0.73%	0.00%	1.98%	1.70%	2.30%	0.92%	2.86%

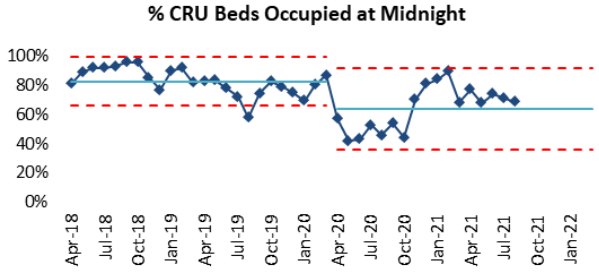
Further work is required to promote and ensure staff participates in exit interviews so their views can be captured and considered. The Trust has recruited our own practice education facilitator primarily to support and co-ordinate pre-registration students however they can further support the transition from student nurse to registered nurse and ensure staff are prepared and well equipped. The senior nursing team has requested to be made aware of any nurses planning to leave so a conversation can be held to determine if any actions can be taken to retain the nurse.

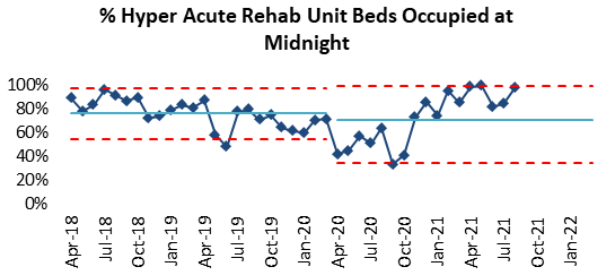
Occupancy

The below chart and graphs show the occupancy levels for all inpatient areas, ITU and the rehabilitation wards. To support renewal of heating and pipework the Trust has had a ward closed since January 2021.

Month	General & Acute beds	ITU	CRU	Lipton
Apr-21	62.59%	58.50%	77.11%	98.89%
May-21	72.22%	56.94%	67.85%	99.64%
Jun-21	75.77%	54.33%	73.89%	82.22%
Jul-21	75.95%	61.45%	71.08%	84.59%
Aug-21	73.99%	60.80%	68.49%	97.85%







Theatres

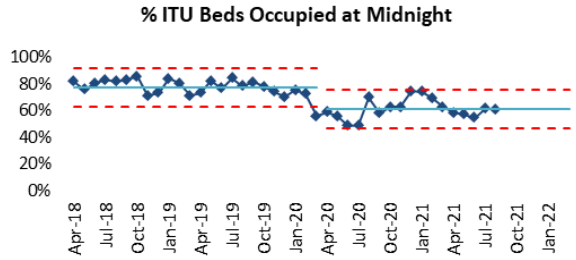
Theatre utilisation continues to increase in line with NHSE covid guidance; we have started to increase normal theatre activity. We agreed that staff would don and doff PPE when moving from dirty to clean areas instead, reinforcing the importance of hand washing and gelling of hands. The exception to this was confirmed COVID 19 positive patients would still use clean and dirty runners.

Several adjustments were required to ensure activity recommenced, different routes were taken for patients with COVID 19 or suspected infection with designated green and amber forward wait areas and recovery areas. Red patients were recovered post operatively in the theatre instead of recovery as they were in the highest risk category.

Theatres have seen an unprecedented demand on staffing due to high levels of sickness across the nursing and ODP staffing, short and long term with some relating to serious illness. Block booking of agency staff have been requested and have recruited x2 ODPs to date. Daily meetings have been put in place across the division to review daily activity versus nurse staffing and staff utilised from other areas and the SMART team to support ITU and theatres.

ITU

ITU continues at times to provide mutual aid to other organisations when staffing allows. ITU is experiencing sickness (short and long term), maternity leave and vacancies. All shifts are out to NHSP and a request has been sent to agency for block bookings to support this. Occupancy levels remain low.



Radiology

Against a continuing backdrop of a national shortage of Consultant Radiologists and Radiographers, WCFT currently have no Consultant Radiologist vacancies, following the appointment of 2 Clinical fellows to Consultant posts in 2020. The ability for staff to report from home has increased reporting volumes and has removed the requirement for reporting waiting list initiatives. There is an increased pressure on reporting with the extension of the Thrombectomy service to 24/ 7. The impact of this will be identified at 2021 job planning.

The Radiographer staffing group, remains relatively stable, but has been under pressure throughout 2021 due to members of the team on Maternity leave and 1 member of the team on a long term career break. Recruitment to vacant posts has so far been successful, although non Neuro trained radiographers take approximately 18 months to train fully in the department. All members of the Radiographic team have had HCPC registration confirmed until 2022.

The department continues to place a high level of importance on the investment of training, together with in house professional development. A further two radiographers are undertaking post graduate courses in CT and MRI advanced Imaging. Deputy Radiology Manager is undertaking a Master's programme in Management, as part of the Trust apprenticeship scheme. Radiology Digital Systems Manager is undertaking a post graduate module in project management to support developments in Radiological information system and Picture archiving and communication system.

In addition, the Department has Advanced Practice Radiographers in Fluoroscopy and Doppler imaging, to support different ways of working.

There has also been an appointment to 1 x Apprenticeship trainee Assistant Practitioner and one further post will be offered in March 2022. There was agreement for 2 in plan, but unfortunately one had to drop out at beginning of course, so the department are 1 short of the plan. The aim is to train the two AP's to undertake screening in theatre, releasing 2 x band 6 posts in the future.

Therapies

The Walton Centre Therapies service consists of 5 AHP disciplines hold valid HCPC registration: Occupational Therapy, Physiotherapy, Speech & Language therapy, Dietetics and Orthoptists. Together these teams provide specialist therapy intervention to acute wards, ITU, rehabilitation units CRU & Lipton Hyper acute, community rehab , out patients, Pain management ,Trauma and Spinal services.

Throughout the pandemic the Therapies service has responded to changing clinical needs with all staff participating in redeployment of roles and working in new ways to support the Trust by providing mutual aid. Therapies worked with LUFT to transfer the Acute stroke service in house and utilised specialist neuro therapy skills to ensure the best care possible for stroke patients. During the first wave of the pandemic all therapies staff worked together to support nursing teams in all areas. Face to face outpatient care was paused during the first lockdown. However, the teams worked quickly and innovatively to restore patient care via telephone and video contact. All therapy teams have successfully adapted to agile working practices where possible and are actively supporting the Trust in resuming inpatient and outpatient services.
The biggest challenge in the past year has been in continuing to provide safe and effective patient care during periods of higher than normal staff absence related to Covid 19 and staff self-isolating a home. However all staff where possible have adapted well to agile working such as supporting administration teams from home. The support of Walton IT team has been key to this in working efficiently to provide equipment and remote access for staff.

The Therapies staffing across the board remains relatively stable, but has been under significant pressure throughout 2020 / 21 due to higher levels of Maternity leave with senior staff. Back fill with internal secondment's plus external appointments has resulted in a 25 % of therapies staffing on fixed term contracts and significant cost pressures.
Recruitment to vacant posts has mostly been successful, although there remains a national shortage of Speech and language therapists.

Undergraduate education:

All registered therapy staff are accredited to provide pre-registration clinical education placements across the Centre. During 2021 the service has joined forces with NW HEE to support the Cheshire & Merseyside strategy for AHP education. In 2020 all undergraduate student placements where curtailed and AHPs resulting in a significantly higher demand for clinical placements. This comes at a time when all AHP undergrad programs have been expanded as part of the future workforce plan. This has required all providers to create innovative approaches to education and Therapies have started delivering new hybrid models of education such as distance learning / virtual clinical placement and 1: 3 student placements. All therapists' continue to be actively involved in providing internal and external training and education .CPD remains an essential component of good quality care and this has been enhanced during 2020 to ensure all staff are able to maintain skills and HCPC registration.

The main body of the service remains at a consistent level and continues to attract skilled staff from across the country. Notably the Principal Dietitian has recently been appointed Head of School for Nutrition and Dietetics at Wrexham University and will continue to work at Walton on a clinical trial. Succession planning is a constant theme within a specialist Trust and leadership opportunities beyond band 6 and 7 for AHPs continues to be limited.

Two physiotherapists have transferred in to Advanced Clinical practice roles within Critical care and the first physiotherapy apprenticeship is underway and one occupational therapy assistant is being supported to complete the part time degree pathway in Occupational therapy. The service has committed to supporting a minimum of two apprenticeships per year from 2021.

Neurophysiology

Clinical Physiologist and Consultant Neurophysiologist staffing has been stable during 2021, in comparison to the previous year where, due to pressures from maternity leave, Clinical Physiologist staffing was a challenge. Following a skill mix review, the service is in the now process of recruiting across the Band 6/7 level to provide support across video telemetry and theatre monitoring. Both degree apprentices graduated with first class honours and both were

recruited into the team in September 2021, a fabulous example of return on investment! Two further degree apprentices have just started their three year training programme and it was encouraging to be inundated with high caliber applicants.

The service continues to have an excellent national reputation for training Clinical Physiologists and actively supports undergraduate, post-graduate and doctorate training programmes, both in terms of academic teaching, exam marking and work based assessments. In addition, two Specialist Registrars have been training alongside the Consultant Neurophysiologists. The service continues to embrace extended roles for Band 7 Clinical Physiologists in terms of independent approval of clinical reports.

All Clinical Physiologists are on the voluntary Registration Council for Clinical Physiologists (RCCP).

The EEG video telemetry service recommenced as part of the Trust's recovery and restoration plans, though the focus to undertake as many tests in the home setting (where clinically appropriate) will continue as we are now utilising technology that allows high quality video recordings without the need for hospital admission. However, as part for of the epilepsy surgery programme there will still remain a cohort of patients for whom hospital admission is essential.

8. Conclusion & Recommendations

The attached review demonstrates a) current compliance against NQB b) current triangulation of a spectrum of outcomes that are evidenced to be directly linked to presence and absence of, registered nurse and health care assistant staffing levels.

It continues to be a challenging period for all staff. There has been one concern raised to CQC from Chavasse ward, following the concern raised the Chief Nurse, Deputy Chief Nurse and the Divisional Nurse Director met with staff on the ward to discuss concerns and actions taken to address. The chief nurse has worked a night shift to spend time with staff and the divisional nurse director has continued to meet with staff on a regular basis. There have been no further concerns raised. There are high levels of flexibility and adaptability has been seen during this period. Due to the ward changes staffing and patient acuity requirements have been reviewed by the Trust's senior nursing team, on a daily basis Trust wide staffing and acuity is considered to ensure all patients can be cared for safely. All shifts have been reported as safe.

Trust Board is asked to:

- Receive assurance that staffing across all areas is considered safe
- Receive the next 6-monthly staffing report in May 2022, unless further changes require reporting.

Appendix One

Clinical Areas
Pre covid all wards had a specific specialty as described below; the senior management teams are currently working with the infection prevention and control team to aim to get back to this position as soon as possible. Currently the Trust is still operating via Red, amber and green pathways.

Cairns: is a 26 bedded acute Neurosurgical ward that predominantly accommodates neuro-oncology patients and patients that have hydrocephalus. The ward is split in to 4 bays and 3 side rooms.
Due to the nature of the sub specialities on this ward a lot of staff time is spent with patients and families who have received life altering news offering advice and support. Some patients suffer cognition issues due to their condition. This ward is currently operating as a green pathway ward.

Caton: is a 25 bedded acute Neurosurgical ward that predominantly accommodates patient that has had routine spinal surgery and those that have suffered spinal trauma. The ward is split in to 4 bays and 3 side rooms.
The sub speciality of the ward means that the patient flow is faster than it may be on other ward areas. On occasions a patient that is admitted with spinal fractures sometimes requires additional staff and equipment to maintain their safety and prevent further damage. This ward is currently closed.

Dott Ward: is a 27 bedded acute Neurosurgical ward that predominantly accommodates patients that have suffered trauma through vascular event i.e. Subarachnoid haemorrhage. The ward is split in to 4 bays and 4 side rooms.
Due to the nature of the sub speciality on the ward some patients suffer cognition issues meaning that these patients can require additional staff supervision and or be violent and aggressive. This cohort of patients is more likely to have spent periods of time in critical care and can have tracheostomies requiring additional observations and input from SMART. This ward is currently operating as a green pathway ward.

Sherrington Ward: is a 25 bedded acute Neurosurgical ward that predominantly accommodates patient that have suffered cranial trauma from head injury and patients that are having routine spinal surgery.
Due to the nature of cranial trauma some patients may suffer cognition issues meaning that these patients can require additional staff supervision and or be violent and aggressive. These cohorts of patients are more likely to have spent periods of time in critical care and can have a tracheostomies requiring additional observations and input from SMART. Having the routine spinal patients also means a quicker patient flow for this ward. In light of the variable number of patients that suffer cranial trauma, Sherrington ward is more likely than the other areas to have a mixture of the other sub speciality patients which again can mean varying levels of patient acuity and dependency. This ward is currently operating as an Amber pathway ward.

Chavasse Ward: - This is a 29 bedded acute Neurology, Pain and long term conditions ward. It also has 4 dedicated Video-telemetry beds which are used for diagnostic and pre surgery purposes. It is made up of 4 bays (each comprising of 4 beds), and 13 individual rooms each with their own en-suite toilet and shower. There is also an assisted bath on the ward. This ward is currently operating as an Amber pathway ward.

Chavasse ward also has a Day room for patients and due to its 'horse track' layout, a central outside courtyard which patients can access.

Complex Rehabilitation Unit (CRU):- This is a 30 bedded Unit commissioned by the Cheshire and Merseyside Rehabilitation Network (CMRN). It comprises of 20 Level 1 and 10 Level 2 complex rehabilitation beds all based in individual en-suite rooms. There is also an independent living flat inside the department for patients aiming towards discharge.

Due to its size and layout the Unit is spilt into two sides (green and purple) each accommodating 15 beds. There is a communal sitting and dining area which aims to help the social and psychological aspect of a patient's rehabilitation. There is also a private outside area for patients and relatives to use to socialise but in addition it can be used by therapists to assess patients. There is a dedicated therapies gym and smaller activity rooms to be used for smaller group/ individual work such as the kitchen.

Lipton Ward: - This is a 10 bedded Hyper-Acute Rehabilitation unit commissioned by the CMRN. These patients are extremely dependent, many needing tracheostomy tubes to protect their airway when they first arrive, having suffered severe trauma. There are 2 bays (1 being 4 bedded and the other 3) and 3 individual rooms with en-suite shower. The ward also has an assisted bath for those patients who are more stable. There is also a gym adjacent to the ward for patients to access with the therapists.

Outpatients Department (OPD):- This department is split over the 2 sites, main OPD has 22 clinic rooms, with a further 11 clinic rooms based in Sid Watkins Building offering a 6 day per week service.

Theatres: - Theatres have the capacity to run 8 fully functioning operating lists covering multiple surgical specialties, these range from Vascular, Oncology, Spinal, Functional, Trauma and Pain. The Trust earlier in 2017 expanded the theatre environment from the provision of 6 operating theatres to 8 and has the facility to provide Intraoperative MRI's during surgical intervention.

Jefferson Ward: - Jefferson ward is located next to the Theatre complex to allow for patients to be transferred for their surgery in a seamless manner. The team work alongside the Theatre surgical and recovery teams to ensure patient safety and experience is maximised. Patient care is supported in this area by Advanced Practitioners who provide hands on care and education to patients and staff alike.

Appendix Two

Total Patient Falls

	18/19	19/20	20/21	21/22	Total
Cairns	37	24	36	22	**119**
Caton	34	24	29	6	**93**
Chavasse	45	36	39	16	**136**
CRU	45	32	25	18	**120**
Dott	29	31	42	12	**114**
Horsley	2	4	3	2	**11**
Lipton	11	2	8	4	**25**
Sherrington	42	64	8	21	**135**
Total	**245**	**217**	**190**	**101**	

Total Moderate & Above Harm Inpatient Falls

	18/19	19/20	20/21	21/22	Total
Cairns	3	0	0	1	**4**
Caton	0	0	0	0	**0**
Chavasse	0	0	0	0	**0**
CRU	0	0	0	0	**0**
Dott	1	0	0	0	**1**
Horsley	0	0	0	0	**0**
Lipton	0	0	0	0	**0**
Sherrington	1	0	0	0	**1**
Total	**5**	**0**	**0**	**1**	**6**

Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable) 2021/22

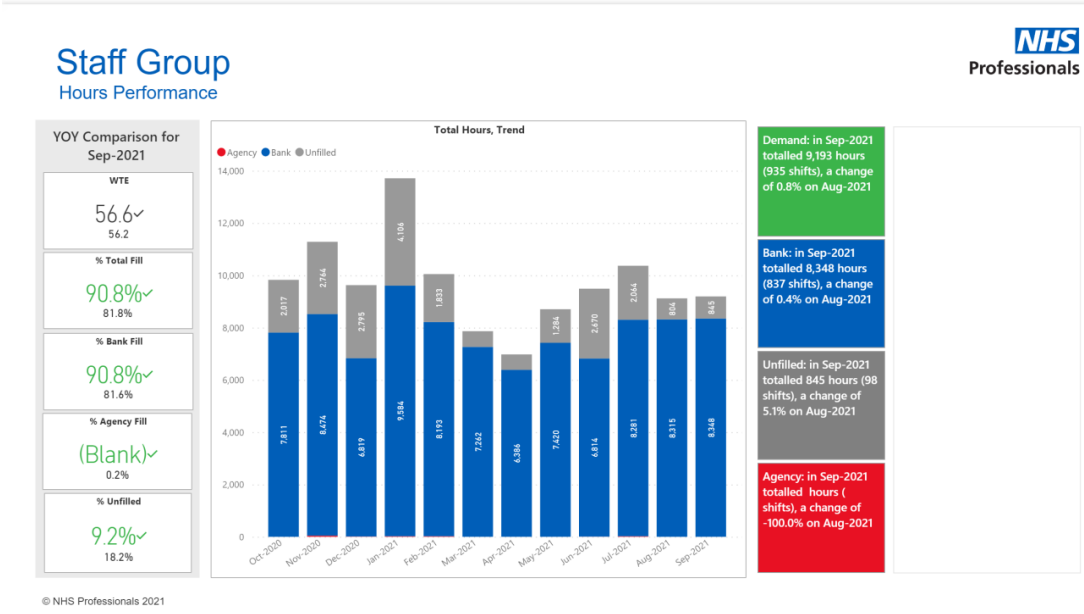
	Category 2	Category 3	Category 4	Unstageable	Total
Cairns					**0**
Caton					**0**
Chavasse					**0**
CRU					**0**
Dott	1				**1**
Horsley					**0**
Lipton	2				**2**
Sherrington					**0**

Total Healthcare Acquired Infections 2021/22

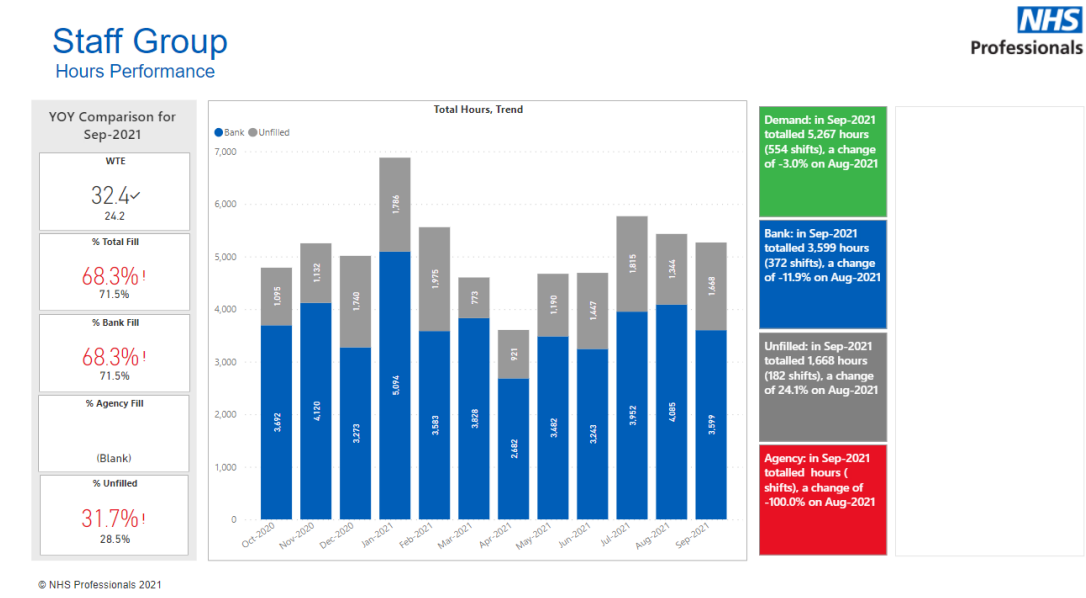
	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		4		2				**6**
Caton								**0**
Chavasse				1			1	**2**
CRU								**0**
Dott				1			1	**2**
Horsley			5	3	3		5	**16**
Lipton								**0**
Sherrington		7	1					**8**
Total	**0**	**11**	**6**	**7**	**3**	**0**	**7**	**34**

Appendix Three

HCAs



RNs



Unfilled shifts highlighted in grey are due to lack of NHSP cover and the senior nursing team do cancel requests on a daily basis following review when areas have empty beds and patients no longer requiring 1:1 supervision.

REPORT TO THE TRUST BOARD
Date: 4th November 2021

Title	**Governance Annual (Quarter 2) Report 2021/22**
Sponsoring Director	**Name:** Lisa Salter **Title:** Chief Nurse
Author (s)	**Name:** Lisa Gurrell **Title:** Head of Patient Experience **Name:** Kate Bailey **Title:** Clinical Governance Lead
Previously considered by:	• Quality Committee

Executive Summary:
The purpose of the report is to:

1. Provide a Quarterly summary of Governance activity across the Trust for Quarter 2 2021/22, comparing results of data with the previous financial Quarter (Quarter 1 2021/22).

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

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

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

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

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Governance, Risk and Patient Experience

Quarter 2 Report

(July – September 2021)

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

1. Introduction

This Quarter 2 report (July – September 2021) provides an overview of activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health & safety.

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

1.1. <u>The purpose of this report is to provide:</u>

- a summary of governance activity in Q2 (2021/22) compared to Q1 (2021/22)
- assurances that actions are in place to mitigate identified risks, in order to reduce harm and ensure that learning is embedded
- assurance to the Trust Board that issues are being identified, escalated and managed effectively

2. Executive Summary

2.1. Throughout Q2, the Risk Team has:

- continued to support with the management of violent and aggressive (V&A) patients:
- supporting staff to ensure that timely interventions are put in place to reduce harm to staff and patients from V&A
- developed the violence, prevention and reduction strategy, in line with the new national standards
- re-established the violence and aggression working group
- continued to deliver additional mandatory training (including evening sessions)
- continued to deliver additional Datix risk and incident training
- provided support to the Divisional Management teams with the review, management and closure of outstanding incidents
- provided support to the Fundraising department to devise a bespoke risk register to manage identified risks associated with charitable funds

2.2. Throughout Q2, the Patient Experience Team has:

- continued to listen to, proactively act on and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided support to families unable to visit their loved-ones as visiting remains restricted and support for the families of the bereaved
- induct, support and safely reintroduce volunteers on site
- continually strive to improve the complaints management process in line with Trust key performance indicators and targets
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge

3. Governance Assurance Framework (GAF)

One new theme has been added to the GAF following review of Q2 statistics:

- Ref 312 – Carbapenemase-Producing Enterobacteriaceae *(added 21st September 2021)*

Two themes have been requested for closure following review of Q2 statistics:

- Ref 286 – Appointment cancellations /delays *(closed 21s September 2021)*
- Ref 301 - Fire Safety Compliance (*Closed 21st September 2021)*

4. Incident Management

4.1. Serious Incidents (SI):

1 serious incident was reported in Q2 compared with 1 in Q1.

4.2. Moderate (& above) incidents:

35 moderate harm (& above) incidents reported in Q2 compared 14 in Q1.

4.3. Duty of Candour:

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

4.4. Incident theme by category:

4.4.1 Infection control Incidents:

- 60 incidents were reported in Q2 compared with 29 in Q1

4.4.2 Communication incidents (GAF entry 304):

- 90 incidents were reported in Q2 compared with 91 in Q1

4.4.3 Information Governance incidents:

- 29 incidents were reported in Q2 compared with 15 in Q1

4.4.4 Medication incidents:

- 56 incidents were reported in Q2 compared with 80 in Q1

4.4.5 Safeguarding incidents and concerns:

- 64 incidents were reported in Q2 compared with 43 in Q1

4.4.6 RIDDOR:

No incidents reportable via RIDDOR in Q2 compared with 6 in Q1.

4.4.7 Violence & Aggression:

- 58 incidents were reported in Q2 compared with 108 in Q1

5. Risks

During Q2 the Trust wide risk register received scrutiny at Quality Committee and Business & Performance Committee.

A review of the Covid 19, Corporate and Neurology risk registers was completed by the Executive Team in Q2.

The rotational review of risk registers divisionally continued via the divisional risk register work plan during Q2.

A bespoke fundraising risk register was devised to support the management of identified charitable funds risks. This will be monitored and managed via the appropriate risk management process dependent upon risk rating and via the charitable funds meeting.

6. Complaints & Concerns

- 100% of formal complaints received in Q2 were acknowledged within 3 working days and responded to within the negotiated timeframe meeting the Trust's KPIs
- 16 new complaints were received in Q2 compared to 16 in Q1 of 2021/22
- 15 complaints closed in Q2; 1 upheld, 7 partially upheld and 6 not upheld
- In Q2, the overall average response time was 27 working days for formal complaint responses. This is higher than the average response time for Q1 which was 20 working days; however, there were 3 complaints in Q2 escalated to Level 2 in comparison with 1 in Q1. We aim to respond within 25 working days for Level 1 complaints and 45 working days for Level 2 complaints in line with our Trust KPIs (our average for Level 1 complaint responses was 23 working days and for Level 2 complaint responses was 44 working days)
- By Division, the average response time for Neurology was 26 working days for Q2 (including 1 Level 2 complaint) in comparison to 18 working days in Q1. Neurosurgery average response time was 28 working days for Q2 (including 2 Level 2 complaints) in comparison to 31 working days in Q1. This has been highlighted to the Divisional Operational Team during the weekly meetings in an aim to improve upon these response times
- The number of concerns remained static from Q1 to Q2 with 159 received in Q1 and 161 received in Q2
- 81 enquiries were received in Q2, in comparison to 65 received in Q1; themes relate to the referral process and general hospital enquiries

- Communication remains the highest theme in Q2 and remains a theme on the GAF (entry 304), this is followed by appointment arrangements and numbers remain higher than previous quarters

6.1. <u>Compliments:</u>

- 47 compliments were reported in Q2 compared with 42 in Q1

6.2. <u>Patient Experience:</u>

- **Outpatients** - 87% **of patients were Extremely Likely/Likely** to recommend based on a total of 474 responses (2.7% response rate)
- **Inpatients** – **98% of patients are Extremely Likely/Likely** to recommend based on a 36% response rate compared to the number of discharges (1,902) in Q2

7. Claims

There was 1 new claim reported in Q2 compared with 4 in Q1. No claims were reopened.

8. Recommendation

Quality Committee is asked to receive and note this report.

9. Governance Assurance Framework (GAF) Log – Q2 2021/22

9.1. Items for closure:

Theme	Context	Analysis	Action	Recommendation
Ref 286 – Appointment cancellations /delays *(closed 21st September 2021)*	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in Do Not Attends (DNAs), complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Patient Access and Performance Director.	There has been an increase in concerns received in 2020/21, regarding appointment arrangements. Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments. Review of call recordings since being provided access has enabled managers to provide timely feedback to staff. It has also allowed us to distinguish between genuinely abusive calls and patients who express frustration due to ineffective communication of the process from staff.	1. MITEL IT/telephony in-depth management training planned for 30/03/21 (complete). 2. The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. However, Covid-19 recovery and restoration plans are being devised and been submitted. 3. Recruitment of 2 additional Band 2 permanent staff members has taken place as opposed to continuous use of Admin Bank and overtime (complete). 4. Continuous review of patient concerns and complaints. 24 concerns were due to patients unable to get through to PAC 01/03/20 - 16/03/2021 compared to 51 from 01/03/19 - 28/02/20, this will continue to be monitored. 5. 28/6/21 the introduction of Synertec became live since end of May. Some teething problems with some letters not being processed. Currently working with Synertec and IT	**Recommendation:** It is recommended that this entry be closed following improvements in patient and staff experience. Close with approval from Quality Committee

Theme	Context	Analysis	Action	Recommendation
Ref 301 Fire Safety Compliance ***(Closed 21st September 2021)***	Following the Outpatient Department fire in 2018, and Merseyside Fire Service investigation and inspection of the Trust, legislative breaches were identified. **Lead:** Estates Manager (BPC).	1. The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. 2. These gaps were as a result of the original building works not being inspected and signed off as being compliant. 3. The registered fire compartmentation contractor has now completed the works.	1. Undertake a validation audit of completed works to establish efficacy of contractual works. (Complete). 2. The minor works identified by the survey to be repaired by the contractor (End of July 2021). 3. Continue to update the Trust's passive fire register with photographic evidence. 4. Estates to manage staff & contractors (particularly network cable installers) works that affect compartment lines. 5. Head of Risk to provide regular update reports to Executive Team. 6. All works now complete 7. Merseyside Fire and Rescue Service (MFRS) have been notified and asked if they would like to undertake an audit. They have declined, at present, and asked that a copy of any report be shared with them. Report produced by RT shared with MFRS	**Recommendation:** Close This will now become a general contractor management task.

9.2. Items for continued monitoring:

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression (Opened 9th October 2017)	The Trust is part of the Mersey Major Trauma & Critical Care and Cheshire and Merseyside Rehabilitation Network. The Trust now treats more complex and challenging patients. Feedback from incidents, staff and staff surveys highlight a higher risk of injury to staff whilst caring for challenging patients who lack capacity. There are often difficulties and delays experienced whilst trying to discharge or transfer complex patients. **Lead:** LSMS (Health Safety & Security Group).	There were 58 incidents in Q2 compared with 108 in Q1. 1 patient responsible for 6 physical assaults (patient on staff). In the majority of incidents, the patient was deemed medically fit for discharge. These delays in discharge usually result in further incidence of violence or aggression.	1. Develop a Strategy to implement the National Violence & Reduction standards (Q3). 2. Undertake a risk profiling exercise and review of risk control measures (Q3). 3. Review of Trust TNA in regards to personal safety training (Q3). 4. Continue to provide support for staff. 5. Violence & Aggression working group (group to meet bi-monthly). 6. Recommendations and actions from MIAA audit of complex discharges to be implemented.	It is recommended that this remains on the GAF for further monitoring. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 300 Rejection Of Pathology samples by LCL (Opened 2nd October 2018)	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. Lead: Labs Quality & Governance Manager (Neurosurgery)	Rejection data reports now received monthly from LCL. Approximately 60 samples a month rejected across the Trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. OPD and HITU are the highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following a Serious Untoward Incident in LCL.	1. IT to prepare a paper and recommendations for an order communications system based on the vision of the Cheshire and Merseyside network in terms of IT and connectivity. **Lead:** Head of IMT. Timescale: December 2021	Incidents to be monitored through Datix**.** **Recommendation:** Continue to monitor.
Ref 304 – Communication (Opened 19th December 2019)	Communication issues have been identified via a number of sources, including the staff survey (2019/20), incidents, concerns and complaints. Lead: Head of Patient Experience/Divisional Director for Neurology/Neurosurgery.	A slight increase in Quarterly incident statistics can be seen on review of communication incidents, increasing from 75 Q4 to 90 in Q1. Also the theme communication seems to be a recurrent theme amongst Incident investigations. Communication continues to be a theme in incidents/ complaints and concerns.	1. Complaints continue to be monitored via the Board KPI Report and bi-monthly at Executive Team. 2. Divisions continue to closely monitor concerns and complaints via weekly meetings with Patient Experience Team (PET). 3. Continue to log actions/learning from concerns/complaints which are monitored at weekly PET/Divisional meetings.	Continue to monitor this theme via incidents, complaints and concerns. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 310 - Pressure Ulcers 24th March 2021	An increase in the number of incidents reported via Datix of patients developing hospital acquired pressure ulcers (PU). This could potentially lead to moderate/severe patient harm and a poor patient experience. **Lead:** Tissue Viability Specialist Nurse.	1. Between Q1 2020/21 & Q4 2020/21 there has been 7 category 2 pressure ulcers (PU), 1 category 3 PU (evolved from unstageable pressure ulcer), 0 category 4 PU, 3 (4) deep tissue injuries & 2 unstageable PU (x1 then verified as category 3 & x1 evolved from deep tissue injury as per 'watch and wait' guidance). This equates to 15 hospital acquired PU. 2. Lack of TVN in post and oversight of tissue viability in clinical areas until November 2021. 3. TVN post will become vacant in Q2 resulting in lack of TVN and oversight of tissue viability in clinical areas until post filled.	1. 12 month PU training plan for all staff. 2. Establish tissue viability link nurses for each ward/dept. 3. Update immediate post incident PU documentation & ensure 72 hour completion, including pressure ulcer flow sheets. 4. Update wound assessment charts (Ep2). 5. Introduction of SSKIN bundles for all wards. 6. Update Pressure Ulcer Policy to reflect changes. 7. Monitor attendance numbers for PU training. 8. Ensure link nurses attend training sessions to cascade up to date information/training to their team/dept. 9. Identify and monitor themes and trends.	**Recommendation:** Continue to work through all actions and monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 311 Theatre Ventilation System – 05th May 2021	Theatres 1 – 5 do not meet the required level of air changes per minute as required by Health Technical Memorandum (HTM) 2025 guidance. **Lead:** Estates Manager (BPC).	During the annual validations of Theatre ventilation system (1 - 5) it has been identified there are not sufficient air change rates. Recent intervention work has taken place which has provided improvements, but fails to meet HTM standards. The National Infection Rate for Theatres does not indicate a high prevalence of infection which is an indicator of a clean environment. Additionally, it is known that the air cascade, as prescribed in HTM 2025 is correct.	1. A options appraisal paper was presented to divisions for discussion and direction. It was agreed that full replacement of the AHUs is required. 2. Engagement has taken place with design consultant to evaluate preferred options and quoations given to develop the design to tender stage. 3. A further paper was taken to Capital Monitoring Group for approval to proceed with Design Development. This was approved to proceed for furtehr approval at Operational Management Group. 4. A further paper is being developed for Board approval, including further refurbishments to Operating Theatres	**Recommendation:** Continue to monitor and work through all actions.

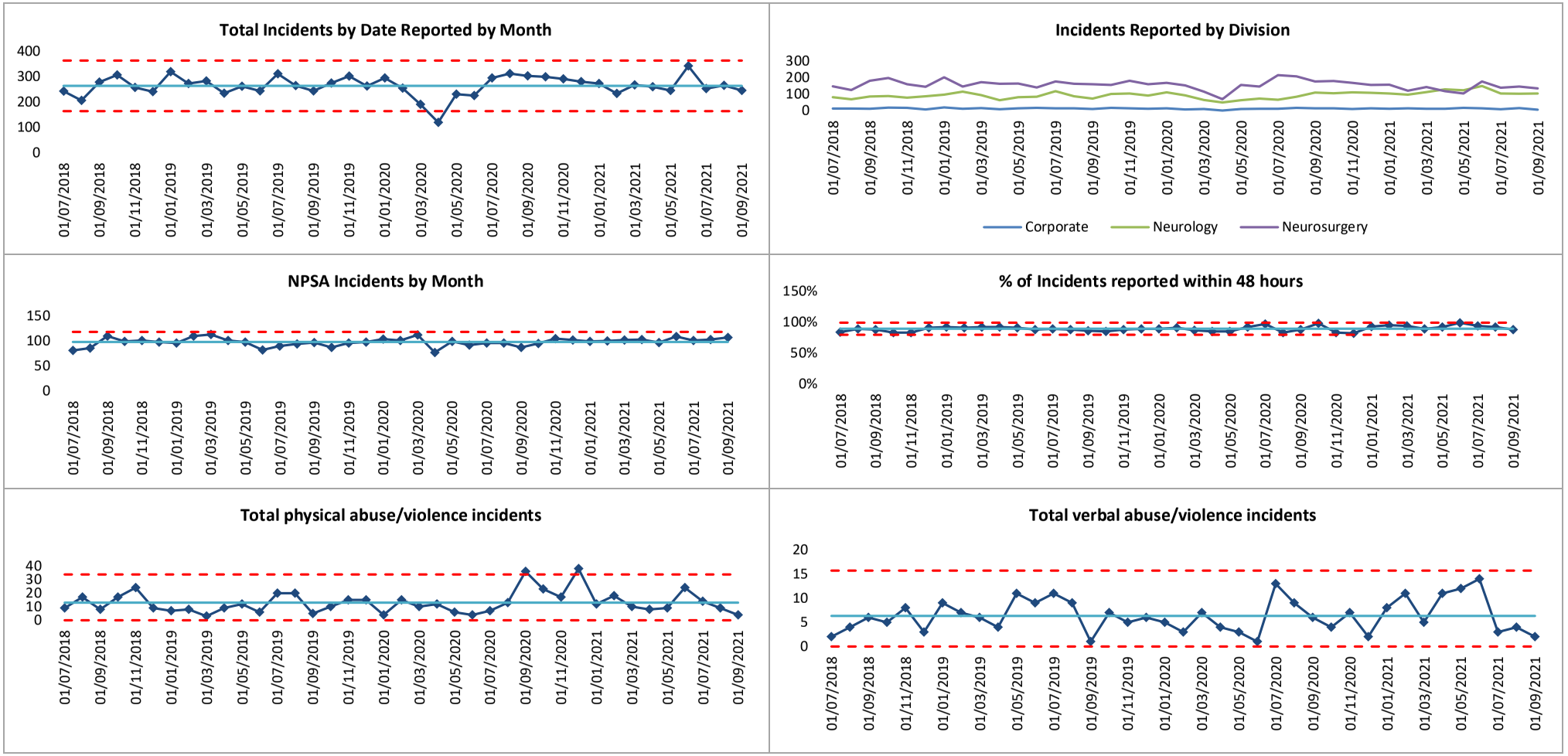
Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	There has been an improvement over recent months of the circulation of hot water temperatures which are now in line with HSE Guidance.	1. Undertake meeting with Estates Manager, Head of Risk, Consultant Microbiologist, Infection Prevention & Control Team (IPCC), Director of Nursing and Trust's external water treatment chemist to establish options for future chlorination and treatment of the water pipework. 2. Establish a process for re-balancing, treatment and testing that will lead towards the future removal of all point of use filters. 3. Continue programme of temperature testing to ensure stability of circulation. 4. Maintain flushing and regime via Compass water management system. 5. Water Safety Group / IPCC to monitor results of above. 6. Prepare a paper with options and potential capital implications for a system wide chemical treatment of the water system.	**Recommendation:** Continue to monitor and work through all actions

Theme	Context	Analysis	Action	Recommendation
Ref 312 – Carbapenemase-Producing Enterobacteriaceae	Significant increase in CPE (Carbapenemase-Producing Enterobacteriaceae) incidents reported throughout Q2. **Lead:** Infection Control Team	Incidents of CPE have increased from 0 in Quarter 1 to 11 in Q2.	1. Enhanced screening for MDRO across high risk areas in place. 2. Expert internal/external group review as needed. 3. Robust action plan and risk reduction actions in place. Which is currently monitored weekly 4. Revisit the option of routinely screening patient all patients on admission and those who are re admitted to the Trust within 12 months 5. Review use of digital system to monitor screening compliance 6. Review process to ensure that changes to policies' are communicated effectively 7. Introduce cleaning sign off sheet for ISS and ward managers 8. Continue with staff education and raising awareness 9. Review process for rapid review to ensure learning is embedded effectively	**Recommendation:** Continue to monitor and work through actions. Review at end of Q3 2021/22.

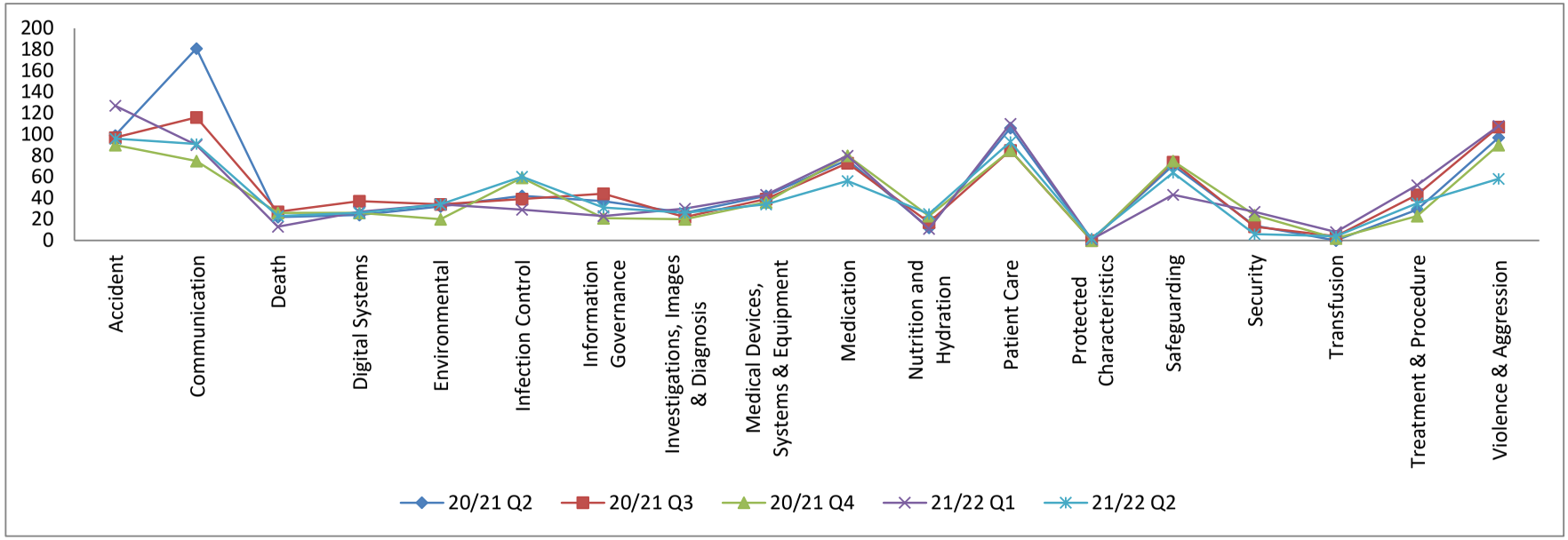
10. Safety and Risk

This section provides an analysis of the number and type of incidents reported during Q2 2021/22, the SPC charts below reflect reporting trends from the previous 5 years. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

10.1. Incident Management Overview



10.2. Incidents by Category & Quarter



10.2.1 Moderate & above incidents:

- 1 serious incident was reported in Q2 compared with 1 in Q1
- 35 moderate incidents were reported in Q2 compared with 14 in Q1
- all incidents complied with the Duty of Candour Regulations

10.2.2 Communication incidents (GAF Entry 304):

- 90 incidents were reported in Q2 compared with 91 in Q1

10.2.3 Infection control incidents:

- 60 incidents were reported in Q2 compared with 29 in Q1

10.2.4 Safeguarding incidents and concerns:

- 64 incidents were reported in Q2 compared with 43 in Q1

10.2.5 Information Governance incidents:

- 29 incidents were reported in Q2 compared with 15 in Q1
- No incidents were externally reported to the Information Commissioners Office (ICO) in Q2 compared with 1 in Q1
- 1 breach of Subject Access Request was reported in Q2 compared with 0 in Q1
- No breaches of Freedom of Information requests noted in Q2

10.2.6 Medication incidents:

- 56 incidents were reported in Q2 compared with 80 in Q1

10.2.7 RIDDOR (staff more than 7 day absence):

There have been no incidents reportable via RIDDOR for Q2 compared with 6 in Q1.

10.3. <u>Violence & Aggression:</u>

- reduction in violence or aggressive incidents from 108 in Q1 to 58 in Q2
- reduction in physical assault incidents against staff, from 41 in Q1 to 27 in Q2 (25 of the 27 incidents in Q2 the patient lacked capacity)
- 1 patient was responsible for 6 of the physical assaults (patient on staff) - No other multiple offenders to note
- GAP analysis for the new 'Violence prevention and reduction standards' presented at the Health, Safety and Security Group
- violence reduction strategy is currently under development
- violence and aggression working group continues to meet bi-monthly
- the Personal Safety Trainer/LSMS continues to support ward staff with challenging patients
- the Neuropsychiatry Team can:
  - review patients who present with agitation and violent and aggressive behaviour
  - provide advice regarding the management of patients who pose a risk towards themselves or others
  - consider environmental and pharmacological changes to patient's treatment to reduce agitation

10.4. <u>Fire safety:</u>

- 5 unwanted fire signals were reported during Q2 of which 4 were out of hours attended by Merseyside FRS
- A Fire Evacuation drill was carried out during Q2 involving the Executive and Consultant/Secretariat areas. This exercise highlighted a number of issues which are being addressed. A further 'Drill' to be planned
- Mandatory training compliance currently stands at 83%

- Fire risk assessments are frequently reviewed with any findings discussed with all relevant parties

10.5. Moving and Handling (M&H):

- 5 incidents reported in Q2 compared with 13 in Q1
- Manual handling E-learning added to new starters training plan
- Assessment of staff competencies with Ward Managers
- Liasion with neighbouring Trusts to identify support with practical manual handling training for an interim period.

10.6. DATIX:

- Datix training has been provided throughout Q2 via both MS teams and face to face sessions for incident and risk management

10.7. Health and Safety:

The Governance Team are currently going through organisational change with interim support being provided by an Interim Health & Safety Manager for 3 months to support the team during recruitment. Work plans are currently being created with focus on the following sections:

- Reviewing business continuity plans and supporting with any required amendments
- Full risk register review
- Establishing a policy review programme
- Ensuring risk assessments are in place
- Ensuring display screen equipment (DSE) arrangements are in place
- Developing COSHH training for identified services
- Establish a Fire Warden system in corporate locations system following the findings from September's fire drill

10.8 Resilience

Fit testing continues as a priority and is currently being delivered by the Fire Safety Advisor

- A Field Safety Notice was received around issues with condensation which has been addressed by the Team
- Drop-in sessions for staff to attend face mask fitting
- Work underway with the Procurement Team on provision of FFP3 stock and identify any future risks
- Continued work to maintain a fit test database available to all ward managers

10.9 Emergency Preparedness, Resilience and Response

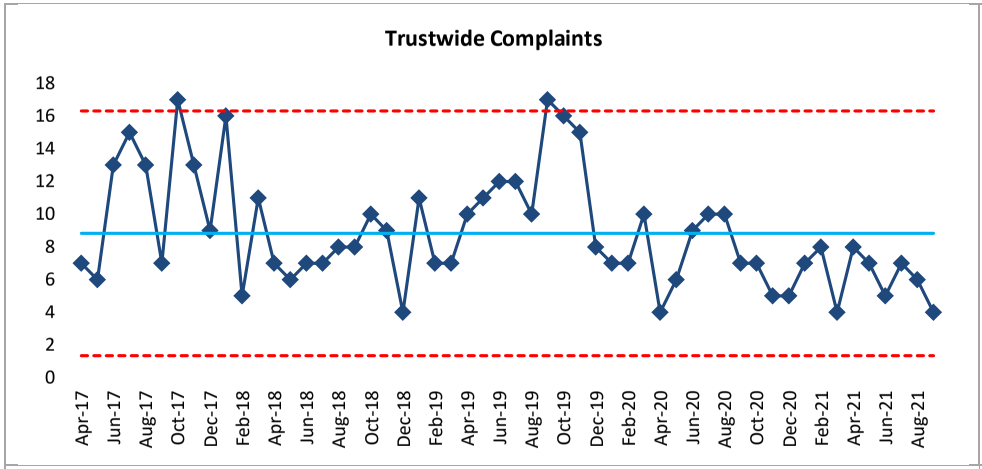
The EPRR function is also supported by the Governance Team and as such interim cover is being provided by the Interim Health & Safety Manager during recruitment to cover this service. The following activities have been completed within this reporting period:

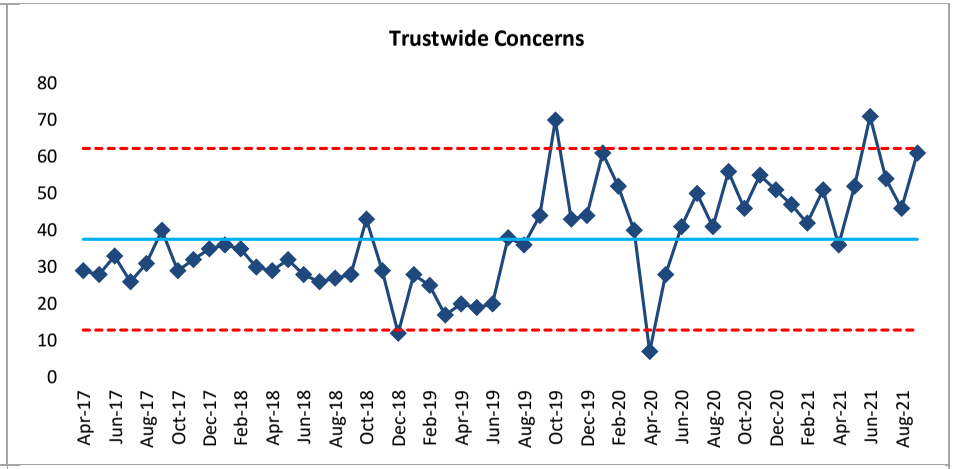
- Review and completion of a power outage and generator fuel tank replenishment return in response to the national fuel shortage
- Completion of a regional EPRR assurance self-assessment return
- Progression of an IT/Cyber resilience assurance questionnaire

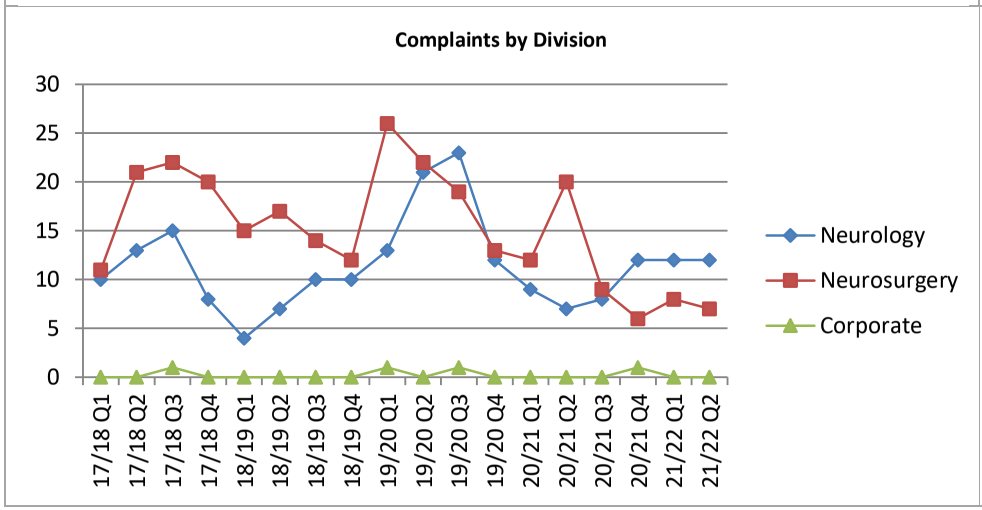
In addition to the above, re-engagement with the regional EPRR Team is underway with a meeting with the regional lead planned for the 19th October 2021 to discuss the Trust's EPRR measures and how it fits in with the local healthcare system.

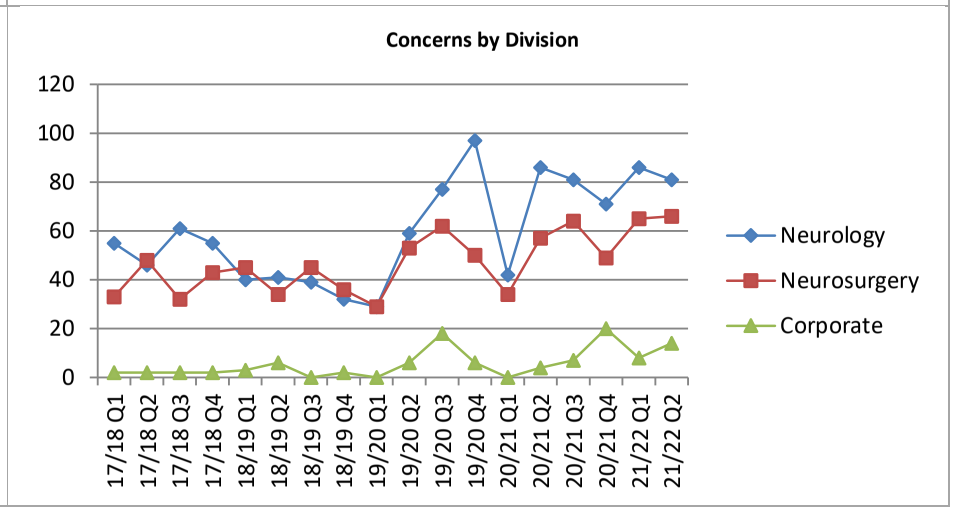
11. Complaints & Concerns

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







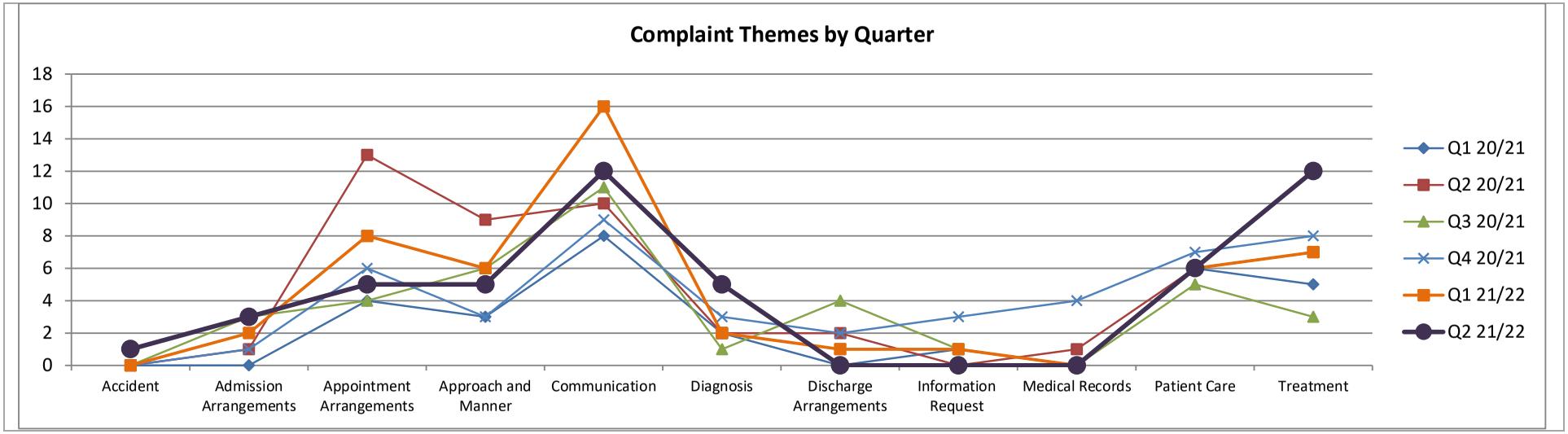


11.1.1 Quarter 2:

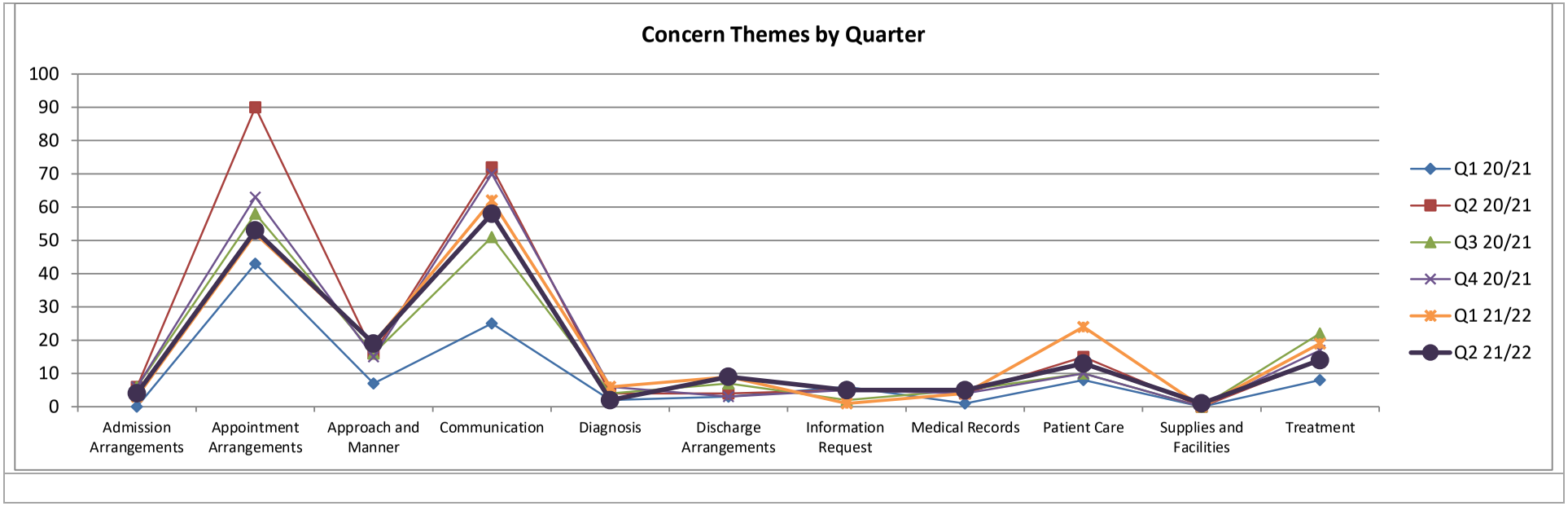
- 100% of complaints received in Q2 were acknowledged within 3 working days and responded to within the negotiated timeframe in line with Trust KPI targets
- 16 new complaints were received in Q2 compared to 16 in Q1 of 2021/22
- 1 complaint was re-opened in Q2 as further clarity was sought in comparison to 4 in Q1
- 15 complaints were closed in Q2; 1 upheld, 7 partially upheld and 6 not upheld
- In Q2 the overall average response time was 27 working days for formal complaint responses. This is higher than the average. response time for Q1 which was 20 working days however there were 3 complaints in Q2 escalated to Level 2 in comparison to 1 in Q1. We aim to respond within 25 working days for Level 1 complaints and 45 working days for Level 2 complaints (our average for Level 1 complaint responses was 23 working days and for Level 2 complaint responses was 44 working days)
- By Division, the average response time for Neurology was 26 days for Q2 (including 1 Level 2 complaint) in comparison to 18 working days in Q1. Neurosurgery average response time was 28 days for Q2 (including 2 Level 2 complaints) in comparison to 31 working days in Q1
- the divisional split of complaints remains fairly static with Neurology receiving 10 (including 1 re-opened) in Q2, compared to 12 (including 2 re-opened) in Q1, Neurosurgery 5 in Q2 compared to 8 (including 2 re-opened) in Q1. There were also 2 cross-divisional complaints received in Q2
- the number of concerns received and resolved remained static from Q1 to Q2 with 159 received in Q1 and 161 received in Q2
- in addition to concerns, 81 enquiries were received and resolved in Q2, in comparison to 65 received in Q1; themes relate to the referral process and general hospital enquiries

11.1.2 Key themes for formal complaints:

- Treatment is the highest theme in Q2, largely in relation to a delay in treatment/procedure
- Communication is the second highest theme although this has reduced from Q1
- Approach and Manner as a subject of complaints has remained reduced in comparison to previous years



11.2. Key themes for concerns:



10.1. Protected Characteristics:

- There were 0 complaints or concerns raised in Q2 in relation to the nine protected characteristics which include race, disability, sex, gender reassignment, religion or belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

10.2. Compliments:

- 47 compliments were received in Q2 compared with 42 in Q1

10.3. Police/Coronial Requests:

- 12 police requests for statements/copies of health records received in Q2 compared to 9 in Q1
- 6 Coroner's requests were received in Q2 compared to 7 in Q1

10.4. Volunteers:

All volunteers are required to undergo induction to ensure they have the training and support required prior to recommencing in roles. In Q2, two inductions were held and volunteers are being encouraged to undertake infection prevention roles as they are being re-introduced into the Trust.

10.5. Friends & Family

- **Outpatients** - **87% of patients were Extremely Likely/Likely** to recommend based on a total of474 responses (2.7 response rate)
- **Inpatients - 98% of patients are Extremely Likely/Likely** to recommend based on a 36% response rate compared to the number of discharges (1,902) in Q2
- Full details contained within Trusts Integrated Performance Report

10.6. Summary:

In Q2 there were 15 formal complaints closed, 173 concerns resolved and 81 enquiries successfully responded to in a timely manner. It is very encouraging to note that the average response times for formal complaints remain in line with the tiered timescales outlined within our policy. The PET and Divisional teams strive to ensure we are rapidly responding and resolving enquiries and concerns to prevent them escalating to formal complaints which is reflected in the number of each received.

12. Claims / Legal

Trust Wide	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
Total new claims received	5	9	9	4	4	1
Neurosurgery claims	5	6	5	1	1	1
Neurology claims	0	1	2	3	1	0
Corporate claims	0	2	2	1	2	0
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	13	7	7	7	16	4
Number of closed claims in quarter	4	5	3	3	10	7
Value of closed claims - Public liability	£0	£0.00	£0.00	£5,000	£3,920.	£1,250.
Value of closed claims - Employer liability	£0	£0.00	£0.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£2,715,964.	£3,203,388.	£209,929.	£128,261.	£374,658.	£337,153.

- All staff involved in claims/coronial reviews or inquests receive full support throughout the process
- 1 new claim
- 0 Re-opened claim in Q2

12.1. Lessons Learnt:

Details for lessons learnt from on-going claims/Coroner Inquests included in section 13. It should be noted that lessons have been learned following an RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.

Three claims are currently under review where there may be an opportunity for lessons learned and an update will be provided in Q2.

12.2. Thematic Review:

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

Diagnosis/Treatment:
Following a recent Clinical Trial in which the Judge found in favour of the Claimant, possible lessons learned were discussed with Neurosurgical Clinical Lead who in turn discussed the case with Medical Director. A decision was made that any possible lessons learned would be looked at on a case by case basis. The Clinical Lead has also discussed the outcome of the Trial with the Consultant in charge of the claimant's care.

12.3. Clinical Negligence Trials:

3 Trials are listed for 2022

13. HM Coroners Inquests updates:

Current status: 1 closed and there are 4 scheduled inquests whereby the Trust is required to attend to give factual evidence and a number of cases remain open, some from 2018 awaiting further updates. Listed below are updated cases for Q2.

13.1. Neurology

Patient was admitted to Hyper acute Specialist Rehabilitation on 06/11/2019 following a cardiac arrest on 16/09/2020 and a period on intensive care at Liverpool University Hospitals (Aintree). The patient was transferred to Oakvale Gardens Rehabilitation Unit (OVG) on 06/04/2020 and sadly died on 08/05/2020. Concerns were raised by the family in relation to the discharge from the Trust to OVG and the details surrounding the death.

Pre Inquest Reviews took place on 22/09/2020 and 22/01/2021 and the Inquest took place on 19/05/2021. The only concern raised by the Coroner related to the Trust's communication with the GP when the patient was initially transferred to OVG. The letter from the virtual clinic of 05/05/2020 was sent to the deceased's previous GP and not the GP affiliated to OVG. The Coroner confirmed that the request for the prescription was not requested on an urgent basis; however, if this had been urgent, as the wrong GP details were recorded the delay could have been critical to the patient's health. The Coroner asked the Trust to investigate this and provide a response to give assurance that processes are now in place. Update to follow in Q2 once investigation completed.

Outcome: Division have written a standard operating procedure (SOP) which has been circulated to Neurology, Neurosurgical and Neuro-Rehabilitation clinical teams who will in turn alert administration staff of the process going forward. The SOP has now been signed off and sent to Coroner.

13.2. Neurosurgery

The family have raised concerns regarding the care/treatment given to their loved one at Southport Hospital (no concerns regarding the Trust). The family have queried a stitched laceration to the right side of the patient's head which they presume was present admission to the Trust as state was commented on by an ICU nurse.

At the time we spoke to the treating clinician and ICU staff who had cared for the patient. None of which could recall such a laceration. Neither was anything recorded on the body map document following surgery on 07/05/2018.

Coroner opened and inquest investigation in 2019 and investigations took place initially. We did not receive any further correspondence from the Coroner after 09/08/2019. The Coroner has now made contact again and requested a statement from the consultant who performed the operation on 07/05/2018. An Inquest date has been set for 18/10/2021. Four members of staff have been asked to give evidence via Teams and this will be facilitated with support from the Claims Manager.

13.3. Neurosurgery

A patient fell on 28/08/2020 outside their home and banged their head on the kerb. The patient was admitted to the Trust on 28/08/2020 and admitted to ICU. They were transferred to the ward on 05/09/2020. They were referred for rehabilitation but the units they were referred to would not accept them as they could not meet the patient's rehab needs. The patient was finally accepted at Church Walk Nursing Home in Rochdale until a bed became available in Liverpool (6-8 weeks). The patient transferred to Church Walk on 05/02/2021. It was expected that a rehab bed would be available to accept the patient in March 2021. The patient had a fall in Church Walk and banged their elbow (their head was protected by staff during the fall). At some point later the patient was taken to the A&E at Oldham Hospital. The patient was admitted and antibiotics were prescribed for 5 days. The patient deteriorated and died on 31/03/2021.

The family have raised concerns with the Coroner regarding the care that the patient received at Church Walk. A complaint was also made to NHSE about Neuro Rehabilitation Case Manager regarding misleading information.

The consultant in charge of care and discharge planner have provided statements to the Coroner. The Coroner's has confirmed that the Inquest will be held on 29/10/2021 in Rochdale and will inform the Trust if any staff are required to attend.

13.4. Neurology

The family raised a query with the Coroner to determine why their loved one was not seen by a Neurologist when they had be referred 12 months previously.

A detailed statement from the Consultant Neurologist has been provided together with a triage referral timeline. The Neurologist has now been asked to attend the Inquest in Wales on 14/10/2021. The Coroner has confirmed that the family are not legally represented and the Consultant has confirmed that they do not require any support at the Inquest.

REPORT TO TRUST BOARD
Date: 4th November 2021

Title	**Freedom to Speak Up Guardian Report Quarter 4 2020/21 & Quarter 1 2021/22**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	• Committee None • Group None • Other None
Executive Summary The report provides an update on the progress of the role and plans for strengthening current speak up arrangements. The report also highlights concerns raised with the Freedom to Speak Up Guardian.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations. There are a number of risks to having a culture where staff do not feel able to raise concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as reputational risk.
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations.
Action required by the Board	• To consider and note

Revised in July 2018
Filepath: S:drive/BoardSecretary/FrontSheets
S:drive/ExecOfficeCentreMins/FrontSheets

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Freedom to Speak Up Guardian Report
Quarter 4 2020/21 and Quarter 1 2021/22

1. INTRODUCTION

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

1.2 Speaking up is about anything that gets in the way of providing good care. When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that all staff feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we should feel able to say something and should expect that suggestions are listened to and used as an opportunity for improvement.

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

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

2. LEADING BY EXAMPLE

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

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

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

3. AWARENESS RAISING

- Walton Weekly/Articles in Team Brief/Neuro Matters/Staff Questionnaires
- Separate email address freedomtospeakup@thewaltoncentre.nhs.uk
- Attendance and hosting Regional Meetings
- National Guardian Visit
- Drop-In Sessions scheduled throughout the year
- Holds 'Speak Up' events to promote the Guardian and Champions roles

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

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

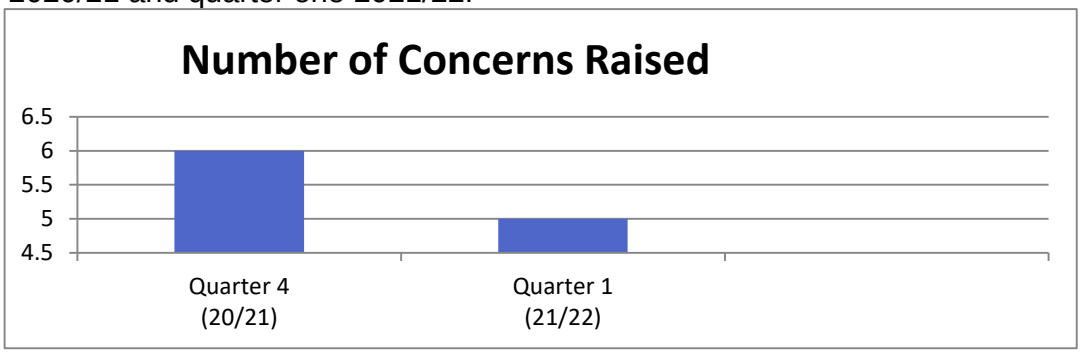
4. MONITORING

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

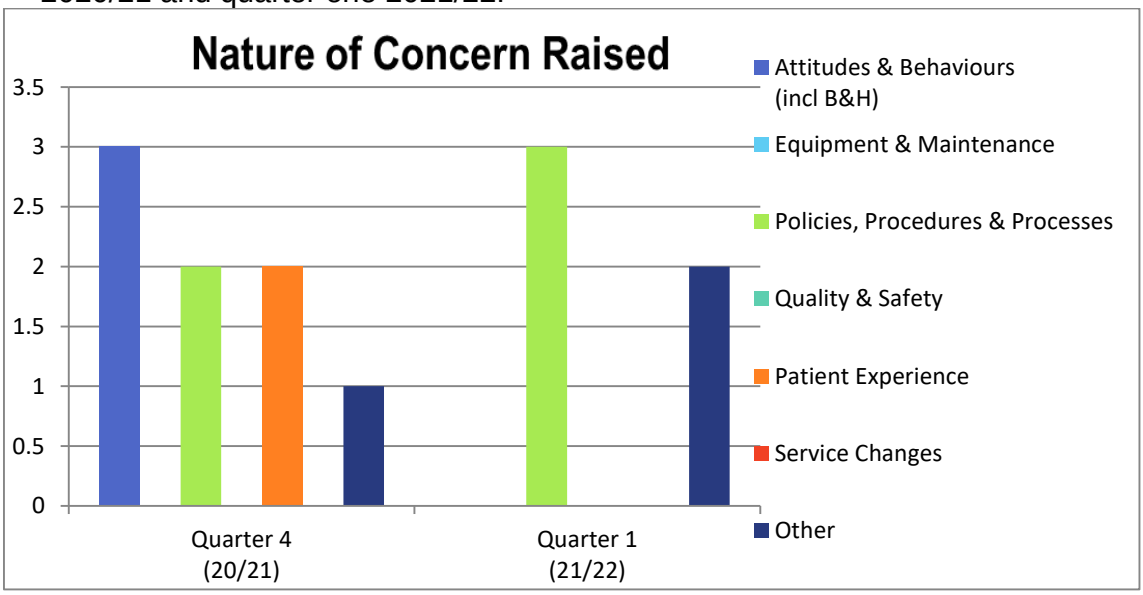
4.2 The NGO undertook a survey as to whether a guardian's ethnicity acts as a barrier to workers speaking up. The survey found that the guardian network is predominantly white, and other ethnicities continue to be under-represented when compared with the NHS workforce as a whole.

5. LOCAL ACTIVITY – Quarter Four 2020/21 and Quarter One 2021/22

5.1 The graph below indicates how many concerns have been raised during quarter four 2020/21 and quarter one 2021/22:

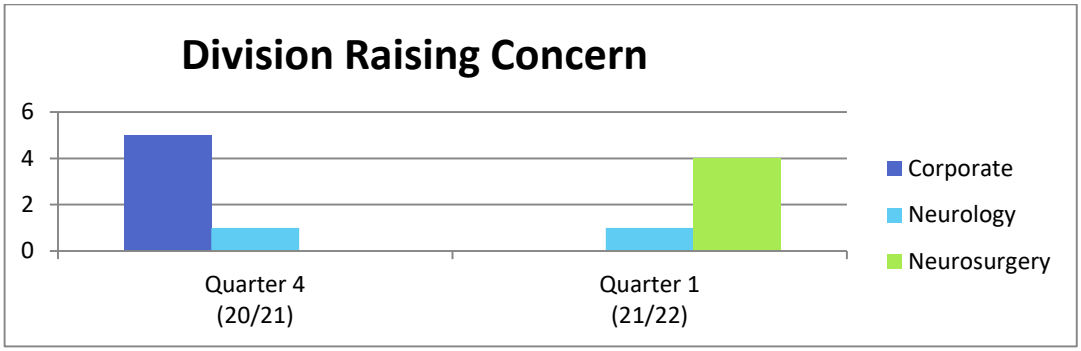


5.2 The graph below indicates the nature of the concerns raised during quarter four 2020/21 and quarter one 2021/22:



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

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



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

5.5 The FTSUG continues to meet with the Non-Executive/Executive Leads for Raising Concerns to discuss concerns raised and review progress made. She meets with the Head of Business HR and HR Manager for Neurology monthly to discuss and review themes and provide progress against reviews which may have been undertaken. Meetings are also scheduled quarterly with the Chair and Chief Executive to keep them appraised of activity.

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

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

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

The information required is listed below:

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

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

	2017/18	2018/19	2019/20	2020/21
Quarter 1	1447	2348	3173	5212
Quarter 2	1515	2604	3486	4927
Quarter 3	1939	3600	4120	5334
Quarter 4	2186	3406	5420	4915
Total	**7087**	**11958**	**16199**	**20388**

The figures above confirm more cases are being raised year on year which is extremely positive and shows a 26% point increase in cases being raised in 2020/21 than in the previous year.

There is now a network of over 700 Freedom to Speak Up Guardians supporting workers in organisations in primary and secondary care, independent health care providers, clinical commissioning groups, hospices and national bodies.

Patient Safety and Quality – 18% of cases involving an element of patient safety/ quality was down 5% since 2019/20.

Bullying and Harassment – the proportion of cases (30.1%) involving elements of bullying and harassment was 5.8% lower than the previous year

Detriment – detriment for speaking up was indicated in 3.1% of cases, down from 5.1% in 2017/18.

Feedback – 84.3% of those who gave feedback to the guardians said they would speak up again.

Anonymous Cases – almost 12% of cases continued to be reported anonymously which is concerning as these can sometimes be more difficult to investigate and difficult to provide feedback on. Equally, they can be an indicator that there is a general lack of trust or fear associated with speaking up. During 2020/21 and quarter one 2021/22 no concerns were raised anonymously to the FTSUG which is very encouraging.

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

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

Respondents have confirmed they would speak up again and have given positive feedback. Some of the feedback received is below:

- ❖ Julie was reassuring and very supportive. She followed up the meeting and made sure I was okay
- ❖ Thankful to you for giving a passionate ear to my vows and resolving them for me on a priority basis
- ❖ I would speak up again as I feel confident my concerns have been taken seriously

- ❖ I am happy to say that there was a positive outcome and I would recommend that staff should feel able to speak up as it helped me
- ❖ Julie is someone independent and trustworthy, I would definitely speak up again if I needed to
- ❖ Could feel the difference within days and things improved out of nowhere
- ❖ Thanks for taking the time to listen to me. I would speak up again as help was given to me and the monitoring has continued
- ❖ I would definitely speak up again as the experience I had I felt completely listened to, treated with respect, and you are so friendly and approachable

7. NATIONAL GUARDIAN'S OFFICE UPDATES & REPORTING

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

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

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

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

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

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

8. Training

8.1 The NGO has launched Freedom to Speak Up e-learning packages for all healthcare workers.

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

The first module, 'Speak Up', is core training for all healthcare workers, including volunteers and students. The e-learning module is undertaken once and takes approximately 45 minutes to complete which includes watching a video.

The FTSUG is working with the Training and Development Team to look at how best to launch this training module and agree when would be the best time to do this within the Trust.

9. NEXT STEPS AND ACTIONS

9.1 During October 2021 the Trust is celebrating 'Speak Up Month' and will be encouraging staff members to complete questionnaires, express their interest in becoming a Speak Up Advocate and empower staff to raise concerns.

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

9.3 Ensure future collaborative working takes place across the Trust.

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

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

9.6 'Drop In' sessions have been scheduled throughout the year and will be circulated.

9.7 Launch the e-learning modules in conjunction with the Training & Development Department.

10. RECOMMENDATIONS

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

The Walton Centre
NHS Foundation Trust

Report to Trust Board

Infection Prevention and Control Board Assurance Framework – COVD-19

Title	**Infection Prevention and Control Annual Report April 2020 – March 2021**	
Sponsoring Director	Name: Lisa Salter Title: Chief Nurse/DIPC	
Author (s)	Name: Helen Oulton Title: Lead Nurse Infection Prevention and Control	
Previously Considered by	N/A	
Executive Summary:- 1. The purpose of this report is to outline that there are processes in place to manage the risk of 19 which include the identification of the current gaps and mitigating actions. 2. The report identifies the areas that require review and action to clearly demonstrate areas of high and low assurance within the Trust.		
Related Trust Strategic objectives/goals	Goals ☐ Always Caring	Strategic Objectives X Quality of Care
Risk and Assurance	Risks associated with infection prevention and control will be recorded on divisional and Trust risk registers and monitored via the Infection Prevention & Control Committee	
Related Assurance Framework entries	Risks associated with infection prevention and control will be recorded on divisional and Trust risk registers and monitored via the Infection Prevention & Control Committee	
Are there any associated legal implications / regulatory requirements?	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 CQC Fundamental Standards	
Equality Impact Assessment completed?	N/A	
Action required by the Committee	To acknowledge and discuss	

1. Background

The purpose of this report is to outline that there are effective processes in place to manage the risk of COVID-19 which include the identification of the current gaps and mitigating actions and describes the process

There have been 17 COVID-19 positive patients, which include nine cases of nosocomial transmission (infection acquired in the Trust) since April 2021.

The Board have received the previous versions of the '*Infection Prevention and Control Board Assurance Framework'* (IPC BAF NHS England, 2020). The framework is structured around the existing 10 quality standards set out in the '*Infection Prevention Control Code of Practice* (2008)' which links directly to Regulation 12 of the '*Health and Social Care Act* (2008)'.

2. Current Position

The Trust has completed a further assessment against the latest version of the IPC BAF V1.6 (2nd Edition) and this assessment is held as an operational document. This review has collated the gaps in compliance that impact on the ability to provide robust assurance that the Trust is undertaking appropriate interventions to keep our patients and staff safe.

Appendix one sets out the areas that require review and action to clearly demonstrate areas of high and low assurance within the Trust.

3. Conclusion

The introduction of the COVID -19 vaccine has led to a reduction in COVID-19 cases and as a result a significant reduction in numbers of COVID-19, nosocomial transmission and outbreaks.

As restrictions continue to be relaxed and the Trust works toward restoration of services, there is the potential for increase in nosocomial transmission of COVID-19. It is therefore critical that the Trust can demonstrate and maintain assurance against the IPC BAF standards.

The Board are asked to note the contents of this report and be assured that current gaps have been identified and that a plan is in place to enable the Trust to gain appropriate assurance in its management of COVID-19. Progress will be reported in future reports.

Helen Oulton
Lead Nurse Infection Prevention & Control/Tissue Viability

IPC BAF Report

Appendix 1

COVID-19 Infection Prevention and Control Board Assurance Framework

Effective infection prevention and control is fundamental to our efforts. This board assurance framework was developed by the NHS to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks.

- **Version 1.0 of this framework was published on 4 May 2020;**
- **Version 1.4 was published in October 2020**
- **Version 1.6 was published in February 2021**
- **2nd Version 1.6 was published on 30th June 2021: updates are highlighted in yellow**

	1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff • The documented risk assessment includes: ○ A review of the effectiveness of the ventilation area ○ Operational capacity ○ Prevalence if infection / variants of concern in the local area • Triaging and SRAS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all pathways	Infection alerts are on EP2 for all patients with a previous IP alert organism. Trust COVID -19 policy in line with PHE guidance Screening policy for COVID is day 0, 3, 5 and then every 5 days of admission to detect infection in a timely manner. Each area has a documented Environmental risk assessment which includes hands.face.space.ventilation. PPE is worn according to PHE guidelines	Adherence to Policy No audits undertaken to provide assurance re compliance No assurance with screening compliance Do require full time cover in day time to cover entrances Need assurance re if risk assessments have been carried out for all entrances Limited assurance that environmental risk assessments have all been completed	Audits/reviews to commence by matrons and IPC team Covid audits to commence by IPC team w/c 4/10/21 A member of staff present on entrance ensuring clean mask and hand hygiene performed Temperature, hand gel and mask station at main entrances COVID-19 screening board on all wards Meeting with IT to determine if covid swab compliance can be provided for each inpatient ward

• When an acceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective equipment RPE for patient care in specific situations should be given	PPE is worn according to PHE guidelines	No prompts within EP2 for staff to be reminded of screening collections, this is reliant on IPC team or ward staff Guidance required to support the patient flow team on emergency admission of extremely vulnerable patients	
• There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative.	Screening/swabbing policies and SOPs are in place for clinical pathways e.g. pre-op/elective and emergency in place patient placement guidance Patient admissions to appropriate ward as per place patient placement guidance	Potential asymptomatic patients may be in incubation phase, therefore risk of infecting other patients. Lack of assurance with swabbing compliance	Contact tracing in place for patients who have been exposed to positive patients Re-admission policy of previous COVID +ve patients Swabbing policy for day 0 , 3 and 5 and thereafter every 5 days Patients with COVID symptoms are transferred to Chavasse ward a designated area. Meeting with IT to determine if figures can be provided for swabbing compliance
• That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	Local Cleaning guidelines available Isolation policy available Guidelines available regarding cohorting patients together with like symptoms or known infections All known areas where COVID patients are nursed are HPV's if practically possible COVID-19 surge /escalation guidance Cleaning schedules in place House keeper cleaning schedules in place	Cleaning procedures are not followed to the standard required	Risk assessments in place. Incident forms completed when cleaning is sub standard Sherrington ward trialing ISS/ward manager sign off sheet
• monitoring of IPC practices, ensuring	Hand hygiene policy	Demand for ISS is not always	

resources are in place to enable compliance with IPC practice ○ staff adherence to hand hygiene ○ Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical / personal care and are wearing appropriate PPE ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a. Clinical b. Non-clinical settings ○ Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting.	Social distancing guidelines available with associated posters, leaflets and floor stickers COVID PPE guidelines reflecting PHE recommendations for all areas Register of staff training for fit testing IPC Audit program Daily escalation Visual aids of PPE guidance patients/staff Audit Safety huddle notes	matched by supply Staff not always following guidelines Staff not aware of the guidelines Socially distanced beds are in use Dividers not in place between bed spaces OPD activity increasing with no additional measures in place No staff competencies foe PPE (DONNING AND DOFFING)	Hand Hygiene compliance audits are monitored weekly – need to improve escalation process Perfect ward coming to do Demo of electronic software which will improve compliance and highlight gaps easier Datix completed when none compliant Trial of clear curtain underway on Sherrington ward Review of OPD areas and request submitted to Procurement to action
• consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	IPC team communicates any changes noted within national guidance in a timely manner. This is managed through command and control (dependent on level) and communications The chief nurse chairs a daily staffing huddle across the organization and IPC is covered at this	PPE guidance changes and staff not aware No staff competencies Need to ensure Lessons learnt from audits fed back to the divisions once audits commence w/c 4/10/21	Lessons learnt from audits fed back to the divisions Communications via trust daily safety huddle
• implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	Local procedures for testing available. Contact tracing in place Weekly Lamp testing commenced Lateral flow tests completed daily for staff returning to work who have been in contact with someone with COVID	Staff do not complete LAMP uptake is poor Lateral flow tests completed daily for staff returning to work who have been in contact with someone with COVID Managers may not check that staff have a negative LFT before attending work	Regular reminders from leaders and managers regarding testing LAMP uptake reports circulated weekly LAMP uptake discussed at daily trust safety huddle PPE discussed at daily Trust wide safety huddle Ongoing education and support IPC Walk about`s Engagement with clinical teams Ongoing education and support

• Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	Staff screening considered/agreed during outbreak control meetings. Covid line in place	Staff refuse screening Staff may not follow the staff screening protocol	Local and regional infection prevention and control/Public Health team invited to all Outbreak meetings and outbreak management plans agreed, including staff testing frequencies and methods
• training in IPC standard infection control and transmission-based precautions are provided to all staff	Fit testing programme in place PPE posters present across site Donning and doffing posters present across site	Staff not always following precautions Staff need testing on more than one mask as per guidance PPE donning and Doffing competency is required and rolled out trust wide	Regular IPC walk rounds by the IPC team observing staff practice and addressing and issues in real time with staff Matrons and senior nursing team also completing walkabouts and addressing issues in realtime
• IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training	IPC measures included in mandatory training and at induction by IPCT Mandatory training data reviewed monthly at Divisional risk and governance	Staff miss induction session	IPC team carry out walkabouts educating staff in real time
• all staff (clinical and non-clinical) are trained in : putting on and removing PPE; what PPE they should wear for each setting and context • All staff,(clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance	All posters and literature reflect national guidance. Posters available for different levels of PPE Donning and Doffing videos on intranet Staff screening guidance Outbreak screening guidance Text notification of staff results COVID Team	Staff not following guidelines	Local induction for all new staff on the ward/department IPC and senior nurse walk about
• There are visual reminders displayed	Local policies reflecting national guidance are updated regularly and available on the intranet.	National supply of FFP3 masks limited and unable to stipulate the model and manufacture of	Donning and doffing training in all areas

	communicating the importance of wearing face masks , compliance with hand hygiene and maintaining physical distance both in and out of the workplace	Staff are updated to changes via regular communications updates and daily safety huddle chaired by chief nurse Posters displaying correct use of PPE in all clinical and non-clinical areas for staff , visitors and patients. Floor signage and posters reminding staff of social distancing requirements. Information leaflets and videos available to down load for ongoing education. Training records Training plan	mask required locally. Need plan for ongoing FITT Testing for staff	Training and education of staff when stock changes Audit patient mask wearing by Matron	
•	IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	PHE/GOV updates are shared at daily meetings, current guidance revised to reflect the changes National guidance reviewed daily and local sop's reviewed to reflect any changes Training records Area specific as required Intranet resources	Staff not knowing that changes have been made Local policies not been updated as national policies change	Messages reiterated via daily safety huddle chaired by chief nurse and attended by IPC SNMT review adherence to guidelines when completing walk rounds. Version control on leaflets and posters.	
•	changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	As above changes managed via control command structure. IPC papers regularly to monthly Quality board and Trust Board re IPC position. Risk Register articulates level of risk. Daily Gov.uk COVID-19 update Communication bulletin PHE communication		All meetings where social distancing cannot be maintained are captured by Microsoft teams.	
•	risks are reflected in risk registers and the	As above, risks in relation to COVID-19		Manual reminders when risk is due for review	

Board Assurance Framework where appropriate	included in the Risk Register along with other IPC risks. All risks reflected in BAF.		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Daily emails circulated Trust wide Daily Safety Huddle Command a & Control structures Tactical meetings Direct escalation to executive team Operational risk on Datix which informs the Trust BAF COVID-19 BAF IPC quarterly reports HCAI surveillance within the Trust reported via Datix Integrated performance report Minutes of Trust Board Minutes of Quality Committee Minutes of IPCC Swabbing protocols. RCA/PIR process for alert organisms. Communicable diseases outbreak management operational guidance followed. Mandatory training compliance reported at local and trust wide IPC meetings. IPC organism specific policies available	Lack of assurance that all risks have been completed Surveillance programme for all alert organisms sent to BI from IPC	Updated IPC side room prioritisation and guidance on patients who are shielding is available Environmental risk assessments available for staff and patient areas
• the Trust CEOs Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep.	Daily data submissions via the daily nosocomial sitrep are signed off by the Chief executive or Chief nurse who is the Director of Infection prevention and Control (DIPC) BI receive all covid + lab reports and will pull through alerts entered on PAS/check with IPCT		
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	BAF is reviewed and updated and shared with IPCC/Quality Committee prior to presenting to the Board.		Completion is monitored by the IPCC Checked and amended by Deputy chief nurse

			and approved by Chief nurse
• The Trust Board has oversight of ongoing outbreaks and action plans.	DIPC included in mins from outbreaks. Outbreak updates delivered by the lead for IPC IPC reports to Board		Outbreak updates within IPC reports at monthly IPCC meeting Outbreaks discussed
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Senior nurse management team complete monthly walk rounds of wards and departments across the trust on a Monthly basis. Executive team carry out monthly walkabout and feedback, update provided to Quality board Director of nursing chairs infection prevention and control committee and carries out walkabouts challenging any practice observed		Concerns raised by staff and those identified by the SNMT are shared with staff at the time of the walk round and learning opportunities identified shared with the wider team.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	e-Roster system and flexing of shifts to ensure staff skills and deployment is are appropriate to requirement. IPC mandated training continues on induction and as part of Core Skills. Training recorded on ESR.	Potential gaps in general training records, some records manual and not electronic. Not all general training is competency assessed nor does staff self-declare compliance with course preparation e.g. pre-course reading material	Daily review of rotas by senior nursing team's staff deployed appropriately following daily risk assessment of areas. Fit testing procedures in place Add hoc training available by the IPC team and practice based educators. Training resources available on the intranet
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Each clinical area has allocated domestic teams. Additional staff employed to provide cleaning in excess of 3 times per day for all high touch areas during the COVID pandemic	Variability in standards of cleaning. COVID-19 related sickness	Standards of cleaning concerns escalated to local supervisor to address.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE	IPC Trust policy and procedures/flow charts. Decontamination policy.	Rooms not cleaned to standard required.	Terminal clean procedure checked following completion by ward manager or equivalent trial on Sherrington ward.

and other national guidance	Decontamination equipment guidelines. Increased cleaning in line with national guidance using combined detergent & chlorine disinfectant. Cleaning information shared. Hydrogen Peroxide Vapor cleaning utilised. UV light cleaning utilized when necessary Disinfection wipes in use effective against Coronaviruses.	Delays can occur due to availability and demand on ISS	Hydrogen Peroxide Vapor cleaning utilised. UV light cleaning utilized when necessary
• Assurance processes are in place for the monitoring and sign off following terminal cleans are part of outbreak management and actions are in place to mitigate any identified risk	Terminal cleaning checklist devised for signing off the required standards of cleaning Clean trace in use	Datix not always completed when cleaning is not of the required standard.	Cleaning shortfalls addressed real time to ensure immediate improvements Started to swab post cleans for assurance level of clean is acceptable
• Cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses;	Chlorine based disinfection is used throughout the Trust as standard by the ISS teams	Staff do not know how to use the products correctly.	
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance	Contact times are followed as per manufacturer guidelines	Unable to check that people are allowing the correct contact time	Remind staff all the time of the contact time needed. Contact time is included within the policy
• a minimum of twice daily cleaning of areas that have higher environmental contamination rates as set out in the PHE and other national guidance • frequently touched' surfaces, eg door/toilet	ISS coordinated additional enhanced cleans ensuring disinfection of all high touched horizontal surfaces on all wards where patients with known or suspected COVID are nursed. Enhanced cleaning of 3 x day is instigated on	Standards of cleaning across the Trust are variable. audits not completed when wards have outbreaks	ISS staff providing additional hours IPC audits monitoring standards reported to IPCC IPC are to commence environmental audits W/C 4/10/21

handles, patient call bells, over-bed tables and bed rails, • electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff	wards where there are clusters/outbreak of infection identified. Enhanced cleans of 2 x day are completed for all patients with known or suspected CDI/CPE/Norovirus/COVID or other alert organisms. ISS has a Domestic Service Cleanliness model that conforms to the Department of Health guidelines on the specification for the planning, application, measurement and review of cleanliness services in hospitals. The standards are governed by the following legislation: • National Specifications for Cleanliness in the NHS 2007 • The Revised Healthcare Manual 2009 • PAS 5748 specification 2014 Audits completed All toilets are cleaned three times a day across site and more frequently when they have multiple users. In area where there is known or suspected infection, where enhanced cleans have been requested these areas are then cleaned more frequently than once per day. Ward Manager checklists available for cleaning on Sherrington ward as a trial	Staff not being aware of the guidance. Staff not knowing what products to use or how to order them Standards of cleaning across the Trust are variable. Shortfall in domestic provision No domestic cover on a late shift Need a process to provide assurance that HPV cleans are completed of all bathrooms /toilets where enteric precautions have been required	Ward matrons, Deputy and chief nurse complete walk rounds of all areas with supervisors to check standards at add hoc periods when concerns are raised Walk rounds of the wards with supervisor and matrons to review standards and agree actions. Increased senior leadership capacity to support compliance in some areas (ITU) Guidance is communicated through the command structure from NHSE/PHE regarding items that can be used more than once. Cleaning guidelines reviewed to provide assurance that all areas are cleaned as per National guidelines and local risk assessments.
• Reusable non-invasive care equipment is decontaminated: ○ Between each use ○ After blood or body fluid contamination	Decontamination policy available Clean Trace ATP		Testing is completed by the IPC Team in areas where patients with infections are nursed to test the efficacy and effectiveness of the cleaning. Audits of cleaning standards completed.

○ At regular pre-defined intervals as part of an equipment cleaning protocol ○ Before inspection, servicing or repair of equipment			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Guidance included in covid policy re IPC Linen and waste policy. Included in IPC mandatory training. Managed service assurance from national accredited service provider that all linen is laundered according to NHS standards.	Adherence to policy	
• single use items are used where possible and according to Single Use Policy	Training provided to all staff re the appropriate use of single use products.	Items that should be single use are reprocessed	Pulp products available for disposal of all bodily fluids Single use B/P cuffs are used for all patients Single use guidance within the medical devices policy
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk	Decontamination Policy IPC Audits Cleaning standards agreed. C4C audit		Audits of cleanliness of Patient shared equipment completed
• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning check list devised for Sherrington to trial for all ward areas initially and now in development for non- clinical areas. Escalation procedure devised for cleaning failures IPC nurse working with Matron to standardize house keeper cleaning checklist	Shortfalls in staffing reflects on the cleaning standards	Audits completed by dedicated domestic team IPC audits/ point prevalence audits for all areas
• Where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	All wards and departments are advised to open their windows x 3 day for 15 mins. Advised staff to open windows during care		Windows checked if open in the weekly point prevalence walk about to commence 4/10/21

	activities which increase the number of people in a room/bay i.e Ward round		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Antimicrobial ward round – virtual if required. Microbiology advice available 24/7 Antimicrobial audits IPC surveillance Minutes of Antimicrobial stewardship meetings	Inconsistency in ward rounds Medical input variable	Clinical engagement Clinical Director review Review of processes
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • national guidance on visiting patients in a care setting is implemented	Trust wide visiting guidance developed based on national guidance. Divisional and trust communications. Leaflets available Guidance revised as national guidance advises.	Staff not heeding to the guidance. Volunteers allowing patients in a the front door	Guidance on visiting under review national as guidance changes
• Areas in which suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access	Clear signage across the Trust including ward entrances identifying the category of ward it is in relation to COVID-19and what the correct PPE is for that area		To be audited during point prevalence walk about which is to commence 4/10/21
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Current information available on the website. which enable easy read and alternative language options. Interpreter contract in place to include sign language, ability to do remotely.	Staff not able to access the intranet	PHE also have easy read leaflets available

	Social media page Transfer form Pre-operative patient letter Hand Hygiene stations		
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Posters on walls have Hands.Face.Space logo's Poster developed stating that all patients and visitors must wear a fluid repellant surgical mask	Patients and visitors are non-compliant with policy	Alternative arrangements are made following a risk assessment for those patients who cannot wear a face mask due to clinical condition Clinicians ask and encourage patients to wear a face mask when on ward rounds.
• Implementation of the supporting excellence infection prevention and control behaviours implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Toolkit reviewed	Require feedback from IPC team as to anything specific utilised IPC Newsletter to commence 2022 IPC link with communication team to review	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases	Local patient screening programme follows national guidelines. Local screening is day of admission (day 0) then day 3 then day 5 and local screening guidelines for outbreak and also screening of patients who have been in contact with a patient with COVID. Assessment undertaken via telephone pre visit Use of telemedicine	There is no process in place to provide executive team compliance with covid swabs	Discussed at daily safety huddles chaired by chief nurse
• front door areas have appropriate triaging	Signage clear at the entrance/reception area	Audit of all admissions to ensure swabs taken.	Meeting with IT to request if data can be provided to ensure compliance with covid

arrangements in place to cohort patients with possible or confirmed COVID-19 cases to minimise the risk of cross-infection as per national guidance • staff are aware of agreed template for triage questions to ask	and on trust website Temperature/PPE stations an entrance/exits Screens in place in reception areas Additional reconfiguration in other clinical areas in line with surge plan. All admissions are swabbed and COVID-19 status is available on EP2. Intranet has policies that cover all patient pathways	History of Covid <90 not recorded on admission documentation Limited access to rapid testing	swabbing Request for work submitted to include on admission documentation
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Policies and protocol are in place COVID-19 policy Guidance for admission of Known or Recent Positive COVID -19 Patients Beds allocated on Chavasse ward for any suspected/ covid positive patients Bed managers risk assessment	Staff not following policy.	All staff made aware of policies
• face coverings are used by all outpatients and visitors	Mask holders available at all entrances to the hospital with posters asking and informing how to use Posters advertising the requirements for staff and patients and visitors to wear surgical masks at all times and at entrances, visitors are asked to change face covering to surgical mask by member of staff Posters asking visitors to replace face covering with face mask when entering the hospital	Patient unable to wear a face covering due to clinical condition No Guidance available if the patient can't wear a face covering, guidance needs to be provided by IPC Patients not aware of the need to wear a face mask Patients do not have a face mask Patients refusing to wear any type of mask or change their face covering for a FRSM	Staff at patient entrances to support and help with patient/visitor enquiries. Visitors/patients refusing to wear the recommended face protection are challenged.

• Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	Side room priority includes CEV patients.	Not enough side rooms to accommodate those that are risk assessed as requiring a side room. No Policy available identifying CEV patients.	Datix promoted to be completed when patients who require a side room are not isolated due to conflicting priorities for the side rooms. Those patients that require a side room are risk assessed
• clear advice to patients on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward)providing it is tolerated and is not detrimental to their (physical or mental) CARE NEEDS.	Posters displayed throughout the ward promoting mask compliance at ALL times for patients. All trust staff encouraged to remind patients to wear a mask at all times to ensure safety of all.	Patients refusing to wear face masks No Patient leaflets available these need to be provided and created by IPC lead Guidance available on assessment of those who report difficulties wearing a surgical face mask'	Posters giving clear guidance on the requirement for all patients to wear a surgical mask at all times Point prevalence audit weekly covers ward walks and observations regarding patients wearing face masks; this is to commence 4/10/21. IPC daily walkabouts
• patients, visitors and staff are able to maintain 2 meter social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens e.g. to protect reception staff	Bed spaces are all 2 metres apart, measured from the middle of the bed where the patient would lie. Patient pathway document Enhanced screening programme	Screens required for outpatient waiting room as capacity increases Socially distanced bed are in continual use Areas are not assessed and screens are available for all areas identified as requiring screens with a screen ordering tracking system. Deputy chief nurse requested IPC commence audits w/c 4/10/21	Additional PVC curtains is being trialed on Sherrington ward
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative.	Covid dashboard Contact tracing takes place for all patients confirmed with COVID	Contact tracing does not take place until confirmed Positive. Incorrectly labelled samples, potential delay in results due to sample not processed	IPC follow up all confirmed COVID patients daily Bay is closed (incl no admissions) and treated as suspected covid where patients who have been exposed to COVID are nursed Labelling of samples discussed at Trust

		Compliance is sub-optimal	safety huddle Trust plan to Order Comms system
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	Local testing protocols reflect National guidance		Need IT solution to provide full assurance Ad hoc audit of screening
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Screening policy developed for all patients, in patients or out patients. Information available regarding shielding patients	No records kept centrally on how many people preset who have COVID symptoms	Patients are asked at the start of their appointment and on admission to the trust if they have symptoms of COVID or if they have been in contact recently with anyone who has COVID
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: Patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Patient pathway Guidance Floor signage Back entrance restricted to Staff only Maximum occupancy notices in break areas additional break areas provided	Visitors attending the hospital out of hours	Front Patient entrances are manned by staff who question visitors regarding purpose of visit.
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance, to ensure their personal safety and working environment is safe	IPC mandated training for all employees. Video remains on line and latest guidance available on intranet and in clinical areas. PPE displays at main reception. Daily monitoring of application of PPE standards. IPC standards re-iterated to all outside contractors.	Not all training records are held centrally and not all electronic Gaps in assurance for FITT testing Specific training has been provided for facilities, estates and contactors including enhanced donning and doffing	Mandatory training reported monthly Process is being developed to ensure all records are updated on OLM. Currently managed manually. Staff received training in changing cartridges, decontaminating and storing their reusable RPE, and donning and doffing procedures. Seats arranged on a marked floor to ensure separation in appropriate areas

	Policies reviewed and revised to reflect national guidelines	and fit testing.	Maximum occupancy sign in place.
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it	PPE policy available.	Unable to provide assurance that staff are trained in donning and doffing	Audit of PPE protocols completed by IPC team when visiting every ward and advice and support given in real time. Perfect ward meeting taken place on 4/10/21 and requested a demo to senior nursing team so as a trust we can start providing audit results in real time and have all clinical audits electronic Posters available to update staff and revised as guidance is reviewed by PHE
• a record of staff training is maintained	Mandatory training on ESR Local records available	Not all records on OLM Audit required	Manual records in place , plan for development of BI portal for live recording of training records
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Practice monitored during walkabouts	Frequency reduced due to PPE requirements and social distancing Documented evidence of review of staff practices is required ANTT roll out and Hand hygiene competencies required	Practice monitored during walkabouts
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters ○ good respiratory hygiene measures ○ staff maintaining physical and social distancing of 2 metres	Hand hygiene technique as a visual picture is available in clinical areas Social distancing guidelines available Checklists developed for identifying high touch surfaces and which staff group cleans what i.e. Domestics and nurses.	Staff not aware of the annual campaign of **catch it, bin it, kill it**. Staff and patients not aware of the trust policies and protocols Staff and domestics not aware of changes in practice	Environmental cleaning audits completed National **Catch it! Bin it! Kill it!** Posters on display throughout the trust in patient and non-patient areas Posters for staff regarding PPE use and when to wear what Checklist visible as an aide memoire and signoff trial in place on Sherrington ward for ISS staff to

wherever possible unless wearing PPE as part of direct care o staff are maintaining physical and social distancing of 2m when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace o frequent decontamination of equipment and environment in both clinical and non-clinical areas o clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Guidance written and verbal to all staff regarding staff maintaining social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace Posters visible throughout the Trust regarding the use of FRSM for patients/visitors and staff		identify when cleaning has taken place and at what frequency Rotas introduced to minimise staff attendance when working from home is not an option. Screens provided at receptions to provide separation between patients and staff and in some offices to provide separation between desks.
• staff regularly undertake hand hygiene and observe standard infection control precautions	Process in place for hand hygiene audits and standard IPC observations. Handwashing competence to be approved as part of ANTT protocol for ALL staff.	Variability of standard of hand hygiene compliance	Monitoring of compliance via IPCC, audits and walkabouts. H/H assessment reviewed
• the use of hand air dryers should be avoided in all clinical areas . Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	No hand dryers in the trust Paper towels available in all visitor toilets Posters on visitor's toilets regarding the need for hand hygiene following using the toilet.		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand hygiene posters are available reflecting information that can be found within the hand hygiene policy regarding the importance of drying hands well with paper towels		Re-iterate the importance of hand drying
• staff understand the requirements for uniform laundering where this is not provided for on site	Uniform policy states standard required when laundering uniforms	Staff leave the site in uniform	Messages via communications on a frequent basis reminding staff of the standards

• All staff understands the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	Trust intranet All pathways revised in line with new symptoms guidance and communicated to staff via Trust communications. Policy available for 'Symptomatic staff and household member swabbing and return to work'	Staff attend work with symptoms Staff are not aware of symptoms	Staff are asked at every safety huddle if they have had symptoms – low threshold Lessons learnt resulting from staff absences /outbreaks when staff have attended work with symptoms is shared with Teams
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Discussed at daily trust wide huddle if required IPC COVID dashboard available. Staff testing data received by Covid team at frequent intervals during the day Patient testing data received at regular intervals		Completion of NHSE/I data base for declaring outbreaks
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	'Management of COVID-19 Case Cluster Outbreaks' p Outbreak meetings take place on a regular basis following the declaration of an outbreak Electronic reporting of Outbreaks once declared, including ongoing updates of any changes, which has replaced the IIMARCH report.	Outbreaks are missed National guidelines are not followed Electronic reporting of all Outbreaks within 48 hrs of the first meeting	Daily updates of positive cases Following national guidelines all COVID infections that are determined probable or definite hospital onset trigger a local RCA. If an outbreak is declared, once it is closed a Table top exercises is arranged to discuss mitigations introduced to bring the outbreak to a close and the lessons learnt during the investigation and management of the process.
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	'Management of COVID-19 Case Cluster Outbreaks' available with clear information regarding roles and responsibilities on how an Outbreak is determined and the action to take	Staffing pressures result in no local ownership of the Outbreak. Bed pressure has a significant impact on following policy and	Senior teams support attendance at Outbreak meetings. Using a risk assessment approach any deviation from the guidelines involves Infection

	All outbreak meetings have agendas, minutes and timelines	guidelines	Prevention. Outbreaks have agendas and are minuted and shared with divisional teams
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Ward RAG rating for placement of patients All side rooms have en-suite facilities All positive patients nursed within the same area COVID-19 Dashboard	Pathways cross as staff are not aware of any changes	Wards identified for different pathways. Multi-disciplinary staff groups informed and information cascaded
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Covid 19 policy	Staff /patients/visitors do not follow the guidance	Perspex Screens and retractable screens available across the site to assist with segregation.
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Ward RAG rating for placement of patients All side rooms on Chavasse have en-suite facilities Bays on Chavasse have toilet/shower facilities in the bay All positive patients nursed within the same area COVID-19 Dashboard	Limited availability of side rooms on general wards Not all side rooms or cohort areas have en-suite facilities.	Monitored via command and control structure. Bed base reviewed by Bed Manager continually
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Patients are admitted when possible to a single negative pressure room / area or a neutral pressure room. Cohort areas are identified when no single rooms are available Isolation policy available		Designated toilet for patients with known or suspected infections Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation

	Decontamination policy available. All efforts are made to continue with isolation/cohorting of patients with alert organisms.		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Daily infection list MDRO Policy Covid 19 policy Isolation policy Standard IPC precautions are adhered to for all patients		Identified cohort areas when isolation is not possible
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	SOP in place for testing, authorized by the Clinical Director, the process has been validated (to UKAS accreditation standard) and staff have been trained appropriately and this has been logged. LCL guidance on testing and packaging of samples SOP for staff testing		Laboratory has accreditation and ongoing site visits by external organisations to assess standards, labs are on Aintree /Royal site. SLA in place
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	All urgent suspected COVID-19 tests are processed in Aintree lab Our trust testing algorithm is based on PHE guidance. COVID Screening in place: a) Diagnostic testing of patients b) Discharge screening of patients to Nursing homes and CRX/WNRU c) Screening of elective cancers surgeries d) Screening of staff e) Screening of admissions	Staff are observed; standards of documentation vary regarding competencies. Turnaround times of swabs can be lengthy Rapid testing availability is limited	

	f) Criteria for rapid testing		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Monitored by Lab and IPC team and escalated if required		Difficulty with turnaround times are raised via command and control/safety huddle any exceptions are escalation
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC review all COVID positive patients to ensure that they follow the individual patient pathway. Covid 19 policy		Meeting planned with It to have IT solution to aid assurance re covid swab compliance
• screening for other potential infections takes place	All admissions are screened in line with the local screening guidance. - Routine diagnostics operational in lab - Systems and SOPs exist in Laboratory for screening all alert organisms (eg MRSA, VRE, C-diffcile, CPE, etc).	Not all screening takes place that follows national guidelines Limited compliance data	
• that all emergency patients are tested for COVID-19 on admission	Covid 19 policy MDRO policy Quarterly audits undertaken MRSA policy HCAI surveillance CPE Policy Outbreak screening guidance Pre op screening Covid dashboard Patient placement guidance Screening policy available that includes • All patients being screened on admission , regardless of symptoms or not. • Patients are screened again on day 3, day 6 and then every 5 days. • Those patients that go onto develop symptoms are screened immediately.	Screening does not follow policy Lack of data to provide assurance to executive team	
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.			
• that sites with high nosocomial rates should consider testing COVID negative patients daily.			
• that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.			
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge			

• that those being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation. • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	• During periods of high nosocomial transmission screening frequencies are discussed by a MDT team • Patients discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge • That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. • That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	All IPC Policies and COVID related Policies (including SOPS) are available to all staff via intranet and these are also cascaded when first ratified by communications Mandatory health and safety training Induction training Ward manager meetings / IPC Committee / PNF	Staff may not always follow Policies and guidance Staff may not always view the intranet	Annual mandatory IPC training Add hoc learning sessions take place with staff as and when required Refer to appropriate policy during education sessions, signpost to intranet page
• any changes to the PHE national guidance on PPE are quickly identified and effectively	Command structure. COVID -19 policy PPE posters		Safety huddles Links available on the intranet Discussion at Trust safety huddle

communicated to staff	COVID 19 intranet page Communicated via Command and Control/daily COVID-19 comms		Staff support and education Mandatory Health and Safety
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Waste disposal policy based on national standards. Covid 19 policy Waste audits Health and safety committee minutes	Waste contractor cannot meet unprecedented demand. Staff do not follow the policy Non-compliance to correct waste segregation	Facilities team informed of all wards status to ensure that the correct waste bags are available and laundry and waste is collected as per policy Monthly report on waste and linen at the H&S meeting
• PPE stock is appropriately stored and accessible to staff who require it	Stock issues and receipts are managed electronically any concerns escalated at trust daily safety huddle PPE stocks are topped up PPE Distribution Hubs have been created to manage regionally and control the distribution of those PPE items in limited supply (specifically FFP3 masks) whilst ensuring staff have access to PPE when required.	Stock deliveries via the national PPE Dedicated Distribution channel are regular. Inability to request a preferred manufacturer and model of FFP3 masks from the center has meant that there is a requirement for staff to be fit tested on available stock.	CMHP has also established a **Mutual Aid** programme, and is developing a system to ensure a more equitable distribution of stock across the region based on accurate daily "burn rate" data provided by each trust. Requests for PPE in very short supply (less than 48 hours in stock) are raised via **NSDR** (National Supply Disruption Route). Fulfilment rates are variable and dependent on the number of COVID-19 patients being treated and the volume of stock held by the Trust. Ongoing fit testing programme in place by a dedicated team to ensure staff are tested on the current stock. Any concerns are escalated and also use daily safety huddle
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and	Risk assessments are being completed by managers for all staff which includes mitigating actions and control measures to protect those at risk.	Adequacy of the risk measures and controls not yet reviewed ? have assurance all are completed	Information has been placed on the intranet and regularly communicated to all staff within the Trust who wishes to access available wellbeing support services.

managed appropriately including ensuring their physical and psychological wellbeing is supported	Guidelines and risk assessments are available regarding 'Reducing risk for BAME' staff. Staff in high risk groups for medical or other reasons have been supported to work from home or reassigned to low risk areas. Other staff working in high risk areas have been supported through the provision of wellbeing hubs, counselling services, night time welfare calls, distribution of food donations, wellbeing packs and information as well as communications and training regarding PPE. Information has been placed on the intranet and regularly communicated to all staff within the Trust who wishes to access available wellbeing support services.	Staff do not wish to engage with support	Trust has health and well being APP Guidance available on the HR section of the intranet regarding staff shielding, working from home assessments, support for staff shielding returning to work. Advice available for managers and employees on how to manage staff regarding COVID 19. Risk assessments are updated as guidance changes.
• that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Policy available following national guidelines	Staff do not complete the risk assessment with their staff	Data on BAME staff and completion of risk assessments are escalated to senior management to enable them to support managers to complete the risk assessment with their BAME staff and all other staff who fall into the at risk groups.
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Fit testing is based on PHE national guidance Link to training resources available on intranet	Variable approaches to cleaning the masks when they were first introduced. Lack of data for assurance	
• staff who carry out fit test training are trained and competent to do so	Accredited fit tester training	Staff may fit test staff without completing the competency training	Records kept for all staff who have undertaken the fit testing competency and they are not allowed to 'fit test;' others unless there is evidence they have completed the competency.
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	There is a guideline available containing the process. – 'SOP COVID-19 -FFP3 Mask Fit Testing' There is a guideline available for staff that have facial hair and require to be fit tested to enable them to undertake their clinical role. '*COVID-*	Staff may use the mask that they were not fit tested to Supply may become compromised	All staff is given the details of the mask they are fit tested to.

	19 Trust Policy for Fit Testing, PPE and Facial Hair' ***Fit test register***		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organization	Information is recorded and stored centrally	Compliance is not reported back to divisions	
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Staff is tested on at least 3-5 disposable masks that are available, those that fail on all disposables are then tested on re-usable half masks, if these fail then the hood is the last option. Personal issue reusable respirators Inputted on database SOP for staff testing COVID -19 staff support helpline Return to work assessment Occupational health HR COVID policy Hoods/reusable (personal issue) respirators provided	As there is no choice of model of FFP3 mask available and we have to use what is delivered there is the potential to not have the mask that staff need.	
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Staff who are unable to wear face protection and RPE are re-assigned to other areas as per national guidelines.		Staff who do not undertake clinical roles who cannot wear and form of face protection are advised and encouraged to work from home.
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Managers work closely with Occupational health and HR to ensure that staff that are unable to continue with their current role due to their inability to wear a mask are managed as per agreed guidelines.	Increased demand on occupational health may prevent the capacity to help each member of staff	
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Managers work closely with Occupational health and HR to ensure that staff who are unable to continue with their current role due to their inability to wear a mask are managed as per agreed guidelines.	Increased demand on occupational health may prevent the capacity to help each member of staff	
• Boards have a system in place that			Centrally held records of staff that have been fit

demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the Board	BOD receives monthly report on RIDDORs and Serious Incidents		tested are available and utilized when investigations are needed as evidence of training.
• consistency in staff allocation should be maintained, reducing movement of staff and the cross-over of care pathways between planned/elective care pathways and urgent/emergency care pathways, as per national guidance	It is local policy for Staff not to move between different categorised areas to promote patient and staff safety across pathways.	Shortages of staff may result in unplanned staff movement	Daily safety huddle to discuss staffing and advice. Local risk assessment completed if staff need to move. Staff advised to move down categories not up as the risk reduces Staff advised to change uniform if they have to move during shift It is advised that staff go directly to the ward they have been moved to when they start duty. Staff are only moved for clinical need and following local risk assessment.
• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in al patient care areas if not wearing a facemask and in non-clinical areas	Policies available regarding social distancing and the use of PPE Guidance for assessment of those who report difficulties wearing a surgical face mask, this is dealt with on an individual basis Guidance when outpatients do not wear a face covering COVID-19 precautions, social distancing & non-compliance - HR Guidance PPE and Alternatives for Respiratory Protection for COVID-19		IPC are contacted when any staff have difficulties with wearing masks to identify alternatives or movement away form a clinical area/working from home.
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated	Risk assessments are available for all departments that are RAG rated once complete. *'COVID-19 Risk Assessment Form'*	A number of areas are red for this escalated at SNT	

maximally for everyone		Departments not completing risk assessments or not rating them accurately	
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas	All staff wear FRSM wherever they work, the only time face mask can be removed is when a member of staff is in a room alone	Non compliance to policy	Posters available Staff work as a team to promote the wearing of face masks at the right time and in the correct manner
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Policy available for internal track and trace process. Covid line		Absence rates are monitored via the daily COVID dashboard and discussed at daily safety huddle chaired by chief nurse
• Staff that test positive have adequate information and support to aid their recovery and return to work.	Managers make contact with all staff who are on long term sick with COVID-19 to check on their welfare and establish a predicted time frame to return to work. Policy available regarding care and management of staff who are shielding that reflects the national guidelines. All staff who receives a positive result is notified accordingly by text message and support provided by IPC team. Any concerns and questions are addressed and advice is given as requested. Follow up support is also available if required. Policy available re : COVID-19 : Symptomatic Staff Swabbing and Return to Work Standard Operating Procedure ESR records Testing provided 7 days per week Access to psychological support	Departments not completing risk assessments or not rating them accurately	The HR team will regularly contact divisions to ask them to update their staff list of people who are shielding.

The Walton Centre NHS Foundation Trust

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date: 4th November 2021

Title	**The Walton Centre Charity Annual Report and Accounts 2020/21**
Sponsoring Director	Name: Mike Burns Title: Chief Financial Officer
Author (s)	Name: Zoe Stevenson Title: Financial Accountant
Previously considered by:	• Committee: The Walton Centre Charity Committee July 2021 (draft) October 2021 (final)

Executive Summary

The 2020/21 Annual Report and Accounts for The Walton Centre Charity are presented for approval by the Board.

The draft annual report and accounts were presented to the July 2021 Charity Committee. Following the completion of an independent examination they were then presented to the October 2021 Charity Committee as a final version. The Independent Examiner's report is contained within the annual report and accounts. No errors were identified during the independent examination.

Related Trust Ambitions	Delete as appropriate: • Be financially strong
Risks associated with this paper	If the accounts are not approved they cannot be submitted to the Charity Commission.
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	Submission to the Charity Commission
Action required by the Board	• To Approve

The Walton Centre Charity
Annual Report and Accounts 2020/21

The Walton Centre Charity
Supporting Excellence in Neuroscience

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Welcome to The Walton Centre Charity Annual Report for 2020/21

The impact of the COVID-19 pandemic has been felt in every corner of the globe, and the effect on the charity sector cannot be underestimated. However, as a hospital charity, the need for our support has never been so important and it is overwhelming how our supporters have continued to raise money and donations for us over the past year through traditional and new ways.

Social restrictions prevented the delivery of the Charity's annual fundraising events such as the Hope Mountain Hike, the Golf Day and the Jan Fairclough Ball, but despite all the challenges and restrictions, there were still amazing efforts made by supporters to fundraise. The result of these donations has meant a huge amount to both our patients and our staff ensuring teams across The Walton Centre can continue to provide the very best treatment and care to patients, and their family and friends – often from afar given the restrictions imposed by the pandemic.

Supporting patients and staff through the COVID-19 pandemic was a big part of our work over the past year. At the onset of the pandemic and in response to the general public's desire to support the NHS during this crisis, the Charity launched an emergency appeal to support Walton Centre staff, volunteers and patients. This raised £16,500. In addition to the local appeal, the Charity also received grants totalling £147,600 from the national Covid-19 appeal co-ordinated by NHS Charities Together. Thank you to every single one of our supporters who generously contributed at what was a difficult time for so many of you.

There was also an incredible outpouring of kindness and generosity from the local community in the form of gifts-in-kind donations. Both the financial and the in-kind donations really helped lift the morale of staff teams at the hospital during stressful and difficult times.

The Charity also continued its funding of innovation and technology, and research across the hospital. Two pieces of surgical equipment which will make a significant difference to patients were funded this year, as well as a pioneering digital platform for use by patients in the Complex Rehabilitation Unit.

While a difficult year for so many people, I have been touched and heartened throughout by the lengths our supporters have gone to, thinking of others before themselves and taking the time to fundraise or make a donation. The kindness and generosity means so much to everyone at The Walton Centre and makes an enormous difference. Thank you.

Su Rai
Chair, The Walton Centre Charity Committee
and Non-Executive Director, The Walton Centre
NHS Foundation Trust

Cover image
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Objective

For any charitable purpose or purposes relating to The Walton Centre NHS Foundation Trust and such other places as the Trustee shall from time to time determine.

The Charity includes 28 earmarked funds which have been set up to enable the Trustee to meet the wishes of donors who have indicated that they would wish to have their money spent to benefit a specific ward/department or area of research. A full list of the funds is provided on page 26 of this report. Details of the fund managers and aims and objectives for each fund are provided on page 27.

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Public benefit statement

The Walton Centre NHS Foundation Trust is the main beneficiary of the Charity and is a related party by virtue of being Corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to best effect for the benefit of the public served by the Trust.

When deciding on the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main objective, strategies and plans of the Trust, whilst ensuring that the grants reflect the wishes of the donors, patients and staff.

The focus of the Charity's activities is to benefit the public who utilise the services of The Walton Centre NHS Foundation Trust. The hospital mainly services the community of Cheshire, Merseyside, North Wales and the Isle of Man, all of whom have equal access to its facilities. Charitable expenditure is made by way of direct grants to The Walton Centre NHS Foundation Trust, to enhance the patient care already provided. The agents of the Corporate Trustee have complied with their duty to have due regard to the guidance on the public benefit published by the Charity Commission in exercising their powers of duty.

Fundraising regulation

The Charity strives to give the best possible donor care to ensure supporters are treated fairly and with respect. The Charity is regulated by the Charity Commission and Fundraising Regulator, the self-regulatory scheme for fundraising in the UK. In addition to this, the Charity is a member of NHS Charities Together and the Chartered Institute of Fundraising.

Fundraising activities, donations and legacies

During the year the total donations, legacies and income from fundraising events (shown as 'Other trading activities' in the Statement of financial activities) came to £508,000 (total income including return on investments £529,000).

As referred to earlier, the effects of the pandemic severely impacted the Charity's ability to fundraise during this year, as government restrictions prevented the delivery of all planned fundraising activities and events. As a result, the total cost of fundraising decreased by £42,000 on the previous year, as there were no costs directly related to managed events. Despite all the challenges of this year there were still amazing efforts made to fundraise despite, but in adherence to, the restrictions in place. Individuals took up their own personal challenges to fundraise – whether that was running, cycling or walking – and there were a number of 'virtual' events using social media and other online platforms. Consequently, the Charity website and other digital platforms played a particularly significant role during this year to help facilitate fundraising in different ways.

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Examples of activities carried out to raise funds during the year under review include:

Fundraising activities and donations

- The launch of an online emergency COVID-19 Appeal through the Charity website to help support the physical and mental health and wellbeing of staff as they cared for patients during the first lockdown. This raised £16,500.
- A 'Virtual' Ladies Lunch where participants were encouraged to hold their own lunch, make a donation and share pictures through social media. This raised £2,000.
- A Christmas Appeal through the Charity website, including the sale of Christmas cards online. This raised £7,400.
- The launch of a weekly lottery scheme in collaboration with Everton in the Community, securing 50 new members between November and end of March 2021.

Grant making trusts and foundations

In addition to the grants from NHS Charities Together totalling £147,600, a further £10,000 was received from the Gwyneth Forrester Trust and £5,000 from the Zoom Trust.

Legacies

During the year under review the Charity received a total of £95,000 in legacy income. In order to facilitate supporters wishing to leave gifts in their wills, the Charity also partnered with an online will writing service, to support legacy marketing and giving.

Review of the year

During the year the Charity received a total income of £529,000 (2019/20: £808,000) which is a decrease of £279,000. The overall decrease can, in the main, be attributed to the drop of £319,000 in legacy income from £414,000 in 2019/20 when the Charity received its single largest legacy to date, to £95,000 in 2020/21.

The year under review also saw an increase in donations from £241,000 in 2019/20 to £409,000 in 2020/21, an upturn of £168,000. A significant proportion of this was grants totalling £147,600 from NHS Charities Together following the national COVID-19 Appeal. The effects of the pandemic severely impacted the Charity's ability to fundraise during this year. Social restrictions prevented the delivery of planned fundraising events and the lockdown periods made it difficult for supporters to carry out any activities or initiatives in the community.

At the onset of the pandemic and in response to the general public's desire to support the NHS during this crisis, the Charity quickly mobilised and launched an emergency appeal to support Walton Centre frontline staff, volunteers and patients. This raised £16,500. In addition to the local appeal, the Charity also received grants totalling £147,600 from the national COVID-19 appeal coordinated by NHS Charities Together.

Donations and grants received from these two appeals funded a number of initiatives in direct response to need and support opportunities identified by the Trust, including free breakfasts and snack bags for staff during peak pressure times, wellbeing packs for volunteers, heated marquee during winter months to ensure social distancing for staff taking breaks, refurbishment of the junior doctors' mess and plans to improve existing staff break areas, and the implementation of a dietician snack trolley for patients.

During the first lockdown there was also an incredible outpouring of kindness and generosity from the local community in the form of gifts-in-kind donations delivered in bulk for the benefit of staff and patients. These included items such as bottled water, soft drinks, Easter eggs, refreshments and treats for staff rooms, toiletries for patients, and scrubs/scrub bags made by volunteers in the community. The Charity's Fundraising Team managed the logistics of all gifts-in-kind donations, ensuring they were promptly and fairly distributed to staff and patients. These gift-in-kind donations were not material so are not reflected in our accounts, but the estimated total value was about £25,000. These acts of kindness really helped lift the morale of staff at the hospital during stressful and difficult times.

The Charity also supported the provision of a 'First Class Lounge' hosted by Project Wingman in June. Project Wingman was launched by furloughed airline crew, who came together to support the wellbeing of frontline NHS staff during the outbreak, by setting up spaces in hospitals for staff to unwind, decompress and destress before, during and after shifts. The 'First Class Lounge' in The Walton Centre was much appreciated by staff!

During the year under review, the Charity spent £685,000 in 2020/21 (2019/20: £422,000). The Charity's expenditure covers its charitable objectives, fundraising and governance support costs. In 2020/21 expenditure on charitable activities was £491,000 (2019/2020 £186,000) covering three main areas:

- **Patient welfare and amenities:** £199,000 (2019/20: £73,000) this included the Home from Home relatives' accommodation, cutting-edge medical equipment including a Spinal Endoscope and a Star Arm-board, and ward games and activities,
- **Staff welfare and amenities:** £158,000 (2019/20: £22,000) – expenditure on staff welfare and amenities increased significantly against the previous year because of the grants from NHS Charities Together, which were specifically to support the health and wellbeing of staff as they responded to the challenges of the pandemic. In addition to welfare and amenities, funding was also made available for professional development, such as enhanced study courses, training and conferences, to ensure staff remain at the forefront of clinical, research and personal developments. £6,905 was provided for this purpose. Expenditure also included enhanced study courses and training and conferences for staff, which will enable them to provide a better service to patients of the Trust.
- **Research:** £95,000 (2019/20: £52,000) – this included funding for research posts, equipment, training, books and journals.

Including the £168,000 net gain on investments, (which is treated as a component of net income), the total income for the Charity exceeded expenditure by £12,000 for the year.

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Volunteers

The Trust currently has approximately 60 registered Volunteers working in various departments throughout the Trust.

The volunteers provide a much needed trolley service for the inpatients and staff. Other volunteer activity includes the meet and greet service, infection control; neuro buddies; gardening; Pain Management Programme and Neurophysiology Outpatient services. The Volunteer service is supported by the Charity.

During the year under review, all the above mentioned roles were suspended as the Volunteers were not able to come to site due to health and safety and infection control restrictions. Some of the Volunteers were identified as having to shield following government guidelines, so the Charity funded health and wellbeing boxes sent to their homes to ensure they felt valued and appreciated, and the Patient Experience Team kept in touch with them on a regular basis throughout the year.

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Forward look

The Charity aims to continue its work to fund a variety of projects which will help improve patient care and services. These include new technology and innovations, and research as well as improved facilities for our patients and families.

The Charity will also continue to support staff with health and wellbeing initiatives, as well as enhanced training opportunities to ensure they can remain at the forefront of clinical and research developments to the benefit of patients today and in the future.

The Charity was due to develop a new three-year Fundraising Strategy for 2021-2023 but due to the uncertainty of the current landscape, both in relation to COVID-19 restrictions and the financial impact caused to the corporate and community sectors, a one year bridging plan will instead be developed.

The plan will explore options to adapt the fundraising business model and strategy to support income generation in this new environment. This will include where possible to restart annual events in person, and in line with government guidelines, but with a more hybrid approach to the delivery in order to enable virtual/online participation if necessary.

Focus will also be to increase individual giving through regular patterns, such as monthly direct debit donations, lottery scheme, and Facebook fundraising events as well as a more proactive legacy marketing campaign.

Work will also continue to implement and promote the process through which future fundraising projects can be identified. The process ensures that wider engagement with clinical staff occurs and includes relevant levels of approval to make sure that any potential major charitable investments are in line with and support the overall corporate strategic direction of the organisation.

Structure, governance and management

The Walton Centre Charity was established in 1992 using the model declaration of trust for NHS charities and all of the funds held on trust at the date of registration were registered under the umbrella Charity.

Following discussions with the Charity Commission it was determined that ward and departmental funds should be registered as part of the General Purpose Fund as would any monies received for purposes which had a finite life. This is on the basis that hospitals are continually evolving organisations and the bureaucratic impact on the Charity and the Charity Commission would be significant if the ward funds were registered as separate charities. This is because of the legal requirements surrounding changing fund objectives or the winding up of funds. Subsequent donations and gifts are added to the appropriate earmarked fund balance within the existing Charity or a new earmarked fund is created.

The Charity has procedures in place to ensure that it fulfils its legal duty of ensuring that funds are spent in accordance with the objects of each fund. The use of earmarked funds also allows the Charity to respect the wishes of donors in indicating how they would like their donation spent without imposing a material administrative burden. A full list of the funds, fund advisors and objectives for each fund are provided in Appendix 2 on page 27.

All expenditure is recorded as grant expenditure as the recipient organisation (normally The Walton Centre NHS Foundation Trust) requires beneficial ownership of any assets. Applications for expenditure are submitted to the Charitable Funds Administrator who ensures that they are properly authorised and in accordance with the relevant fund's objectives.

Each separate fund has a fund advisor who is an authorised signatory and has delegated authority to approve expenditure in line with the objective of the fund up to £1,000. Items of expenditure between £1,000 and £5,000 must also be authorised by the Director of Finance. Any expenditure in excess of £5,000 is approved by the Committee.

Non-Executive members of the Trust Board are appointed by the Foundation Trust Governors and Executive members of the Board are subject to recruitment by the NHS Foundation Trust. Members of the Trust Board and the Committee are not individual trustees under charity law but act as agents on behalf of the Trustee.

Day-to-day administration of the funds is dealt with by the Financial Accounts section of the Finance Department.

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Reference and administration details

Name

The Walton Centre Charity

Charity Commission number

1050050

HM Revenue and Customs number

XR4801

The principal contact of the Charity

Mike Burns
Director of Finance and Information Technology
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

T 0151 556 3482
E Mike.Burns@thewaltoncentre.nhs.uk

Bankers

Royal Bank of Scotland
Liverpool Group of Branches
1 Dale Street
Liverpool L2 2PP

Independent examiner

Peter Taaffe FCA CTA DChA
BWM Chartered Accountants
Castle Chambers, 43 Castle Street
Liverpool L2 9SH

Investment advisors

CCLA
Senator House
85 Queen Victoria Street
London EC4V 4ET

Ruffer LLP
80 Victoria Street
London SW1E 5JL

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Trustee

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. For the purpose of this annual report and these accounts the sole corporate trustee is referred to as The Walton Centre NHS Foundation Trust ("the Trust").

The Board of the aforementioned Trust has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee ("the Committee") which administers the funding on behalf of the Trustee. In the year ended 31 March 21 the following people served as directors of the Trustee:

Janet Rosser
Chair

Hayley Citrine
Chief Executive

Dr Andrew Nicolson
Medical Director

Seth Crofts
Non-Executive Director

Sheila Samuels
Non-Executive Director (to 31/08/20)

Nalin Thakkar
Non-Executive Director

Barbara Spicer
Non-Executive Director (to 30/09/20)

Su Rai
Non-Executive Director

Karen Bentley
Non-Executive Director (from 01/11/20)

David Topliffe
Non-Executive Director (from 01/11/20)

Mike Burns
Director of Finance and Information Technology

Mike Gibney
Director of Workforce and Innovation

Jan Ross
Director of Operations and Strategy
and Deputy Chief Executive

Lisa Salter
Director of Nursing and Governance

Lindsey Vlasman
Acting Director of Nursing and Governance
(from 07/09/20 to 10/01/21)

In the year ended 31 March 2021 the following people served on the Committee as agents for the Trustee, as permitted under Regulation 16 of the NHS Trust's (Membership and Procedures) Regulations 1990:

Su Rai
Non-Executive Director (Chair)

Nalin Thakkar
Non-Executive Director

Mike Burns:
Director of Finance and Information Technology

Lisa Salter
Director of Nursing and Governance

Lindsey Vlasman
Acting Director of Nursing and Governance (from 07/09/20 to 10/01/21)

Dr Sacha Niven
Consultant Neuroradiologist and Deputy Medical Director

Mr Neil Buxton
Consultant Neurosurgeon

Dr Peter Moore
Consultant Neurologist

Risk management

The Committee has examined the major risks affecting the Charity and identified the system and mechanisms in place to mitigate these risks.

The most significant risk identified is the potential loss incurred by a fall in the value of the Charity's investments. The Committee believe that the higher returns available from the stock market over the longer-term means that this is an acceptable risk, and also the Charity has balanced its investment portfolio to safeguard against a material loss in value, and has concluded that there is no material risk to the fund at present.

The close relationship between the Charity and the Trust means that the Charity benefits from the same controls designed to manage risk as the Trust. The Trust has developed various controls designed to mitigate the risk of loss through fraud or maladministration which have been applied to the Charity. Mersey Internal Audit Agency has developed a risk based approach which reviews the operation and effectiveness of these controls. The various controls are examined on a cyclical basis and the frequency is determined by the level of risk relating to that area of control.

Reserves

The Charity has a reserves policy that is reviewed every year. Reserves are part of the Charity's funds that are available for its general purpose after meeting its commitments and other planned expenditure. Reserves include unrestricted funds or income that can be expended at the Trustee's discretion in furtherance of the Charity's aims and objectives.

Such funds can be earmarked for a particular project but such a designation has an administration purpose only and does not legally restrict the Trustee s discretion to apply the fund.

The Trustee has adopted a policy which states that reserves will not be permitted to fall below a level equivalent to three months unavoidable expenditure, currently estimated at £60,000. At 31 March 2021 the Charity held £1,861,000 in reserves, all of which related to unrestricted funds.

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Investments

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. The Trust Board therefore has overall responsibility for the investment of the Charity's funds.

The Board has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee. In turn, full discretion has been given to external investment managers in the day-to-day management of the assets. The Trustee believes that the investment strategy inherent in the investment managers' discretionary actions is appropriate for controlling risk.

The main assets of the Charity were previously held in a segregated portfolio of investments managed by Investec Wealth and Investment Ltd. The Charity Committee, supported by the Trust Board, transferred the Charity's investments to two multi-asset pooled charity funds in July 2018: CCLA Ethical Investment Fund (50%) and Ruffer LLP Charity Assets Trust (50%).

The aim was to create greater diversification (minimising risk) and improved performance over the longer-term, as well as generating potentially lower fees.

Ethical investment describes a way of making financial investments which reflects the Charity's values and ethos and does not run counter to its aims. A Charity can decide to invest ethically, even if the investment might provide a lower rate of return than an alternative investment. The law permits the following reasons:

- A particular investment conflicts with the aims of the Charity,
- The Charity might lose supporters or beneficiaries if it does not invest ethically, and
- There is no significant financial detriment.

As an NHS Charity, The Walton Centre Charity has determined that it should not invest in tobacco companies because of the proven link between smoking and poor health which would make such investments contrary to its charitable aims.

The pooled funds operated by CCLA and Ruffer LLP satisfy this requirement. Any other restrictions applied by the investment managers should not limit the operations of the Charity.

During the year ending the 31 March 2021 the stock market continued the fairly volatile trend of the past few years. The market value of the funds at the 31 March 2021 was £1,162,000 which is £195,000 higher than the market value at the 31 March 2020. The Charity benefited from dividends and interest of £21,000 which represents a positive result, given the low risk nature of the investment portfolio.

Statement of Trustee responsibilities

It is a pleasure to present the Annual Report for The Walton Centre Charity ("the charity") together with the financial statements for the year ended 31 March 2021 which have been subject to an independent examination.

The annual report and accounts have been prepared in accordance with Part 8 of the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (effective 1 January 2016). The Charity's report and accounts include all of the separate funds for which The Walton Centre NHS Foundation Trust is the sole corporate trustee (the "Trustee").

All of the separate funds are designated parts of the Charity registered with the Charity Commission under the umbrella of The Walton Centre Charity with the registered Charity Number 1050050 in accordance with the Charities Act 2011.

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year and of its financial position at the end of the year.

In preparing financial statements giving a true and fair view, the Trustee should follow best practice and:

- Select suitable accounting policies and then apply them consistently,
- Make judgements and estimates that are reasonable and prudent,
- State whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements, and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enable them to ascertain the financial position of the charity and which enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed. The Trustee is responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements and notes set out on pages 16 to 25 have been compiled from and are in accordance with the financial records maintained by the Trustee.

Signed on behalf of the Trustee

Su Rai
Chair of the Charity Committee
00 October 2021

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Independent examiner's report to the corporate trustee of The Walton Centre Charity

I report to the Trustees on my examination of the accounts of The Walton Centre Charity (the charity) for the year ended 31 March 2021.

This report is made solely to the charity's trustees, as a body, in accordance with Section 145 of the Charities Act 2011. My examination has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an Independent Examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my examination, for this report, or for the opinions I have formed.

Responsibilities and basis of report

As the Trustees of the charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the Trust's accounts as carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I am a member of the ICAEW, which is one of the listed bodies.

Your attention is drawn to the fact that the charity has prepared financial statements in accordance with Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to the Accounting and Reporting by Charities: Statement of Recommended Practice issued on 1 April 2005 which is referred to in the extant regulations but has now been withdrawn.

I understand that this has been done in order for the financial statements to provide a true and fair view in accordance with Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the Act; or
2. the accounts do not accord with those records; or
3. the accounts do not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Peter Taaffe FCA CTA DChA
Independent Examiner
BWM Chartered Accountants
00 October 2021

Statement of financial activities

For the year ended 31 March 2021

	Note	2020/21	2019/20
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Income and endowments from:			
Donations and legacies		504	655
Other trading activities		4	126
Investments		21	27
Total income and endowments	3	**529**	**808**
Expenditure on:			
Raising funds		194	236
Charitable activities		491	186
Total expenditure	4	**685**	**422**
Net gains/(losses) on investments		168	(4)
Net income/(expenditure) and net movement in funds		**12**	**382**
Reconciliation of funds:			
Fund balances brought forward		1,850	1,468
Fund balances carried forward		**1,861**	**1,850**

All of the Charity's funds are unrestricted. The net expenditure for the year arises from the Charity's continuing operations. The notes on pages 19 to 25 form part of these accounts.

Balance Sheet

As at 31 March 2021

	Note	2020/21	2019/20
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Fixed assets			
Investments	6	1,162	967
Total fixed assets		**1,162**	**967**
Current assets			
Debtors	7	80	5
Cash at bank and in hand	8	680	951
Total current assets		**760**	**956**
Creditors: amounts falling due within one year	9	61	73
Net current assets/(liabilities)		**699**	**883**
Total assets less current liabilities		**1,861**	**1,850**
Total net assets		**1,861**	**1,850**
Funds of the Charity			
Unrestricted	10	1,861	1,850
Total funds		**1,861**	**1,850**

The notes on pages 19 to 25 form part of these accounts.

Signed on behalf of the Trustee

Su Rai
Chair
00 October 2021

Statement of cash flows

For the year ended 31 March 2021

	Note	2020/21	2019/20
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**(265)**	**379**
Cash flows from investing activities:			
Dividends and interest from investments		21	27
Proceeds from sale of investments		0	0
Purchase of investments		(27)	0
Net cash provided by (used in) investing activities		**(6)**	**27**
Change in cash and cash equivalents in the reporting period		(271)	406
Cash and cash equivalents at the beginning of the reporting period		951	545
Cash and cash equivalents at the end of the reporting period	8	**680**	**951**
Reconciliation of net income/(expenditure) to net cash flow from operating activities:			
Net income/(expenditure) for the reporting period (as per the statement of financial activities)		12	382
Adjustments for:			
(Gains)/losses on investments		(168)	4
Dividends and interest from investments		(21)	(27)
(Increase)/decrease in debtors		(75)	22
Increase/(decrease) in creditors		(14)	(2)
Net cash provided by (used in) operating activities		**(265)**	**379**

Notes to the financial statements

For the year ended 31 March 2021

1. Accounting Policies

1a. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments. The financial statements have also been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (effective 1 January 2016) and applicable UK Accounting Standards and the Charities Act 2011.

This is the sixth year that financial statements have been prepared in compliance with the Charities Statement of Recommended Practice (FRS 102). A Statement of Cash Flows has also been included.

1b. Incoming Resources

a. All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

   i. Entitlement – arises when control over the rights or other access to the economic benefit has passed to the Charity;

   ii. Probable – when it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity; and

   iii. Measurement – when the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

b. Legacies are accounted for as incoming resources when it is probable that they will be received. Receipt is normally probable when:

   i. There has been grant of probate;

   ii. The executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and

   iii. Any conditions attached to the legacy are either within the control of the Charity or have been met.

1c. Resource Expended

a. The funds held on Trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised when all of the following criteria are met:

   i. Obligation – a present legal or constructive obligation exists at the reporting date as a result of a past event;

   ii. Probable – it is more likely than not that a transfer of economic benefits, often cash, will be required in settlement; and

   iii. Measurement – the amount of the obligation can be measured or estimated reliably.

b. Cost of generating funds comprises the costs associated with attracting voluntary income.

c. Charitable expenditure comprises those costs incurred by the Charity in the delivery of its activities and services for its beneficiaries. It includes both costs that can be allocated directly to such activities and any costs of an indirect nature necessary to support them.

d. Governance costs include those costs associated with meeting the constitutional and statutory requirements of the Charity and include accountancy fees and costs linked to the strategic management of the Charity.

1d. Structure of Funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Other funds are classified as unrestricted funds. These are funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes as classified funds. The major funds held within these categories are disclosed in note 10.

1e. Investment Fixed Assets

Stocks and shares are shown at market value.

1f. Realised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between marked value at the year-end and opening market value or date of purchase if later.

1g. Foreign Currency transactions

All expenditure and income arising from transactions denominated in a foreign currency are translated into sterling at the exchange rate in operation on the date on which the transactions occurred.

1h. Change in the Basis of Accounting

This is the sixth year that financial statements have been prepared in compliance with the Charities SORP (FRS 102). There has been no material change in the basis of accounting during the year.

1i. Prior Year Adjustments

There has been no change to the accounts of prior years.

1j. Going Concern Assumption

The accounts have been prepared on a going concern basis and the Trustee has no plans to wind up the Charity, or concerns that it cannot continue as a viable entity.

2. Dividends and interests

Dividends are received for all stocks and shares in beneficial ownership of the Charity and are shown after recovery of tax where allowed. Interest is recorded for all bank accounts and short-term deposits made by the Charity.

The Walton Centre Charity Annual Report and Accounts 2020/21

3. Details of Income

	2020/21	2019/20
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Income and endowments		
Donations	409	241
Legacies	95	414
Fundraising activities and events	4	126
Investment income	21	27
Total income and endowments	**529**	**808**

4. Details of Expenditure

	2020/21	2019/20
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Raising Funds:		
Fundraising staff costs	169	164
Fundraising activities and events	25	72
	194	**236**
Charitable Activities:		
Patients welfare and amenities	199	73
Staff welfare and amenities	158	22
Research	95	52
Independent examination	1	1
Administrative support	38	38
	491	**186**
Total	**685**	**422**

All of the expenditure is accounted for as grants to benefit the staff and patients of The Walton Centre in line with the Charity's objectives.

5. Analysis of Staff Costs

	2020/21	2019/20
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Fundraising Staff Costs		
Salaries and wages	136	131
Social security costs	15	14
Employers pension contribution	19	19
Total Fundraising Staff Costs	**170**	**164**

The average number of full-time equivalent employees during the year was 3.3 (2019/20: 3.3). One employee received emoluments in excess of £60,000 in the current year in the salary band £60,000 – £70,000 (2019/20: one).

No Trustee remuneration or any other benefits have been paid from an employment with the Charity and no Trustee expenses have been incurred.

6. Analysis of Fixed Asset Investments

The investment portfolio is managed by CCLA and Ruffer LLP and the total amount invested with each manager to £500,000. The movement in the portfolio can be analysed as follows:

	2020/21	2019/20
	£000	£000
Market value at the beginning of the reporting period	967	971
Less Disposals at carrying value	0	0
Aquisitions at cost	27	0
Unrealised gains/(losses)	168	(4)
Market value at the end of the reporting period	**1,162**	**967**
Book cost at the end of the reporting period	1,000	1,000

All investments are held in the UK and the market value can be analysed as follows:

	2020/21	2019/20
	£000	£000
Listed investments	1,162	967
Total	**1,162**	**967**

7. Debtors

Debtors in respect of the following are represented in the accounts:

	2020/21	2019/20
	£000	£000
Prepayments and accrued income	80	5
Total	**80**	**5**

There were no debtors falling due over one year.

8. Cash and Cash Equivalents

Cash at bank and in hand is held to meet the day-to-day running costs of the Charity as they fall due. Cash equivalents are short-term, highly liquid investments, usually in 90 day notice interest bearing savings accounts:

	2020/21	2019/20
	£000	£000
Cash at bank and in hand	680	951
Total cash and cash equivalents	**680**	**951**

9. Creditors

The creditor position can be summarised as follows:

	2020/21	2019/20
	£000	£000
Amounts due to NHS Foundation Trust	0	25
Accruals	61	48
Total	**61**	**73**

There were no creditors falling due over one year.

10. Analysis of Funds

The movement in the funds during the year can be analysed as follows

	Balance as at 1 April 2020	Income	Expenditure	Revaluation of investments	Balance as at 31 March 2021
	£000	£000	£000	£000	£000
Unrestricted Funds	1,850	529	(686)	0	1,693
Revaluation Reserve	0	0	0	168	168
Total	**1,850**	**529**	**(686)**	**168**	**1,861**

A list of the unrestricted funds and their balances as at 31 March 2021 is shown in Appendix 1.

11. Related Party Transactions

During the year the Trustee, members of The Walton Centre Charity Committee and the key management staff, and parties related to them, had no personal interest in any contract, nor undertook any material transactions with The Walton Centre Charity.

The Charity delivers its charitable objectives by making grants to The Walton Centre NHS Foundation Trust. Grants made amounted to £453,000 (2019/20: £56,000). This included £116,000 for cutting edge technology which included a a Fully Endoscopic Spine Surgery (FESS) and a Star Arm board, also an individual grant of £27,000 from the Home from Home appeal to cover the running costs of the building. The Walton Centre NHS Foundation Trust provides administrative support to the Charity and in 2020/21 charged a fee of £36,000 (2019/20: £36,000).

12. Events after the Reporting Date

The Trustee is not aware of any events after 31 March 2021 and up to the date the financial statements have been approved which will affect the accounts.

Appendix 1

List of Funds and Fund Balances as at 31 March 2021

Fund Name		Fund Balance	
		2020/21	2019/20
		£000	£000
4009	General Fund	818	864
4010	NRU Fund	20	25
4015	Wards Fund	18	19
4017	Roy Ferguson Compassionate Care Fund	71	70
4019	Headache and Neurology Fund	1	1
4422	Pain Relief Research Fund	4	5
4442	Neuro General Research Fund	8	9
4457	Neuro Muscular Diseases Fund	1	2
4464	Cerebro Vascular Fund	28	29
4465	Home From Home	35	33
4481	Neurosurgical General Fund	32	44
4487	Horsley ITU Fund	76	85
4499	Epilepsy Fund	27	37
4527	R&D & Higher Study	20	21
4528	Neurophysiology Train. & Educ.	1	3
4530	Neurological Disability Fund	95	116
4533	Alan Sutcliffe Kerr Lecture Fund	11	12
4537	Cognitive Research Fund	3	3
4538	Stereotactic Fund	10	12
4541	Neurobiochemistry Fund	7	7
4543	Disorders Of Movement Gen Fund	60	61
4550	Research Fellowship	1	2
4552	Parkinsons Disease	9	17
4900	Neuro X-Ray Research	21	21
4905	Neurosurgical Neuro-Oncology	30	44
4910	Brain Infections Research	7	8
4911	Nmo And Atypical Disorders	18	18
4915	The Sid Watkins Innovation Fund	261	282
		1,693	**1,850**

Appendix 2

List of Funds, Fund Managers and Objectives

Fund	Fund Name	Fund Manager	Aims and Objectives
4009	General Fund	Finance Director/Quorum of Panel	Any charitable purpose relating to The Walton Centre
4010	NRU	E Cottier/R Moreton	Social and recreational facilities for inpatients, improving quality of life
4015	Wards Fund	L Salter	Items for wards to benefit patients, carers and staff; staff study support
4017	Roy Ferguson Comp Care Award	L Salter	Annual compassionate care project
4019	Headache And Neurology Fund	Dr Silver	Research into headache and allied disorders; support presentations
4422	Pain Relief Research Fund	Dr M Gupta/J Tetlow	Research and education
4442	Neuro General Research Fund	Dr Nicolson	Research projects relating to any aspect of clinical science
4457	Neuro Muscular Diseases Fund	Dr C Dougan	Research and teaching in the field of neuromuscular diseases
4464	Cerebro Vascular Fund	Dr Nicolson	Research, education, training and equipment
4465	Home From Home	Finance Director/Quorum of Panel	Maintain the relatives' accommodation
4481	Neurosurgical General Fund	Dr S Niven	Research, education, training and equipment
4487	Horsley ITU Fund	Dr Lakhani/M Rackham	Improve standard of care to patients and their relatives; study support
4499	Epilepsy Fund	Dr T Marson	Research
4527	R&D & Higher Study	C Chadwick	Research, education, training and equipment
4528	Neurophysiology Train. & Educ.	C Finnegan	Training/education for Neurophysiology staff
4530	Neurological Disability Fund	Prof C Young	Research/service development activities in disabling conditions
4533	Alan Sutcliffe Kerr Lecture Fund	Finance Director	Specialist research and education
4537	Cognitive Research Fund	Dr M Doran	Research and development
4538	Stereotactic Fund	Mr J Farah	Research and training
4541	Neurobiochemistry Fund	C Chadwick/N Moxham	Research, education, training and equipment
4543	Disorders Of Movement Gen Fund	Dr AP Moore	Research, education, development of new service initiatives
4550	Neuropsychology Fund	J Martlew	Research, patient education and equipment to benefit patients
4552	Parkinson's Disease	Dr M Steiger	Research, education and training
4900	Neuro X-Ray Research	Dr S Niven	Advancement of Neuroradiology
4905	Neurosurgical Neuro-Oncology	Mr A Brodbelt/ Mr M Jenkinson	Research, education, training and equipment
4910	Brain Infections Research	Prof T Solomon	Research
4911	Nmo and Atypical Disorders	Dr A Jacob	Research and patient care
4915	The Sid Watkins Innovation Fund	Finance Director/Quorum of Panel	Support innovation through The Walton Centre in research, prevention, diagnosis, treatment and the overall care of people with diseases or injury of the nervous system

Thank you

The Charity is grateful to all our donors and supporters for all they do to raise funds and awareness for The Walton Centre Charity, to help us make a difference to patients and their families both now and in the future.

Caption illaut omnis dolum et voluptia dolo quia cusant quide rero perferitium nis solorunt.

Contact us

If you would like to contact us about fundraising, events or volunteering please get in touch.

Call
0151 556 3466

Write
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L7 9LJ

Visit
thewaltoncentrecharity.org

The Walton Centre Charity
Supporting Excellence in Neuroscience

13 October 2021

PHT/AM/TP/WA034/481048

The Trustees
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
The Walton Centre
Lower Lane
Liverpool
L9 7LJ

Dear Sirs

During the course of the independent examination of the accounts for the year ended 31 March 2021, the following representations were made to us by management and trustees. Please read these representations carefully and if you agree with our understanding please sign and return a copy of this letter to us as confirmation of this.

1 You acknowledge as trustees that you have fulfilled your responsibilities under the Charities Act 2011 for making accurate representations to us and you confirm that the accounts for the charity are in accordance with the applicable financial reporting framework FRS 102.

You confirm that in your opinion the financial statements give a true and fair view and in particular that where any additional information must be disclosed in order to give a true and fair view that information has in fact been disclosed.

2 You confirm that all accounting records have been made available to us for the purposes of our independent examination and that all transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings, have been made available to us.

3 You confirm that significant assumptions used by you in making accounting estimates, including those measured at fair value, are reasonable, as set out in the attached list.

4 You confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the accounts have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

5 You confirm that there have been no events since the balance sheet date which require disclosing or which would materially affect the amounts in the accounts, other than those already disclosed or included in the accounts.

6 You confirm that you are aware that a related party of the charity is a person or organisation which either (directly or indirectly) controls, has joint control of, or significantly influences the charity or vice versa and as a result will include shareholders (as a guide with more than 20% of the voting rights), directors, trustees, other key management, close family and other business interests of the previous. You confirm that the related party relationships and transactions set out as

attached are a complete list of such relationships and transactions and that you are not aware of any further related parties or transactions.

7 You confirm that all related party relationships and transactions have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

8 You confirm that the charity has not contracted for any capital expenditure other than as disclosed in the accounts.

9 You have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the accounts.

10 The charity has satisfactory title to all assets, and there are no liens or encumbrances on the assets except for those disclosed in the accounts.

11 There are no liabilities or provisions other than those recognised and no contingent liabilities or guarantees to third parties other than those disclosed in the accounts.

12 You confirm that you are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its business, and which are central to the charity's ability to conduct its business (as set out in the attached list) except as explained to us and as disclosed in the accounts. The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance.

13 You acknowledge your responsibility for the design, implementation and maintenance of controls to prevent and detect fraud. You confirm that you have disclosed to us the results of your assessment of the risk that the financial statements may be materially misstated as a result of fraud.

14 You confirm that there have been no actual or suspected instances of fraud involving management or employees who have a significant role in internal control or that could have a material effect on the accounts. You also confirm that you are not aware of any allegations of fraud by employees, former employees, regulators or others.

15 You confirm that, having considered your expectations and intentions for the next twelve months, and the availability of unrestricted reserves, the charity is a going concern. You also confirm that the period that you have considered covers a minimum of twelve months from the date of this letter.

You confirm that, as detailed in the Trustees report, you have considered the impact of Covid-19 on the charity and have a reasonable expectation that the charity has adequate resources to continue in operational existence for the foreseeable future.

16 You confirm the accounts are free of material misstatements, including omissions. In your opinion, the effects of unadjusted misstatements are immaterial, both individually and in aggregate, to the accounts as a whole.

17 You confirm the following specific representations made to us during the course of preparing your accounts:

You confirm that you make use of internet banking and that adequate and appropriate controls over your internet banking facility/access were operational and effective throughout the year.

You confirm that your IT back up procedures and off-site cyber security are adequate, regularly tested, current and appropriate and that an up to date back up is available. You confirm that disaster recovery planning is conducted and reviewed periodically, and that adequate and appropriate insurance is carried.

You confirm that historic records are maintained for the minimum required (that is for the current and previous six years) to ensure, for example, that any future HMRC audit will proceed without irregularity.

You confirm that all of the related party transactions have been conducted at 'normal market rates', so that their disclosure in the financial statements is not required in order for the financial statements to show a true and fair view in accordance with the applicable financial reporting framework FRS 102.

You confirm that all grants, donations and other income, including any subject to special terms or conditions or received for restricted purposes, have been notified to us. There have been no breaches of terms or conditions regarding the application of such income.

You confirm that you are not aware of any matters of material significance that should be reported to the Charity Commission.

You confirm that all donated funds are correctly classified as unrestricted funds within the accounts and are correctly recorded within their separate funds.

Yours faithfully

BWM

The Walton Centre Charity

I confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and expertise (and, where appropriate of supporting documentation) sufficient to satisfy myself that I can properly make these representations to you and that to the best of my knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your work.

Signed on behalf of the Board of Trustees.

..... Date .....

Su Rai
Chair of The Walton Centre Charity Committee

Related party details

	Related party	Transactions
Corporate Trustee	The Walton Centre NHS Foundation Trust	Grants made amounting to £453,000 Admin support - £36,000

Directors of the Corporate Trustee:

Ms J Rosser	None
Ms H Citrine	None
Mr A Nicolson	None
Mr S Crofts	None
Ms S Samuels (*Resigned 31 August 2020*)	None
Mr N Thakkar	None
Ms B Spicer (*Resigned 30 September 2020*)	None
Ms Su Rai (Chair of TWCCC)	None
Ms K Bentley *(Appointed 1 November 2020)*	None
Mr D Topliffe *(Appointed 1 November 2020)*	None
Mr M Burns	None
Mr M Gibney	None
Ms J Ross	None
Ms L Salter	None
Ms L Vlasman (*Appointed 7 September 2020; Resigned 10 January 2021*)	None

And their close families

Laws and regulations

Charities Act 2011
Charities SORP
General Data Protection Regulations - GDPR
Money Laundering Regulations

The Walton Centre Charity
Year ended 31 March 2021

Accounting estimates

Estimate	How identified	Estimation method	Level of uncertainty
Year end accruals	Review invoices and payments after the year end	A provision is made in the year end accounts for any goods / service received in the year where the invoices / payments are not processed until after the year end date.	Low
Accrued income	Review of past income remittances received	Based on average of remittances received	Low
Year end prepayments	Review invoices and payments around the year end	Review invoices and adjust accordingly	Low

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 04/11/21		**Report of:** Quality Committee
Date of last meeting: 21 October 2021		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Medical Director's update • Integrated Performance Report • Infection Prevention & Control update • Quarterly Governance & Risk Management Report • End of Life Care update • Quality & Clinical Strategy progress update • Seizure management presentation (deferred) • Digital Strategy Update (deferred) • Local Cancer Patient Survey update • Quarterly Pharmacy KPI • Equality, Diversity & Inclusion update • Pathology Quality Assurance Dashboard (PQAD) • In Patient Survey Results report • Quality Committee Cycle of Business • Sub-Committees Chairs' reports and minutes
2.	**Alert**	• The patient story centred on a patient who collapsed at home due to an aneurysm. The patient's husband is tetraplegic and the family felt there were elements of unconscious bias with references being made that the patient is her husband's carer when this is not the case. Risks for the family were identified and addressed. The Committee recognised the issues highlighted by this story and felt it should be shared with staff. Some actions have been noted. • The Medical Director advised there had been a never event in which medication had been administered via the incorrect route. The patient was unharmed and appropriate investigations are in progress. Duty of Candour was actioned. • The Committee noted the excellent results from the In-Patient Survey with WCFT moving up from 9th positon to 8th. Work is on-going to continually improve the service.
3	**Assurance**	• The Medical Director advised that the CQC visit to Radiology with regards to Ionising Radiation on 30/09/21 was very successful with no areas for immediate improvement. It was also noted that the 24 hour/7day Thrombectomy service commenced in October and has been well received.

		• The Committee received assurances from the Risk Team that significant work is underway to support staff with violence and aggression incidents. The Violence & Aggression Strategy has been completed and will be presented to Trust Board. 100% of formal complaints received in Q2 were acknowledged within 3 working days and responded to within the negotiated timeframe meeting the Trust's KPIs. It was noted that a new risk pertaining to CPE has been added to the Governance Assurance Framework. • The Chief Nurse presented the KPIs on behalf of the Pharmacy Team noting that the majority of KPIs are on track. There are some areas that are reduced due to staffing challenges. It is hoped that a representative from Pharmacy will be able to attend the next QC meeting. • The Pathology Quality Assurance Dashboard was presented with assurances that the majority of areas are rag rated as green. Ms Hayes was unable to attend the meeting and has been asked to attend in November to provide an update with regards to the three areas RAG rated as red within Clinical Governance. • The E, D&I Lead provided an update of current workstreams noting that the Trust has joined a Race Equality Business Support Group, the SBAC meeting is scheduled for 08/11/21with actions being progressed. Black History month was celebrated with an E, D &I stand on the 1st floor. Advice was provided for colleagues on the covid vaccine. The need to relaunch disability work across the Trust was noted.
4	**Advise**	• The Medical Director advised that meetings have taken place with LUHFT regarding the transfer of Spinal Services to WCFT. • IPR – it was noted that nursing turnover has increased following a sustained period of improvement. Clarification of the recruitment and retention process was provided. A number of incidents within the Neurology Division remain open, however processes have been reviewed and incidents have been closed which will be reflected next month. The Divisional Nurse Director is pushing for Friends & Family Tests to be completed within Neurosurgery. Concerns were raised that risk assessments are not being completed and work is being undertaken to improve compliance. • The Committee received an update with regards to Infection, Prevention & Control. There are concerns with regards to the increases in incidents of MSSA especially within ITU. One of the Consultant Anaesthetists is taking the lead for IPC within the department. It was verified that action plans for MSSA & C. Difficile will be presented at the next IPCC meeting and actions are updated weekly. Hand hygiene is being closely monitored. • As part of Local Cancer Patient Survey update, Ms Crofton provided an update on progress of actions to date. It was noted that the team had planned to revise the local survey in quarter three however The Brain Tumour Charity have developed patient and carer surveys which can be accessed via the BRIAN app and the charity website. Ms Crofton also highlighted that the Neuro Oncology team is preparing for The Tessa Jowell Brain Cancer Mission (TJBCM) Centre of Excellence designation virtual site visit on the 10th November to showcase the service. • The Committee were advised that an SLA for EOL support from the Palliative

		Care Team has been embedded. The ToR for the EOL Group are to be reviewed. Bereavement services are to be reviewed post covid. Ms Crofton also shared a partial patient story which highlighted that visiting arrangements for patients at EOL had not been optimal. The Patient Experience Team will offer extra support to relatives who have a family member at the Trust who is at EOL. • The Quality & Clinical Strategy is to be reviewed at the November QC meeting.		
5	**Risks Identified**	**Recommendations for Trust Board** • Visiting for EOL patients		
6	**Report Compiled by**	Seth Crofts Non-Executive Director	Minutes available from:	Corporate Secretary

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Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 04/11/21		**Report of:** Business Performance Committee
Date of last meeting: 26/10/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Finance & Procurement Delivery Update • Integrated Performance Report • Transformation & QIP Monthly Exception Report • Digital Aspirant Programme Financial Forecast 2021-22 & Digital Aspirant Monthly update • Long Term Sickness • Sustainability Plan • Response to People Plan & Annual Staff Survey • Five Year Capital Plan Update • 2021-22 Cycle of Business • Chair Reports from 7 subcommittees • H2 Draft Plan
2.	**Alert**	• Integrated Performance Report (IPR): Elective and Day Case activity continues to lag the recovery plan, totalling 83.78% for September. Under performance was mainly due to staffing shortages in theatres. Average Referral to Treatment (RTT) wait increased in September for the first time in 6 months although month-to-date indicates an improvement. • The vast majority of the year's larger-than normal capital spend, for both Digital Aspirant and other capital, is now phased into the latter part of the year. Delay in equipment availability (especially those involving semi-conductors) risks overrun beyond year end which could result in a loss of funding and impact next year's plans. A decision on the award of 'Project Jupiter' (Transcranial MR Guided Brain focussed ultrasound system, tcMRgFuS) would add clarity. Spend will need be managed closely including bringing forward projects planned for next year to avoid loss of funding • With regards to the Cycle of Business, it was noted that several 'sub-strategies which were due for update/review had been deferred to better align with the overall Trust Strategy review.
	Assurance	• IPR: Performance for cancer treatment standards, outpatient activity and 6 week diagnostic performance continue to be met against the recovery plan. The new text reminder service had improved the Outpatient DNA rates in the first month of

		implementation • Sickness has increased to 7%. The deep dive into the management of long-term sickness was reviewed with line-manager/professional support provided. Appraisal compliance remains below target and the Committee asked that this was addressed by the People Group with a view to devising an action plan • H1 21/22 (April – September 2021) ended with a break-even position for income and expenditure as per plan. QIP schemes also achieved plan, albeit non-recurrently. However achieving the higher target required in H2 (October – March 2022) will be challenging. • The Transformation Projects for outpatients, patient flow and e-roster are on track but projects for theatres are delayed primarily due to staffing challenges • The Finance & Procurement departments have made good progress against their strategic plans, despite challenges. Significant progress is being made on the Health Procurement Liverpool Procurement Hub for Specialist Trusts • Positive progress is being made against the implementation of the People Plan and actions from the staff survey. It was noted that implementation of the Carer's Passport has been delayed due to staff capacity • The Digital Aspirant project programme is on track and RAG rated green against central tracking. Some concerns regarding equipment availability were noted.		

	Advise	• The Trust has been short-listed for two, high profile, international Health & Well-being awards through Investors in People and Engage Awards.
		• Following a meeting with the CEOs of LUHFT & WCFT is expected that the Spinal Services will transfer formally to WCFT from 1st December 2021.
		• The Finance Department suffered a 25% loss of staff over recent months, mainly via progression opportunities to other Trusts. Interview exits were conducted and no concerns were raised. A new revenue neutral organisational structure has been agreed. Recruitment will emphasise Walton as an employer of choice, highlighting development opportunities and other non-cash benefits.
		• A 5 year capital plan, largely based on replacement of assets (such as scanners) and risk registers suggests sustained shortfalls against likely capital allocations.
		• The updated Terms of Reference for the Capital Management Group were approved by the Committee.
		• The Committee commented on the Sustainability Plan which will be brought to Board in the coming months for approval by financial-year end.
		• Mr Burns outlined the first draft submission for H2 21/22 plan based on initial premises. Further revisions are likely through November in line with system reviews.
		• BPC Priorities remain unchanged:
		  • Short-Term: Recovery plan & financial break-even this year
		  • Medium Term: Transformation & QIP programmes; People Plan Implementations; Digital Strategy Implementation.		

2.	Risks Identified	Achieving 21/22 capital plan		
3.	Report Compiled	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

REPORT TO THE TRUST BOARD
Date 27th October 2021

The Walton Centre NHS Foundation Trust

Title	**Emergency Preparedness, Resilience and Response October 2021 Update**
Sponsoring Director	Name: Michael Woods Title: Interim Chief Operating Officer
Author (s)	Name: David Callaway Title: Interim Head of Risk
Previously considered by:	• Committee - N/A • Group - N/A • Other - N/A

Executive Summary

This paper is intended to update the Trust Board on recent Emergency Preparedness, Resilience and Response (EPRR) activity through October 2021

Key updates:

1. An Interim Head of Risk is now in post and is working to cover the service until permanent recruitment is completed.

2. An engagement meeting with the regional lead for EPRR has been carried out to foster a collaborative approach with the sector, key discussion points were as follow:

    - An update on the Walton Centre EPRR structure plans
    - A presentation was provided detailing regional EPRR risks and how the Walton Centre can support the wider health economy
    - Upcoming work streams and opportunities to support
    - Future collaboration and shared resource thoughts

3. The Walton Centre have submitted an annual self assurance process which has been verified and approved by the regional EPRR team

    There were 38 key lines of enquiry and the Walton Centre reported

    - 36 as full compliance
    - 2 as partial compliance

The partial compliance items involved capacity to manage a Chemical, Biological, Radioactive and Nuclear incident and resourcing requirements whilst a resourcing review is carried out within the EPRR function.

4. Work has begun to improve the Business Continuity process within the following wards/units:

    - Cairns
    - Caton
    - Horsley

CONSENT AGENDA - C - EPRR Core Standards Self Assessment

- Jefferson
- Lipton
- Sherrington

In coordination with the department leads the BCP's are being reviewed and improved to include practical guidance on how to activate and use the plan during an emergency. Stronger instruction around internal and external communications and critical service functions will be added to improve the Trust resilience and provide clearer guidance to the clinicians.

5. EPRR is a primary focus of the Interim Head of Risk and a work plan has been created to address gaps and create a permanent resourcing plan for the function.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	• N/A
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• Not required
Any associated legal implications / regulatory requirements?	• No legal or regulatory implications/requirements information provided as an update only
Action required by the Board	• To consider and note

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance									
1	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual	1. Major Incident Plan details AEO. 2. AEO (Interim) Michael Woods has taken up role and has experience of LHRP and EPRR from previous roles. 3. Non-Executive Director is David Topliffe	Fully compliant				
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	1. Evidence contained within MIP. 2. Funding, equipment purchases in year, radios, laptops, emergency boxes and high vis etc. 3. Funding of equipment, televisions, PCs, Video links etc for Command and Control (ICC) during Covid.	Fully compliant				
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	1. Assurance statement is sent to public Board (Board Secretary). 2. Six monthly EPRR report goes to BPC detailing any significant events, AEO discussed report. 3. Updates to BPC and Board in relation to: - Covid 19 response - BREXIT updates - Fit Testing report - IPC Assurance Framwework (Covid)	Fully compliant				
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	1.EPRR resource evidenced contained within MIP. Interim support provided whilst recruitment for the full time Head of Risk is undertaken. Contact established with regional EPRR lead for additional support and guidance	Partially compliant	Resource requirement to be reviewed. Recruitment to role dependent on outcome of resource review.	Michael Woods/ David Callaway	3 months	

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy statement	1. Evidence contained within MIP. 2. High level incident response overview provided in Section 5.2. 3. On call pack includes high level overview. 4. Debriefing held following wave 1 & 2 of Covid. 5. RCA investigation following Power Outage incident (Dec 2020), debrief completed and review of BCP, including EPMA. Outcome reported to BPC and Audit Committee.	Fully compliant				
Domain 2 - Duty to risk assess									
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	1. Evidence contained within MIP. 2. Specific EPRR/BIA risks included on DATIX and reviewed bimonthly at PSG. 3. Heating scheme evidence of BC risks, informing BAF entry. 4. EPRR related risks shared via LHRP Practitioners Group.	Fully compliant				
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	1. Evidence contained within MIP. 2. See Section 5.7 for specific detailand 15.1.	Fully compliant				
Domain 3 - Duty to maintain plans									
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Evidence contained within MIP. 2. Equipment list checks reported to RPG meeting. 3. List of loggists and contacts maintained within ICC files. 4. Dedicated SITREP support from Business Intelligence (including weekend reporting capability).	Fully compliant				
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Evidence contained within MIP. 2. Review of EPRR response throughout Covid, documentary evidence held within C&C action logs and emails throughout pandemic response.	Fully compliant				
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Heatwave Plan. 2. Evidence of operation in 2021, daily safety huddle reports and matrons emails. 3. Estates Dept undertook temperature monitoring to maintain thermal balance, particularly in clinical areas.	Fully compliant				

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
14	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Cold Weather Plan, approved and incorporates national guidance.	Fully compliant				
18	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Evidence contained within MIP. 2. MIP was updated following a multidisclinary Strategic and Operational clinical workinig groups. Evidence includes minutes etc.	Fully compliant				
19	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Evidence contained within MIP. 2. MIP was updated following a multidisclinary Strategic and Operational clinical workinig groups. Evidence includes minutes etc. 3. Considered during joint working with MTC in event of mass cas incident.	Fully compliant				
20	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Fire evacuation plans and alternative locations. 2. Collaboration with Aintree relocation of critical patients or relocate to SWB.	Fully compliant				
21	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Major Incident Plan + action cards 2. Annual lockdown test and ICC testing arrangements established. 3. Training and awareness delivered by Head of Risk. 4. One to one training for Gold, Silver and Bleepholders.	Fully compliant				
22	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	1. Major Incident Plan section 10.4. 2. Number of high profile patients.	Fully compliant				
Domain 4 - Command and control									
24	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	1. Bleep holder via Aintree Switchboard. 2. On call managers/directors access to RD. 3. Whattsapp Groups. 4. Testing as part of ex 1st call. 5. Link to Liverpool CCG, weekend pressures etc.	Fully compliant				
Domain 5 - Training and exercising									
Domain 6 - Response									

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
30	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements		1. Evidence contained within MIP. The Trusts Boardroom was used as the ICC throughout Covid 19. 2. VOIP and analogue (bespoke ring group for ICC's) - Boardroom (63688) and Theatre Seminar room (63689) VoIP Phone has been installed. Ring group (63690) has been set up and all VoIP (Major Incidents, Board room and Theatre Seminar room) numbers have been added. 3. Independent laptops and desktop printers now in place in incident cupboards. 4. Schematic maps and diagrams held in ICC.	Fully compliant				
32	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans	1. Trust BCP. 2. BCP Incident Plan. 3. Divisional and bespoke BC Plans. 4. BCMS document.	Fully compliant				
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps	1. Evidence contained within MIP. The Trust has robust arrangements in place for SITREP reporting which was evidenced throughout EU EXIT and Covid 19. This included daily telconferences etc. 2. See section 3.3 and detail within respective action cards.	Fully compliant				
Domain 7 - Warning and informing									
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	1. Evidence contained within MIP. 2. This element was tested throguhout the Covid 19 response. regular messages were sent to patients, families and staff throughout Covid, including staff working at home using "KEY MESSAGES." 3. Internal Comms procedures including a profile of comms capability in an incident, e.g.: a. Resources, people, equipment and support. b. Continue to update and maintain Internet ability to have pre-prepared messages, social media, radio etc. c. Reporting internal and external e.g. Liverpool and Mersey Comms Group. 4. Media handling guidelines.	Fully compliant				

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
38	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	1. Comms involved in Startegic and Tactical Response throughout Covid, this included debriefs and lessons learnt. 2. Command and Control, evidence of regular communications to staff and public.	Fully compliant				
39	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	1. Evidence contained within MIP. 2. Internal Comms procedures.	Fully compliant				
Domain 8 - Cooperation									
42	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	1. Major Incident Plan includes all of suggested evidence. 2. Mutual aid was invoked during Covid 19 response when the Trust housed the Aintree Stroke service. 2. See section 8.	Fully compliant				
46	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	1. Trust Data Sharing Agreement Policy. 2. Summary of Data Sharing Regulations Relating to Major Incidents (Aug 2017)	Fully compliant				
Domain 9 - Business Continuity									
47	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	1. Trust BCP aligned with ISO 22301:2012.	Fully compliant				
48	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	1. Trust BCP, suggested evidence held within document and supporting plans.	Fully compliant				
50	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	1. Trust statement of compliance for ISO 27001 standards.	Fully compliant				
51	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	1. Trust BCP, suggested evidence held within document and supporting plans. All Ward and Dept BCPs reviewed prior to Covid 19 and held centrally on Sharepoint Policy Page. 2. Evidence within DATIX risk and BIA.	Fully compliant				

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	1. Reports to RPG and subsequently BPC (Board Committee).	Fully compliant				
54	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	1. Reports to RPG and subsequently BPC (Board Committee). 2. Post EU EXIT and Covid, relevant BCPS reviewed, including Procurement and Estates and Facilities (ISS).	Fully compliant				
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	1. Evidence from Procurement re contractors and suppliers have BCPs - all provided during EU EXIT process - Medical devices (EBME) - ISS - Mercers heating scheme - Medstrom	Fully compliant				
Domain 10: CBRN									
56	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	1. Trust does not have CBRN capability, continuous review in agreement with NHSE. 2. Developed in house basic response, documentation, escalation and dry decontamination.	Fully compliant				
57	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	1. Trust does not have CBRN capability, continuous review in agreement with NHSE. 2. Developed in house basic response, documentation, escalation and dry decontamination.	Fully compliant				
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	1. Trust does not have CBRN capability, continuous review in agreement with NHSE. 2. Developed in house basic response, documentation, escalation and dry decontamination.	Fully compliant				

Ref	Standard	Detail	Evidence - examples listed below	Organisational Evidence	RAG	Action to be taken	Lead	Timescale	Comments
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Completed equipment inventories; including completion date	1. Trust does not have CBRN capability, continuous review in agreement with NHSE. 2. Developed in house basic response, documentation, escalation and dry decontamination.	Fully compliant				
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	1. Trust does not have CBRN capability, continuous review in agreement with NHSE. 2. Developed in house basic response, documentation, escalation and dry decontamination.	Partially compliant	IOR training requirement identified. Will be addressed following EPRR resource review and recruitment. Interim measure is to raise awareness of IOR by displaying awareness resources in appropriate areas of the Trust			
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		1. Evidence of Fit testing register and documented evidence. 2. 30 + fit testing competent staff. 3. Fit testing solutions for qualititative and quantitative in place. 4. majority of staff who compete AGPs have been issued with resusable masks.	Fully compliant				

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART										
Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										

H13	HART	Effective deployment policy	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	HART	Identification appropriate incidents / patients	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	HART	Notification of changes to capability delivery	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	HART	Recording resource levels	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	HART	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	HART	Local risk assessments	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	HART	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	HART	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	HART	Initial deployment requirement	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	HART	Mutual aid	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										
H27	HART	Capital depreciation and revenue replacement schemes	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	HART	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						

H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA										
Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						

M14	MTFA	Change Management Process	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	MTFA	Record of compliance with response time standards	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	MTFA	Notification of changes to capability delivery	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	MTFA	Recording resource levels	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	MTFA	Local risk assessments	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	MTFA	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	MTFA	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	MTFA	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	MTFA	Readiness to deploy to Model Response Sites	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	MTFA	10minute response time	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	MTFA	PPE availability	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	MTFA	Equipment procurement via national buying frameworks	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	MTFA	Equipment maintenance	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	MTFA	Revenue depreciation scheme	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						
M28	MTFA	MTFA asset register	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
CBRN Domain: Capability										

B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						

B22	CBRN	CBRN local risk assessments	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y							
B23	CBRN	Risk assessments for high risk areas	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y							
Domain: Response time standards											
B24	CBRN	Model response locations - deployment	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y							
Domain: logistics											
B25	CBRN	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y							
B26	CBRN	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y							
B27	CBRN	Equipment maintenance - British or EN standards	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y							
B28	CBRN	Equipment maintenance - National Equipment Data Sheet	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y							
B29	CBRN	Equipment maintenance - assets register	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y							
B30	CBRN	PRPS - minimum number of suits	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y							
B31	CBRN	PRPS - replacement plan	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y							
B32	CBRN	Individual / role responsible fore CBRN assets	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y							
Mass Casualty Vehicles **Domain: Administration**											
V1	MassCas	MCV accommodation	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y							
V2	MassCas	Maintenance and insurance	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y							
V3	MassCas	Mobilisation arrangements	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y							
V4	MassCas	Mass oxygen delivery system	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y							
Domain: NHS England Mass Casualties Concept of Operations											
V6	MassCas	Mass casualty response arrangements	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y							
V7	MassCas	Arrangements to work with NACC	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y							
V8	MassCas	EOC arrangements	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y							
V9	MassCas	Casualty management arrangements	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y							
V10	MassCas	Casualty Clearing Station arrangements	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y							

V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control										
Domain: General										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						

C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						

C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP **Domain: Embedding doctrine**										

J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						
J15	JESIP	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	JESIP	Training - review process	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	JESIP	JESIP trainers	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	JESIP	JESIP self-assessment survey	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						

J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply													
Domain: Oxygen Suuply													
DD1	Oxygen Supply	Medical gasses - governance	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable						
DD2	Oxygen Supply	Medical gasses - planning	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable						
DD3	Oxygen Supply	Medical gasses - planning	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable						
DD4	Oxygen Supply	Medical gasses -workforce	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable						
DD5	Oxygen Supply	Oxygen systems - escalation	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable						
DD6	Oxygen Supply	Oxygen systems	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable						
DD7	Oxygen Supply	Oxygen systems	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable						

REPORT TO THE TRUST BOARD
Date: 4th November 2021

Title	**Modern Slavery Act Statement**
Sponsoring Director	Name: Lisa Salter Title: Chief Nurse
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary The statement constitutes the Walton Centre's annual response to the requirements of the Modern Slavery Act 2015 to be published online in accordance with the public sector duties under that Act.	
Related Trust Ambitions	• Be recognised as excellent in all we do
Risks associated with this paper	There are no risks identified that are associated with this paper, as the actions undertaken by the Trust which are mentioned in the paper have already been undertaken and those actions, taken alongside the Board considering the paper and the Trust publishing the paper online, constitute full compliance with the Trusts duties in respect of the Modern Slavery Act 2015.
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• N/A
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	The Board is requested to: • Approve the Modern Slavery Act Statement • Note that it will be published via the Trust's Website

Modern Slavery Statement Act November 2021

The Walton Centre's Response to the Requirements of the Modern Slavery Act 2015

This Act was brought about to make provision about slavery, servitude and forced or compulsory labour and about human trafficking; including provision for the protection of victims; to make provision for an Independent Anti-Slavery Commissioner; and for connected purposes.

Slavery is not an issue confined to history or an issue that only exists in certain countries – it is something that is still happening today. It is a global problem and the UK is no exception.

Modern slavery is part of the safeguarding agenda for children and adults.

All staff at the Walton Centre, be they in clinical or non-clinical roles, have a responsibility to consider issues regarding modern slavery, and incorporate their understanding of these issues into their day to day practice. Front line NHS staff are well placed to be able to identify and report any concerns they may have about individual patients who present for treatment.

Modern slavery is a real issue.

It is also a serious concern for public services.

As a Trust we are committed to working in partnership with local authorities to identify cases of modern day slavery and to intervene to protect vulnerable adults and children when they are identified.

Who is affected?

Victims found in the United Kingdom come from many different countries, including Romania, Albania, Nigeria, Vietnam and the United Kingdom itself.

Social and economic deprivation, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are some of the key drivers that contribute to the trafficking of victims.

Victims can also face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

The Walton Centre is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain and has taken steps to ensure that all staff are aware of the issue of Modern Slavery and what they can do to prevent it by including information in the Safeguarding Adult and Children Policies.. Any concerns are raised with the Safeguarding Matron who will escalate accordingly.

Modern Slavery

Starting in 1 November 2015, specified public authorities have been given a duty to notify the Home Office of any individual encountered in England and Wales who they believe is a suspected victim of slavery or human trafficking.

The 'duty to notify' provision is set out in the Modern Slavery Act 2015 and applies to all police forces and local authorities in England and Wales, the Gang masters Licensing Authority and the National Crime Agency.

Procurement arrangements:

All contracts established by The Walton Centre use the NHS Terms and Conditions for Supply of Goods, which contains Anti-Slavery clauses that require providers/contractors to comply with Law and Guidance, use Industry Good Practice and to notify the authorities if they become aware of any actual or suspected incident of slavery or human trafficking. The Walton Centre Procurement team has issued Modern Slavery Act 2015 compliance letters to our supply chain and keeps a database of responses. Also, the Trust's purchase orders to suppliers now set out the Trusts expectations in terms of compliance with the Act.

In addition to the above The Walton Centre will investigate any concern raised with the service. This could be by national or local media publicity, through supply chain contacts or by individuals.

Employment arrangements: As an NHS Employer we are required to comply with the NHS employment check standard for all directly recruited staff.

The six checks which make up the NHS Employment Check Standards are:

1. Verification of identity checks

2. Right to work checks

3. Professional registration and qualification checks

4. Employment history and reference checks 5. Criminal record checks

6. Occupational health checks

No individual is permitted to commence employment with the Trust without these checks having been completed. The checks are carried out centrally by the recruitment team and recorded on the Trust workforce information system (ESR). These measures ensure that the Trust does not unwittingly employ people subjected to modern slavery.

If staff have concerns about the supply chain or any other suspicions related to modern slavery they will be encouraged to raise these concerns through line management and report the issues to appropriate agencies. This will be raised particularly with clinical staff that may be in contact with vulnerable people.

Date approved: 4th November 2021