NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 7th October 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
Thursday 7th October 2021
Face to Face Meeting – Aintree Racecourse (room TBC)
09:30am – 12:15pm

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 2 September 2021	S Crofts	Decision (d)
4	09.40	Staff Story – Allied Health Professionals Showcase Session	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.10	Chair and Chief Executive's Update	S Crofts / J Ross	Information (d)
PERFORMANCE & GOVERNANCE				
6	10.30	Recovery & Restoration Update	M Woods	Information (d)
7	10.40	Integrated Performance Report	CEO/Execs	Assurance (d)
8	11.00	Gender Pay Gap Annual Report	M Gibney	Assurance (d)
9	11.10	Guardian of Safe Working Report	A Nicolson	Assurance (d)
10	11.20	Senior Information Responsible Officer (SIRO) Report	M Burns	Assurance (d)
11	11.30	Update from the Wellbeing Guardian	K Bentley	Information (v)
12	11.40	Board Assurance Framework	P Buckingham	Assurance (d)
13	11.50	Quality Committee Key Issues Report	S Crofts	Assurance (d)
14	11.55	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: •				
CONCLUDING BUSINESS				
15		Any Other Business	S Crofts	Information

Date and Time of Next Meeting:
4 November 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

2nd September 2021

Present:

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

In attendance:

Ms G Woods	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary
Mr A Lynch	Equality and Inclusion Lead (items TB72-21/22 and TB73-21/22 only)
Ms E Sutton	Patient Experience Manager (item TB68-21/22 only)

Observing:

Mr W Givens	Public Governor – Merseyside
Ms K Dowson	Member of the public
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					
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			✓	✓	✓					

TB65-21/22 Welcome and apologies

Apologies were noted from Ms Rosser and Professor Thakkar. Mr Crofts welcomed those present to the meeting via Microsoft Teams and noted that Mr W Givens was observing in his capacity as Public Governor for Merseyside and Ms B Strong was observing in her capacity as Public Governor for Merseyside. Ms K Dowson was also observing the meeting in advance of her joining the Trust in October in the Corporate Secretary role.

TB66-21/22 Declarations of interest

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

TB67-21/22 Minutes of the meeting held on 1st July 2021

It was noted that Ms Ross title would be amended to Chief Executive. Following completion of this amendment the minutes of the meeting held on 1st July 2021 were agreed as a true and accurate record.

TB68-21/22 Patient Story

Ms Sutton joined the meeting.

Ms Sutton presented the patient story and noted that the story had been provided following meetings held with close friends and the next of kin of the patient. The patient had been a patient of the Trust for a number of years following an aneurysm which had been diagnosed in 2013, the patient had initially been referred to the Trust with migraines however there were no treatments available for the patient at that time. New options had become available since the diagnosis and the patient was admitted for a procedure and attended fully informed of the potential risks. The patient was noted to be a Jehovah's Witness and was very clear on their care plan and noted during admission that they felt that staff were taking good care of them and had full confidence in the team.

It was highlighted that the initial surgery went well with no concerns noted however the patient suffered a stroke the following day and later developed pneumonia. The patient deteriorated over the next few days and was unable to tolerate non-invasive ventilation. Open conversations were held with the patient's friends and next of kin in relation to the patient requiring intubation or a potential tracheostomy however the patient was clear in their wishes not to proceed and also outlined that they did not wish to be resuscitated if their condition worsened. The patient sadly passed away a short time later.

The patient's close friends and next of kin were invited to meet with the medical team to discuss the patient's pathway and were very thankful for the opportunity to ask questions and reported that the patient had no doubts throughout their journey and all treatment was in line with the patient's wishes and personal choice.

Ms Rai noted that this may have been a difficult case for staff as they may have had different treatments options that they wished to pursue and queried what the impact was on staff. Ms Sutton stated that staff had requested the meeting with the patient's friends and next of kin and had also found it helpful and important to have these conversations. Ms Salter noted that the case highlighted how the Trust focussed on the person behind the patient and how important the individual views of the patient and their family and friends were when caring for a patient during end of life care.

Ms Sutton left the meeting.

TB69-21/22 Chair & Chief Executive's Report

Ms Ross provided an update noting that Covid remained a risk with a number of pressures on capacity and demand across the region. Issues regarding critical care capacity had arisen during the previous month with an increase in patients requiring critical care beds. Regional calls to manage the system were held on a daily basis and the Trust was supporting the wider system as much as possible via mutual aid. It was highlighted that staffing levels had improved following national changes in self-isolation

guidance and there was currently one Covid positive patient in the hospital. Most Covid positive patients at the Trust had been confirmed as positive on screening with very few nosocomial infections recorded. It was recognised that patient flows were likely to be difficult to manage across the system moving into the winter period.

The Trust continued to work with CCGs during the transition period to Integrated Care System working and it was noted that interim leadership for the ICS was in place with Sheena Cumiskey undertaking the Interim Chief Executive role and David Florrie undertaking the Interim Chair position.

A HR and Staff Side away day was recently held and the Board recognised the positive relationship between both teams and noted the good work undertaken by all involved to resolve staff issues.

An Executive Team visibility plan had been devised in collaboration with the Communications Team and this would ensure that staff had access to all members of the Executive Team and the opportunity to discuss any issues that they may have.

Mr Crofts advised that, in his role as Deputy Chair, he was undertaking responsibilities of the Chair during her period of absence and noted that he had held meetings with members of the Executive team and key staff across the Trust. Mr Crofts and Mr Gibney had recently attended a meeting with the One Liverpool Integrated Care System which had highlighted that the pace of change was accelerating as work towards CCGs being wound up progressed in preparation for the Integrated Care System to take over the CCG role in April 2022. Collaborative working within the healthcare and local authority systems was moving at pace and the Executive Team were working on different aspects of this across the system. It was noted that One Liverpool were introducing Command Leaders who would implement revised commissioning arrangements. Themes of chaotic lives and communities with challenges would be reviewed by the One Liverpool programme going forward along with issues regarding PLACE based care. Additional guidance regarding the next steps for implementing the Integrated Care System Boards would be published shortly with CCG staff redeployed to Integrated Care Boards with effect from April 2022.

The Board:

- **noted the report.**

TB70-21/22 Recovery and Restoration Update

Mr Woods provided an update on the Trust's recovery and restoration programme noting that the Trust had undertaken a phased planning approach through to March 2022 that had been originally based on 85% of 2019/20 activity levels. However, the Trust had been informed in July 2021 that the requirement had increased to 95% of 2019/20 activity levels which would prove to be challenging. Daily meetings to review performance were being held and it was noted that the Trust had met day case and outpatient targets during July however the elective case performance was over 20% below target and a full review regarding this was underway. It was highlighted that performance had been affected by a number of factors including Covid, self-isolation and staff sickness along with some occasional patient flow pressures.

Performance in August had improved further for outpatient and day case targets however elective performance remained below plan by 77 cases and a review of case complexity

would be undertaken. Discussions had been held with the Divisional Leads to identify what support was required to build up activity and a briefing paper regarding this would be presented to the Executive Team on 8th September. It was recognised that this under-performance would impact on the Trust's ability to access ERF funding.

Ms Bentley queried what the key challenges to recovering performance levels were and Mr Woods highlighted that these were mostly related to theatre staffing levels due to sickness and a high level of case complexity. Ms Salter noted that staff vacancies had increased across the Trust and the Trust was working with NHSE/I regarding theatre staffing and also continuing to explore international recruitment options along with ongoing internal recruitment programmes and a review of the pathways into Nursing.

The Board:

- **noted the progress made against the Trust recovery and restoration programme.**

TB71-21/22 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 there had been a significant reduction in the number of complaints and targets relating to mandatory training had been met. It was recognised that Nursing turnover remained high however this was clarified to be in line with national figures. It was also highlighted that cancer and diagnostic targets continued to be achieved.

Quality

Ms Salter provided an overview of infection control performance and noted that both Klebsiella and C.Difficile had exceeded trajectories. There had been a national increase in the number of MRSA infections identified however it was noted that there had not been an incidence of MRSA within the Trust since October 2017. There had been 6 cases of MSSA reported against a trajectory of 8 and concerns had been raised regarding ITU in relation to MSSA, it was also recognised that there had only been 3 recorded cases during 2020/21. Specialist Trusts across the region were reporting an increase in E.Coli and MSSA infections and it was highlighted that Trusts were working closely with the Infection Prevention and Control teams along with Microbiology teams to understand why this had been the case however no rationale yet had been identified. This would continue to be monitored closely by the Quality Committee.

Ms Rai queried if any cases of C.Difficile were hospital acquired and Ms Salter confirmed that there had been some hospital acquired cases. Work was underway to explore what strands these cases were and how patients had contracted the infection and it was noted that labs had suspended ribotyping during the pandemic which had resulted in difficulties in understanding what strains patients had contracted however the Trust continued to work with the Infection Control team to review each case. The clear message to staff remained a back to basics approach focussing on hand washing, adherence to the Trust uniform policy and ensuring staff follow policies relating to accessing lines etc.

Ms Rai queried the content of the ward scorecard and it was clarified that the narrative from the scorecard had not been included. It was highlighted that the drop in staffing levels illustrated on Cairns ward had been due to staffing and patient moves to other

wards to accommodate essential heating and pipework repairs to be undertaken however the correct number of staff had been on the ward at the start of the shift. It was noted that each ward aspired to 100% staffing however there were some variances recorded due to patient acuity and specialling requirements. Some wards had experienced staffing difficulties and it was noted that some staff had temporarily moved to other wards to provide cover and ensure patient safety.

Workforce

Mr Gibney advised that labour market conditions were changing and there had been a lot of analysis undertaken by local councils and it was clear that the biggest factors had been Brexit and an increase in the number of people taking retirement. It was recognised that Liverpool was the fourth largest tourism destination and the hospitality sector was competing for HCA staffing which had mainly affected social care however health care was also experiencing an impact. Nursing recruitment was mostly seasonal with the next intake due in February 2022 which had already been recruited to. A workforce review was ongoing within the One Liverpool programme to bring social care roles in line with health care roles.

It was noted that Covid continued to have an effect on sickness levels with Covid related absence equating to approximately 1% which was mostly related to Covid positive staff with a decrease in the number of staff having to isolate as contacts following changes to national guidance. Ms Rai noted that appraisal levels had been an issue for some time and queried when this was likely to improve. Mr Gibney noted that targets should be achieved in the coming months providing no further lockdowns were announced. It was recognised that the Trust did not suspend appraisals during the pandemic however the rate had slowed as appraisals had not been prioritised.

Ms Rai highlighted that the staff stability index had decreased from 87% to 82% and Mr Gibney stated that the key issue was around recruitment. It was recognised that there had been a lot of staff movement and retirements and there was a need to consider the Trust approach and reporting process to provide assurance.

Finance

Mr Burns noted that a plan to break even during H1 had been submitted in May and updated that at month 4 the Trust had posted a deficit of £75k in month against a planned deficit of £104k. This position had included £1.9m of ERF income which was an improvement of £600k against original ERF plans for the first 3 months of H1. It was noted that ERF income had also been assumed from Wales however no ERF income had been assumed for month 4 as activity targets had not been met. The main reason for the Trust's over-performance against plan was related to NHSE contract income along with some Isle of Man contract income. It was highlighted that the injury cost recovery scheme had also over-performed.

Expenditure was £190k below plan and this was mainly due to an under spend on clinical supplies. It was noted that there had been a capital spend of £104k against a plan of £133k in month 4, this excluded digital aspirant funding which was currently £100k below plan for the year to date. Capital projections would be revisited in conjunction with the Divisions to ensure that the Trust meets its end of year capital expenditure plans.

Mr Burns noted that the better payment practice code was under review as there was a lot of cash within the system and highlighted that the code aimed to ensure that at least 95%

of non-NHS providers were paid within 30 days by value. The Trust was currently slightly below target at 92.7% and work was ongoing to understand why this target was not being met and to implement improved practices to ensure that this target was met going forward.

Ms Bentley recognised that the Trust was working in partnership to achieve a system wide financial balance and requested that the Board receive an update on the whole system position. Mr Burns noted that it was planned for the system to break even at the end of H1 and highlighted that an update would be provided however this would need to be system driven.

Ms Rai noted the requirement for the Trust to achieve a QIP of £4.2m across the year and queried how much had been identified and how much had been delivered. Mr Burns highlighted the difficulty in taking recurrent costs out of the system and noted that the Trust was trying to take non-recurrent costs out of the system. When the system returned to budget setting and established contracts this would enable costs to be taken out recurrently. Planning guidance for H2 was being awaited however it was recognised that this would be a challenge. Mr Burns also noted that the potential for system-wide QIP projects was being explored at the regional Directors of Finance meetings along with the potential for standardised pay dates and overtime payments.

The Board:

- **noted the Integrated Performance Report.**

TB72-21/22 Workforce Race Equality Standard Report

Mr Lynch joined the meeting and presented the Workforce Race Equality Standard (WRES) report.

Mr Gibney noted that WRES and WDES had both continued to be collated when business as usual was suspended due to Covid and highlighted that there had been a stronger focus on the Black Lives Matter movement and also Black, Asian and Minority Ethnic (BAME) this year in relation to the disproportionate effect of Covid on the BAME community.

Mr Lynch advised that the WRES data had been collated for a number of years so the Trust now had a better understanding of the outcomes from the report. The report was grouped into sections in response to staff survey questions and it was noted that the Trust had performed above average when benchmarked against other Specialist Trusts.

An overview of each indictor was provided and it was highlighted that training data had not been included under Indicator 4 in the published report however this data was now available and showed that a higher proportion of BAME staff were accessing non-mandatory training and CPD than white staff. It was also noted that there were currently 14 Consultants who were also senior managers and Mr Lynch informed that 7 of these Consultants were BAME and 7 were white.

One of the largest elements of the WRES report related to how many BAME staff the Trust employed and what departments and positions they were employed within and it was noted that there had been a small improvement in diversity recorded however little movement in where BAME staff were employed in non-clinical roles. Nationally set targets

would be implemented around the proportion of BAME staff in non-clinical roles at Band 6 and above and it was recognised that an increase in the numbers of BAME staff appointed would be required to change this demographic.

It was recognised that all figures relating to the percentage of BAME staff experiencing bullying, harassment or abuse from patients were worse than those for white staff and this was highlighted to be due to the patient cohort and measures were in place to support staff if any incidents did occur.

Board diversity within the Trust was wider than the general workforce however it was recognised that the general workforce was reflective of the local demographic. It was noted that issues relating to the WRES report would be monitored and actions would be progressed by the Strategic BAME Advisory Committee. Ms Rai highlighted that there were also a number of other forums such as the Walton Centre @Race Forum for staff to raise any issues. Ms Rai also noted the requirement to keep the spotlight on patient abuse of staff in light of the ongoing international recruitment programme to ensure that this was managed and support provided where required.

Mr Topliffe highlighted that under Indicator 9 the number of voting members on the Board was incorrect and there were actually 11 voting members which resulted in the percentage figure of BAME Board members being higher than that reported. Mr Lynch noted this amendment.

Ms Bentley queried the timescale for the introduction of the proposed bystander training and what format this was likely to take. Mr Lynch clarified that this training was likely to be face to face training and open to all staff however would not be mandatory and it was hoped that this would be introduced from early 2022.

The Board:

- **noted the Workforce Race Equality Structure report and approved publication of the report on the Trust website.**

TB73-21/22 Workforce Disability Equality Structure Report

Mr Lynch presented the Workforce Disability Equality Standard (WDES) report and highlighted that the recording of numbers of disabled staff was under-reported as many staff did not class themselves as disabled and therefore the figures included in the report were not fully representative of the Trust. The need for engagement with disabled staff to be more embedded within the Trust was recognised and it was noted that there was a strong culture within the Trust as a disability friendly organisation.

It was highlighted that the Trust performed above average within the benchmark group however there had not been much movement in trajectories since the previous report with the exception of metric number 6 which related to the percentage of disabled staff reporting that they had felt pressure from their manager to attend work despite not feeling well enough to perform their duties in comparison to non-disabled staff. It was noted that this metric had increased from 24.4% to 40% however the number of respondents had decreased from 78 to 60. It was highlighted that this survey had been completed prior to the pandemic so that had not been an impact and the Trust needed to be aware and prioritise this in the action plan going forward.

Mr Lynch noted that the WDES data would be reviewed and monitored by the ED&I Steering Group moving forward. Ms Salter stated that she was part of a national group that reviewed this data and would discuss with Mr Lynch how best to feed this into the ED&I Steering Group.

The Board:

- **noted the Workforce Disability Equality Structure report and approved publication of the report on the Trust website.**

Mr Lynch left the meeting.

TB74-21/22 Strategic BAME Advisory Committee Key Issues Report

Ms Rai provided an update from the meeting of the Strategic BAME Advisory Committee held on 16th August 2021 and highlighted that that the key issue for escalation was the introduction of recruitment targets to improve BAME representation in band 6 and above non-clinical roles. Anti-racism badges had been received into the Trust and these would be distributed in October with a communications campaign to be launched to accompany. Plans for Black History Month were in progress and it was noted that there would be a focus on black health and vaccine hesitancy along with the impact of black staff across the Trust and wider health service. It was recognised that the Committee was now well established and meetings would be held on a quarterly basis moving forward to allow for additional progress to be made between each meeting.

The Board:

- **noted the Strategic BAME Advisory Committee Key Issues Report.**

TB75-21/22 Audit Committee Key Issues Report

Ms Rai provided an update from the meeting of the Audit Committee held on 20th July 2021 and highlighted that work to finalise the value for money audit was in the process of being concluded with an extraordinary Audit Committee meeting scheduled to review the final version of the Auditor's Annual Report.

An internal audit review of Complex Discharge processes had resulted in an assessment of limited assurance and highlighted weaknesses in controls and procedures. An overview of areas for improvement was provided. It was also noted that audit reports into Cyber Security and Data Protection and Security Toolkit had provided substantial assurance and the audit report into the complaints process had provided high assurance.

It was noted that there was an ongoing issue relating to old audit recommendations not being completed and the relevant leads would be invited to the October meeting to provide assurance and an update on progress.

The Board:

- **noted the Audit Committee Key Issues Report.**

TB76-21/22 Walton Centre Charity Committee Key Issues Report

Ms Rai provided an update from the meeting of the Walton Centre Charity Committee held on 15th July 2021 and highlighted that a donation of equipment had been made to the Maiduguri Teaching Hospital and it was noted that this was an exceptional case. The fundraising strategy for 2022-25 had been paused to enable approval of a proposed bridging plan for 2021/22 due to the impact of the pandemic.

The Charitable Project Prioritisation Process report outlined the process that had been developed to ensure fundraising was in line with what the Trust required and projects had been invited for submission in accordance with this process. It was noted that agreement had been made to support the Neuro VR Simulator project as a future fundraising project.

It was noted that there had been a positive outcome following completion of the committee effectiveness review.

The terms of reference for the committee were also presented for approval following periodic review.

The Board:

- **noted the Walton Centre Charity Committee Key Issues Report and approved the terms of reference.**

TB77-21/22 Quality Committee Key Issues Report

Mr Crofts provided an update from the meeting of the Quality Committee held on 22nd July 2021 and highlighted that the results from the national inpatient survey were embargoed until October and would be reported when published. Issues around Pharmacy KPIs were raised in relation to TTOs and it was noted that these were under review to ensure that the associated data was presented correctly.

The Board:

- **noted the Quality Committee Key Issues Report.**

TB78-21/22 Research, Innovation and Medical Education Committee Chair's Report

Mr Crofts provided an update from the meeting of the Research, Innovation and Medical Education Committee held on 7th July 2021 and noted that there were challenges regarding the level of activity and income that could be undertaken regarding research. If the current financial activity was mapped across the year this would result in a deficit of £260k. However, it was highlighted that there had been a significant increase in the number of patients participating in commercial studies which should bring some financial benefit.

It was noted that work to review the department and leadership within the department had taken longer than anticipated in relation to unpacking how the financial models worked however this work was coming to an end and a detailed action plan was being compiled which would be presented to the Executive Team prior to Trust Board. It was recognised that there was a lot of redesign required regarding how to move investment opportunities forward.

There was a presentation of the ERNST project which was reported to be making good progress and work to review the potential for commercialisation was underway. It was noted that the report received following the recent GMC survey regarding undergraduate medical education was positive and the Trust continued to be strong in this area.

The Board:

- **noted the Research, Innovation and Medical Education Committee Chair's Report.**

TB79-21/22 Remuneration Committee Key Issues Report

Mr Crofts provided an update from the meeting of the Remuneration Committee held on 13th August 2021 and highlighted the appointment of an Interim Director of Operations and revised Executive portfolios including the Deputy Chief Executive role.

The terms of reference for the Committee were also presented for approval following periodic review.

The Board:

- **noted the Remuneration Committee Key Issues Report and approved the terms of reference.**

TB80-21/22 Business Performance Committee Key Issues Report

Mr Topliffe provided an update from the meeting of the Business Performance Committee (BPC) held on 27th July 2021 and noted that the adjustment to the ERF highlighted within the alert section had been implemented. An updated process for the presentation and approval of business cases had been implemented and it was highlighted that business cases above £150k would be approved by BPC and business cases over £500k would require Board approval. The process included the potential for business cases requiring Board approval to be presented directly to the Board without prior review by the BPC. However, it had been agreed that the Lead Executive for such business cases would assess whether prior review by the BPC should be undertaken based on the complexity of the proposals.

The Board:

- **noted the Business Performance Committee Key Issues Report.**

TB81-21/22 Consent Agenda

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

- **Quarterly Governance Report** – considered the report and noted the assurance provided.
- **Nursing Revalidation Report** – considered the report and noted the assurance provided.
- **Medical Education Annual Report** – considered the report and noted the assurance provided.

TB82-21/22 Any Other Business

There was no other business to be discussed.

The meeting was reviewed by all and it was agreed that, although the amount of time allocated to each item was appropriate, improvements could be made in the preparation of reports to facilitate more time for discussion rather than time spent presenting. This would then allow more time to be utilised regarding the strategic elements of Board business.

There being no further business the meeting closed at 11.45am

Date and time of next meeting
Thursday 7th October 2021 at 09:30am, venue to be confirmed.

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.	~~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.	~~02/09/21~~ 07/10/21	

Actions not yet due

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

Report to the Board of Directors
Date: 7 October 2021

Title	**Chief Executive's Report**
Sponsoring Director	Jan Ross Chief Executive
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	Not Applicable
Executive Summary The purpose of this report is to advise the Board of correspondence received from NHS England / NHS Improvement regarding the North Mersey Hyper Acute Stroke Services Review.	
Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	
Action required by the Board	The Board of Directors is recommended to: • Receive the report and note the correspondence from NHS England dated 15 September 2021 included at Annex A of the report.

1.0 Introduction

The purpose of this report is to advise the Board of correspondence received from NHS England / NHS Improvement regarding the North Mersey Hyper Acute Stroke Services Review.

2.0 Background

The North Mersey Stroke board undertook a programme of work to review the current stroke delivery model for North Mersey, outlining a case for change which would enable transformation of services to deliver the following ambitions:

- Provide the best stroke service in the country
- Have all patients receive the right care, in the right place first time
- Have a service that is sustainable, both clinically and financially
- Improve patient outcomes
- Give patients the best possible experience

This work was commissioned by the Cheshire and Merseyside Healthcare Partnership and was completed in May 2019. This was in response to concerns regarding performance and sustainability of some stroke units in the North Mersey area. The case for change was developed by clinical teams from the North Mersey Stroke Services using clinical evidence and standards. The North Mersey Stroke Services review (NMSSR) has supported the development of the case for change document which outlines the feasibility of the Walton Centre expanding its portfolio to include or participate in a Comprehensive Stroke Centre (CSC) for North Mersey.

3.0 Current Situation

The current providers of inpatient stroke services for North Mersey are as follows:

- Liverpool University Hospitals NHS FT which delivers stroke services across two sites:
    - Royal Liverpool
    - Aintree Hospitals
- Southport & Ormskirk Hospitals NHS Trust.

Tertiary neuroscience services are provided by The Walton Centre (WCFT), providing regional thrombectomy across most of the Cheshire & Merseyside footprint. Following the publication of a Pre Consultation Business Case (PCBC) a Clinical Senate was held in the summer of 2021 exploring the Key Lines of Enquiry (KLOE). A panel meeting was subsequently held on 31 August 2021 for the NHS England Service Change Stage Two Assurance Checkpoint with outcomes reported in a letter from NHS England dated 15 September 2021. This letter, which is included for reference at Annex A to this report, expresses support for the proposals with the support conditional on a number of additional requirements being met.

4.0 Walton Centre – Continuing Involvement

The Trust is actively involved in the service review, attending both the Board and operational meetings along with providing the Thrombectomy service, which will, from the

second week in October 2021 provide a 24 hour service. There is also active involvement in the stroke rehabilitation discussions and meetings.

The Trust remains a key and active partner in the review and will continue to:

- Attend relevant meetings and provide challenge in the meeting and feedback to the Trust's Executive Team
- Support appropriate responses to the requirements detailed in the NHS England letter
- Work collaboratively with the Stroke rehabilitation service
- Implement 24 hour Thrombectomy from October 2021.

5.0 Recommendations

The Board of Directors is recommended to:

- Receive the report and note the correspondence from NHS England dated 15 September 2021 included at Annex A of the report.

To:
Carole Hill
Director of Strategy
Communications and Integrations
Liverpool CCG

NHS England and NHS Improvement
Preston Business Centre,
Watling St Road,
Preston,
Lancashire.
PR2 8DY

15th September 2021

Dear Carole,

NHS England Service Change Assurance Stage Two Assurance Checkpoint – North Mersey Hyper Acute Stroke Services Review

Thank you to you and your colleagues for attending the panel meeting on the 31st of August 2021 for the NHS England service change assurance stage two assurance checkpoint.

I am writing to confirm NHSEI's assurance position of your proposals regarding North Mersey Hyper Acute Stroke Services, following a review at the North West Regional Management Team on INSERT DATE September 2021 and subsequent approval from the Regional Director.

As you will be aware, your reconfiguration proposals have been subject to a comprehensive stage 2 assurance review following the high-level strategic sense check that confirmed alignment of your proposals with national policy and strategy.

NHSEI formed a reconfiguration assurance panel to review the documentary evidence provided by your team against the four reconfiguration tests, the additional NHSE check and best practice checks as described in the NHS England guidance, Planning, Assuring and Delivering Service Change (NHS England, 2018).

The outcomes of this panel were subsequently discussed by the Regional Management Team and, in line with NHSEI's decision making thresholds, a decision on the level of assurance provided has been made by the Regional Director.

In considering our assurance position, we took account of the case for change and the need to ensure that stroke services are of a high quality and sustainable for the long term. The CCG and partners will now need to carefully consider the public's view on the proposed vision and options when deciding the best way forward.

We have concluded that NHSE/I can support the CCG and its partners to progress their proposals for the future of North Mersey Stroke Services. However, this support is conditional upon the following requirements being met as soon as possible.

- Provide an updated version of the consultation plan
- Detail of the capital programme to be shared when known
- Details of revenue requirement to be shared
- An update as to how the costs compare to another area's Stroke spend, that is achieving the outcome KPIs.
- Detail describing the national historic growth in stoke, mimic and TIA

- Provide a workforce strategy to include recruitment plans which addresses the requirements and sustainability of each site.
- Provide confirmation of the decision as to whether services provided by Liverpool Women's NHS Foundation Trust will be required to move from the Aintree site as this an interdependency to this proposal
- Confirm West Lancashire membership to joint committee
- Letters of support or an agreed position statement from all impacted Trusts / commissioners, providing assurance that the impact of a proposed model on their organisations has been considered and is recognised

While not within the scope of this proposal, community stroke services are acknowledged as a key interdependency to the development of hyper acute stroke services. We received assurance that the scope of the North Mersey Stroke Programme does include community services and that commissioners are undertaking work to assess the costs of community services that meet the national specification. You advised that a paper describing the baseline position across the 9 places and the requirements of the national community stroke specification is due to be considered in September. While not a condition to the progress of this proposal, we would ask that this paper be shared with NHSEI for review.

In offering this conditional NHS England and NHS Improvement support, I am sympathetic to the challenges the CCG and wider system are seeking to address and grateful to colleagues locally for their commitment to addressing these challenges and their hard work to date. We will continue to work with you and other local organisations to ensure that local people have safe and sustainable services.

In the event of any changes to your plans can you please notify NHS North West, along with emerging risks and mitigating actions.

Please do not hesitate to contact me if you wish to discuss the contents of this letter or require any clarification regarding the requirements for NHS England assurance.

Yours sincerely

Clare Duggan

Regional Director of Strategy and Transformation

NHS England and NHS Improvement – North West

Cc Linda Buckley – Director of Strategic Transformation C&M (NHSEI)
Jan Ledward – Chief Officer, Liverpool CCG
Helen Murphy – Assistant Director of Integration, Liverpool University Hospital NHS Trust
Sarah O'Brien - Executive Director of Strategy & System Development, C&M Health and Care Partnership

Sheena Cumiskey – Chief Executive Officer, C&M ICS
Jamie Sinclair - Senior Manager, Strategy & Transformation (NHSEI)

The Walton Centre
NHS Foundation Trust

REPORT TO THE Trust Board
Date 7th October 2021

Title	**Presentation regarding Recovery and Restoration of elective activity**
Sponsoring Director	Name: Michael Woods Title: (Interim) Chief Operating Officer
Author (s)	Name: Michael Woods & Laura Abernethy Title: (Interim Chief Operating Officer & Patient Access & Performance)
Previously considered by:	• Committee (please specify) ____N/A_____ • Group (please specify) ____N/A_____ • Other (please specify) ____N/A_____
Executive Summary The purpose of this presentation is to fully inform the Trust Board of Directors regarding the progress made, forecasted recovery and risks to delivery	
Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	• Critical staff group shortages & delays in recruitment • Spinal services transfer
Related Assurance Framework entries	BAF Risk 002
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify) _____N/A_____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____No_____
Action required by the Board	Delete as Appropriate • To consider and note

Elective Recovery

Trust Board – 7th October 2021

Background

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- The pressures of Covid-19 and the national plans put in place to flatten the curve placed delays in across elective care, this has resulted in waiting lists back logs that could include clinical risks for some long waiters.
- Recovery of services, and reducing the waiting list backlog are priorities for the Trust and wider system, along with ensuring services are sustainable for the long term.
- The Hospital Cell commissioned the Elective Transformation Programme (ETP) to ensure a system-approach to tackling the waiting list pressures and provide safe and timely care for patients.

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Plans submitted

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- Initial recovery plan submitted to form part of Cheshire and Merseyside Healthcare Partnership incorporating:
  - Trajectory for recovery of elective services 100% by March 2022.
  - Trajectory to eradicate the 52 week waiters by January 2022.
  - How we ensure that staff look after themselves and colleagues during the recovery phase following wave 3, and how the Trust will create the conditions for a healthy work environment providing support for staff during this period.

- Table below details the % of 2019/20 activity levels submitted as part of the H1 plan (H1 refers to April to September 2021)

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Elective	65%	70%	75%	80%	80%	85%
New Outpatient	80%	81%	83%	91%	86%	93%
Follow Up Outpatient	99%	99%	100%	100%	100%	100%

- The Trust received notification on 9th July that the % of activity to be delivered in order to receive allocation of Elective Recovery Fund (ERF) was increasing to 95% for the period July to September 2021

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Activity Performance

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		Apr	May	Jun	Jul	Aug	Sep**	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	19/20	626	634	639.1	774	729	770	832	769	652	885	860	907
	21/22	736	653	741	743	764	*628*						
	% of 19/20	118%	103%	116%	96%	105%	*82%*						
Elective	19/20	307	301	266	272	264	272	277	274	229	253	241	214
	21/22	155	244	225	221	172	*223*						
	% of 19/20	50%	81%	85%	81%	65%	*82%*						
New	19/20	3,916	4,129	3,944	4,174	3,760	4,367	4,684	4,476	4,008	4,805	4,222	2,993
	21/22	3,580	3,800	3,901	3,783	3,400	*4,097*						
	% of 19/20	91%	92%	99%	91%	90%	*94%*						
Follow Up	19/20	7,421	7,518	7,552	8,120	7,237	7,839	8,293	8,023	6,531	8,543	7,431	5,989
	21/22	8,084	8,178	8,456	8,502	7,384	*8,371*						
	% of 19/20	109%	109%	112%	105%	102%	*107%*						

*Outpatient % may differ from IPR due to data being refreshed

**September is current forecast for month end

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System Performance - September

The Walton Centre NHS Foundation Trust

	System % of 19/20	Walton Centre as @ 29/09/21
Daycase	77%	82%
Elective	91%	82%
New	104%	94%
Follow up	105%	107%

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Long Waiters

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- Currently there are 101 patients waiting over 52 weeks against a trajectory of 196. (System volume: 13,043)
- Trust is forecasting zero 104 week breaches. (System volume: 248)

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Additional ERF Gateway Criteria

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- Clinical Validation, Waiting List and Long Waits ✓
  - Use of P coding embedded
- Referral Optimisation ✓
  - Action plan submitted to Healthcare Partnership
- Patient Initiated Follow Ups ✓
  - Launch in 3 specialties by September 2021
- Addressing Health Inequalities ✓
  - BI Team have produced reports based on this
  - Strategic BAME Advisory Committee
- Remote consultations ✓
  - Trust has continued with the use of AA for appropriate pathways
- System-led recovery ✓
  - Trust is submitting minimum dataset required
  - Participation in system wide discussions
- People recovery ✓

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October to March (H2)

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- Planning guidance as of 29th September not released, however it is expected that the activity requirements will be at least 95% of 19/20
- Planned transfer of Spinal service (waiting list as a whole is currently unknown)
- Operational plans in place to tackle challenges observed during H1
- COO focus for next four months is restoration and recovery including divisional led transformational improvement programmes

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Key Risks

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- Comparison with 19/20 includes a proportion of waiting list initiatives for elective cases.
- Timing of transfer of Spinal service and impact on waiting lists.
- How Elective Recovery Fund (ERF) is distributed based on system led performance.
- ERF is based on financial achievement against 19/20 rather than volume related.
- Covid resurge and winter pressures
- Changes in commissioning environment
- Staff Resilience

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REPORT TO TRUST BOARD

Date 07/10/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations and Strategy
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Access & Performance Director
Previously considered by:	• Committee Quality Committee Business & Performance Committee
Executive Summary This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's. Measures have been grouped into three categories to highlight high performing measures, measures with opportunity for improvement and those measures currently under performing. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking.	
Related Trust Ambitions	• Best Practice Care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	Associated access and performance risks all contained in divisional and corporate risk registers.
Related Assurance Framework entries	Associated BAF entries: • 001 Covid-19 • 003 Performance Standards • 005 Quality
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

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Board KPI Report
October 2021

Data for August 2021 unless indicated

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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

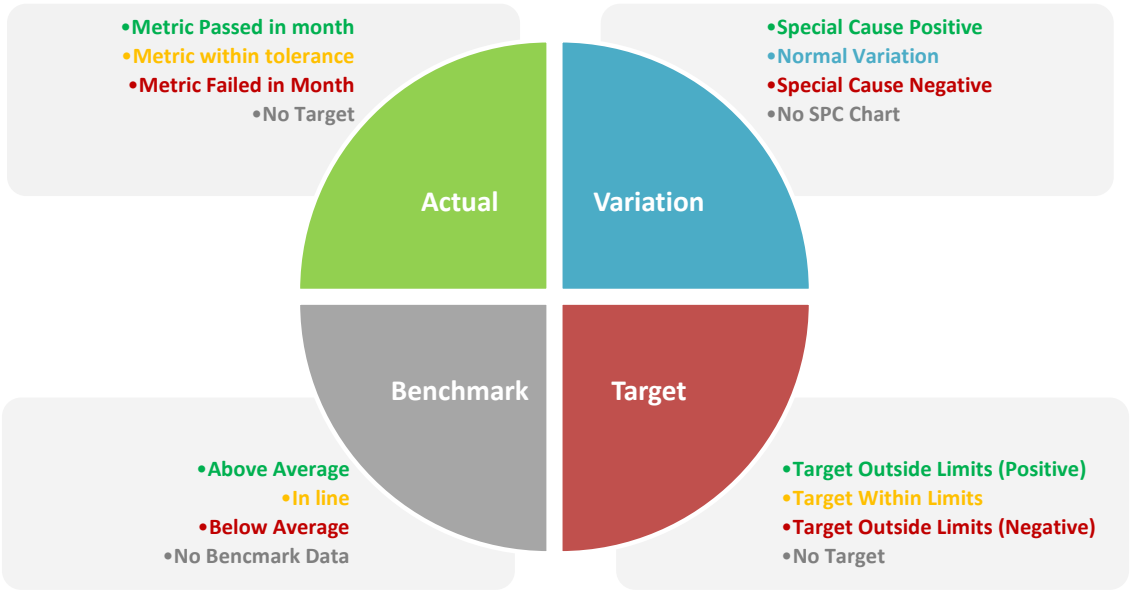
Actual — UCL — Average — LCL — National Average — Target

= 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.



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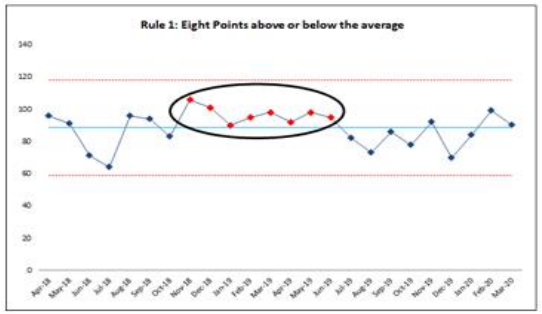
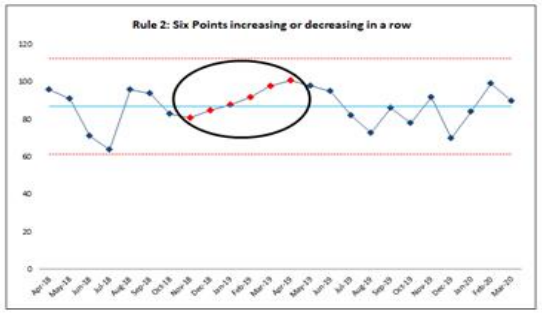
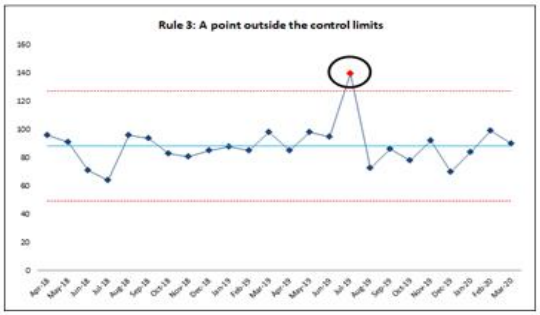
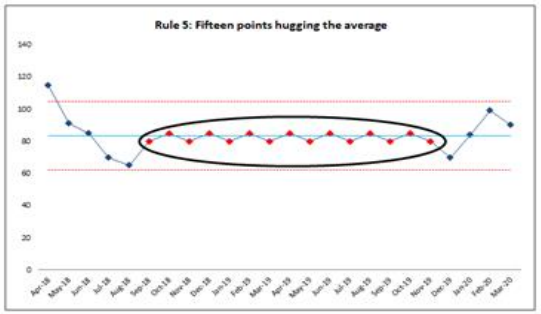
SPC Chart Rules

When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in 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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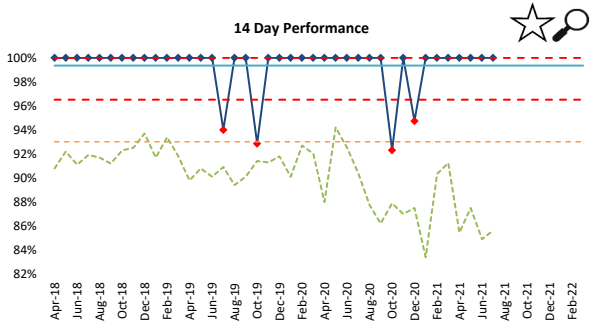
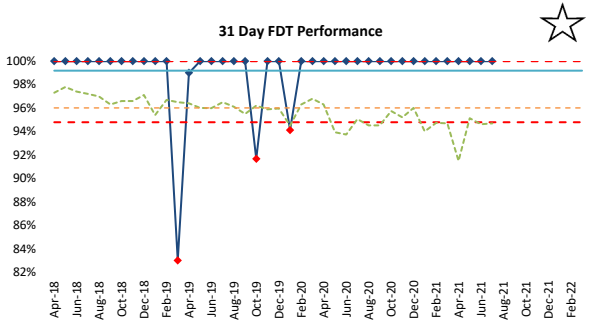
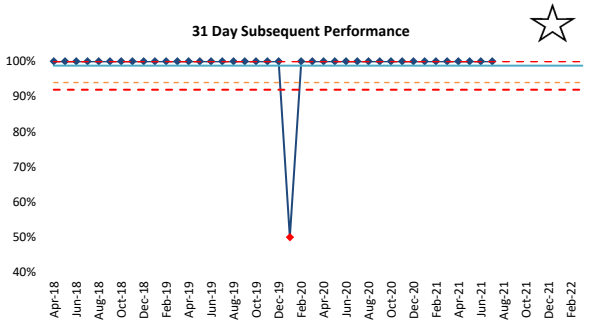
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	-	
28 Day Faster Diagnosis Standard	70%	100%	

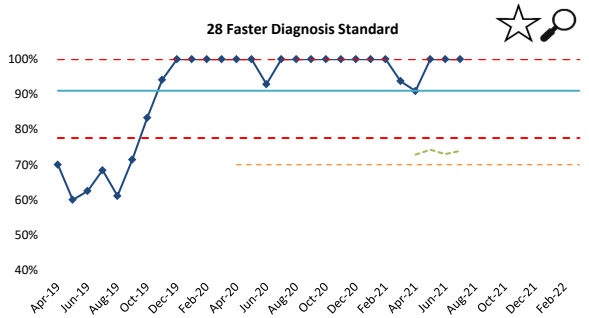
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

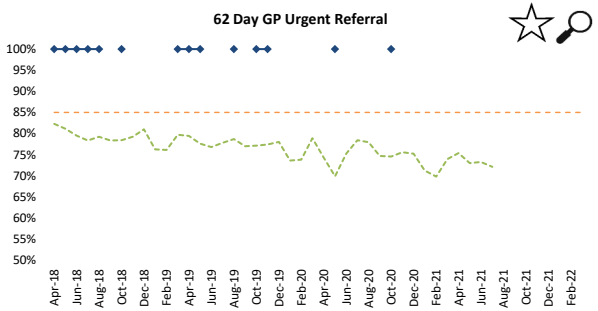
Associated Risks
001 - Covid-19
003 - Performance Standards

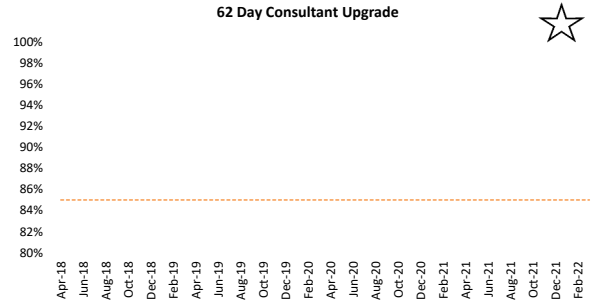












Operational

Responsive - Diagnostics

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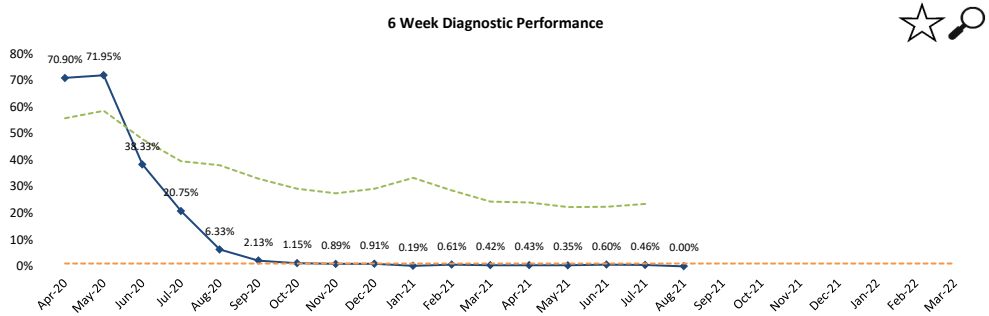
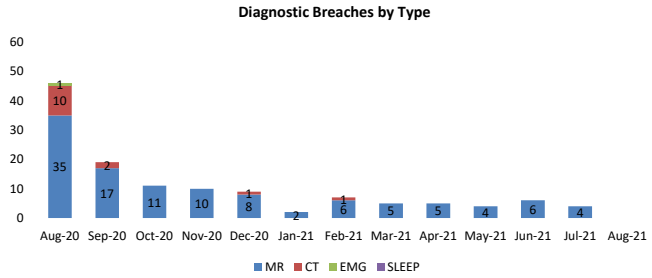
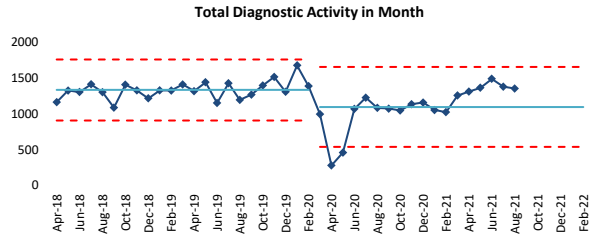
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.00%	

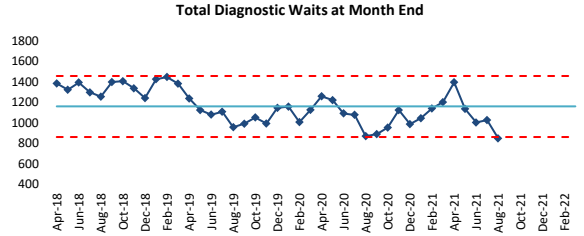
Associated Risks
001 - Covid-19
003 - Performance Standards

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









Operational

Effective - Theatres

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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

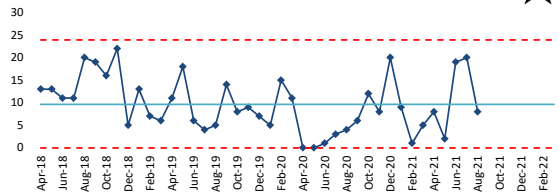
There were 8 patients cancelled at last minute for non-clinical reasons in August 2021, the reasons for the cancellations were bed unavailable (7) and equipment failure (1). Three patients were not rebooked within the 28 day target in month.

Theatres – Theatre Utilisation

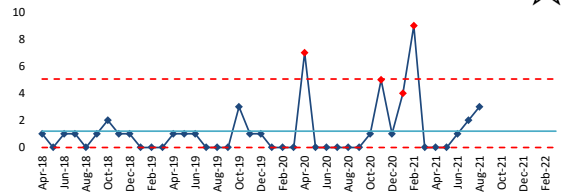
Elective in-session utilisation was 80.30% during August 2021. The Trust is continuing to focus on urgent cases in addition to reducing the number of 52 week waiters, t herefore it is more difficult than normal to effectively utilise in session theatre time. 25 of the 40 sessions lost in August were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

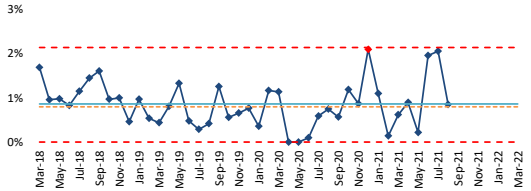
Number of Cancelled operations non clinical (on day)



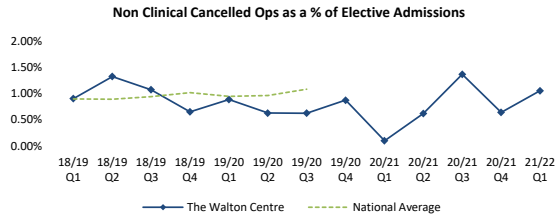
Number of cancelled operations not re-admitted within 28 days



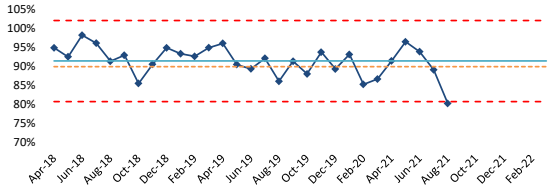
% of Cancelled operations non clinical (on day)



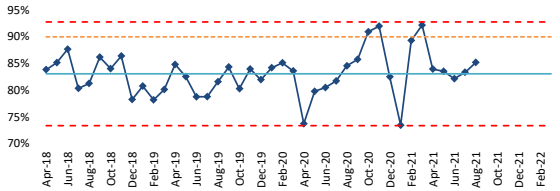
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational

Effective - Activity Recovery Plan

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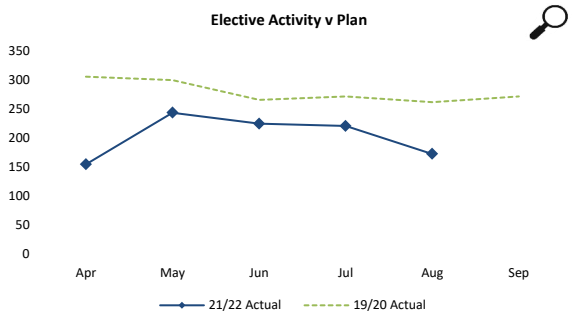
August 21 Activity Performance

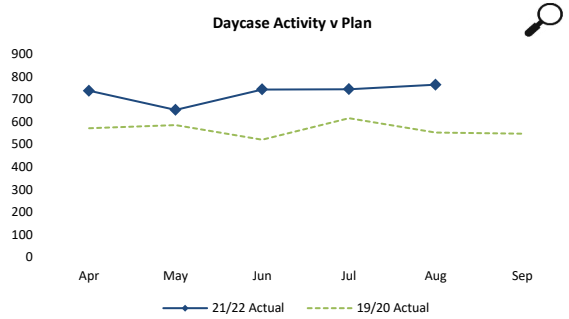
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	138.16%	95%
Elective	66.03%	95%
Elective & Daycase Total	**94.55%**	**95%**
Non Elective	83.33%	-
New Outpatients	89.94%	95%
Follow Up Outpatients	101.26%	95%
Outpatient Total	**97.38%**	**95%**

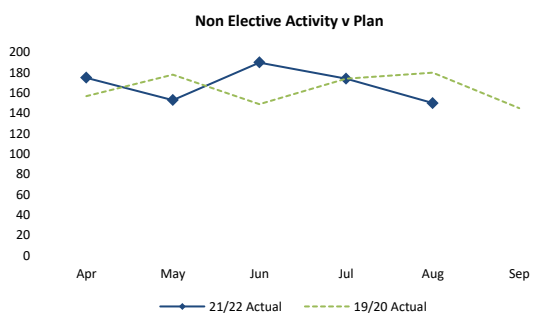
As part of plans to restore services to pre-COVID levels, each Trust was required to include trajectories and timescales for delivery of 100% of the pre-COVID activity levels (comparing with the baseline of actual 19/20 SUS activity levels). The Trust is forecasting delivery of 100% of all elective activity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

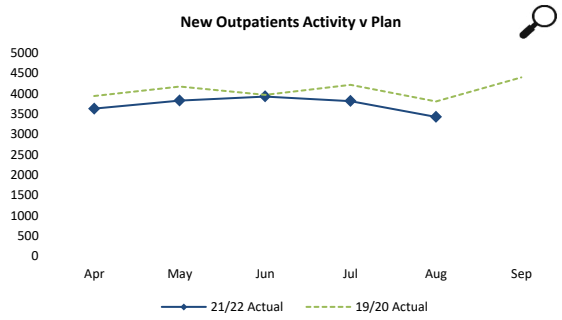
On 9th July the Trust received updated guidance stating that Elective Recovery Fund thresholds have been reviewed and have be en adjusted to 95% of 2019/20 activity levels from 1 July 2021. Daily operational huddles continue to review the activity performance against the revised thresholds set for the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

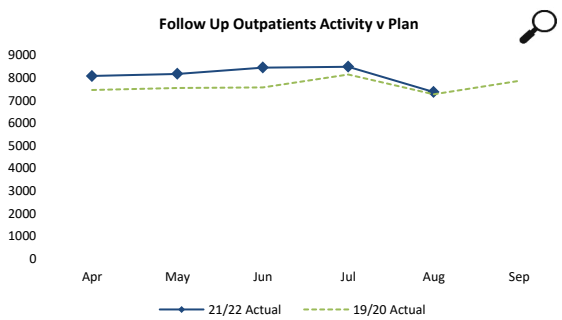
During August 2021 the Trust exceeded the national threshold of 95% for daycase activity and overall outpatient activity combined, however elective activity was below at 66.03%. Under-performance in month for elective activity is in the main due staff availability.











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Workforce Indicators

Workforce

Well Led - Workforce KPIs

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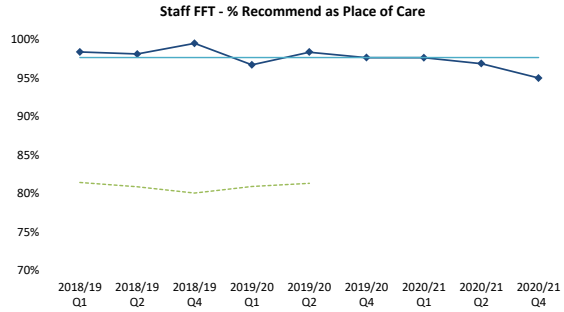
Well Led - Workforce	Target	Actual	Assurance
Staff FFT - Recommend Care (Q4 20/21)	-	95.00%	
Staff FFT - Recommend Work (Q4 20/21)	-	79.44%	
Appraisal Compliance	85%	77.64%	
Mandatory Training Compliance	85%	87.15%	

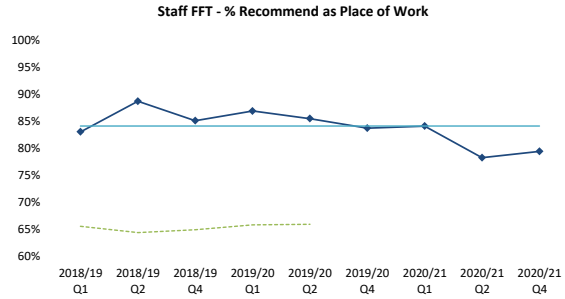
Mandatory Training Compliance

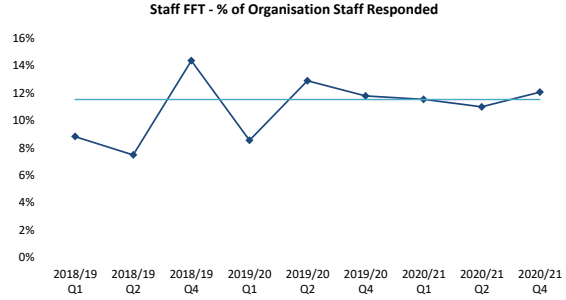
Overall mandatory training compliance in August 2021 was still above the target of 85% with some individual topics dropping below target. Compliance remains high for E-Learning topics and hopefully now training has restarted we will see an increase in topics included on study days.

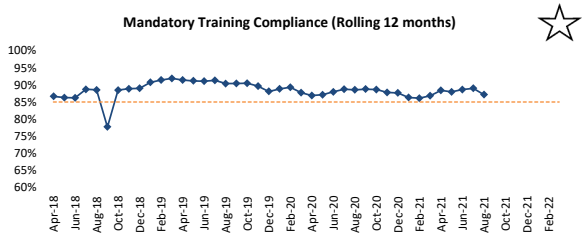
Appraisal Compliance

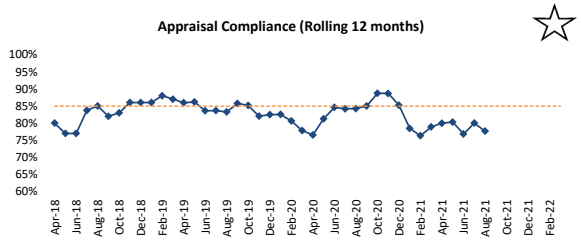
Appraisal compliance in August 2021 is 77.64% compared with 80.00% in July 2021. The training team are continuing to work with individual departments to improve compliance.











Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

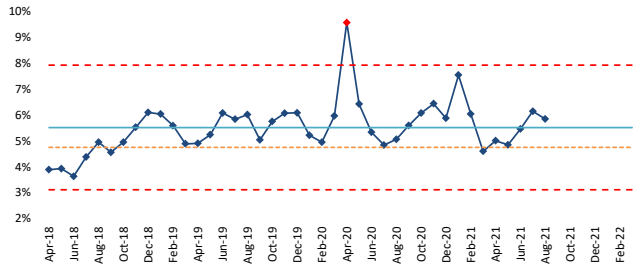
Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	5.85%	
Vacancy Levels	-	4.23%	
Nursing Turnover	10%	13.58%	
Other Staff Turnover	-	11.33%	

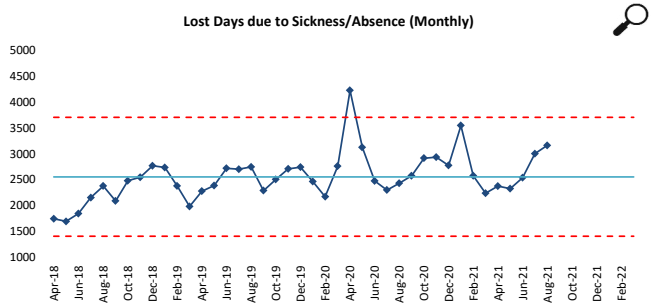
Sickness/Absence

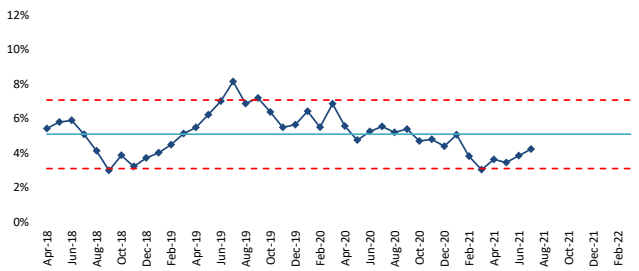
Sickness/Absence levels in August 2021 were above the target of 4.75% at 5.85%.

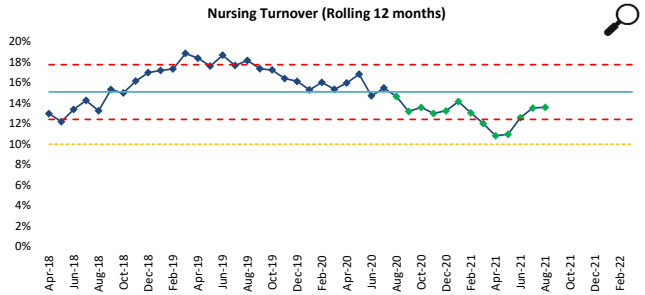
Nursing Turnover

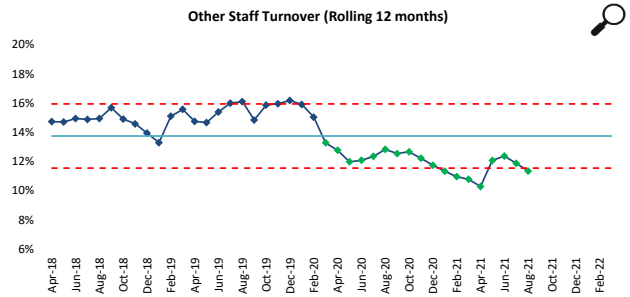
Nursing turnover has worsened when compared with last month following a period of consistent improvement and now stands at 13.58% for August 2021.

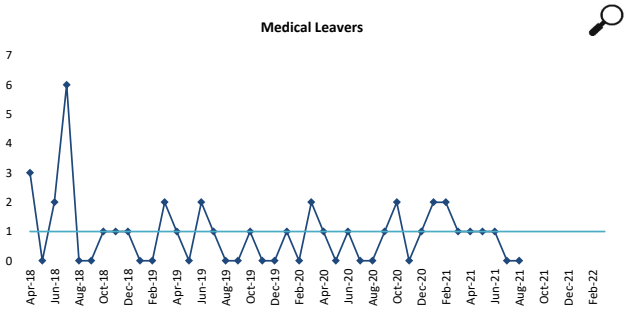












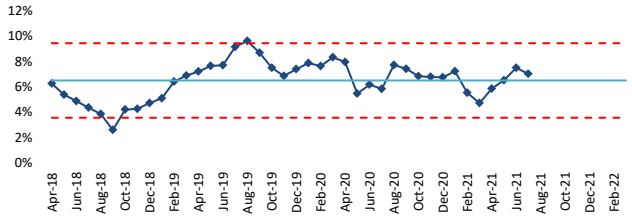
Quality of Care

Well Led - Workforce KPIs

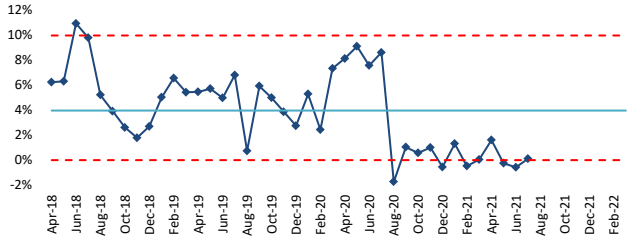
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

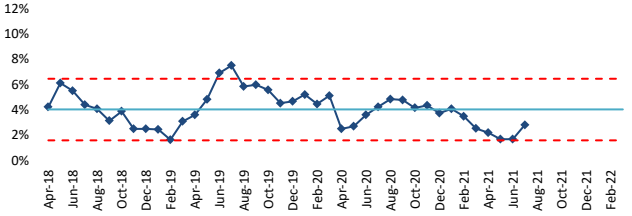
Nursing Vacancy Level %



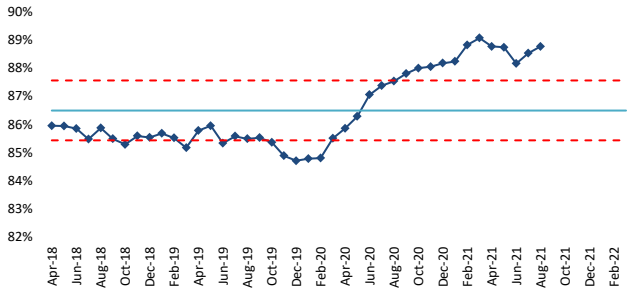
Medical Vacancy Level %



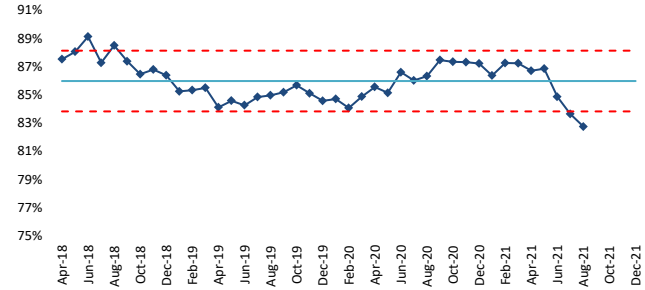
Other Staff Vacancy Level %



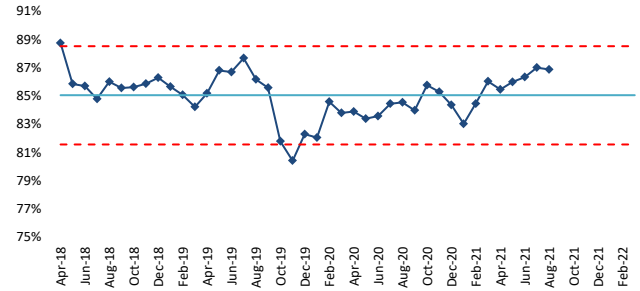
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



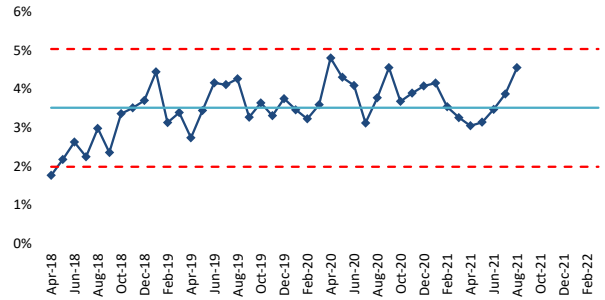
Quality of Care

Well Led - Workforce KPIs

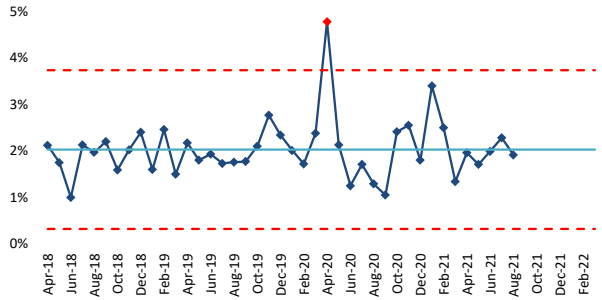
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

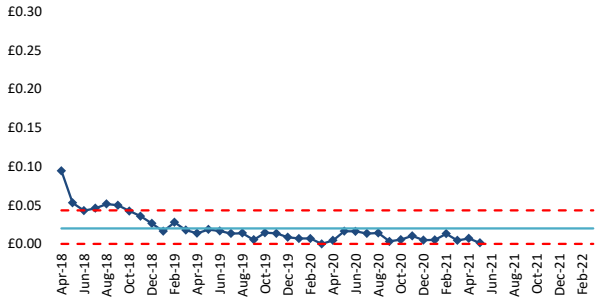
Long Term Sickness/Absence (Monthly)



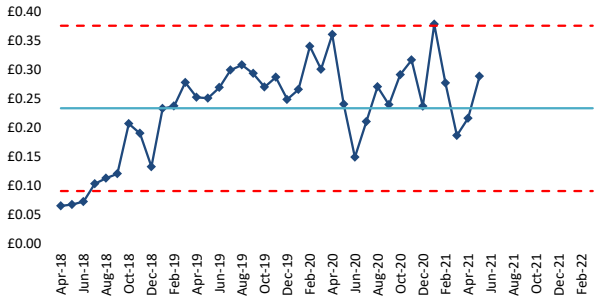
Short Term Sickness/Absence (Monthly)



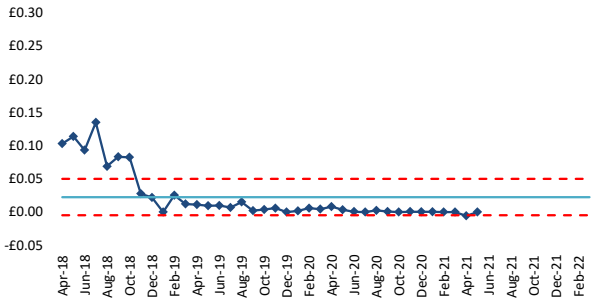
Nursing & HCA Overtime Spend (£m)



Nursing & HCA Bank Spend (£m)



Nursing & HCA Agency Spend (£m)



The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Indicators

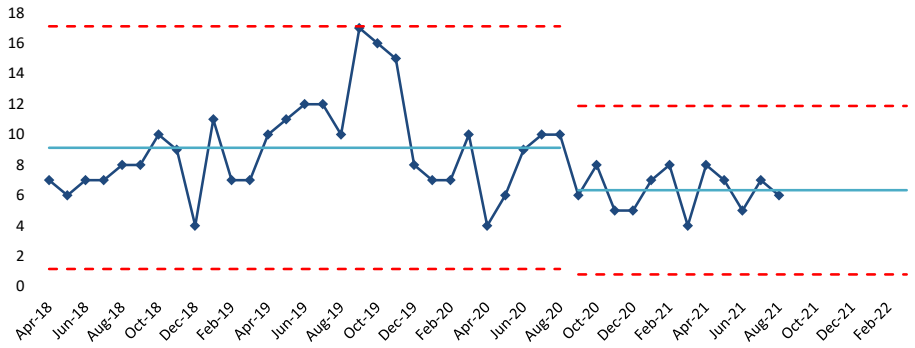
Quality of Care

Caring - Complaints

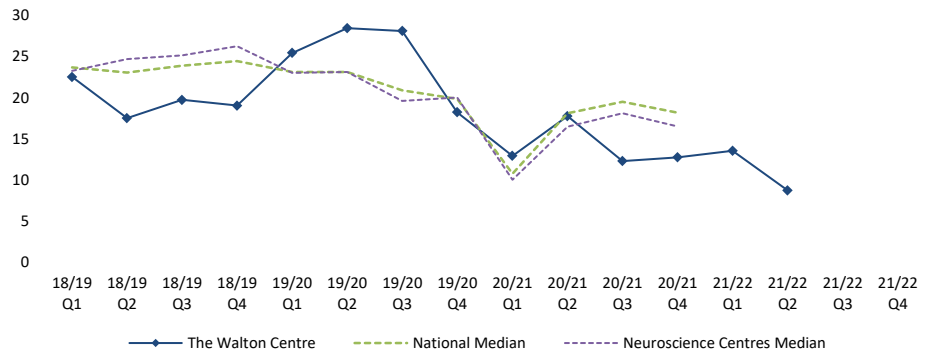
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

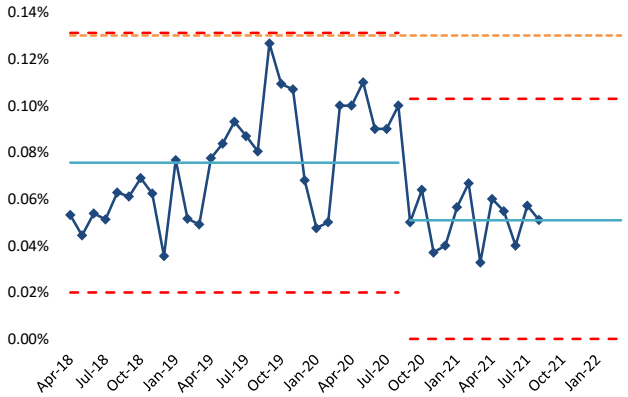
Total Complaints Received in month



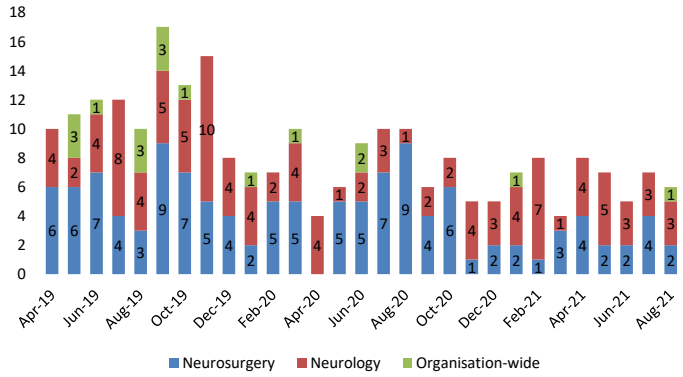
Quarterly Complaints per 1000 WTE



% 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.

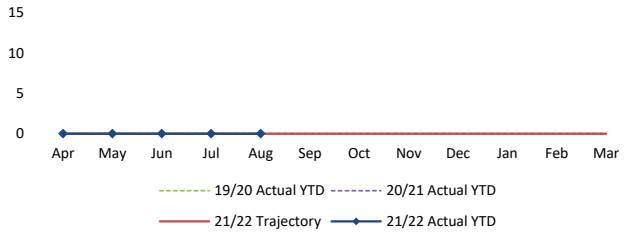
Quality of Care

Safe - Infection Control

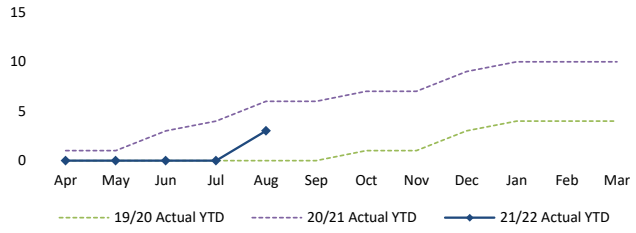
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

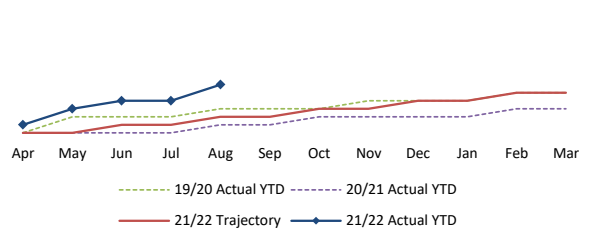
MRSA Bacteraemia



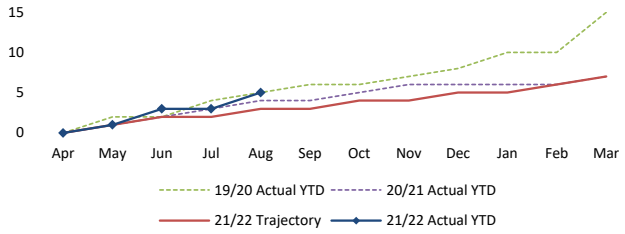
CPE



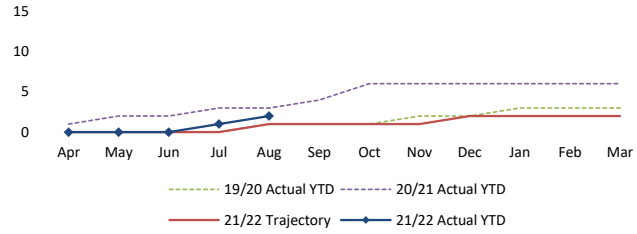
C.Diff



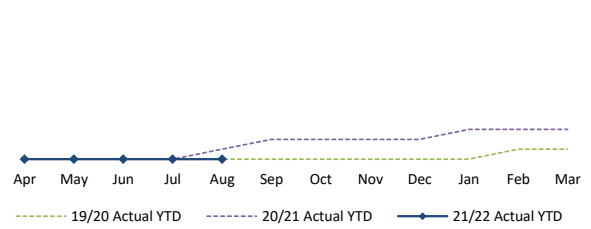
E.Coli



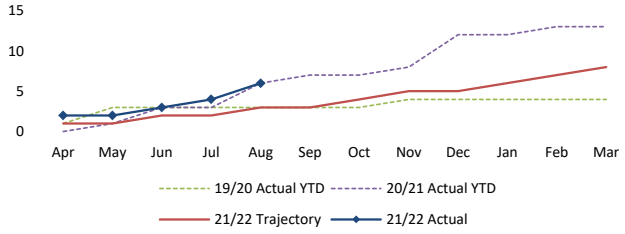
Klebsiella Bacteraemia



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

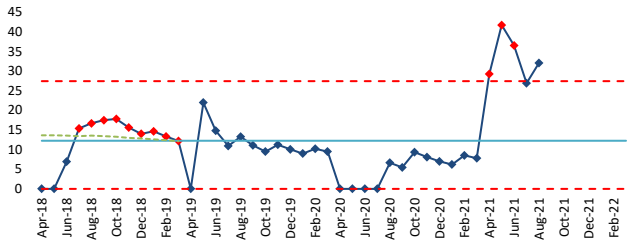
Quality of Care

Safe - Infection Control

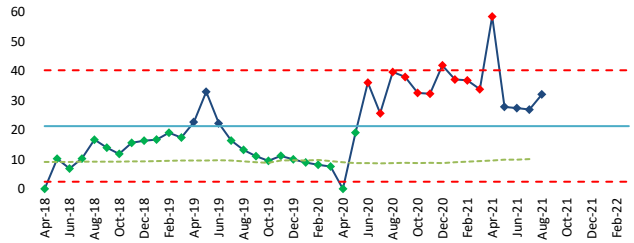
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

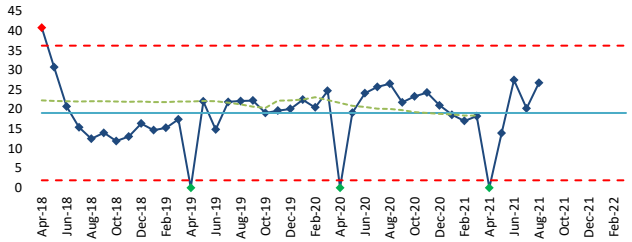
C.Diff Rate per 100,000 Bed Days YTD



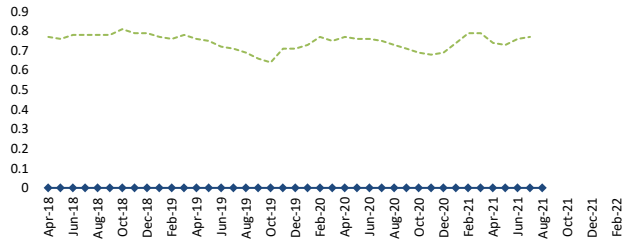
MSSA Rate per 100,000 Bed Days YTD



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

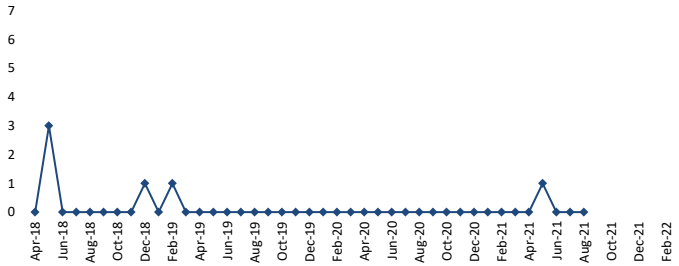
Quality of Care

Safe - Harm Free Care

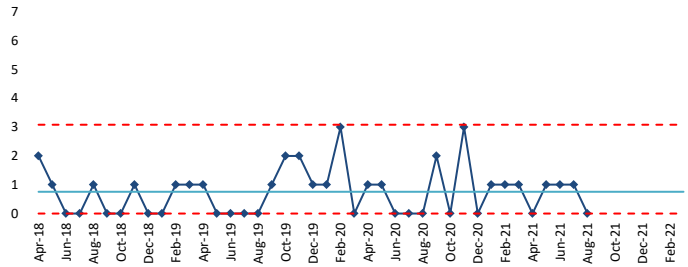
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

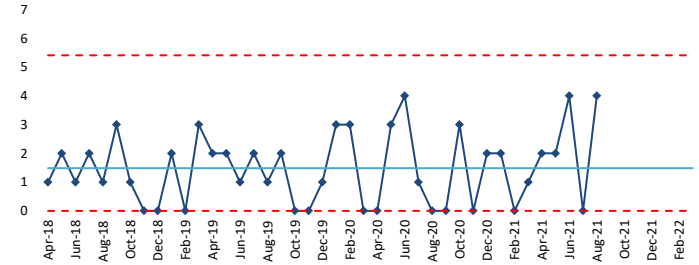
Total Moderate or Above Harm Inpatient Falls



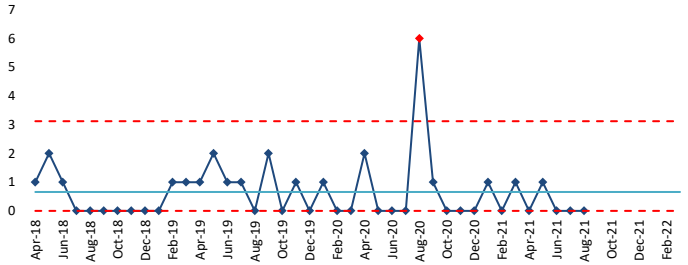
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



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	9,002	(366)	46,842	47,203	361	56,209	56,185	(24)
Exclusions	2,063	2,190	127	10,315	10,863	548	12,379	13,204	825
Private Patients	9	3	(6)	43	8	(35)	52	10	(42)
Other Operating Income	458	618	160	2,290	2,641	351	2,748	3,136	388
Total Operating Income	**11,898**	**11,813**	**(85)**	**59,490**	**60,715**	**1,225**	**71,388**	**72,535**	**1,147**
Pay	(6,267)	(6,397)	(130)	(31,086)	(31,608)	(522)	(37,470)	(38,015)	(545)
Non-Pay	(2,724)	(2,524)	200	(13,793)	(14,119)	(326)	(16,691)	(16,716)	(25)
Exclusions	(2,063)	(2,164)	(101)	(10,316)	(11,054)	(738)	(12,379)	(13,451)	(1,072)
COVID	(161)	(95)	66	(805)	(453)	352	(966)	(536)	430
Total Operating Expenditure	**(11,215)**	**(11,180)**	**35**	**(56,000)**	**(57,234)**	**(1,234)**	**(67,506)**	**(68,718)**	**(1,212)**
EBITDA	**683**	**633**	**(50)**	**3,490**	**3,481**	**(9)**	**3,882**	**3,817**	**(65)**
Depreciation	(487)	(490)	(3)	(2,435)	(2,435)	0	(2,922)	(2,922)	0
Profit / Loss On Disp Of Asset	0	16	16	0	68	68	0	68	68
Interest Receivable	0	0	0	0	0	0	0	0	0
Financing Costs	(53)	(50)	3	(265)	(246)	19	(318)	(296)	22
Dividends on PDC	(127)	(127)	0	(635)	(635)	0	(762)	(762)	0
I & E Surplus / (Deficit)	**16**	**(18)**	**(34)**	**155**	**233**	**78**	**(120)**	**(95)**	**25**
Capital donations I&E impact	**20**	**22**	**2**	**100**	**73**	**(27)**	**120**	**95**	**(25)**
I & E Surplus / (Deficit)	**36**	**4**	**(32)**	**255**	**306**	**51**	**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 5, the Trust reported a £4k surplus position. This is a £32k deterioration on the planned in month position of £36k surplus. This deterioration in month is due to an under-performance in ERF income offset by an over-performance in Isle of Man activity, Health Education England funding and blood and organ donation funding, as well as lower spend than planned on clinical supplies to deliver increased ERF activity.

The position includes £2,040k elective recovery fund against a planned position of £2,015k, £25k above plan (relating to over performance national trajectories in M1-3). In M4 and 5 the Trust was under 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 has yet to confirm ERF income values for M3-5 to the Trust therefore this may be subject to change.

The in-month position includes £97k spend incurred as a result of COVID-19.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	August-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	815	(54)
Tangible Assets	86,164	84,561	(1,603)
TOTAL NON CURRENT ASSETS	**87,033**	**85,376**	**(1,657)**
Inventories	1,157	2,096	939
Receivables	7,523	6,976	(547)
Cash at bank and in hand	35,689	35,728	39
TOTAL CURRENT ASSETS	**44,369**	**44,800**	**431**
Payables	(25,914)	(25,230)	684
Provisions	(245)	(245)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,518)	51
TOTAL CURRENT LIABILITIES	**(27,780)**	**(27,045)**	**735**
NET CURRENT ASSETS/(LIABILITIES)	**16,589**	**17,755**	**1,166**
Provisions	(701)	(686)	15
Finance Lease	(63)	(48)	15
Loans	(23,635)	(22,941)	694
TOTAL ASSETS EMPLOYED	**79,223**	**79,456**	**233**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,996	233
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,456**	**233**

STATEMENT OF CASH FLOW - 2021/22	August-21 plan	August-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**155**	**233**	**78**
Non-Cash Flows In Operating Surplus/(Deficit)	3,223	3,334	111
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**3,378**	**3,567**	**189**
Increase/(Decrease) In Working Capital	(152)	164	316
Increase/(Decrease) In Non-Current Provisions	(7)	(14)	(7)
Net Cash Inflow/(Outflow) From Investing Activities	(4,115)	(2,673)	1,442
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(896)**	**1,044**	**1,940**
Net Cash Inflow/(Outflow) From Financing Activities	474	(1,005)	(1,479)
NET INCREASE/(DECREASE) IN CASH	**(422)**	**38**	**460**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**35,267**	**35,727**	**460**

COVID-19 expenditure:

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

In month Actual: £97k.

Year to date Actual: £452k.

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	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	54	303
Decontamination	0	7	3	0	0	10
Agile working	0	12	1	0	0	13
Infection Control	0	0	0	0	22	22
Other	20	1	43	19	21	104
TOTAL	**113**	**70**	**104**	**68**	**97**	**452**

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

Capital

In month variance - £261k below plan.

Year to date variance - £1,402k 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	91	67	24	458	333	125	1,100	900	200
Estates	0	0	0	0	0	0	850	738	112
IM&T	81	26	55	404	174	230	969	1,027	(58)
Neurology	0	0	0	0	9	(9)	2,349	1,694	655
Neurosurgery	0	36	(36)	0	36	(36)	2,594	2,193	401
Corporate	0	0	0	0	0	0	491	150	341
Capital Slippage	(39)	0	(39)	(205)	0	(205)	(2,150)	(499)	(1,651)
TOTAL (excl. external funding)	**133**	**129**	**4**	**657**	**552**	**105**	**6,203**	**6,203**	**0**
Donated Assets	0	0	0	32	32	0	32	32	0
Digital Aspirant	302	45	257	1,510	213	1,297	3,623	3,623	0
TOTAL (incl. external funding)	**302**	**45**	**257**	**1,542**	**245**	**1,297**	**3,655**	**3,655**	**0**
TOTAL	**435**	**174**	**261**	**2,199**	**797**	**1,402**	**9,858**	**9,858**	**0**

Capital spend in month is £174k.

- **Heating & Pipework**: £67k – Phase 4 works;
- **IM&T:** £26k - Staffing in relation to specific projects;
- **Neurosurgery:** £36k Leica cassette printer and slide printer (Labs);
- **Digital Aspirant (PDC funded):** £45k – Whiteboard development, NHS mail migration and neurophysiology development.

The year-end capital forecast is £9.9m (including external funding) which is in-line with the agreed funding allocations. This assumes that a further £0.5m slippage is managed to bring anticipated spend back in line with the annual capital allocation.

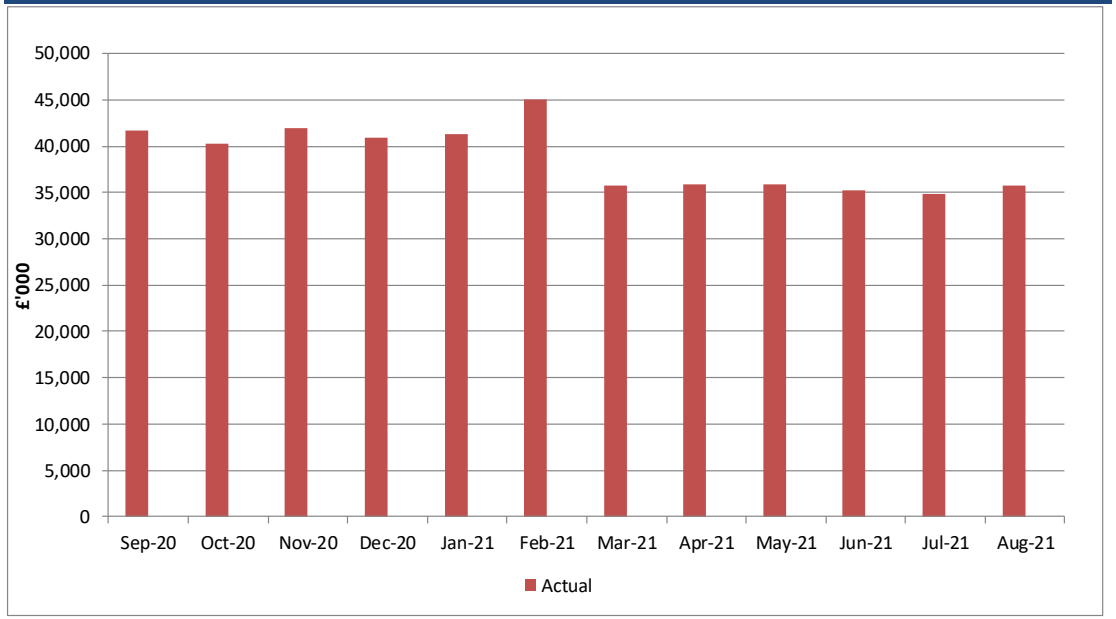
Work is ongoing with clinical and operational leads to prioritise capital spend for 21/22 to ensure that it is delivered in line with agreed funding levels. If capital is not spent in line with plan it could result in HCP allocations being reduced next year.

As of the end of August:

Actual Cash Balance: £35.7m.

Number of days operating expenses = 94 days.

Cashflow against plan (Rolling 12 months)



The Trust cash balance at the end of August was £35.7m. This is an increase of £0.9m compared with the end of July due to

- an increase in non-cash flows within the operating deficit
- a decrease in receivables
- an increase in payables
- offset by an increase in inventories (VCM).

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.

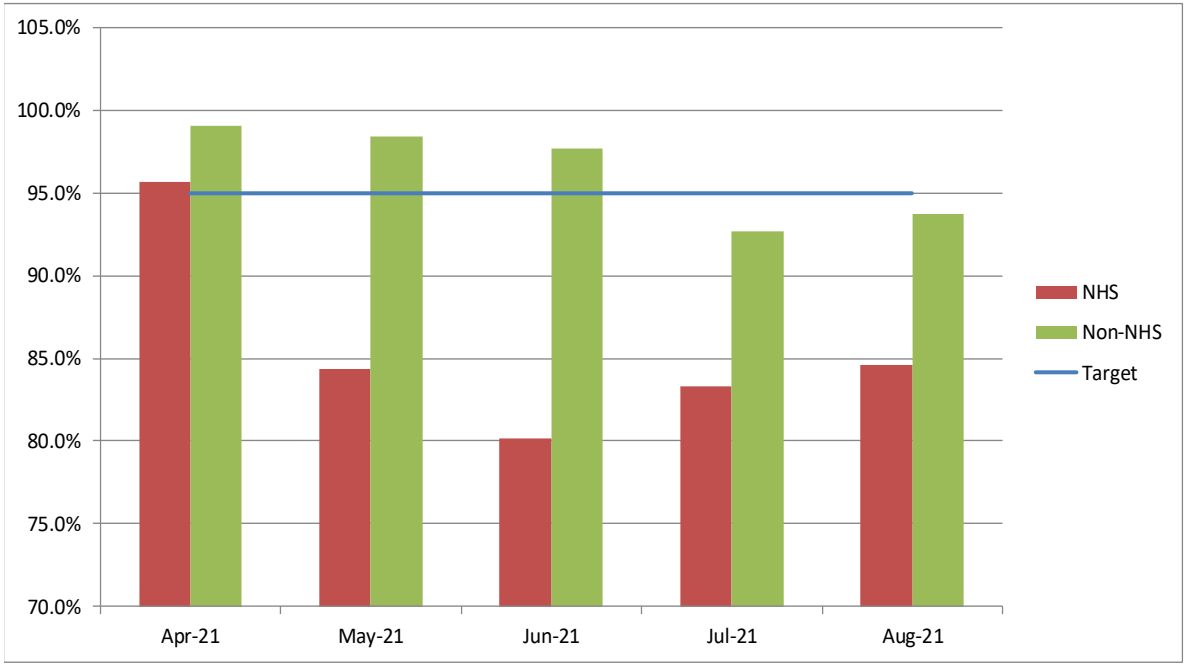
Block payments will be made in month and not in advance throughout 2021/22.

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 August against the target of 95.0% was:

- Non NHS 93.7%;
- NHS 84.6%;
- Total 90.5%.

This has seen an improvement in non-NHS payments of 1.0% and an improvement in NHS payments of 1.3% since the end of July.

The Trust BPPC percentage (by number of invoices paid) at the end of August is 92.8%.

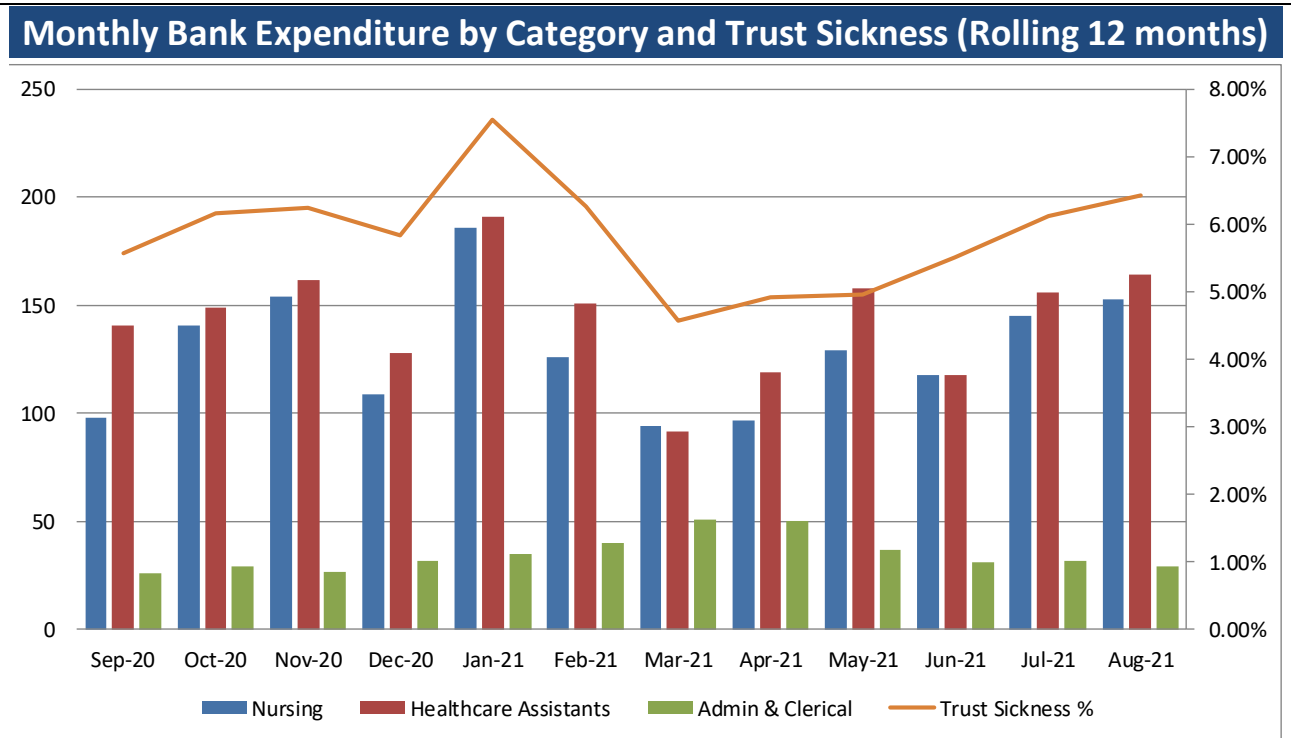
The finance team have put in place a weekly meeting to review and implement payment processes to bring payment to within 30 days.

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

Bank Expenditure:

In month Actual: £353k.

Year to date Actual: £1,572k.



Bank expenditure incurred in August was £353k, an increase of £16k when compared to July.

At the end of August, £225k bank expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

The trusts overall sickness rate increased from 6.12% to 6.43% in August.

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 and 2022/23 will start to take place for H2 in September 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	The operational requirements for 2021/22 to aid restoration of outpatient and elective inpatient services within the NHS, the Trust is required to meet national targets for activity and income as follows:
	• Overall outpatient and elective activity value against 2019/20:
	  ○ 70% for April 2021;
	  ○ 75% for May 2021;
	  ○ 80% for June 2021; and
	  ○ 95% from July to March 2022 - updated trajectory.

	Elective recovery gateway criteria; in order to receive additional funding for over-performing the national operational requirements per above the following criteria must also be met: • Addressing health inequalities; • Transforming outpatient services; • System-led recovery; • Clinical validation, waiting list data quality and reducing long waits; and • People recovery In addition the elective recovery fund will be managed and monitored at system level, therefore if the trust meets the national recovery targets set there is a risk that if the C&M HCP does not meet the requirements that the Trust will not receive the additional funding to meet the increased levels of activity. As the national activity trajectory has increased to 95% from 1st July it is highly unlikely that the ERF income assumed in the H1 plan will be received which will impact on the Trust's ability to deliver a breakeven position at the end of H1.
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification has been received that 2021/22 financial planning was deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for at least the 1st half of 2021/22. Current national guidance states that H1 funding will be based on Q3 20/21 spend extrapolated for 6 months with system allocations for providers to achieve a breakeven position. Further work has been undertaken to understand the financial forecast for H1 and final financial plans have been submitted to the HCP and NHSE/I. The financial framework will continue for H2 in line with H1. There will be at least a 3% efficiency requirement and a 0.82% deflator applied to envelopes along

	with inflation and the 3% pay award. Planning guidance will be released in the coming weeks. The finance team are currently reviewing plans for H2 with submission of these plans expected early October.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be in H2 of this financial year and as such planning to deliver recurrent savings is difficult. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements and it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans. However recurrent efficiencies will be required to be delivered in 2021/22 and work is being undertaken to identify these. Currently, it looks like efficiency targets of 3% will be required though this is a national target and there will be local efficiencies that may be required on top of this to reflect system envelopes.
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 change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as elective activity was suspended during the first wave of the pandemic and fewer patients will be able to be seen given the additional PPE/ social distancing requirements). There is also a risk to delivery of activity as a result of staff sickness due to COVID-19r and also the potential impact on services if the Trust is required to support other Trusts in the region with mutual aid e.g. critical care surge capacity.

REPORT TO
The Trust Board
7th October 2021

The Walton Centre NHS Foundation Trust

Title	Gender Pay Gap Report 2020/2021
Sponsoring Director	Mike Gibney, Director of Workforce and Innovation
Author (s)	Andrew Lynch, Equality and Inclusion Lead
Previously considered by:	N/A

Executive Summary

This report shows the Walton Centre NHS Foundation Trust's Gender Pay Gap figures from the snapshot date of 31 March 2020. The findings reflect pay by gender for the previous financial year to that date.

In summary, this year's Gender Pay Gap is consistent with reporting in the previous years. This is in line with the wider health care labour market and accelerated progress is limited as Trust's are not permitted to use positive discrimination. It is important to note that the pay gap percentage is a very limited gauge of the level of discrimination and the opportunities for advancement for female employees.

On a more positive note, the Trust has more females than males in the upper quartile of salary. Although a crude measure, this does indicate that career progression is not impeded by the characteristic of gender. Further, the overall workforce is significantly more female than male and many of the lower paid roles are traditionally undertaken by more females than males.

Related Trust Ambitions	• Be recognised as excellent in all we do
Risks associated with this paper	The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 apply to all private and voluntary sector employers with 250 or more employees. The Trust is required to submit Gender Pay Gap data to the Government and publish its Gender Pay Gap on the Trust website by 5th October 2021. The Trust Board must analyse the Gender Pay Gap. The regulations allow for the date at which the Trust Board analyses the Gender Pay Gap to be later than the publication deadline, so long as the proposed date for the Trust Board meeting is included in the published Gender Pay Gap report. All regulatory requirements have been met.
Related Assurance Framework entries	**N/A**
Equality Impact Assessment completed	• No – N/A this report it a regulatory requirement designed to advance Gender Equality.
Any associated legal implications / regulatory requirements?	• Yes – See Risks associated with this paper section above.
Action required by the Board	• To consider and note

GENDER PAY GAP REPORT 2020/2021

Reporting to Trust Board in 2021

1. Background

This report is intended to be published in September 2021, which is compliant with the Gender Pay Gap reporting deadline date of 5th October 2021. Publication of this data will place the Trust in a strong position in terms of its assurance that action planning to close the Gender Pay Gap is effective. The Gender Pay Gap report is due to be discussed at Trust Board on 7th October 2021, which is allowed under the reporting regulations. Any amendments made by the Trust Board will be subsequently incorporated into the published version.

In 2018 the government made Gender Pay Gap (GPG) reporting mandatory by amending the Equalities Act 2010 (Specific Duties and Public Authorities) Regulations 2017 so that all public sector employers with more than 250 employees are required annually to measure and publish their Gender Pay Gap prominently on the government website and their own.

This report shows the Walton Centre NHS Foundation Trust's Gender Pay Gap figures from the snapshot date of 31 March 2020. The findings reflect pay by gender for the previous financial year to that date. This report covers all staff including those under Agenda for Change terms and conditions, medical staff and very senior managers. The Gender Pay Gap information must be published on a website that is accessible to employees and the public free of charge. The information should remain on the website for a period of at least three years beginning with the date of publication. The Trust must also register the relevant data with the Government online reporting service no later than 5th October 2021. The Gender Pay Gap is the difference between the average earnings of men and women, expressed relative to men's earnings. This is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The Gender Pay Gap shows the differences in the average pay between men and women rather than unequal pay.

2 Organisational Context

The Walton Centre is committed to promoting equality, diversity and inclusion and to tackling any inequalities that are identified in the workforce. This report details the Trust's 4th set of findings following the introduction of Gender Pay Gap reporting and also details how the organisation plans to respond to the data analysis.

It is important to note that although our Gender Pay Gap reflects a senior manager/consultant gender ratio that cannot be resolved in a short period of time, the Trust has been working on a number of initiatives that help to create the best culture in which all staff can prosper. The Walton Centre NHS Foundation Trust acknowledges that society exhibits widespread disparities in the pay that women receive in comparison with men and that public sector organisation such as the Walton Centre both reflect these disparities and have a part to play in eliminating

them. The Walton Centre is happy to publish this Gender Pay Gap report as an expression of our Walton Way value of Openness: being open and honest in all we do. The Trusts Gender Pay Gap has remained constant since reporting has been introduced: 2017/18 = (33.23%), 2018/19 = (32.45%) 2019/20 = (29.10%) 2020/21= (29.52%).

2.1 The limitations of the Gender Pay Gap as a tool for understanding if the Trust is discrimination on the grounds of gender or not.

Nationally, statistical decomposition of the overall pay gap indicated that occupational segregation is the main driver of pay differences between men and women. Source: (The Nuffield Trust Briefing May 2019, The gender pay gap in the English NHS Analysis of some of the underlying causes).
https://www.nuffieldtrust.org.uk/files/2019-05/gender-pay-gap-briefing-ne1883-5.pdf

The numbers the Female when considered in quartiles ranging from the highest to the lowest paid, show that each quartile has relatively similar numbers. By contrast, the pattern for the numbers of Males when considered in quartiles ranging from the highest to the lowest paid indicates that there are about twice as many Males in the highest paid quartile than Males in each of the other quartiles.

This different pattern in pay between Female and Male staff produces the Gender Pay Gap despite the fact that the Trust has considerably more Females than Males, both overall and in the highest paid quartile. So the Gender Pay Gap does not indicate that there are fewer opportunities for advancement for Female staff at the Trust. To understand this data, it helps if we set it in the context of the NHS in general. The Walton Centre, like most NHS trusts, has high levels of gender occupational segregation with more Females than Males being represented in the clinical workforce, which also represents the largest proportion of the overall workforce. The levels of pay in the medical workforce are generally higher and a higher percentage of Males are represented in the Medical workforce than is the case for Females. This general gender segregation of both the UK and international labour market in clinical and medical staff accounts for much of the Gender Pay Gap at the Walton Centre. The aggregated Gender Pay Gap is useful for understanding if there is general pay discrimination across the whole population because there are roughly equal numbers of working age Females and Males, which makes the percentage difference reflect the numbers of Females and Males involved. This is not the case with the Walton Centre, where we have far more Female staff than Male staff. So the difference in the percentages is not an indication of the numbers of Females in higher paid positions at the Trust. In fact, the Trust has nearly twice as many Female staff in the upper average salary quartile than Males. The numbers of staff in the upper quartiles are the better indication of the opportunities for advancement at the Trust than the percentages. The relevant numbers do in fact show that being Female is not a general barrier to career advancement at the Trust. The numbers also show that recruitment of more males into the Trust at the three lower quartiles would close the Gender Pay Gap significantly.

As a consequence of the above considerations, the percentage Gender Pay Gap can be seen as useful information, but it cannot in and of itself be taken as indicating discrimination by the Trust in its recruitment practices or in the opportunities made

available for the advancement of Female staff e.g. as of September 2021 there are 5 Females and 7 Males on the Trust Board. The Trust Board has had roughly equal numbers of Females and males for the four preceding years to this.

3 Gender Pay Gap Data as at 31st March 2020

Total Number of staff: 1519
Female: 1161
Male: 358

The mean (average) gender pay gap using hourly pay and the median gender pay gap using hourly pay as at 31st March 2020.

Table 1

Gender	Average Hourly Rate	Median Hourly Rate
Female	£16.91	£15.25
Male	£24.05	£18.33
Difference	£ 7.10	£ 3.05
Pay Gap %	**29.52%**	**16.93%**

3.2 Bonus Pay

As an NHS organisation the only pay elements that fall under the bonus pay criteria are clinical excellence awards (CEA's) awarded to consultants only, and staff recognition awards which include long service awards, employee of the month and annual awards.

Table 2
The table 2 details the number of staff, broken down by gender, who received any kind of bonus payment as defined above.

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	9	1161	0.78%
Male	29	358	8.10%

Table 3

Table 3 outlines bonus payments and Pay Gap in the year to 31 March 2020.

Gender	Average Bonus Pay	Median Bonus Pay
Female	£9,378	£6,032
Male	£9,469	£6,032
Difference	£91	0.0
Pay Gap %	**0.96%** in favour of Males	**0.0%**

3.3 Quartile Analysis of Hourly Pay Rates

Table 4

Table 4 shows the Number of Females and Males in quartiles related hourly pay rates.

Salary Quartiles	Female Headcount	Male Headcount	Female %	Male %
Upper quartile	220	132	62.50%	37.50%
Upper middle quartile	288	64	81.82%	18.18%
Lower middle quartile	296	56	84.09%	15.91%
Lower quartile	273	78	77.78%	22.22%

Average salary for each quartile as follows:
Upper = £61,943
Upper Middle = £32,377
Lower Middle = £23,343
Lower = £16,852

4. Actions to Reduce the Gender Pay Gap

The Trust will undertake a self-assessment checklist that highlights key considerations that may affect the Gender Pay Gap. Completing the checklist will enable the Trust to assess our progress against different areas and understand those which require focus and should be addressed with further actions. The self-assessment checklist will ensure the following:

Branding/communication/transparency

- We are transparent about our promotion, pay and reward processes.
- We consider the language, images and branding that we use to promote and advertise roles and careers within our organisation.
- We encourage salary negotiation by showing salary ranges when advertising vacancies.

Recruitment and promotion processes

- We provide good-quality guidance to our line managers.
- We support progression for part-time and flexible workers.
- We give recruiters structured interview templates so they give every candidate an equal chance.

Maternity and paternity and parental leave policies

- We actively support women on maternity leave and encourage line managers to ensure staff use keeping in touch days as a stepping stone to creating a positive return to work experience.
- We actively target women who have not returned to the organisation after maternity leave and encourage them to return in a way that works for them.
- We actively promote the existence of a shared parental leave policy and encourage new parents to take advantage of the scheme.

Wellbeing and retention

- We offer and actively promote a range of opportunities for flexible working to all staff, to suit their parental and caring responsibilities and commitments outside of work.
- We actively analyse our staff survey data from a gender perspective by comparing the experiences of our male and female staff, particularly around the themes of equality, diversity and inclusion, line management and appraisals.

Supporting female staff

- We identify and support aspiring women leaders within our organisation by providing them with opportunities for development and career progression.
- We offer women networking opportunities promote access to mentoring and coaching from colleagues and peers.
- We actively support our female staff in considering and applying for clinical excellence awards (if appropriate) and other opportunities to seek recognition for their work.

5 Action Plan

The EDI steering Group will be responsible for developing and implementing the Trust's future Gender Pay Gap actions.

Area and objective	Action	Lead	Timescales	Resources	Outcome and impact
Action planning and review.	Complete the checklist and identify and carry out further actions based on any gaps found.	The EDI Steering Group.	November 2021	Data and information. Internal communications.	The Trust will gain a more detailed analysis and action plans in relation to closing the Gender Pay Gap.
Recruitment processes – to improve guidance for recruiting managers.	Guidance offered and develop a plan for all managers to Receive good-quality guidance.	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	Guidance to be developed by February 2022. Guidance to be distributed to managers March 2022.	Data and information. Internal communications.	All recruiting managers are aware of good practice for interviews.
Communication Improving staff understanding of and support for closing the Gender Pay Gap.	A member of the Trust Board will write a piece for Walton Weekly.	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	December 2021.	Data and information. Internal communications.	All staff will be informed about the Trusts commitment to reduce our gender pay gap,
Supporting female staff to take up more opportunities for career advancement.	Offer and promote networking opportunities to female staff.	Lead: Equality and Inclusion Lead, supported by The EDI Steering Group.	December 2021	Data and information. Internal communications.	Female staff will be supported to know about and take advantage of the opportunities for career advancement that are available.

Further sources of advice and actions to close the Gander Pay Gap:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf

https://www.nhsemployers.org/sites/default/files/2021-06/Addressing-your-gender-pay-gap-guide.pdf

Appendix

Data on the Gender Pay Gap 2021/2022 based on data relating to 31st March 2021

Total Number of relevant staff:	1446	Female 1106	Male: 340

1. The mean (average) gender pay gap using hourly pay and the median gender pay gap using hourly pay as at 31st March 2021.

Table 1

Gender	Average Hourly Rate	Median Hourly Rate
Female	£17.24	£15.33
Male	£24.75	£18.85
Difference	£7.51	£3.52
Pay Gap %	**30.54%**	**18.67%**

2. Percentage of men and women receiving bonus pay 31st March 2021.

Table 2

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	*8*	*1193*	*0.67%*
Male	*27*	*371*	*7.28%*

3. The mean (average) gender pay gap using bonus pay and the median gender pay gap using bonus pay as at 31st March 2021.

Table 3

Gender	Average Bonus Pay	Median Bonus Pay
Female	£10,189	£6,032
Male	£8,979	£6,032
Difference	£1,210	0.0
Pay Gap %	**20.05%** in favour of Females	**0.0**

4. Percentage of men and women in each hourly pay quarter as at 31st March 2021.

Table 4

Quartile	Female Headcount	Male Headcount	Female %	Male %
Upper quartile = £63,634	223	139	61.60%	38.40%
Upper middle quartile = £33,314	297	64	82.87%	17.73%
Lower middle quartile = £23,733	301	61	83.15%	16.85%
Lower quartile = £17,254	285	76	78.95%	21.05%

The Walton Centre NHS Foundation Trust

Doc Ref GoSW AR 2021

REPORT TO THE TRUST BOARD
7th October 2021

Title	**Guardian of Safe Working Annual Report**
Sponsoring Director	Name: Dr Andrew Nicolson Title: Medical Director
Author (s)	Name: Dr Christine Burness Title: Guardian of Safe Working
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____
Executive Summary There are currently 52 junior doctors on the new contract at the Trust. We have no vacant posts. During the report period (August 2020 to July 2021), £152,000 has been spent on covering junior doctors rota gaps. We have had 31 exception reports during this period.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be financially strong • Research, education and innovation • Be recognised as excellent in all we do
Risks associated with this paper	Cost associated with rota gaps.
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – Completed in keeping with the Junior Doctors Contract Terms and Conditions
Any associated legal implications / regulatory requirements?	• Yes – European Working Time Directive, Junior Doctor Contract
Action required by the Board	Delete as Appropriate • To consider and note

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Current Situation	During the reporting period, the coronavirus pandemic has impacted junior doctors at the Walton Centre in a number of ways:- • The BMA and NHS Employers issued a joint statement suspending the 2016 T&C during the Coronavirus pandemic (Appendix 1). Adaptations to rotas will need to be considered and pragmatic The safety of junior doctors and minimising the risk of fatigue and burnout remains a priority. • At the Walton Centre, rotas have had to be updated due to the changes and doctors are required to provide cover for colleagues, often at short notice. New rotas were implemented across all specialties in March 2020 and were continuously updated and adjusted in response to changing demands. By the end of the year, most rotas were back to a more usual pattern (without a standby doctor for each shift). • Rotations for Foundation Year and Core trainees were suspended in many specialties (at the Walton Centre, the only rotation between February and August 2020 was of the F2 doctor in Neuroanaesthetics). That F2 post will remain within Neurocritical care until at least July 2022. • Training has been impacted due to the cancellation of routine clinical work including face to face clinics and elective surgery. As routine specialty work resumes, the College Tutors and Training Programme Directors are supporting junior doctors to ensure that opportunities for training are optimised (for example via weekly online tutorials in anaesthetics). Specialist trainees have continued to provide telephone advice and a combination of face to face, telephone and video clinics. Core and foundation trainees will be encouraged to attend theatre sessions and clinics within the constraints of social distancing and infection control. • The impact of coronavirus both professionally and personally is a threat to the wellbeing of all members of staff. Junior doctors require support during this time. The Trust regularly circulates details of how staff may access support via an internal Neuropsychology service and also external sources. The junior doctor's mess has been refurbished and a coffee machine has been provided. In August 2021, the structural work and decorating was complete but we are awaiting some of the furniture and fittings. At the height of the pandemic, the GoSW set up an online group for junior doctors to allow easy communication between colleagues who may not all be on site. Junior Doctor Forum Meetings were held remotely when face to face group meetings were not possible and one-to-one meetings (in person with social distancing or by telephone or zoom) with the guardian of safe working are available on several days each week. The training programme directors and rota co-ordinators are working closely with junior doctors to ensure that they are supported and updated as the situation changes.
Background	The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors' placed in the Trust have moved onto the new 2016 terms and conditions of service.

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In June 2019, amendments to the 2016 were agreed as follows:

- Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am)
- Maximum of 72 hours to be worked within any 7 day period.
- Increased pay for weekend a night shifts (shifts ending between midnight and 4am)
- £1000 per year extra for LTFT trainees
- A fifth nodal point on the payscale when doctors reach ST6
- Transitional pay protection extended until 2015
- Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive)
- Exception reporting for all ARCP/ portfolio requirements
- Guaranteed annual pay uplift of 2% per year for the next 4 years
- Fines to be levied by the GoSW for any breach of safe working hours

The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue.

Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be;

- Differences in the total hours of work (including opportunities for rest breaks)
- Differences in the pattern of hours worked
- Differences in the educational opportunities and support available to the doctor
- Differences in the support available to the doctor during service commitments

We use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner.

Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust.

Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian.

During the report period, there have been 31 exception reports at the Walton Centre. All have been submitted by registrars in Neurology and all have been resolved with time of in lieu (TOIL).

The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum alternating with to the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract.

The Annual Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

Report

High Level Data (requested by NHS Employers)

Number of doctors in training (total)	52
Number of doctors on 2016 T&C (total)	52
Amount of time in job plan for guardian to fulfil the role	1PA
Admin support provided to the guardian Support provided by Heather Doyle	0
Amount of job-planned time for educational supervisors	0.25 (for education and training)

Annual expenditure to cover junior doctor rota gaps (see Appendix 1 for breakdown by month)

Neurology	-£1000
Neurosurgery	£153,000
Total	**£152,000**

a) Exception reports

There have been 31 exception reports during this period (and none during the last quarter).

b) Work schedule reviews

We have not had to undertake any work schedule reviews.

c) Vacancies

The Trust has 52 established training posts, currently none are unfilled.

d) Fines

No directorate within the Trust has received a fine.

Qualitative Information

The exception reports during this period have all been resolved by offering time of in lieu.

Issues arising

The change in the junior doctors contract will have the most impact on the senior neurosurgery registrar 24 hour on call rota. For the next 3-4 years, we will have 2 or 3 doctors on the new contract who must comply with the new T&Cs from February 2020.

Actions taken to resolve issues

The hours monitoring exercise is to be repeated annually for the Neurology Specialist Trainees in order to ensure that the rota accurately represents the hours worked. The senior neurosurgical registrar rota is also to be monitored. These plans have been put on hold due to the disruption in working patterns during the current pandemic.

Trainees are aware that they can request a work schedule review or hours monitoring exercise at any time of they have concerned. Potential rota changes to resolve any issues are reviewed in anticipation.

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	Summary There are currently 52 doctors at the Walton Centre on the new 2016 terms and conditions. Overall, the feedback from junior doctors is positive. Since the introduction of the new contract in August 2016, there have been 47 exception reports. All have been resolved with TOIL. The current coronavirus pandemic leads to new challenges for rota compliance and working patterns. Work schedules and working hours have not been changed (the latter were in some cases reduced at the height of the pandemic). Since August 2020, rota patterns have returned to normal although flexibility has been required due to the increased numbers of absences. We are trying to engage with broader junior representation across specialties at the JDF & encourage better teamwork within divisions between core trainees & specialist training grades to optimise working relationships & educational opportunities. We are conscious of the potential impact of the current situation on junior doctors training and wellbeing and are taking all opportunities to offer support and educational experiences throughout this time. .
Actions	The Board is asked to receive, review and comment upon the Guardian's annual report.

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Appendix 1: Locum agency expenditure to cover junior doctor rota gaps (by month)

	Aug 2020	Sept 2020	Oct 2020	Nov 2019	Dec 2019	Jan 2020	Feb 2021	March 2021	April 2021	May 2020	June 2020	July 2020
Neurology	-5000	0	0	4,000	0	0	0	0	0	0	0	0
Neurosurgery	28,000	13,000	27,000	26,000	6,000	-2,000	6,000	8,000	9,000	14,000	10,000	8,000
Total	**23,000**	**13,000**	**27,000**	**30,000**	**6,000**	**-2,000**	**6,000**	**8,000**	**9,000**	**14,000**	**10,000**	**8,000**

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The Walton Centre
NHS Foundation Trust

REPORT TO THE Trust Board
Date 7th October 2021

Title	**Annual Report 2020/21 : Senior Information Risk Owner (SIRO)**
Sponsoring Director	Name: Mike Burns Title: Director of Finance and IT
Author (s)	Name: Mike Burns /Lorraine Blyth Title: SIRO/ Information Governance Manager
Previously considered by:	Business Performance Committee 28th September 2021

Executive Summary

In recent years compliance with developing information governance requirements has become a key concern for the public sector. The cabinet review of data security requires all public sector organisations to appoint a Senior Information Risk Owner (SIRO) whose role is outlined as:-

"The SIRO will act as an advocate for information risk on the board and in internal discussions and will provide written advice to the Accounting Officer on the content of the annual Statement of Internal Control (SIC) in regard to information risk" *(Data Security and Protection Toolkit)*

Throughout the past year the Trust has strived to make improvements and to raise awareness as part of the Information Governance/Security Agenda which include:

- **Substantial Assurance -** gained for the 11th year in succession from internal audit on the Data Security and Protection Toolkit
- **Data Security and Protection Toolkit scores** – All assertions and mandatory evidence items were met for the new Data Security and Protection toolkit that was submitted to NHS Digital on 30th July 2021. The trust obtained Standards met again for the third year which was the second highest level available.
- **ISO27001 accreditation** – The Trust had its external audit in October 2020 and successfully obtained the full ISO27001:20013 accreditation. There were no majors, minor or observations noted which is an excellent result and a testament to the work of the teams involved.
- **FOI** – There have been 366 requests from April 2020 to March 2021 in comparison to 520 (29.62% decrease) on the previous year. This year has seen the Trust receive five internal review requests, which were dealt with within the relevant timeframe and there has been no subsequent correspondence from the requestors or from the ICO. The report for this year highlights that although the number of requests have decreased, the information requested is becoming more complex. We are seeing multiple questions and multiple departments targeted within one request, which reflects in the time spent in managing requests as this has increased by 26.47% from 310 hours in 2019/20 to 392 hours in 2020/21. This could also however be due to the new mandatory field on the system to complete how long a request took to answer which could now be showing us more accurately as a Trust how much time we spend managing requests. There are still technical issues with the system that need to be implemented to ensure the system runs smoothly and is more easily accessible which have been raised to the Project Management Team. However clinical work has taken priority. This will be addressed during 2021/22. There have never been any Freedom of Information breaches ever, which is something the Trust should be very proud of.
- **NHS Digital /CareCert** – (Computer Emergency Response Team). The Trust is also signed up to this cyber security alert service and receives weekly data and cyber security threat bulletins and risk notifications, which it tracks and acts upon. There have been 288 CareCerts received and completed in 2020/21

- **Data Protection Impact Assessments –** DPIA assessments are being carried out in line with the Policy and being monitored through the IG Department, DPO, SIRO and IGSF. The Trust sees engagement from various departments when initially introducing projects. The new DPIA screening and full assessments were reviewed in June 2020 and combined in order to streamline the process and make it more user friendly. A list of completed DPIA's is regularly published on the Trust external website in line with the new Data Security and Protection Toolkit requirements. There have been 20 Data Protection Impact Assessments submitted to the forum throughout 2020/21.

- **Incidents –** There have been 121 Walton Centre incidents reported for this period against 213 in the previous year. The significant decrease in incidents this year is assumed to be due to Covid-19 and the impact it has had on the Trust. Due to Covid-19 staff were not able to work in their usual way due to social distancing, lockdowns and staff shielding, etc. New ways of working had to be developed at the Trust which enabled staff to work from different locations such as home, bookable Trust office pods, etc. Similarly, case notes being provided for outpatient clinic appointments significantly decreased. Therefore, most of the previous incidents that were commonly caused by human error and the handling of documentation have seen a decline due to staff now working digitally and not being on site as often as they were previously. There have been 3 externally reportable Information Governance incidents which were reported to the Information Commissioner during this period. The ICO has now responded to all three incidents to advise that all appropriate remedial action had been taken and the Information Commissioner is satisified with the responses submitted by the Trust.Data Security Awareness Training - The Trust successfully met the national 95% mandatory training target with 95% of staff completing training by 30th June 2021.
- **Cyber Security –** The Trust has completed various exercises in relation to cyber security during the year such as: Cyber Desktop Exercise, MIAA Penetration Test and MIAA Cyber Audit. The Trust also commissioned an external HiMSS audit, where the Trusts Cyber Security stance received a good score, and the Trust scored level 5 overall. There are various different members from the Trust including IT & Executive Team (SIRO) who are also now signed up to the Cheshire and Mersey Cyber Group membership.

Related Trust Ambitions	• Best practice care • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	As detailed in the report
Related Assurance Framework entries	As detailed in the report
Equality Impact Assessment completed	• **No** – The annual report is the report to show the Trust is meeting its statutory & regulatory requirements.
Any associated legal implications / regulatory requirements?	• **Yes** – General Data Protection Regulation, Freedom of Information Act 2000, Access to Health Records Act 1990, Data Protection Act 2018, National Data Security Standards, Network and Information Systems Regulation.
Action required by the Board	• To consider and note

The Walton Centre NHS Foundation Trust

Report to Board of Directors
September 2021

Senior Information Risk owner (SIRO) Report

Background and Purpose

The purpose of this report is to:-

- Provide an overview of the Trusts compliance with legislative and regulatory requirements relating to the handling of information, including compliance with current Data Protection Laws and Freedom of Information Act (2000);
- Describe achievements relating to Information Governance within the Trust during the year 2020/21;
- To provide assurances on the progress and developments made in Information Governance/Security and to outline the strategic direction and actions for 2021/22;
- Present any Externally Reportable incidents within the preceding twelve months, relating to any accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

Executive Summary

In recent years compliance with developing Information Governance requirements has become a key concern for the public sector. The cabinet review of data security requires all public sector organisations to appoint a Senior Information Risk Owner (SIRO) whose role is outlined as:-

"The SIRO will act as an advocate for information risk on the board and in internal discussions and will provide written advice to the Accounting Officer on the content of the Annual Statement of Internal Control (SIC) in regard to information risk" *(Data Security and Protection Toolkit)*

The Trust has again consistently performed well in relation to Information Governance and Information Security. This has resulted in meeting all 42 assertions, 110 mandatory evidence items and achieving Standards met for the Data Security and Protection Toolkit (DSPT), which was submitted to NHS Digital on 30th June 2021. The deadline for submitting the Toolkit was delayed from March 2021 to June 2021 due to the impact of Covid 19.

Each year there are additional new requirements to meet within the Data Security and Protection Toolkit with increasing focus on data security. The Trust has worked throughout the year to ensure actions plan were in place and processes were implemented to enable the new requirements to be met, and for the Trust to remain compliant.

The strong Information Governance framework and robust processes and policies that the Trust already has in place, has undoubtedly continued to contribute to the Trust being able to meet the new standards within the DSPT.

The Trust successfully met the national 95% mandatory training target, with 95% of staff completing Information Governance training by 30th June 2021. The period for which the 95% target related to has been increased this year from 1st April 2020 to 30th June 2021 in line with the extended deadline for the Toolkit. Due to Covid 19, additional classroom sessions could not be held this year, however the target has still been achieved. The training is solely managed through Information Governance, the only training function to sit outside the Training and Development Team, therefore a lot of resource goes into regular communications to remind line managers and staff of their obligations to achieve this.

The challenge over the past year has been to maintain and improve upon the standards, systems and processes already in place and to keep up with the changing legislation to ensure that the Trust continues to meet evolving Data Protection requirements. This continued alongside the Covid pandemic and all the added pressure and workload this has brought. Due to social distancing guidelines, many virtual ways of working had to be introduced and the Trust also put its agile plan into place earlier than planned which meant increased demand for the Information Governance Team in assisting with mobilising all of the projects and assessing the risks.

The GDPR Compliance Group that commenced in June 2018 was combined with the Corporate Records Audit Group in 2020. It has continued to meet regularly throughout the year and has had good attendance. This combined Group has addressed many GDPR issues, increased communication and has ensured continuing compliance with GDPR as well as monitoring corporate records compliance and audits. Outcomes and concerns have been reported to BPC during this time with any items to be reported by exception going forward.

The IG Manager, the SIRO, the DPO and the Caldicott Guardian have continued to work together closely when advice or agreement is required on behalf of the Trust. The Information Asset Register within the Trust continues to ensure that the SIRO receives regular progress and summary reports from the IG Manager and Information Asset Owners (IAO's) on information risks, mitigations and on the progress of any associated Action Plans. The IG team will continue to monitor the Asset Register to ensure all processing arrangements and lawful bases have been captured and recorded.

Only four actions were not met from the previous Action Plan for 2020/21 and all four had mitigating circumstances which is a credit to all involved. Each year it is acknowledged that full compliance with the continually changing Data Protection Laws will be ongoing and considered as work in progress.

Throughout the past year the Trust has strived to make improvements and to raise awareness as part of the Information Governance/Security Agenda which include:

- **IG Toolkit Annual Review –** Resulted in Substantial Assurance being awarded by MIAA for the 11th year in succession. The basis for scoring has changed this year as the auditors now assess the Trust both on the assurance against the National Data Guardian level as well as assessing the Trust's Self-assessment rating for the Toolkit. Substantial assurance was achieved against both.
- **IG Toolkit -** The final toolkit submission to NHS Digital on the 30th June 2021 resulted in a score of standards met with all 42 assertions and mandatory evidence items being completed.
- **ISO27001 accreditation -** The Trust had its external audit in October 2020 and successfully obtained the full ISO27001:20013 accreditation. There were no majors, minor or observations noted which is an excellent result and a testament to the work of the teams involved.
- **Cyber Security –** The Trust has completed various exercises in relation to cyber security during the year such as: Cyber Desktop Exercise, MIAA Penetration Test and MIAA Cyber Audit. The Trust also commissioned an external HiMSS audit, where the Trusts Cyber Security stance received a good score, and the Trust scored level 5 overall. There are various different members from the Trust including IT & Executive Team (SIRO) who are also now signed up to the Cheshire and Mersey Cyber Group membership.

- **NHS Digital /CareCert –** (Computer Emergency Response Team). The Trust is also signed up to this cyber security alert service and receives weekly data and cyber security threat bulletins and risk notifications, which it tracks and acts upon. There have been 288 CareCerts received and completed in 2020/21
- **Freedom of Information** - There have been 366 requests from April 2020 to March 2021 in comparison to 520 (29.62% decrease) on the previous year. This year has seen the Trust receive five internal review requests, which were dealt with within the relevant timeframe and there has been no subsequent correspondence from the requestors or from the ICO. The report for this year highlights that although the number of requests have decreased, the information requested is becoming more complex. We are seeing multiple questions and multiple departments targeted within one request, which reflects in the time spent in managing requests as this has increased by 26.47% from 310 hours in 2019/20 to 392 hours in 2020/21. This could also however be due to the new mandatory field on the system to complete how long a request took to answer which could now be showing us more accurately as a Trust how much time we spend managing requests. There are still technical issues with the system that need to be implemented to ensure the system runs smoothly and is more easily accessible which have been raised to the Project Management Team. However clinical work has taken priority. This will be addressed during 2021/22. There have never been any Freedom of Information breaches ever, which is something the Trust should be very proud of.

  The SIRO is the Corporate Records lead for the sign off of all FOI requests. The FOI Annual Report was presented to IGSF in May 2021 and then to Business Performance Committee in July 2021.

- **Corporate Records Management -** There have been 11 Corporate Records audits carried out in 2020/21 in comparison to the previous year of 8, however the results have remained very similar and positive. The Information Governance Department has been the main point of contact for the Group and continues to be responsible for setting up and arranging the audits with the responsible leads and providing training on the system. All departmental audits reports are submitted to the Deputy Information Governance Manager to compile the annual report. All recommendations and actions are discussed through the GDPR and Corporate Records Audit Group. The 2019 NHS England Corporate Records Retention and Disposal Schedule was communicated through the Group and to the wider Trust when this was introduced. The Group also allows members to come and discuss any queries with retention periods and agree actions with all members. The Trust is still committed to deliver corporate records management via a digital tool. The current plan is to utilise Microsoft SharePoint to allow greater control over record retention. Under the new NHS Microsoft agreement there is an opportunity that is being investigated in utilising the latest version of SharePoint rather than the current Trust pilot which is using SharePoint 2010. The annual audit report was presented to IGSF in June 2021.
- **Data Flow Mapping** is a mandatory requirement for all NHS Trusts. The Trust must adequately protect transfers/ flows of information. The Information Asset Register incorporates all the data flows and holds detailed information about the Trusts data processing activities. The Trust has incorporated the capability to record the lawful basis for processing on the Information Asset Register in line with national requirements. Not only does it allow the Trust to remain compliant, it ensures that the data remains secure in transit and that it reaches its destination promptly, securely and safely in line with the Data Protection laws. The Trust has ensured that all known data flows that leave the UK/EEA have been fully reviewed and meet DPA requirements. A report was presented to IGSF in March 2021. No high risks have been identified or reported.
- **Data Sharing Agreements -** The Trust has continued to see a steady number of Data Sharing Agreements being implemented. The Information Governance Department continue to work closely with all departments to ensure that agreements have been reviewed and a legal basis has been identified. Across the Trust the involvement of Information Governance at the beginning of projects is much more common, which is a positive development. The Trust also continues to fully implement the Share2Care collaborative programme between Cheshire and Merseyside, and the Lancashire

and South Cumbria Health and Care Partnerships, to deliver the electronic sharing of health and care records. The Data Sharing Agreements for this have been fully signed off by the Trust. The Trust has also fully signed up to the Combined Intelligence for Population Health Action (CIPHA) programme, which supports a set of COVID related population health analytics designed to inform both population level planning for COVID recovery and support the targeting of direct care to vulnerable populations. This programme is currently moving in to general population health as well.

- **Policies** – All Information Governance policies were agreed to be changed to a 3 yearly review date as this is no longer a requirement of the DS&P toolkit and is in line with the rest of the Trust policies. None of the policies were due for review until 2021 but were reviewed by the DPO during May – August 2020. No new policies were introduced during 2020/21.
- **Data Protection Impact Assessments –** A DPIA policy and relevant guidance is in place which clearly defines how the Trust manages assurance in relation to privacy, data protection and confidentiality when developing and implementing policies, projects, systems and procedures initiated by the Trust, which process personal and sensitive data. DPIA assessments are being carried out in line with the Policy and being monitored through the IG Department, DPO, SIRO and IGSF. The Trust sees engagement from various departments when initially introducing projects. The new DPIA screening and full assessments were reviewed in June 2020 and combined in order to streamline the process and make it more user friendly. A list of completed DPIA's is regularly published on the Trust external website in line with the new Data Security and Protection Toolkit requirements. There have been 20 Data Protection Impact Assessments submitted to the forum throughout 2020/21.
- **Incidents -** There have been 121 Walton Centre incidents reported for this period against 213 in the previous year. The significant decrease in incidents this year is assumed to be due to Covid-19 and the impact it has had on the Trust. Due to Covid-19 staff were not able to work in their usual way due to social distancing, lockdowns and staff shielding, etc. New ways of working had to be developed at the Trust which enabled staff to work from different locations such as home, bookable Trust office pods, etc. Similarly, case notes being provided for outpatient clinic appointments significantly decreased. Therefore, most of the previous incidents that were commonly caused by human error and the handling of documentation have seen a decline due to staff now working digitally and not being on site as often as they were previously.

  There have been 3 externally reportable Information Governance incidents which were reported to the Information Commissioner during this period. The ICO has now responded to all three incidents to advise that all appropriate remedial action had been taken and the Information Commissioner is satisified with the responses submitted by the Trust. This figure has decreased from 12 in 2019/20. A lot of work has been undertaken to ensure that actions have been implemented following every externally reportable incident. Overall, it does appear that the way the incidents are being acted upon and fed back to both managers and staff members is leading to lessons being learnt. The Trust has already seen a decrease of externally reportable incidents and it is hoped this will continue into 2021/22. It is evident the continued work from the IG Team with other departments is imperative to ensure incidents are fed back and awareness is increased in order to try to minimize the incidents re-occurring. The IG Team will continue to monitor incident trends and look at new ways to eliminate future occurrence's to further reduce the risk of future externally reportable incidents. The Annual Incident Report was presented to IGSF in July 2021.

Full details of the improvements made for 2020/21 can be found in the Information Governance Annual Report 2020/21.

IG/ Information Security framework in place

Senior Information Risk Owner SIRO

The current SIRO (Director of Finance and IT) has been in the role since November 2015. He is responsible for ensuring that there is an appropriate and effective framework of resources and support in place to provide assurance on the provision of Data Protection compliance. The SIRO is responsible for bringing Information Governance issues to the attention of the Board, and for providing a framework to identify and manage the risks associated with handling information under the control and ownership of the Trust.

He has undertaken training for the role by completing the NHS Digital training modules for Introduction to Risk management for SIRO's and IAO's in October 2017. Further SIRO training provided by Information Governance Limited was also attended in November 2018 and Legal Training for Caldicott Guardians and Senior Information Risk Owners provided by Hill Dickinson was attended on the 8th January 2020.
The SIRO is registered on the NHS Digital Register of SIRO's.

The SIRO is chair of the Information Governance Security Forum and works very closely with the Caldicott Guardian, the IG Manager, the Information Asset Owners and the ISMS Review Group to ensure the following:

- Develop, implement and monitor the processes that support Information Governance compliance and support a culture that values, protects and uses information for the success of the organisation and benefit of its clients;
- Know what information assets the organisation has, who owns them and understand the nature of information flows to and from these assets and any associated risks;
- Completion and timely submission of the Trusts Data Security and Protection Toolkit, identifying areas of risk and target improvement initiatives through action planning and progress monitoring;
- Owning the organisation's information incident management framework;
- ISMS compliance and re accreditation;
- Responsible for the Corporate Records Management Function.

Caldicott Guardian

The trusts Medical Director is the nominated Caldicott Guardian for the Trust and has undertaken this role since September 2016. He has undertaken Caldicott Guardian in Health and Social Care training in October 2017. Further training on Caldicott and Adult Safeguarding was also attended in November 2018 and Legal Training for Caldicott Guardians and Senior Information Risk Owners provided by Hill Dickinson was attended on the 8th January 2020. The Caldicott Guardian oversees the use and sharing of patient information, championing confidentiality and information sharing within and outside the Trust. The Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient-identifiable information. He is registered on the NHS Digital Register for Caldicott Guardians. He also plays an active part in the Information Governance and Security Forum and maintains a Caldicott log in which he records confidentiality queries and Information Governance issues on which he provides regular updates to the SIRO and IG Manager.

Information Governance Manager

The current Information Governance Manager has been in post since January 2018. She is responsible for coordinating the implementation of the Information Governance work programme within the Trust along with the Information Governance Team. The IG Manager has continued to develop, implement and monitor

the processes that support information governance compliance and is responsible for promoting a culture that values, protects and uses information for the success of the organisation and benefit of its clients.

The IG Manager completed her Data Protection Foundation and Practitioner Qualifications in June 2019 and obtained a distinction in the Freedom of Information Practitioner course completed in July 2020.

Data Protection Officer

This role was introduced in January 2018. It shows the Trust recognises its obligations and accountability responsibilities with the General Data Protection Regulation (GDPR) and Data Protection Laws. Since the previous DPO left in December 2019 the Trust has bought into a 'DPO service' provided by Mersey Internal Audit Agency - MIAA is an NHS shared service hosted by the Liverpool University Hospitals NHS Foundation Trust. MIAA provide an independent DPO service to the organisation. The DPO is responsible for providing the Trust with independent risk-based advice to support its decision-making in the appropriateness of processing 'personal and Special Categories of Data' as laid down in the GDPR, and any superseding Data Protection regulations. The DPO is required to provide advice and guidance on all data protection legislation queries to staff, patients, and the Board.

Business Performance Committee

The Business Performance Committee receives a monthly chairs report from IGSF and updates on performance against the Data Security and Protection toolkit. The Committee reviews any information risks identified through the Risk Assurance Framework before presentation at the Audit Committee. The Board of Directors and the Business Performance Committee receive exception reports on serious untoward incidents via the Quarterly Governance report.

Information Governance Security Forum (IGSF)

The Forum continues as the organisational focus for all matters relating to Information Governance and security. The Group has overseen the successful implementation of the IG Action and Improvement Plans and has continued to be an effective forum for debate and decision making. The Group considers all IG/Medical Records incidents reported, ensuring appropriate action and mitigation plans are in place as necessary and risk assessed (Appendix 1). Regular monthly updates are provided to the Group by the DPO.

The DPO and IG Manager participate in the Cheshire and Mersey IG Network, a local forum for IG specialist staff and give regular updates at the Information Governance Security Forum and attend National events to ensure they are up to date with current legislation and any changes which could impact on the Trust.

They also attend the Information Governance Strategy Group which was set up to review Information Governance processes with the aim of delivering them in a more collaborative and standardized environment across the Cheshire and Mersey Health and Care Partnership. This group consists of a set of professional network experts such as SIRO's, Caldicott Guardians, CIOs, IG Managers, DPOs, with patient and social care representatives present also. The Group is currently reviewing all documents related to four ongoing work programmes – Share2Care, CIPHA, Empower and CIPHA Expanse and the implementation of the Information Sharing Gateway, and an electronic DPIA.

Digital Systems Programme Board

This Board constitutes of four subgroups to deliver the Trust digital roadmap under authority of the Business Performance Committee. The Board oversees the development and the operational stability and effectiveness of the digital infrastructure and systems that support patient care and corporate functions ensuring that the overall clinical system functionality is managed alongside the defined Digital Strategy. The Board is a subgroup of Business Performance Committee which it reports through to on a bi-monthly basis. Regular updates are also fed into IGSF and Digital Systems Clinical Safety Group. During early 2020, given the challenges of the pandemic and the need to implement agile working the priorities have had to change within the strategy to accommodate business process changes and an updated strategy was presented to

executives to facilitate this. The strategy will continue its focus on the delivery of clinical systems and given the success of the Trust in securing £6m of Digital Aspirant funds over the next 2 years will help the Trust on its journey to full EPR which is the next major milestone.

ISMS Management Review and Risk Group

The Information Security Management Systems (ISMS) Review Group was implemented in 2013 and is responsible for establishing, implementing, operating, monitoring, reviewing, maintaining and the improvement of the Information Security Management System (ISMS), ISO27001. The Group has now been expanded to include representation from the Risk, Information and Procurement Department and further includes HR, Security and Estates as interested parties when required. The SIRO is responsible for signing off the ISMS documentation and function. The Information Security Management Systems (ISMS) Risk Group manages risks that fall within the scope of the ISMS and is managed and reviewed in line with the ISO27001 standard. The IM&T Department have internally developed a Risk Register which assists the Group in managing risks and escalating where necessary as a *plan – do – check - act* methodology. A Risk Dashboard assists in confidence levels through use of weighting formula of an individual risk and as a collective score to assist in how risks are dealt with and prioritised. Solutions to continually improve Risk Management processes are reviewed within the Group. Both groups are well attended and have been instrumental in successfully achieving and retaining the ISO27001:20013 accreditation.

Strategic Direction

Throughout 2021/22 and beyond the Information Governance function will continue to work across all areas of the organisation to:-

- Actively support the delivery of the Trust's strategic plan;
- Identify and secure the resources, processes and skills required for the Trust to effectively deliver against emerging national NHS IG and Information security requirements;
- Work collaboratively with partner organisations to achieve continuous improvements in meeting national, statutory and good practice requirements;
- Implement effective mechanisms for achieving compliance with changing statutory requirements e.g. GDPR, DPA, FOI, Data Security, Ten National Data Standards etc;
- Work alongside IM&T and Information to ensure the Trust is ready for the mandatory National Data Opt Out Programme in September 2021;
- Undertake DPIA assessments and report on risks associated with information systems, data and processes through the established risk management mechanisms;
- Continue to work closely with IM&T staff and system implementation teams to assess, implement and provide continuing support to new clinical and corporate records systems;
- Continue to raise levels of awareness amongst staff of their IG/Information Security responsibilities through the delivery of effective training and communications and play a key role in supporting staff training and development;
- Ensure all policies and processes are continually reviewed;
- Continue to ensure all staff where appropriate achieve training in the area of Information Governance and Data Protection and this is built into the Training Needs Analysis so is considered financially;
- Continue to contribute and work collaboratively with all at the external Cheshire and Merseyside IG meeting and the Information Governance Strategy meeting;
- Maintain the status of "no breaches" within the Freedom of Information function and ensure the external publication scheme is reviewed with all departments;
- Maintain or exceed a "standards met" status for the Data Security and Protection Toolkit and "substantial assurance" for the twelfth year on the external MIAA audit.

Conclusion

The Information Governance Department continues to have thorough monitoring and reporting arrangements in place which allows gaps to be identified quickly and actions to be taken where necessary. The results within this report highlight again the significant achievements the Information Governance Department and the Trust are making. The Department consistently pushes to maintain and where possible exceed the same high standards with the aim to continue to provide the same levels of assurance.

The Trust has successfully attained standards met against the Data Security and Protection Toolkit (DSPT) and substantial assurance for the eleventh successive year following the external audit of the Toolkit by Mersey Internal Audit Agency. The Trust has been consistent in its Toolkit submissions over the past eleven years and hopes to continue with this moving forward.

Almost all actions from the 2020/21 Action Plan have been met, except for four - the National Data Opt out Programme which was delayed to September 2021 so is ongoing; the developments needed on both Freedom of Information systems and Information Asset Register which were delayed due Covid 19; and clinical systems taking priority; as well as the Data Protection Impact Assessment not becoming electronic, due to an alternative solution being investigated by the Cheshire and Mersey IG Strategy Group, though this has not yet progressed to date.

Following Covid-19 occurring in March 2020 there was a significant impact for the Information Governance Team as different ways of working had to be implemented which led to new project/software and increased queries. Processes that were implemented quickly without full due diligence, and as advised by the Information Commissioner have now been fully examined and documented during 2020/21. It is expected that new changes will continue with the extension of the COPI (Control of Patient Information Notice) until September 2021, virtual ways of working, future collaborative arrangements, and the agile working which was already underway within the Trust. Delays to processing Freedom of information and Subject Access requests were also advised to be communicated to requestors by the ICO during the pandemic however the Trust continued to deliver and did not incur any breaches which is a credit to all involved.

The Department will continue to strive to make improvements and are already on board with virtual ways of working such as the introduction of Survey Monkey to allow compliance checks to still continue, and also now a solution for the patient satisfaction questions to be answered virtually with less patients physically attending the Trust. Continuing work this year will also be required to ensure the Trust is ready for the delayed National Data Opt out Programme deadline by September 2021, and continuing the required work for the fourth version of the Data Security and Protection Toolkit and the audits surrounding this as the work for this was seen to heavily increase in 2020/21.

Improving staff training and awareness will continue to be driven forward by the IG Department each year. The results show that the Trust is in a very fortunate position where Information Governance is driven throughout the organisation and that staff are very aware of the guidelines they must work within. The 95% Data Security Awareness target was met again through consistent hard work by the IG staff and collaboration with line managers and staff across the Trust, which was a credit to everyone involved. Whilst there are always changing times ahead for Information Governance, the Trust is in a very strong position to continue to remain consistent and deliver all requirements.

The high level actions plans outlined in the full Annual Information Governance Report for 2020/21 coupled with the continuous IG training and development should help to ensure the Walton Centre NHS Foundation Trust continues to improve and build on its Information Governance Framework to meet its statutory, regulatory and performance obligations for the forthcoming year.

Mike Burns
Director of Finance (SIRO)
September 2021

Report to the Board of Directors
Date: 7 October 2021

The Walton Centre NHS Foundation Trust

Title	**Board Assurance Framework 2021-22**
Sponsoring Director	Lisa Salter Chief Nurse
Author (s)	Paul Buckingham Interim Corporate Secretary
Previously considered by:	• Executive Team - 8 September 2021

Executive Summary

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review. The BAF was last reviewed by the Board of Directors on 1 April 2021 and BAF entries have been reviewed by Lead Executives, the Executive Team and relevant Committees during September 2021. There have been no changes to either the Trust's strategic objectives or the associated principal risks during Quarter 2 2021/22.

There are currently a total of 15 principal risks identified in the BAF and the current BAF entries are included for reference at Appendix 1 to this report. Content which has been updated since the last review by the Board can be identified by the use of bold blue font and strikethrough. The table at s3 of the report provides a summary of risk scores for BAF entries at Quarter 2 2021/22 and the previous two Quarters. A reduction in risk score is proposed for 2 of the 15 BAF entries with the Board requested to take a view on increasing the risk score for Risk ID 013, Financial Plan.

Related Trust Ambitions	All
Risks associated with this paper	
Related Assurance Framework entries	All
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Board Assurance Framework supports the Annual Governance Statement which is a requirement of the annual report in line with the NHS Improvement Annual Reporting Manual.
Action required by the Board	The Board of Directors is recommended to: a) review and approve the BAF content for 2021/22 as detailed at Appendix 1 b) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board

1.0 Introduction

The purpose of this report is to present the Board Assurance Framework (BAF) 2021/22 to the Board of Directors for review.

2.0 Background

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

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

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

An effective BAF:

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

3.0 Current Position

The BAF was last reviewed by the Board of Directors on 1 July 2021. BAF entries have been reviewed and updated by Lead Executives prior to initial review by the Executive Team on 8 September 2021. Relevant BAF entries were subsequently reviewed by the Quality Committee and Business Performance Committee on 23 September and 28 September 2021 respectively. There have been no changes to either the Trust's strategic objectives or the associated principal risks during Quarter 2 2021/22.

There are currently a total of 15 principal risks identified in the BAF and current BAF entries are included for reference at Appendix 1 to this report. Content which has been updated since the last review by the Board can be identified by the use of bold blue font and

strikethrough. The table below details the risk scores in Quarter 2 2021/22 together with the risk scores from Quarter 1 2021/22 and Quarter 4 2020/21.

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

Movements in risk scores during Quarter 2, both of which reflect a reduced risk score are summarised as follows:

- Risk ID 001, Covid-19 - Risk score reduced from 16 to 12
- Risk ID 002, Operational Performance - Risk score reduced from 16 to 9

Board members should note that the reduction in risk score for Risk ID 002 was recommended by the Business Performance Committee (BPC) on the basis of Trust

performance against standards in the context wider system performance. In considering Risk ID 013, Financial Plan, the BPC noted the potential for an increase in risk score to 16 due to changes in the requirements for the Elective Recovery Fund (ERF) and the current level of uncertainty over planning arrangements for H2 2021/22. The BPC agreed that the current risk score of 12 was appropriate for Quarter 2 but recommended that the Board take a view as to whether the risk score should be increased to 16 as the opening position for Quarter 3.

No new principal risks have been identified for inclusion in the BAF during the Quarter 2 2021/22 review process.

4.0 Next Steps

BAF entries will continue to be reviewed by the relevant lead Committees in accordance with agreed business cycles. The next iteration of the BAF, reflecting the position for Quarter 3 2021/22, is scheduled for review by the Board of Directors on 3 February 2022.

5.0 Recommendations

The Board of Directors is recommended to:

a) review and approve the BAF content for 2021/22 as detailed at Appendix 1
b) consider the control and assurance gaps and identify any further actions required or additional assurances that should be presented to the Board.

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

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

	Consequence	Likelihood	Rating
	Catastrophic	Likely	
Initial	5	4	20
	~~Major~~Moderate	Likely	
Current	43	4	~~16~~12
	Catastrophic	Unlikely	
Target	5	2	10

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
~~1. Loss of life, Patients / Staff~~ 2. Disruption to business as usual 3. High levels of sickness absence leading to delays in treatment of patients due to decreased workforce	~~National Lockdown with effect from 6 January 2021~~ **1, Continued uncertainty regarding new variants and lockdown relaxation.** **2. >90% of staff double vaccinated.** **3. Booster vaccination campaign to commence September 2021.**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Major Incident Plan – Jan 2018 2. Business Continuity Policy Oct 2019 - Command and control 3. Business Continuity Plans and escalation plans for all departments 2018 4. Infection Prevention and Control Policy and Programme 2020 5. Visitor Policy – March 2020 6. Flu Policy – April 2019 7. Health & Wellbeing Programme – Aug 2018 8. Shiny Minds App – Approved Aug 2018 9. Daily Staff Bulletin based on PHE advice 10. COVID WCFT Standard Operating Procedure– approved by Exec March 2020 11. Psychological support for staff available via internal helpline 12. FIT Testing and Training of key staff 13. Modification of estate to provide additional capacity in ITU ~~14. SLA with Aintree for Pharmacy/Pharmaceutical supplies~~ 15. Regional Operations Meeting – Weekly ~~16. Cheshire & Merseyside EPRR Network Meeting – twice per week~~ 17. Critical Care Network Operational Meeting 18. Corona Bill – passed March 2020 19. Staff vaccination programme via LUHFT Covid Vaccination Hub 20. Weekly LAMP testing 21. **Command & Control Inbox for National communications** 22. **Booster programme from September 2021** 23. **Internal patient vaccination plan** 24. **Regular staff reminders regarding IPC procedures, through Trust communications and daily safety huddle**	~~1. Push deliveries being managed centrally~~ **Staff compliance with LAMP testing and IPC procedures post-lockdown easing.** 2. Mutual aid **requests** ~~being managed through hospital cell~~ ~~3. Vaccination programme and vaccine availability~~ 4. Risk of further Covid waves as a result of mutations and new variants

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 ~~Daily COVID-19 Control Meetings~~ Daily Safety Huddle Divisional Daily Huddle Infection Prevention and Control Committee – monthly ~~Pandemic Testing Reported to Resilience Planning Group Aug 2019~~ ~~Daily Executive Meeting~~ ~~Ethics Committee~~ **IPC Audits and Root Cause Analysis for cases** **Senior staff walk-abouts recommenced** **Regular staff reminders regarding IPC procedures, through Trust communications and daily safety huddles.** **Level 2** Infection Prevention & Control Quarterly Report – Quality Committee Quarterly Governance Report –Quality Committee, Trust Board Covid-19 Update – Trust Board	~~1. Asymptomatic screening provides inconsistent results~~ ~~2. Managing potential consequences of enhanced regional testing regime~~ ~~3. 88% of staff have had their Covid-19 vaccination~~ 1. **Staff compliance with IPC guidelines** 2. **Risk of further Covid waves as a result of mutations and new variants.**

~~EPRR Self-Assessment – Nov 2019 Trust Board~~ ~~Assessment of Interim Governance arrangements to Trust Board – April 2020~~ Covid-19 Board Assurance Framework **Trust Elective Recovery Plan** **Level 3** Daily Sit Rep Reports submitted to NHS Digital ~~EPRR – Self Assessment submitted to NHSI – Nov 2019~~ ~~NHSI National call – weekly~~ **NHSE DON's National call – bi-weekly** NHSE/I Visit – February 2021 **– action plan completed**	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Terms of Reference, membership and reporting arrangements re Ethics Committee to be finalised	AN	End of April	Completed
2	Ongoing participation in regional and national plans **(Recovery Plans)**	~~JR~~ **MW**	~~March 2021~~ ~~July 2021~~ **September 2021**	On track
3	Promotion and support for staff who have not had the Covid-19 vaccination with a communications plan	LS	July 2021	~~On track~~ **Completed**
4	**Promotion and encouragement for staff to follow Trust IPC guidance (LAMP / Lateral Flow / General IPC guidelines)**	**LS**	**October 2021**	~~**On track**~~ **Ongoing**

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

Linked Operational Risks		
43	Failure to meet mandatory waiting time standards	16
815	RTT / Average Wait performance and volume of 52-week waiters	16
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
	Major	Almost Certain	
Initial	4	5	20
	~~Major~~Moderate	~~Likely~~Possible	
Current	~~4~~3	~~4~~3	~~16~~9
	Major	Unlikely	
Target	4	2	8

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Draft Operational Plan 2020-21 - discussed at Exec Feb 20 ~~2. Workforce Plan 2018-2019~~ 3. COVID-19 Recovery Plan Phase 3 ~~4. Job Planning for consultants - Ongoing for 2020-21 / 2021/22~~ ~~5. National Call - NHSI - Weekly~~ 6. Performance Dashboard in Real-time 7. From October 2020, no longer accept GP referrals for pain as per NHSE published guidance in relation to Adult Pain Service Specification for Tier 3 services. 8. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 9. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 10. Submission of Recovery and Restoration plans for 2021/22 11. Use of Halton Hospital to deliver Pain daycase activity from May 2021 12. **Stretch recovery target set for 100% of 2019/20 activity** 13. **Daily COO-led performance catch up** 14. **Divisional recovery plans** 15. **52 week recovery plan** 16. **Regular Spinal meetings at Divisional level and escalations to appropriate commissioners.**	1. **Activity** ~~Workforce~~ plans do not take into account impact of sickness, shielding requirements due to COVID-19 ~~2.~~ COVID-19 Recovery Plan based on assumptions of business as usual with an element of adjustment to take into account new ways of working. This does not factor in patient or staff behaviours **/ compliance**. ~~3. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives~~ ~~4. Lack of clarity re waiting time standard - RTT /Average wait going forward~~ 5. Planned transfer of Spinal services from LUHFT September / October 2021 – impact in relation to overall Trust RTT performance is currently unknown.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 **Daily performance review with Divisions** Weekly monitoring of performance of RTT Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly PA Consulting have been contracted to work through C&M data and plan based on assumptions and winter plans. **Divisional plan presented to support recruitment of key staff** **Daily monitoring of critical staff absences at Huddle.** **Level 2** Integrated Performance Report – Reported monthly at Trust Board COVID Update – Reported at Board meetings from April 2020 **Level 3** Meetings with Commissioners – ~~bi-~~monthly	1. Transformation Board delayed due to COVID response 2. C&M approach to access and planning 3. **Non-elective activity / ICU capacity** 4. **Thrombectomy demands** 5. **Sickness and self-isolation of critical staff** 6. **Recruitment and retention of key staff**

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Transformation Board to be formally established and re-focused to address outpatient productivity flow and theatres in the context of COVID-19 Recovery	DoSO	April 2021	Commenced
2	Implementation of COVID Recovery Plan to increase activity	DoSO	End of July	Phase 1 complete
3	Understand pain referrals across C&M discuss with Commissioners	DoSO	June 2020	Superseded
4	Explore alternative capacity for pain patients to inform system discussions around a solution	DoSO	May 2021	Commenced
5	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue	DoSO	May 2021	Delayed
6	Continued Job Planning for consultants for 2021/22	DoSO	~~Mar 2021~~ Mar 2022	On track
7	Data requested from LUHFT to inform RTT position.	DoSO	June 2021	On track
8	**Closer monitoring of position and forecasted position**	**COO**	**September 2021**	**Complete**
9	**Divisions to provide workforce recovery plan in key areas (Theatres)**	**COO**	**September 2021**	**On track**

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Physical Injury /- Emotional/psychological impact on staff and other patients - Low morale - Increased sickness levels - Litigation - Involvement with Regulators e.g. HSE, CQC, NHSE/I due to increased level of RIDDOR reports, staff harm due to violence and aggression (V&A), 4 fractures reported to HSE in past 12 months - Increase in staff turnover	**Physical Assaults on staff** **2019/20** **2020/21** **2021/22** **Q1 = 27 Q2 = 45** **Q1 = 22 Q2 = 56** **Q1 = 41** **Q3 = 40 Q4 = 29** **Q3= 78 Q4 = 40** **Related Claims** 1 claim received in 2019/20 **Staff Survey (relating to staff reporting physical harm)** **2020 - 20.3% (**against the national average of 4.1%) **2019 - 22.3%** (15.25% higher than acute specialist sector average of 5. 7%) **2018 – 21.9%** (National average 2018 over 6.7%, compared to best performing Trust at 1.8%)

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Violence and Aggression Policy - approved Feb 2018 2. Lone Worker Policy - approved Feb 2018 3. Mental Capacity Act Policy - approved Jul 2019 4. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach) 5. Security Function (ISS) 6. ED&I Lead and Local Security Management Specialist attending ward areas to support staff where required 7. Personal Safety Trainer Programme of work Apr-2019 8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 9. Additional Consultant reviews RVs where V&A has increased 10. LASTLAP Initiative – Looking after Staff to look after patients (Initial Pilot) 11.Restraint Training rolled out in CRU and other ward areas **– 287 staff have completed Restraint Training** 12. Personal safety trainer and LSMS attending ward to undertake observations of staff with patients who are aggressive 13. National Violence Reduction Standards issued: • V&A Strategy in development in line with national standards • Baseline audit completed – reported to Health, Safety & Security Group May 2021 14. Special Observation of Patients Policy in place 15. Post-incident staff debriefing in place (MDT approach) **16. Violence and Aggression Prevention operational group established July 2021**	1. Lack of agreed KPI's within the Security Contract 2. Compliance with statutory and mandatory training 3. Restraint Training to be rolled out across all wards 4. Psychologist sessions to be rolled out to all wards 5. Potential for HSE visit due to increase in RIDDOR incidents related to fractures

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – daily Monday-~~Sunday~~ **Friday** Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – bi monthly Violence and Aggression Group **–** bi-monthly Transformation Board - monthly **Level 2** Annual Governance Report – Quality Committee Quality Dashboard – Quality Committee – monthly 2020	1. Outcome of Shiny Minds App to be evaluated 2. Lack of benchmarking data across similar Trusts – to commence with Queen's Square in Q1 20201/22

Level 3 Staff Survey 2020 Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance Oct 2018 – actions completed Dec 2019 Quarterly review meetings with commissioners CQC Inspection Report 2019 Investors in People Health & Wellbeing Gold – re-accredited May 2019 Investors in People re-evaluation retained as Gold in 2020	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	KPI's for the Security Contract to be developed and monitored by the Health Safety and Security Group **Update Sep 21 – The new contract will go live in April 2022 with KPIs in place.**	LS	~~End of Nov 19~~ ~~Oct 2020~~ June 2021	~~Delayed~~ **Completed**
2	Continued focus on statutory and mandatory training compliance Trust Wide – in line with new social distancing requirements	MG	~~End of March 2021~~ June 2021	On track
3	Pilot of Shiny Minds App to be evaluated	MG	~~End of March 2020~~ ~~September 2020~~ ~~December 2020~~ June 2021	~~Delayed~~ **Completed**
4	Benchmarking of nurse turnover of similar Trusts across Cheshire & Merseyside	LS	End of Sept 2020	Complete
5	Roll out of Looking After Staff to Look after Patients to all wards	LS	End of Aug 2020	Complete
6	Audit of LASTLAP to be completed Update 17 Jun 21 – Audit completed in May 2021	LS	~~Jan 2021~~ Quarter 1 2021/22	Complete
7	Outcome of Investors in People to be reported	MG	~~Jan 2021~~ June 2021	~~On track~~ **~~Completed~~**
8	Roll out of Restraint Training across all wards **Update Sep 21 – Incorporated in new training package and now delivered as part of induction and all refresher training. Additional sessions have been offered including bespoke training in response to current incidents.**	LS	~~March 2021~~ June 2021 **Sep 21**	~~On track~~ ~~Delayed~~ On track **Completed**
9	Roll out of psychology sessions across the wards for staff health and well being	LV	~~March 2021~~ June 2021	On track **Completed**
10	**Implementation of Violence and Aggression Prevention operational group.**	**LS**	**~~July 2021~~**	**On track**
11	**Benchmarking commenced with Queen's Square regarding management of patients displaying violent and aggressive tendencies.**	**NM**	**~~Nov 2021~~**	**On track**

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Key objectives not met - Poor - patient experience - Reputational damage - Standards of care	1. Increase in reported deaths from 92 in 2019/20 to 112 in 2020/21. 2. Reduction in the number of formal complaints received with 67 in 2020/21 compared to 129 in 2019/20 3. Zero Never Events in 2020/21 4. 13 cases of MSSA against a threshold of 8 in 2020/21 5. Increase in Nosocomial Infections 6. Covid-19 pandemic **and visiting suspended** 7. **C-Diff and Kiebsiella trajectory not currently being met in 2021/22 and MSSA infections increasing.**
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Quality Strategy 2020 – 23 – approved Sept 2019 2. KPI's for Year 2 of the Quality Strategy March 2021 3. CARES Review Programme 2021/22 4. HCAI Reduction Plan 2021/22 5. FOCUS Programme 2021/22 6. Theatre Utilisation Programme 7. Patient Family Centred Care Group 8. COVID-19 Recovery Plan – May 2020 9. Clinical Audit Plan – CESG June 2021 10. IPC –strategic COVID 19 Plan January 2021 11. Trust Recovery Roadmap 12. **Virtual visiting with 'Facetime' etc and regular phone calls to family / next of kin by nursing and medical staff** 13. **Monthly meetings with staff to manage quality accounts within timescales**	1. Alignment of year 1 priorities across all strategies not tested 2. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 3. Lack of resource within IPC to support Covid-19 response 4. Covid-19 pandemic – reduction in staffing
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Trust Safety Huddle – Daily Ward / Departmental Huddle Theatre User Group Divisional Governance Meetings – monthly Mortality Review Group – monthly Serious Incident Group - monthly Transformation Board Balance Score Cards – monthly Operational Management Board - monthly **Level 2** Quality Dashboard – Quality Committee – monthly Quarterly Governance Report IPC Annual Report – May 2021 Safeguarding Annual Report – June 2021 Annual Governance Report 2020/21 Medicines Management Annual Report – June 2021 Quality Strategy Progress Report – March 2021 COVID- Update to Trust Board – monthly **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meeting with Commissioners – Quarterly National Inpatient Survey Results – September 2020 CQC Mental Health Inspection – December 2020	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Review of all Trust Strategies to ensure alignment of priorities in year 1/2	J Ross	~~April 2020~~ Aug 2020	Not started
2	Recruit to Tissue Viability Team or test alternative options to fulfill the role	L Vlasman	~~May 2020~~ Sept 2020	Completed
3	Transformation Board and reporting arrangements to be introduced	J Ross	~~February 2020~~ June 2020	Completed
4	On-going participation in discussions to ensure influence in future system wide plans	~~H Citrine~~ J Ross	~~March 2020~~ ~~March 2021~~ March 2022	On track
5	Recruit to additional post within the IPC Team to lead on the response to Covid	L Vlasman	~~March 2021~~ May 2021	On track
6	Address reduction in staffing due to Covid-19.	L Vlasman	June 2021	On track

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

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning 2019 3. Five year education plan to ensure supply 2017 4. Quality Strategy Sept 2019 5. People Strategy revised in line with the national People Plan Sept 20 6. Staff Survey / People Action Plan June 21 7. Partnership working with universities to recruit newly qualified staff 8. Extension of apprentice roles July 2019 9. Involvement with Regional Talent Management Board 10. WCFT Health and Wellbeing Programme 11. NHSP Bank 12. Collaborative Bank within North West 13. COVID-19 Recovery Plan 14. MoU across C&M in relation to staffing during COVID-19 15. National Nursing Bursary – 2020/21 16. Staff Survey regarding working during COVID-19 17. Agile Working Project 18. De-briefs following first wave of COVID 19. Mental Health First Aid Training 20. Collaborative International Recruitment 21. Virtual recruitment days for Qualified Nursing staff 22. Quarterly Staff Pulse Survey – commenced April 2021 23. **Alternative methods of training devised and a blended approach is in place** 24. **Regular updates received re pensions and visa arrangements**	1. Implications of Brexit i.e. Visas on recruitment not yet known 2. Changes to pension arrangements 2020/21 ~~and~~ **complete though** implications for recruitment and retention still not understood 3. Traditional training no longer appropriate due to social distancing and therefore alternative delivery methods to be developed 4. Continued national shortage in supply of nursing staff

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Vacancy monitoring – weekly Daily escalation undertaken and all outcomes are reported to Senior Nursing Team. Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events – quarterly **Staff Support sessions provided by NOSS** **Participation in Quarterly People Pulse Survey** **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC – Mar 2021 **(linked to People**	~~1. Outcome of Shiny Minds App to be evaluated~~ 2. Delivery of National People Plan

Plan) Communication and Engagement Strategy – Trust Board Sept 2020 **Level 3** **Outcomes of 2020** Staff Survey ~~March 2021~~ **2021 Staff Survey to commence September 2021** Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance Investors in People Accreditation 2020 – Gold Status Investors in People Wellbeing Award **2021** – **Gold Status** ~~Reassessment June 2021~~ **Final evaluation of Shiny Minds app**	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Outcome of Brexit and implications for recruitment and retention not fully understood. Ongoing involvement and discussion with NHS Employers, NW Staff Partnership Forums and Brexit Council for Liverpool.	DoW	Ongoing ~~Mar 2020~~ ~~Dec 2020~~	Complete
2	Outcome of national review of the 2015 NHS Pension Scheme and its implications awaited	DOW	~~Dec 2020~~ March 2021	On track
3	Alternative solutions for statutory and mandatory training in development whilst socially distanced training continues	DOW	March 2021	On track
4	Continued progress to develop a C&M Collaboration at Scale for Nursing Workforce and progress recommendations	DoW	End of March 2020	Delayed
5	Outcome of Shiny Minds app to be evaluated	DOW	~~End of March 2020~~ ~~September 2020~~ ~~Dec 2020~~	Complete
6	On-going participation in National/Regional Meetings to inform local policy and realign strategy where necessary	DOW	March ~~2021~~ 2022	On track
7	Await outcome of Investors in People Assessment process for 2020 not received	DOW	November	Complete
8	Commit to international recruitment as part of a regional collaborative campaign Update June 2021 – Arrival of recruits delayed due to Covid-19 situation.	DoW & DoN	~~May 2021~~ Dec 2021	~~On track~~ Delayed

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

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Estates Strategy – approved 2015 2. Operational Plan 2019-20 3. Revenue and Capital budgets - Ongoing 4. Backlog Maintenance Register **- updated June 2021** ~~June 2018~~ **5.** Maintenance Programme **6. Estates related policies** • Electrical Safety Policy - **2020** • Water Management Policy – ~~2014~~ **2021** • Control and management of Contractors 2018 • Fire Safety Policy – **2019** ~~2010~~ 7. Specialist contracts - Ongoing 8. Site based partnership/SLA with Aintree Hospital - 2016 9. Contractual agreement with specialist contractors Ongoing 10. Recovery Plan following COVID-19 11. Water Management Action Plan including remaining Legionella actions 12. **Premises Assurance Model – completed 2021** 13. **Completed Phase 3 of the heating replacement scheme** 14. **Remedial works through site to increase hot water circulation temperatures** 15. **Continued flushing of water outlets** 16. **Replacement of thermostatic mixing valves** 17. **Sink and pipework replacement programme, as possible** 18. **Use of 'point of use' filters to clinical outlets** 19. **Completion of the fire compartmentation reinstatement works** 20. **Sustainability plan update in progress**	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post COVID-19 2. Under resourced Estates function 3. Limited access to certain areas prevents visual inspection ~~4. 20% reduction required for 2019-20 Capital Programme~~ 5. Lack of a Sustainability ~~Development Management~~ Plan 6. Policies require review to ensure that they are reflective of current legislation 7. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 8. Capital programme now being managed at an STP level. 9. Programme for Pipework replacement incomplete ~~10.~~ The national Premises Assurance Model (PAM) **outcomes** ~~not yet in place~~

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily Safety Huddle Water Safety Group – reporting into IPC Committee Health & Safety Group Contract review meetings with AUH – monthly Heating and Pipework Project Board – monthly **Level 2** Capital Programme approved by Trust Board	1. Limited AUH planned maintenance/KPI reporting in place 2. Lack of reporting of sustainability data

Level 3 6 Facet Survey – **updated July 2021** ~~Jul 2019~~ CQC Inspection Report Aug 2019 NHS Digital acceptance of ERIC return **2021** ~~2018~~ Cladding Review – Sept 2016 Fire Brigade post-incident review of Fire Processes - 2019	

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

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

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

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

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
~~1. Digital Strategy – approved January 2020~~ 2. Outpatient Transformation Project 3. Inpatient Transformation Project 4. Theatres Project 5. Paper Light Project ~~6. EPR Milestone group with clinical representation~~ **Digital Transformation Board aligned to governance groups across the organization (structure sign-off by Executive Team Q1 21/22)** 7. IT Technical Programme of work 8. Cyber Security Programme 9. PMO Function underpinning the Digital Strategy ~~10. Member of North Mersey / C&M H&C Partnership – aligning strategies~~ 11. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 12. Post covid EPR rollout plan ~~for 20/21~~ ~~13.~~ Digital Transformation Programme **(LoA/MoU NHSD/X)** ~~2021-23 to be completed Q1 2021/22 to lay out competition of digital roadmap for the organization~~ 14. Digital Aspirant status to allow Digital Transformation 15. HiMSS Level 5 achieved, planning for Level 6 16. **New Digital strategy with stakeholder involvement facilitated by MIAA** 17. **Representation on HCP Programme Boards** 18. **Head of IM&T SRO for upcoming NHSX 'What Good Looks Like' HCP Programme Board.**	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy post COVID-19 across Hospital Cell may be different to Trust's internal digital strategy 3. Change in national priorities around Digital post Covid response may not be aligned to Trust digital priorities

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

Level 2 Quarterly updates on digital strategy progress to BPC Specialist Trust Digital Group C&M CIO Digital Collaboration Group **Level 3** Critical Applications Audit – Jan 2020 ~~ePatient Neurophysiology system – Limited Assurance Jan 2020~~ ~~Digital Matrix Index score 2018~~ **HIMSS Level 5 Q1 2021/22** ISMS Certification IS27001 accreditation Aug 2019 Cyber security CertCare progress monitored by NHS Digital Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to STP by C&M Digit@LL NHSX monitoring Digital Aspirant via CORA against LoA.	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Approval of the milestone plan by Digital Programme Board	AN	~~April 20~~	Complete
2	Regular updates regarding the Trust's Digital objectives and alignment to the C&M Hospital Cell objectives around digital to Exec Team Update 1 Apr 21 – Slide deck containing HCP project dependencies and full Digital projects is shown at Operational Management Board and Digital Programme Board along with HCP updates	MB	March 2021	Complete
3	New Digital Strategy **with MIAA / CMHCP**	MB	~~May 2021~~ **December 2021**	Commenced
4	Digital Aspirant MoU signed by all parties	MB	March 2021	Complete

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of operational and clinical disruption or a ransom; - Potential financial loss due to loss of activity - Likely to lead to financial, business and operational impacts as well as reputational damage; - potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover - Non-compliance with Data Protection Laws/NIS Directive - Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to.	Q1 20/21 - 72 Carecerts (3 High, 3 Medium,66 Low Level) Q2 20/21 - 67 Carecerts (6 High Level, 61 Low Level) Q3 20/21 - 66 Carecerts (2 High Level, 64 Low Level) Q1 21/22 - 64 Carecerts (1 High Level, 63 Low Level)

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 TIAG review of CareCERTs - Weekly Cyber Security Awareness Presentation to Executive Team - July 19 **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board July 2020 **Level 3** ISO27001 – accreditation August 2019 for 3 years MIAA audits of Data Security and Protection Toolkit –Jan 2020 - Substantial Assurance (draft outcome Jan 2021 – Substantial Assurance) External Penetration Testing – May 2021 Regional Desktop Exercise – March 2021 Internal Desktop Cyber Exercise – May 2021 Trust Board Cyber Security Training – April 2021 **Full Cyber Library completed by CMHCP – August 2021**	1. Third party assurances required regarding satellite sites 2. Ongoing work with NHS Digital to inform funding requirements

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

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

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

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

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

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

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Innovation Team Meeting – monthly • Medical Innovation Group – bi-monthly • Regular innovation meetings with procurement, IT, IG, service improvement, clinical and other teams • Executive Team approval of innovation business cases and initiatives **Level 2** • Innovation bi-monthly update to RIME Committee • RIME Committee Chairs Report to Trust Board • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC • CQC Inspection report 2019 • CQC well-led criteria now includes innovation	1. Benefit realization for innovative business cases not yet feasible due to limited time that Trust has had Innovation posts in place 2. Peer review of Innovation Programme and deliverables not available – work with Innovation Agency and potentially commercial innovators to identify appropriate process

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Competitor analysis to be initiated and presented to Trust Board	DW&I/HCE&M	TBC (due to COVID-19)	On hold
2	Further engagement of stakeholders through communication and engagement (including patient involvement)	DW&I/HCE&M	Review progress Q3 2021/22	On track
3	Benefits realization of Multitom Rax Business Case to be presented to Executive Team and Trust Board	DW&I	April 2021	On track

4	Further development of innovation processes and guidance	DW&I/HCE&M	Q3 2021/22	On track
5	Peer Review/review process	DW&I/HCE&M	~~Q3~~ Q4 2021/22	~~On track~~ Planned
6	Income generation initiative (Spinal Improvement Partnership) being prioritised	DW&I/HCE&M	~~October 2020~~ ~~March 2021~~ ~~August 2021~~ October 2021	On track
7	Investors in People Assessment	DW&I	October 2020	Completed
8	Addressing resourcing issues in Innovation / Commercial team and strategic review	DW&I	~~June 2021~~ Q2 & Q3 2021	~~On track~~ Ongoing

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

Linked Operational Risks		Consequence	Likelihood	Rating
Potential link to all high level operational delivery risks				
	Initial	Major 4	Possible 3	12
	Current	Major 4	Possible 3	12
	Target	Major 4	Unlikely 2	8
Risk Appetite	**Cautious**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Potential reduction of Trust autonomy with a consequent impact on delivery of objectives.	• Hospital Cell and Governance arrangements determined at regional level without consultation • Changes in national policy due to COVID-19 • White Paper indicates decreased autonomy for individual Trusts with increased control by ICS / central Government • **Establishment of Provider Collaboratives** • **Guidance published on ICS and ICBs including model Constitution**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Trust Strategy 2018-2023 **– plans in place to refresh** 2. Communication and Engagement Strategy 2020 3. Active membership of Cheshire and Merseyside Health Partnership (C&MHCP) and Collaboration at Scale Programme 4. Member of Liverpool Health Partnership 5. Member of Liverpool PLACE 6. Member of Trauma Partnership 7. Membership of Specialist Trust Alliance 8. Medical Directors Group ~~STP~~ **HCP** level 9. Chief Operating Officer Group ~~STP~~ **HCP** level 10. Membership of DOFs Group ~~STP~~ **HCP** level 11. Management Side Chair of NW Staff Partnership Forum 12. Membership of Director of Nursing Group ~~STP~~ **HCP** level 13. Membership of Director of Workforce Group ~~STP~~ **HCP** level 14. Neuroscience Programme Board – Quarterly 15. Revised MoU provides for Specialist Trusts to have 1 x Chair and 1 x CEO representative on the HCP Board which will aid influence 16. **Member of the newly-established Provider Collaborative** 17. **Interim HCP leadership team in place**	1. Hospital Cell and Governance arrangements potentially result in greater influence for larger providers 2. Financial arrangements now determined across ~~STP~~ **HCP** level 3. Clarity on the ability of Provider trusts to influence future ICS arrangements 4. Completion of review of Stakeholder Analysis ~~5. Lack of clarity on planned legal challenges and full details of White Paper~~ 6. Lack of certainty on future ICS financial arrangements – clarification anticipated Q2 ~~1~~ 2021/22

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

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Ongoing engagement with regional partners	CEO	March ~~2021~~ **2022**	Ongoing
2	Meeting with Mrs J Bene (CMHCP)	CEO	January 2021	Complete
3	**Meeting with Sheena Cumiskey arranged**	**CEO**	**Sep 2021**	**Complete**

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

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

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

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

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

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

Risk ID: 012	Date risk identified October 2020	Date of last review: July 2021
Risk Title: There is a risk that the allocation of capital set by the HCP to the Trust will not support the full capital plan for 2021-22 **There is therefore a risk that the Trust will overspend the capital allocation or defer schemes which may result in maintenance and revenue costs or deterioration of the Estate.**		**Date of next review:** October 2021
		CQC Regulation: 17 Good Governance
		Ambition: Be financially strong and invest in services
		Assurance Committee: Business Performance Committee
		Lead Executive: Director of Finance ~~Operations and Strategy~~

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Capital allocations have been set on ICS footprints with the Trust's capital resource limit (CRL) allocated from the HCP total. The Trust's allocation was 50% higher than if based on historical capital allocation calculations but was nonetheless oversubscribed. - On-going replacement equipment will not be able to be paid through capital given the Trust's Capital Resource Limit (CRL) has been set at £6.2m - Any overspend on capital against out CRL will need to be covered by the other Trusts in the STP (reducing their ability to spend capital); - Impact on revenue budgets should there be a risk to patient safety;	Between the draft plan and the intended final plan submission, some additional material capital requests have been raised. The Trust received additional capital funding in 2020/21 through Public Dividend Capital as well as additional CRL agreed with the HCP. It is unlikely that this will be repeated in 2021/22 which gives minimal flexibility in management of the capital programme. **The Trust currently has one of the lowest capital spends year to date (Sep 21) of its overall allocated plan in the North West.**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Capital Management Group reviews all capital business cases and sanctions expenditure based on budget allocations – Chaired by DO&S; 2. SFI's/SORD have appropriate approval levels for capital expenditure so DoF&IT / DO&S are sighted on expenditure; 3. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc.; 4. Monthly reporting of capital expenditure in board report so cumulative spend is transparent to senior management and board members. 5. Capital prioritization being undertaken by Ops, Clinical and Finance staff utilizing a range of criteria to enable RAG rating of all schemes and prioritization of the capital plan 6. Regular capital updates provided to BPC (in addition to updates provided in the Finance IPR)	1. Unplanned replacement of equipment that fails will lead to additional spend against plan; 2. Some items are not specified in detail and therefore there is an ability to substitute items in year which means capital slippage is difficult to manage. 3. Limitations of regional approach to capital allocations

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

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Long term capital plan to be completed to ensure all requirements and replacements known	DoF/DoSO	31 Mar 21	On track – continuous review
2	Application of criteria for capital schemes to prepare prioritised capital programme.	DoF/DoSO	11 Jun 21	On track – continuous review
3	Ensure that maintenance contracts are all up to date so equipment covered	DoF/SoSO	Ongoing	On track
4	Regular capital forecasts to provide up to date position on the year end projections	DoF	Ongoing	On track
5	Continued discussions with HCP DoF to ensure aware of capital pressures and so allocations forthcoming as required from other provider underspends.	DOF	Ongoing	On track

Risk ID: 013	Date risk identified October 2020	Date of last review:	July 2021
Risk Title: If the Trust does not deliver the financial plan for 2021/22 **due** to the changes in the financial framework and the impact of Covid-19 then it will fail to meet its financial duties and may be unable to deliver its strategic objectives leading to regulatory scrutiny and level of financial efficiencies will not be deliverable		**Date of next review:**	October 2021
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Underlying Operational Risks		Consequence	Likelihood	Rating
Additional Elective Recovery Fund (ERF) income is based on the delivery of a % of 2019/20 activity. If these thresholds are not achieved it could lead to a detrimental impact on financial performance.	Initial	Major 4	Likely 4	16
	Current	Major 4	Possible 3	12
Risk Appetite **Cautious**	Target	Major 4	Unlikely 2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Financial risk rating may decline and lead to increased regulatory scrutiny • Potential breach of statutory duties • Inability to deliver strategic objectives • Loss of decision making responsibilities • Reduced ability to influence across the system	Original plan submission £1.4m **deficit** (for H1 2021/22). However, in accordance with system plans, there was a requirement for all provider organisations to report a breakeven position (resulting in an increased efficiency requirement for the Trust). Additional income anticipated through Elective Recovery Fund (ERF) to bridge this gap but benefit lost through initial removal of Covid top-up and growth funding from the HCP. Additional £1.6m allocated to the Trust to partially address this gap which has reduced the level of required financial savings in H1.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Financial plan submitted for H1 2021/22 in May 2021 2. Capital Programme – allocation by HCP in April 2021 and regularly monitored by Capital Management Group. See BAF Risk ID 012 3. Finance and Procurement Strategy – approved July 2019 and progress report to BPC May 2021 4. Budgetary Control Process including run rate information - monthly 5. Standing Financial Instructions (SFI's) & Scheme of Reservation and Delegation – approved November 2020 6. Divisional Finance meetings to highlight on-going financial issues - monthly 7. Block Contract in place for H1 2021/22 due to COVID-19 8. Monthly financial forecasts based on current run rates to assess anticipated H1 position compared to plan.	1. Financial plan approved by BPC (with delegated authority from the Board) in May 2021. Extremely short deadlines meant that there was insufficient time to gain full assurance that a breakeven position was achievable. 2. Expenditure budgets based on average run rates for Q3 2020/21 updated for anticipated changes in H1 2021/22. Budgets do not, however, take account of agreed establishments for departments. 3. Block contract based on Q3 values in 2020/21 uplifted for inflation. It is currently not clear whether the block contract values will be representative of 2021/22 given the intermittent stop/start of elective activity and potential ongoing Covid requirements 4. QIP plan will be required in 2021/22 to close the gap to individual plans. Value of QIP to be delivered is being finalized but ability to deliver recurrent savings for H1 impaired by lateness in plan submissions and methodology of using Q3 run rates as allocations. Aim to cover QIP non-recurrently in H1 allowing time to identify and deliver recurrent savings in H2 2021/22. 5. Welsh / IOM commissioners do not need to follow the NHSE/I contract payment guidance 6. Currently no guidance on financial regime beyond 30 Sep 21 as national guidance has yet to be issued. Consequently, financial planning for the full financial year is not possible.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monitoring expenditure and income against budgets via Finance Calculation of forecast position for the H1 financial period for comparison against budgets - monthly Covid allocation to recover directly related costs Bed Management Meetings – daily Performance Management Review meetings – monthly Executive review of financial position – monthly NHSI/E review of financial position on a regular basis HCP review of system-wide financial position – monthly **Level 2** Integrated Performance Report – monthly review by Business Performance Committee Integrated Performance Report – review by Trust Board each meeting	1. Budgetary control process not accurate for comparison purposes as no formal plan approved for 20/21 and plan for H1 2021/22 based on average run rates in Q3 2020/21 meaning comparison of budgets is not accurate 2. Financial Framework suspension means Trust not being managed via regulator directly but through system / regional approach which is reviewing overall balance; 3. Covid expenditure audit by external party yet to be carried out so unsure if any expenditure will need to be repaid; 4. Covid cost allocation insufficient to cover actual costs incurred.

Financial Plan Five year financial planning exercise being undertaken, in collaboration with Operational teams, despite lack of national guidance beyond September 2021 **Level 3** Internal Audit review of Accounts Payable – Substantial Assurance Jan 2021 Internal Audit review of Accounts Receivable – High Assurance – Jan 2021 Treasury Management Review – High Assurance –Jan 2021 Internal Audit review of General Ledger – High Assurance Jan 2021 Internal Audit review of Budgetary control (including CIP) – high assurance - Jan 2021 Internal Audit review of financial reporting – High Assurance – April 2020 ESR Payroll – Substantial Assurance – April 2019 GIRFT Review – Spinal Contract Review Meetings with Commissioners – bi-monthly Internal Audit review of coding systems – Substantial assurance – Dec 19	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Bi-monthly update to Finance NED to ensure NEDs are kept up to date with latest finance requirements	DoF	March 2022 - ongoing	On track
2	~~DoF on HCP planning group weekly calls~~ **Weekly feedback from the HCP FARG on the direction of travel for HCP finances.**	DoF	March 2022 - ongoing	On track
3	Raising issues with non-English commissioners to NHSI/E	DoF	March 2022 - ongoing	On track

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Compliance with education contract and operational delivery of undergraduate and postgraduate clinical placement outcomes **including**: • Supervision • Teaching • Site infrastructure **Robust i**nternal educational governance, **effective** succession planning and support for educators and learners. **Medical learner experience and progression hindered – impact on Trust reputation, staff morale and attractiveness to recruit highest caliber medics.**	• Difficulties experienced during the 2020/21 academic year recruiting to undergraduate supervisor roles. ~~Approx 24 consultants signed up as supervisors for 4th year programme but just 10 have committed thus far. Reasons for withdrawing include not having activity within current job plan as well as post-covid service pressures~~ • Postgrad supervisors also drawn from same supervisor 'pool', exacerbating demand on a limited consultant resource • Challenge **experienced** responding to rapid changes in teaching delivery / accessing external platforms and databases e.g. university Zoom teaching. **Ability to facilitate remote** ~~Facilitating~~ student access to clinical activity. ~~remotely.~~ WiFi strength • **Perception can be** ~~A perception that~~ education is an additional~~l~~ rather than integral activity, can make educator roles less attractive and is a lost opportunity to develop potential education leaders. • **Trainee doctor feedback has suggested education progression for 'SHO' grades can be perceived to be limited and therefore WCFT placements educationally unfulfilling.**

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Established Medical Education Committee and clear reporting line to the Board of Directors 2. Lead educator roles established with DME engagement with regard to recruitment, job descriptions reviewed prior to new appointments 3. Medical Undergraduate Working Group is active and meets at least bi-monthly, more frequently when planning for the new academic year. Clinical Sub-Dean actively engaging with consultant body to raise awareness and encourage support 4. Established leadership roles for registrars within Undergraduate and Postgraduate education programmes 5. Teaching and education programmes are now streamed. 6. SOPs have been created to standardize and assure processes. 7. **Delivery of education has been consolidated with new roles including two education fellows at a junior doctor grade and six named lead educator roles for consultants (August 2021)** 8. **SPA has been allocated for UG educational supervision to ensure consultants who perform this role are formally recognized and remunerated through job planned activities (July 2021)** 9. **Educational Supervisor guidance based on GMC trainer standards and UoL placement expectations has been issued to relevant consultants and shared with Directorate managers to support job planning discussions (August 2021)** 10. **Joint working between Neurology postgraduate education leads to address junior doctor experience / progression concerns and modify practical and clinical exposure.**	~~1. Ensuring educator roles are fully understood along with commitment required, activity has transformed over past 5 years, SOP / definition of role expectations to provide transparency for trust and individual~~ ~~2. Silo working - communication between postgrad and undergrad in regard to available resource, are expectations to be a joint supervisor realistic?~~ ~~3. Will a template of an optimal week be adequate to help inform / support supervisors during job planning process or is more robust 'intervention' needed? No routine auditing cycle of SOPs.~~ 1. **New UG roles are untested** 2. **Educator support under development including educational appraisal** 3. **No routine auditing cycle of SOPs** 4. **Silo working - communication between postgrad and undergrad in regard to available resource**

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 • Medical Education Committee **minutes** • Medical Education overarching Action Plan • Medical Undergraduate Working Group **minutes** • Junior Doctor Forum (held alongside Guardian of Safe Working) • End of Placement Feedback – Undergraduate • Placement Exit Survey – Postgraduate **Level 2**	1. Medical Education Committee now reports to RIME and will provide quarterly performance updates as well as an annual report of activity as a means to assure the Board of activity and performance against the HEE Quality Framework. This is a new relationship and the effectiveness will be evaluated over the next year.

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

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	**Creation of new SPA funded enhanced education roles, including recognition for UG supervision to support DME/Clinical Sub Dean with education delivery. Effectiveness of new roles to be reviewed after 12 months.**	**DME**	**July 2022**	**On track**
2	**Creation of document – Guidance for Educational Supervisors sets expectations for role and responsibility**	**DME**	**August 2021**	**Complete**
3	**RIME work plan reviewed with consideration of Medical Education contribution to the Committee**	**DoW**	**Ongoing**	**On track**
4	**Medical Education SOPs to be reviewed/ratified by Director of Medical Education/relevant groups**	**DME**	**Ongoing**	**On track**
5	**Educational Appraisal is a new role as part of the enhanced education roles created summer 2021, will support improved educator support**	**DME**	**Ongoing**	**On track**
6	**Education Fellows are helping the admin team overcome silo working with practical support to ensure equitable allocation of clinical experiences for Ug and Pg learners. Success to be evaluated via student and junior doctor satisfaction surveys**	**DME / Clinical Education Fellows**	**May 2022**	**On track**

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

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Potential deterioration of the Trust's financial position through commissioning / tariff changes; - Loss of decision making responsibilities as move to system based financial targets; - Working with different tariff systems (Wales and Isle of Man); - Loss of key relationships in commissioning to Trust.	Recent NHSI/E consultation shows that there will be a move to system working Tariff consultation also requested feedback on changes to both tariff and the move to population based funding. Lack of clarity around financial regime beyond September 2021 (block funding has remained in place for Apr-Sep 2021)

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Trust engagement on C&M HCP meetings. 2. Existing relationships with Specialised Commissioning through the transitional period. 3. Trust has fed back on consultation to changes on tariffs / population based commissioning. 4. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) on this agenda. ~~5. DoF currently a member of the weekly HCP finance planning group so able to raise issues and get an understanding of direction of travel in relation to HCP position.~~ ~~6. CEO is part of in hospital cell which is likely to be influential in the Provider Alliance which constitutes part of the HCP structure.~~ ~~7.~~ **DoF currently a member of the FoSH Finance Group which is reviewing impact of the new financial framework on the system for specialist providers and engaging with the wider system on potential changes.**	1. Move to system allocations via HCP puts trust at risk as no longer dealing with commissioners who have detailed knowledge of trust services. 2. Larger acute trusts with underlying structural deficits may have a bigger influence with**in the** HCP in terms of funding allocations. 3. Some of Walton Centre patient population lies outside C&M HCP and therefore does not align with population basis for commissioning / funding allocations. 4. Trust basis for funding based on historical local tariffs recognising disproportionate costs of delivery may not be taken into account for services leaving trust with financial gap. 5. Affordability given the C&M system already has a large deficit historically meaning that the Trust may having to take a proportion of this deficit. 6. Governance around the provider model and how this fits in with the wider HCP financial system delivery, especially around some timescales required for delivery of financial returns (and incompatibility with Board / Committee meetings) 7. Lack of clarity on future financial framework beyond 30 September 2021. Lack of longer term financial planning creates further uncertainty for the Trust.

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Regular review of risks at Board level and on-going review of mitigations. **Level 2** Risk being reviewed across several organisations and also by FoSH so potential to influence the agenda. Transitional period in 2021/22 will ensure that financials will be broadly in line with current regime for a year until full implementation of population based commissioning. c75% of current referrals within the current HCP boundary with 12% outside so not as fragmented population base for referrals given the size of C&M HCP (the rest are Wales / IOM) which limits though does not eliminate financial risk. **Trust engaging on the collation of a 5 year plan with specialist trusts in C&M to understand what the longer term finances look like for each of the trusts.** **Level 3**	1. Move from existing regulatory relationship with NHSI/E and commissioning relationships with NHSE, Specialised Commissioning to single relationship with HCP and how this will work. 2. Post transitional period finances i.e. population based commissioning will still leave a potential c12%+ income at risk if they no longer are commissioned from Trust. 3. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR.

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with HCP on system development. Previously responded on consultation, fed back on Memorandum of Understanding. Separately also fed back to NHSI/E on tariff consultation.	ALL	On-going	On track
2	Meeting planned with HCP DoF and Specialist Trust DoFs to show how specialist trusts can support the system in terms of finance and activity restoration etc.	DoF	On-going	On track
3	Review of out of HCP referrals / activity to understand the largest CCG's and formulate what can be done to continue activity into 2022/23 with the Trust.	DoF	~~Mar 21~~ Sep 21	On track
4	Continue to work with FoSH around a national response on how specialised trusts will benefit the new way of system working.	CEO/DoF	On-going	On track
5	Continue to provide mutual aid during the pandemic response to enhance reputation as a system player.	DOO/CEO/MD	On-going	On track
6	Prepare internal 5-year financial plan based on anticipated changes to tariff to understand longer term financial risks for the Trust and support strategic planning.	DoF / DoSO	Sep 21	On track

Covid risk register - Date report produced: 27.09.2021

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
797	13/07/2020	Risk Assessment	**If controls are not put into place to prevent surgical face masks being used for self-harm attempts of suicide, there is a risk to patient safety.**	Catastrophic	Unlikely	Mod 10	1. Patients monitored and observed closely. 2. Any concerns escalated appropriately. 3. Neuropsychiatry and Neuropsychology input when required 4. Masks only used within clinical areas.	1. No gaps in controls, storage space to be provided for surgical masks to ensure they are placed in a safe storage area.	1. No incidents to date June 2021. 2. Neuropsychiatry service monitored and manages any risk identified.	1. Patients may not express suicidal tendencies.	1. None currently identified	25/10/2021	Neuropsychiatry Advanced Nurse Practitioner
793	07/07/2020	Business Continuity	**If increased cancellations, capacity/demand and limitations on the number of patient visitors continue, due to Covid-19, then there is a risk of poor patient experience and outcomes.**	Moderate	Likely	Mod 12	1. Divisions working towards getting back to normal activity - via telephone/video consultations in order of patient need. 2. New telephone line in PACs recording calls. 3. Any identified themes and trends are escalated to Deputy Director of Nursing and Governance and Director of Nursing and Governance. 4. Patients receive regular updates and communication from the division. 5. Visiting continues to be restricted due to the increased levels of Covid 19 across Cheshire and Merseyside 6. Recovery plan now commenced alongside the Walton Centre Roadmap	1. As this is a new risks there are currently no identified gaps. Will continue to monitor.	1. Patient Experience Team escalating all new concerns/complaints on a weekly basis in a weekly meeting with both Divisions. 2.Regular communication with patients and families from the Division. 3. Calls to loved ones campaign initiated by the Divisional Nurse Directors using Ipads, mobile phones and social media.	1.Will continue to monitor for gaps in assurance, currently none.	1. None currently identified.	20/10/2021	Deputy Director of Nursing & Governance
813	15/10/2020	Business Continuity	**If the Walton centre is required to support the C&M system with capacity there are several associated risks including training and development – staff may not be experienced in caring for and managing different conditions. Neuroscience patients will have reduced access to services and will wait longer.**	Major	Possible	Mod 12	1.Support system decision making ensuring clinical outcomes are taken into account 2.TWC CEO is part of the hospital cell 3.TWC MD participates in a weekly call 4.TWC director of operations supports all regional calls 5.Phase 3 plans submitted. 6. TWC is currently working in partnership with Cheshire and Merseyside to implement the recovery plan.	1. Overall decision making is made at a system level	1. Commissions aware of TWC clinical decision making and current waiting list size they are supportive are continuing with elective activity Discussions taking place with LUFT about available capacity that would support the system with minimal impact on neurological patients.	1. None currently identified.	1. Currently none identified	30/10/2021	Interim Chief Operating Officer

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
796	13/07/2020	Business Continuity	**If nosocomial Covid 19 infections (hospital acquired) are not identified and contained, then patients and staff will be at increased risk of getting Covid 19.**	Moderate	Likely	Mod 12	1.Implementation of national guidance to reduce nosocomial infections 2. COVID-19 screening regime 3. Infection Prevention Policies and SOPs. 4. Daily updates via safety huddle and communication bulletin 5. Compliance with Operating framework for urgent and planned services within hospitals 6. Chavasse is designated RED ward 7. SBARs and action plan 8. Observations of PPE 9. All staff offered Covid-19 vaccine 10. Lamp testing available to all staff 11. Roll out of vaccination programme 88% of staff	1. Potential for asymptomatic Covid-19 positive patients to be admitted to trust 2. Non compliance with IPC control measures. 3. Communication process between transferring organisations 4. Core group of staff may not access vaccine/Lamp testing 5. Uptake of LAMP testing sub optimal in clinical staff 6. Cohorting of Green and amber pathway patients on Sherrington	4. Covid-19 BAF 5. Covid-19 dashboard 1. SITREP to NHSE/I 2. Surveillance outcomes 3. Screening programme	1.Non compliance with IPC interventions as per guidance 2.potential of importing COVID-19 cases from the community 3. Delay in transferring symptomatic patients to Chavasse	1.Outbreak meeting held daily as required. 2.Rescreening of patients then repeat screening in 5 days then at 14 days to enhance detectability. 3.Enhanced staff and patient screening 4.Admitted patients must be symptomatic or positive to move onto Chavasse ward (reinstate Chavasse as the red status ward). Symptomatic patients to remain in amber bay 5. Staff breaks reviewed to enable social distancing 6.Ensure enhance cleaning is completed (2 stage process) 7.Daily meeting to be held in the boardroom 9am (1/2 hour) – bed managers to maintain ward patient status on the wall. 8. Continue to liaise with PHE 9. Ensure 2 metre guidance is adhered to. 10. Trust research leads are working to encompass activities within the Liverpool Biomedical Research Centre to address risks (although the precise studies to be undertaken are not yet specified).	29/10/2021	Lead Nurse for Infection Prevention & Tissue Viability
783	05/05/2020	Business Continuity	**If the Covid-19 pandemic continues for an extended period, then there is a risk to staff safety following evidence indicating Black, Asian and Minority Ethnic (BAME) communities are disproportionately affected by Covid-19.**	Major	Possible	Mod 12	1. Staff will be advised to follow guidance on shielding as and when appropriate. These employees cannot remain in work during this time, but if well, may wish to explore home working. 2. Adjustments to working practices may include working remotely or moving to a lower risk area. 3. Actions to be taken for staff will depend upon their medical condition and how stable it is. 4. Where a condition is unstable and there may be an increased risk to staff, Managers may seek support from the Occupational Health & Wellbeing Team and/or HR. 5. Staff redeployed or working from home will be fully supported in completing their role. 6.BAME staff have been offered access to the vaccine as a priority. 7. BAME staff will be prioritised for any future booster campaign	1. Currently no gaps in controls	1.Risk Assessment Guidance - COVID-19 made available via communications to staff. 2. All BAME staff have received an individual letter with a risk assessment attached asking them to discuss with their manager. 3. All managers have been asked to ensure they proactively speak to all of their BAME and vulnerable staff to complete a risk assessment 4. Decisions about possible redeployment, special leave, working from home will be agreed with the individual based on the results from the risk assessment. 5. monitor uptake of vaccine.	1. The possibilities of remote working for clinical staff are reducing . Opportunities for redeployment to a lower risk area are reducing.	1. Risk Assessments for all vulnerable staff are now completed . Actions taken for individual staff will depend upon the outcome from the risk assessment. Risk assessments reviewed and updated for shielding staff returning to site.	30/10/2021	Deputy Director of Workforce & Innovation
775	20/04/2020	Business Continuity	**If safe staffing levels are unable to be maintained as a result of Covid 19, then there is a risk to patient care.**	Moderate	Unlikely	Mod 6	1.Specialist Nurses working on wards as appropriate 2.Other clinical staff supporting ward areas i.e. Radiographers, Neurophysiologists, Therapists when required. 3.Admin staff redeployed where possible, register of staff who can support the wards held centrally. 4. Working closely with NHSP. 6.Staffing reviewed through staffing meeting daily	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness or may need to return to their own areas of work 2. As the Neuroscience Laboratories Department is specialist department, there is no-one else to cover for our staff should levels be severely depleted.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Work with NHSP to ensure gaps are covered.	1. Being able to manage absences across the organisation. External factors i.e. no summer school clubs for child care	1.Daily Huddle. 2. Daily review of staffing. Redeployment register held centrally. 3.Absence management continues 4. Local and National Health and Well being programme of support in place. 5.Daily communications to staff. 6. Risk assessments to be reviewed for all staff on a regular basis 7. Access to C&M resilience hub	31/10/2021	Deputy Director of Workforce & Innovation

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
773	08/04/2020	Business Continuity	**If supplies of PPE equipment continue to be of short supply nationally, then the Trusts may not have sufficient PPE for staff to treat patients.**	Moderate	Unlikely	Mod 6	1. Trust stock levels are now stable, the Trust has additional reusable PPE and clinical consumables. 2. Nationally this is recognised as an issue. This has resulted in the introduction of a national stock recording and ordering system. 3.Regionally Trusts are working together and ensuring that orders of stocks are being received and distributed. 4. A 'mutual aid' system has been implemented across C&M to enable Trusts to share stock where there are shortages. 5. Daily stock returns (including usage levels) are submitted to NHSE and C&M collaborative. 6. WCFT is also working closely with other Specialist Trusts to ensure that all organisations have equitable share of supplies (e.g. WCFT have received a supply 8833 3M masks from Bridgewater and CWP).	1. Trust dependant on the Department of Health/NHSE for deliveries of PPE and critical consumables. The situation has improved in the past months with daily deliveries of PPE. Daily monitoring of stock levels and usage help identify potential shortages in advance.	1. Deliveries for Covid stock are now reaching the Trust, due to increased availability on a national basis. 2. Head of Procurement and Head of Materials Management are in constant contact with Supply Chain and also wards to ensure that stocks are kept as complete as possible moving to a 'push model' of supply (supplying people who need it). 3. Sufficient stock for the majority of PPE items are now received with other key items being monitored on a daily basis. 4. Daily stock levels (and usage) provided to NHSE and C&M collaborative to ensure that all Trusts have adequate stocks (through a mutual aid scheme). 5. Shortages are raised via NHS England's National Supplier Disruption Service to ensure stocks do not deplete.	1. Central Teams/MOD determine PPE to be delivered by Push, therefore they do not always supply the required PPE. Global shortages for specific PPE with no suitable alternative e.g. FFP3 3M 8833 masks. Lack of freedom to source PPE through local procurement as items will be provided through the national route. PPE shipments will not be guaranteed to support increased activity within the Trust. 2. PPE shipments may not be guaranteed to support increased activity within the Trust.	1. In partnership with other Trusts/Social Care etc., potential to work collectively to develop the local PPE supply chain to mitigate risks (in support of anchor institution objectives).	30/10/2021	Deputy Director of Finance
779	20/04/2020	Business Continuity	**If an increased demand for oxygen supply continues across the Trust (supplied by Aintree University hospital), due to Covid 19, then there is a risk that oxygen supply to patients may be affected.**	Major	Unlikely	Mod 8	1. Liaison with Aintree to keep consumption levels under review. 2. Increased monitoring. 3. Increased deliveries from O2 supplier. 4. clinical and estates co-ordination.	1.Unknown escalation of COVID-19 patients requiring oxygen support 2. Walton Centre dependent upon Aintree Hospital bulk liquid oxygen supply	1. Regular readings taken from back-up oxygen manifold. 2. Feedback from Aintree re:site wide situation and Walton Centre consumption. 3. Predicted calcs undertaken between S Shaw / S Holland & Mike Hill 4. Regular contact between Command and Control, Estates team, Risk team and Anaesthetics team 5. Back up/resilience plan in place 6. Various NHSEI Cas Alerts	1. Aintree Hospital back up plan involves moving Walton Centre onto "older" bulk oxygen supply which is normally reserved for resilience. This may compromise our system resilience options	1. Close communication between Aintree and Walton Centre Estates teams 2. Continual monitoring of VIE and back up supply 3. local agreement with oxygen supplies for top up of VIE and bottle exchange/delivery, as needed 4. Increased maintenance 5. close liaison between clinical and estates teams	30/10/2021	Estates Manager
807	01/10/2020	Business Continuity	**If compliance with the 2 metre social distancing rule is not adhered too, then there is a risk of staff contracting Covid 19.**	Major	Unlikely	Mod 8	1.All staff are provided with appropriate PPE 2.Social distancing is enhanced in all staff rooms 3.Posters and floor markings are in place 4.Patient day rooms are now in use for staff to be able to manage breaks across 2 areas to support with social distancing 5.Staggered break times, 6. Additional staff areas i.e. marque sort to support social distancing during staff break time.	1.Non-compliance with IPC control measures	1.Continuous promotion of IPC guidelines 2.Managers working with the areas to ensure social distancing is maintained 3.Daily safety huddle 4.Daily walkabout to monitor the use of PPE 5. Observational audits by the IPC team. 6. 88% of staff have now been vaccinated.	1.Non-compliance with IPC guideline and social distancing	1.Continue with promotion via daily safety huddle 2.Regular communications reminding staff of PPE guidance 3.Managers to review all of their break areas to ensure they are compliant with social distancing 4. Additional areas that can be used for breaks to be implemented into break areas.	27/10/2021	Deputy Director of Nursing & Governance
774	08/04/2020	Business Continuity	**If staffing levels within the Material Management Team are unable to be maintained, as a result of covid 19, then there is a risk to transfers of supplies to clinical areas and service delivery.**	Major	Unlikely	Mod 8	1. Staff situation is monitored by Acting Head of Procurement and Head of Materials Management on a daily basis to ensure that there are sufficient staff to manage delivery of stocks onto wards and clinical areas. 2. A number of finance staff are also being trained in materials management so that they can cover staff absence if required 3 .Ordering of stocks can be done remotely	1. No gaps in controls	1. Deputy DoF constantly monitoring staff situation and ensuring that staff are trained to support this area	1. Given the high infection rate if a number of cover staff from other departments are also unable to support then this may delay stock put away	1. Continue to expand the pool/resource of staff that are trained to cover with stock put away duties.	28/12/2021	Deputy Director Finance
842	30/03/2021	Business Continuity	**If covid infections continue, then there is a risk that we will not be able to get sufficient stock of shunt valves and monometers. This risk is increased further as a result of Brexit.**	Major	Unlikely	Mod 8	1. Regular stock checks 2. Order stock in plenty of time to allow for delays	1. Staff may forget to order stock when needed	1. ANP to check stock during ward rounds	1. None currently identified.	1. None currently	30/10/2021	Divisional Manager - Neurosurgery

ID	Opened	Source of Risk	Risk	Consequence (current)	Likelihood (current)	Risk level (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Action Plan	Review date	Risk Lead
806	01/10/2020	Business Continuity	**If school children are sent home due to displaying Covid 19 symptoms, parents will need to self-isolate for 14 days and children will need to be swabbed then there is a risk of reduced staffing in all areas of the trust during this period of time.**	Moderate	Possible	Mod 9	1.Systems in place for the swabbing of children including a SOP 2. No children under the age of 2 to be swabbed at the trust 119 to be used for this group of children. 3. Support provided to the management of swabbing arrangements and outpatients department 4. Daily staffing and bed meetings to manage safe staffing. 5. Daily safety huddle and daily command and control. 6. Daily communications 7. Close working with NHSP 8. Close working with the bed management team to ensure we are using bed capacity appropriately 9. Redeploying staff across all areas. 10. Children now have biweekly testing 11. 88% of staff now vaccinated	1. Reliance on bank and agency and redeployment of staff. 2. Dependant on LUHFT for swab results. 3. Shifts not covered low fill rates.	1. Team in place for managing and arranging the swabs and the governance around this 2. SOP in place. 3.Daily safety huddle / command and control.	1. Being able to manage the amount of children sent home from school and the reduction in staffing. 2. Reduced capacity in the lab to process the swabs and delays in results and further delays in getting staff back to work.	1. Continue with daily safety huddle, command and control and bed meetings 2. Working closely with NHSP to see if all staff can be registered on NHSP 3. Ensure SOP is used and staff are compliant 4. Work closely with LUHFT to ensure that the text messaging service is in place	21/10/2021	Deputy Director of Nursing & Governance
810	09/09/2020	Adverse Event /Incident	**If a neurosurgical registrar were to test positive for COVID then there is a risk that the on call system could collapse. This is due to the office space being too small to accommodate social distancing.'**	Moderate	Possible	Mod 9	1. Registrars to wear masks 2. Meetings via MS Teams to minimise face to face attendance 3. Shared desks in secretariat 4. Roll out of the vaccination programme, 88% of staff now vaccinated 5. New Doctors office.	1.Mask wearing during breaks	1. None currently identified.	1. None currently identified.	1. None currently identified.	30/10/2021	Divisional Director of Operations - Neurosurgery
812	15/10/2020	Business Continuity	**If staffing levels decrease, then there is a risk to staff's health and wellbeing and work life balance not being maintained.**	Moderate	Possible	Mod 9	1. Well established health & wellbeing programme 2. Shiny minds resilience app available for staff 3.Closed staff Facebook for mutual support 4.Regional/National helpline 5.Trust 24/7 counselling 6. Mental Health First Aid training has commenced. 7. Access to Cheshire and Merseyside Resilience Hub 8. implementation of NOSS support programme for staff.	1. No face to face support.	1.Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. 2.Work with NHSP to ensure gaps are covered 3.Testing capacity is sufficient to date.	1. Ability to manage absences across the Organisation	1. On line training for Mental Health First Aiders 2. Debriefs to learn lessons 3. Review of health and wellbeing communications 4. Daily safety huddles. 5. Trusts counselling service are providing a number of workshops for frontline staff on site 6. H&W conversations in place	25/10/2021	Deputy Director of Workforce & Innovation
808	01/10/2020	Business Continuity	**Neurology Division - If safe staffing levels are unable to be maintained as a result of COVID 19, then there is a risk to patient care and activity performance within the Neurology division. This includes staff absences due to childcare i.e. children being sent home from school with or without symptoms.**	Moderate	Possible	Mod 9	1. Redeployment of Specialist Nurses working on wards. 2. Identified other clinical staff suitable to work in ward areas i.e. Radiographers, Neurophysiologists, Therapists. 3. Admin staff redeployment where possible, register of staff who can support the wards held centrally 4.Working closely with NHSP. 5. Ward staffing reviewed through daily bed meeting. 6. Testing capacity for household members. 7. Established rotation of working from home practices for key admin staff. 8. Cross Divisional weekly activity performance meeting. 9. Virtual, telephone and face to face outpatient activity in place aligned to phase 3 guidance.	1. Reliance on staff from other areas to support the wards, there is a risk they will be absent due to sickness/childcare responsibilities/self isolation or may need to return to their own areas of work. 2. Outpatient activity ceasing if COVID surge happens, there is a risk the medical and specialist nurses will be needed to increase staffing numbers in ward areas.	1. Staffing has been adequate to date with the measures put in place during the covid 19 pandemic. Wards working with NHSP to ensure gaps are covered 2. Testing capacity is sufficient to date. 3. Weekly monitoring through divisional performance meetings	1. Being able to manage absences across the divisional admin and clinical teams. 2. External factors i.e. school clubs for child care / children being sent home from school.	1. None currently identified .	25/10/2021	Divisional Director of Operations - Neurology

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

Consequence score (severity levels) and examples of descriptors

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

LIKELIHOOD SCORE

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

CONSEQUENCES

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

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

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 07/10/21		**Report of:** Quality Committee
Date of last meeting: 23/09/32		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Medical Director's update • Integrated Performance Report • Quality & Clinical Strategy Progress update • Visibility & Walkabout Quarterly Report • PLACE Report Update • Quarterly Trust Risk Register • Complex Discharge Update • Spinal Cord Stimulation Update • Pharmacy Review on Critical Care • Board Assurance Framework • ACCP (Advanced Critical Care Practitioners) Presentation • Sub-Committees Chairs' reports
2.	**Alert**	• IPR – Ms Salter advised that there had been an incident of whistleblowing to the CQC on Chavasse Ward and that information has been shared with the CQC following engagement with ward staff. No further communication has been received from CQC. The Quality Committee discussed the importance of staff well-being and Ms Salter provided an update of the staff support mechanisms which are in place. • Ms Salter verified that the CQC are undertaking a proactive visit to the Trust on 30/09/21 as part of the IRMER review which looks at Ionising Radiation. The Radiology team have sent all the necessary paperwork that was requested and were commended for their rapid response.
	Assurance	• The Deputy Medical Director advised that the Cranial Neurosurgery GiRFT visit had taken place. The meeting was positive but no formal feedback has been received. It was noted that length of stay was the only area which was slightly higher than other trusts. • IPR – Mr Foy advised there were positive improvements in the RAMI data over the last 12 months. • Walkabouts have continued during Covid-19 with focussed discussions with staff teams on agile working, the impact of Covid 19. Education and updates regarding Lamp testing and vaccinations were also shared. • Pharmacy Review on Critical Care – Ms Riley advised that Pharmacy cover

		for ITC has increased but is not 24/7 cover. However following bench marking, this is in line with other organisations. It was noted that incidents have not increased and have reduced since the pharmacy cover was altered. Mr Lakhani confirmed he is satisfied with the service on ITU and expressed no concerns. The Quality Committee were happy to support this decision. • Mr M Jennings, Advanced Critical Care Practitioner (ACCP) provided a comprehensive presentation explaining the role of ACCPs. The ACCPs support the medical staff establishments and are highly trained (MSC level & specialist training). Significant work has been undertaken to ensure education is provided for the team. It is evident that the team are passionate about their work and that feedback from colleagues is positive.		
	Advise	• IPR - Ms Salter noted that there had been a decrease in FFT scores. In some instances this arose from IT issues within Outpatients/virtual appointments with patients waiting for some time on-line for their appointment to start. Ms Abernethy is investigating the implementation of a virtual assistant to keep patients updated regarding wait times. • IPR – Updates were provided with regards to nurse recruitment. It is envisaged that 40 international nurses will have taken up their places by the end of December. Recruitment and retention remains a focus for teams. It was noted that nurse bank fill rates were a challenge over the summer but teams ensured patient safety. Ms Martin & Ms Fisher are undertaking work with NHSP with regards to fill rates and late cancellations. • IPR – Ms Salter provided an update with regards to HCAI and the extensive work that has been put in place to mitigate further cases. A robust action plan is in place which is being monitored closely by Ms Martin and the IPC team. It was noted that HCAI are on the Board Assurance Framework (BAF) and will be included when the BAF is next presented to Quality Committee. • Quality & Clinical Strategy – Ms Salter advised that 3 priorities for each element are to be identified and taken to the Quality Committee in October for sign off whilst awaiting the Trust strategy to be written and ratified. • PLACE report – the PLACE inspections were suspended last year due to Covid 19. A new process is being launched with regards to PLACE this year. In the meantime a PLACE 'lite' is being undertaken in the autumn.		
2.	Risks Identified	• Trust Risk Register – New Risk 869 regarding Moving & Handling. Ms Salter noted that a new Health & Safety Manager is due to commence in post next week and that another Trust will support with Moving & Handling in addition to the Health & Safety Manager. Ms Salter met with Prof. Thakkar who raised concerns with regards to the lack of actions for this risk and was satisfied that the Trust were addressing the risks appropriately.		
3.	Report Compiled by	Seth Crofts Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 07/10/21		**Report of:** Business Performance Committee
Date of last meeting: 28/09/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Elective Recovery Fund (ERF) Thresholds update • Integrated Performance Report • Transformation & QIP Exception Report • Digital Aspirant Programme Financial Plan 2021-22 • Digital Aspirant Business Cases • Communication, Marketing & Commercial Update • Winter Plan • Terms of Reference – People Group and Transformation Board • Chair's Reports from 5 Sub committees
2.	**Alert**	• The Committee reviewed the Integrated Performance Report, which detailed performance in August 2021, and noted that performance for Elective activity in month had been just 66.03% against the target of 95%. The Committee was advised that the deterioration in performance was associated with staffing levels in Theatres due to a combination of annual leave and sickness absences. The Interim Chief Operating Officer (COO) briefed the Committee on actions taken to improve performance which included daily performance meetings and the setting of stretch targets. The Interim COO advised that there had been a significant improvement in performance in September 2021 with performance of circa 81% at the date of the meeting. Board members should note the consequent impact on income from the Elective Recovery Fund as a result of this under-performance. • On a more positive note, the Committee noted excellent performance against the Diagnostic 6-week Standard with zero breaches in month and consequent 0% performance against the 1% target. The Trust also achieved 100% performance in August 2021 against each of the four Cancer Standards.
3.	**Assurance**	• Mr B Davies, Service Improvement & Transformation Lead, joined the meeting to report progress with the Transformation projects and the Trust's Quality Improvement Programme (QIP). The Committee took positive assurance from the report with projects related to Patient Flow, Outpatients and E-roster roll out

		all currently Green-rated. The Committee also noted that the Trust was expected to achieve the H1 QIP target by 30 September 2021. • The Committee also took positive assurance from a report on progress against the Digital Aspirant Programme which was presented by Mr J Griffiths, Head of IM&T. The Committee was advised that the overall confidence level of the Programme for the reporting period February – August 2021 was Green-rated, with each of the core elements also green-rated. In considering the report, the Committee noted the importance of effective procurement planning, in the context of a worldwide shortage of semi-conductor devices, and was assured by Mr Griffiths that plans were in place to mitigate this risk. • The Committee reviewed the 8 principal risks in the Board Assurance Framework (BAF) where BPC is identified as the Assurance Committee and endorsed the amendments to BAF entries proposed by the relevant Lead Executives. The Committee queried a proposed reduction in the risk score for Risk ID 002, which relates to operational performance, in the context of performance on elective activity and the Interim COO provided assurance that the reduction was justified given the controls in place and Trust performance in comparison with wider system performance. With regard to Risk ID 013, Financial Plan, the Committee was advised by the Chief Finance Officer that uncertainty around H2 planning requirements may necessitate an increase in the risk score for Quarter 3. The Committee agreed that this should be brought to the attention of the Board during consideration of the BAF on 7 October 2021.
4.	**Advise**	• The Committee considered and approved a number of Business Cases relating to the Digital Aspirant Programme. The Business Cases were: o Datacentre Replacement o Main build LAN Upgrade o Wireless Lan Upgrade o Ward Hardware Refresh o Bed Management Upgrade o Clinical Locations Hardware Refresh The value of all the above Business Cases were within the Committee's delegated financial limits and approval was subject to clarification of associated capital charges. • The Committee reviewed a Communications, Marketing and Commercial Update report which was presented by Dr A Rose, Head of Commercial Engagement & Marketing, and Ms E Parr, Communications & Marketing Manager. The Committee noted a range of positive developments in each of these areas and acknowledged the need for a Commercial Strategy and updated Communications & Engagement Strategy to be developed as work on the refresh of the Trust Strategy is progressed.

		• The Committee reviewed a report from the Interim COO which provided an overview of the Trust's Winter Plan 2021/22 and detailed arrangements in relation to; Influenza / Covid-19 vaccination programmes, Managing Capacity & Demand and Escalation Plans. The Committee noted the likelihood of the Trust's participation in mutual aid support through the Critical Care Network and Rapid Access to Neurology Assessment (RANA) programmes. The Trust's internal Winter Plan will contribute to the system winter plan which is coordinated by the North Merseyside & Southport A&E Delivery Board. • The Committee reviewed a report detailing compliance against the Emergency Planning Resilience & Response (EPRR) Core Standards in advance of submission for regional review on 1 October 2021. While the report identified a non-compliant position against 1 of the 38 standards, the Committee was advised by the Interim COO that the non-compliant position had been addressed subsequent to preparation of the report. The final Statement of Compliance will be presented to the Board of Directors for approval on 4 November 2021. • The Committee reviewed and approved Terms of Reference for the People Group and the Transformation Programme Board.		
5.	Risks Identified			
6.	Report Compiled by	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary